Draft Report - ICON - Integrated Care One - Phase 3 of Programme

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“I KNOW THAT IF PEOPLE EXPERIENCE THE BENEFITS OF TEAM WORKING FOR THEMSELVES AND PATIENTS, THEY WILL WONDER WHY THEY EVER WORKED IN ANY OTHER WAY.”

Professor Brendan Drumm

Chief Executive Officer

Health Service Executive

Health Matters Newsletter September 2005

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1 EXECUTIVE SUMMARY

1.1 Introduction

1.1.1 The Health Service Executive Midland Area (HSE MA) formerly the Midland Health Board (MHB) has been investing in improving the way that primary, community and continuing care services are provided for the benefit of local people. The programme is to improve the coordination and integration of services and is known as the ICON programme (Integrated Care One Network). This paper reports on Phase 3 of the programme. This report describes the lead up and background in Phase 1 and 2, the process and outcome of Phase 3 and makes recommendations for Phase 4.

1.2 Context

1.2.1 The national and international context for this programme is the priority being given to integrating care. ICON is unique amongst international programmes in that it provides a structured approach to facilitating integrated care, has been developed by the staff, service users and associated agencies and involves a wide range of clients and services across the whole organisation.

1.3 Background - Phases 1 and 2

1.3.1 Phase 1 of the programme took place from January 2003 to June 2003 and focused on the design and development of a model of care.

1.3.2 Phase 2 of the programme was from September 2003 to June 2004 and was designed to develop the model further by testing the model with two teams which had been identified by the Steering Group:

- Primary Care Team for Portarlington
- Early Intervention Team for Children with Developmental Delay in Mullingar.

1.3.3 The ICON Project Team worked with the teams to develop the way they delivered their service with a structured system that facilitated integrated care. A priority issue was advising professionals how they managed the sharing of patient information with team members whilst preserving professional standards and confidentiality. The ICON project team in collaboration with the teams and the Office of the Data Protection Commission developed an Information Sharing Framework which was used as a guide for developing local protocols. The teams also wanted to improve the way that patients came into the service and how their needs were assessed. This led to work on simplifying and standardising referral procedures, and agreeing a common assessment process. This phase also focused on supporting tasks such as drawing up a specification for Information Communication Technology (ICT) to facilitate this way of working. A Measurement Tool based on Microsoft Access was designed by the Project Team in conjunction with a Software specialist company to measure levels of integration both at team & client level. The importance of working with all those who have a stake in the service was recognised, and in particular patients and clients. A Strategic Framework for Stakeholder Engagement was drafted in collaboration and cooperation with the Phase 2 teams. The evaluation of Phases 1 and 2 were applied in the design of Phase 3.

1.4 Phase 3 – Design

1.4.1 Phase 3 of the programme was from November 2004 to June 2005. This report describes the programme that supported the implementation of ICON.

1.4.2 The overarching objectives of Phase 3 were to:

- Further develop integrated working across the organisation to the benefit of the patient, the staff, the service and the organisation
- Widen the experience of working in an integrated way across the organisation, so that the benefits and challenges of working in this way could be tested across a wide range of services and situations.

1.4.3 Phase 3 had four main strands:

- Supporting Implementation Teams
- Research and Development,
- Information Communication and Technology (ICT)
- Governance

1.4.4 These four strands were addressed as priorities from the recommendations in the Phase I and 2 reports. The phase has been evaluated on an ongoing basis and the outcome of this is incorporated into this report.

1.5 The Implementation Teams

1.5.1 Phase 3 had as its main focus to work with teams, known as implementation sites. These were sponsored by the Steering Group, and were diverse in that they covered a wide range of clients, geographical areas and types of service.

1.5.2 The objectives of working with teams as ICON implementation sites were to:

- widen the experience of working in an integrated way
  - test and develop the model
  - implement the component parts
  - prepare for rolling out integrated care across the organisation.

1.5.3 This was done through:

- supporting teams and team leaders
  - the provision of advice
  - allocation of resources
  - offering training and support
  - inviting team leaders to join monthly Action Learning Sets.

1.5.4 18 teams took an active part in the programme, involving 156 staff.

Figure 1

CLIENT / SERVICE	NO.	TEAMS
Children & Young Adults	4	Early Intervention Teams (2) Le Cheile Young Vulnerable Adults St Hilda's – intellectual disability
Older People	6	Falls Team Respite Care Team Admission & Discharge Nursing home subvention Community Rehabilitation Leg Ulcer
Disability	1	Springfield Centre
Support	2	Aids & Appliances Occupational Health
Mental Health	1	Adult Mental Health
General	4	Primary Care Team (2) Travellers Health (2)

1.5.5 Team leaders led the work to pursue the implementation of the component parts of integration following existing ICON guidelines and protocols. In addition to facilitating the monthly meetings, members of the ICON team visited the teams and provided onsite support and training. Offsite support from the Project Team was available on an ongoing basis. The design of the process encouraged networking across teams, with peer support and mentoring emerging through the process.

1.5.6 The programme involved 156 staff in core teams, and many other individuals in the wider network. The team sizes increased over the programme, particularly with clerical support and social workers, which had been identified as a need. There was also a greater awareness of the wider network. Each of the teams recorded progress in integration, with many developing systems and processes to support this work such as a protocol for sharing information, leaflets and referral pathway.

1.6 Research and Development

1.6.1 The research and development agenda has been part of the ICON programme from the start of the programme. A discussion document on integrated care, which summarised research and good practice, was disseminated at the launch of the programme in Phase 1. Reports on integrated care developments and research findings have been shared throughout the process. The Steering Group has ensured that the evaluation of ICON would be incorporated throughout the process.

1.6.2 The ICON Team became active members of INIC (International Network of Integrated Care. The ICON team committed time and resources in an international context by co-hosting the International Network of Integrated Care conference in Dublin in February, 2005. As co-hosts and organisers of the conference, the HSE Midland Area signalled a strong commitment to the integration agenda, and contributed to raising the profile of integration in Ireland. This endeavour received affirmation from the Minister for Health & Children who opened the conference and referred to the ICON work being a model of good practice and that integration was a high priority in her department as a key objective for service delivery.

1.6.3 Two papers on the progress of the ICON Project in the HSE Midland Area have been published in the Journal of Integrated Care in 2004 and 2005. The ICON programme has been short-listed for the first Health Innovations Award in Ireland which requires demonstration of research and evaluation and transferable learning.

1.6.4 A programme of education and professional development for staff within the HSE MA and also for partners such as staff in Non-Governmental Organisations (NGOs) is being pursued. HSE MA has developed links with the University of Warwick, through the proposal to introduce a Masters Module on integrated care supported by distance learning and also a local academic institution. The National University of Ireland Galway has requested that the ICON Project be included as part of the programme of training for its Diploma in Primary Health Care Management. The ICON programme is also a case study for research as part of a PhD at the University of Warwick.

1.7 Information Communication and Technology

1.7.1 The Information Communication and Technology **(**ICT) agenda was to forge links with the National ICT solution which is currently being developed across Ireland, and to ensure that the specification from the ICON programme is incorporated into the future solution. There was also an objective of preparing staff for the introduction of an ICT solution by implementing interim software (the Measurement Tool) that offered a database and a system of measuring integration at both team and client level. To further achieve this objective, a number of proof of concepts were initiated and under current development.

1.7.2 The ICON Project Team have been a key player in the development of the work to progress and ICT solution for PCCC that facilitates integration this is proceeding in a national context. The work that has been carried out on developing the concept of a digital hospital in the HSE MA, included the principles of ICON. The negotiations with iSoft for a community system are ongoing and this solution will have to have the capacity to address the PCCC requirements. The Measurement Tool has provided an interim solution for teams, which has enabled them to compile databases, measure levels of integration at a team and client level, and have access to protocols and guidelines. Training has been provided to teams throughout Phase 3.

1.8 Governance

1.8.1 In order to pursue the governance agenda, clarification was required from those responsible for planning, managing, implementing and monitoring health and social care services which systems, processes and structures need to be put in place for the programme and for integration to work in the longer term.

1.8.2 Governance of the project has been at three levels

1. Strategic level through the Steering Group of senior managers,
2. Management level with the Line Managers,
3. Operational level with the team leaders and teams.

1.8.3 At all three levels, clarity of reporting and accountability is discussed and the need to incorporate integration principles into new structures and systems addressed.

1.8.4 The Governance section discusses the governance issues for integrated care in respect of corporate and clinical governance for integrated care overall, and for the programme in particular.

1.9 Evaluation

1.9.1 Phase 3 has incorporated evaluation throughout the programme, with all participants being offered an opportunity to contribute their views and suggestions about all aspects of the programme. Evaluations were undertaken throughout the process, and included the Steering Group, Line Managers, Teams, and members of the ICON project team.

1.9.2 The impact of integrated working in respect of the patient experience was represented through illustrative case studies and vignettes. These showed the benefit to patients such as a key worker to help organise their care, less appointments and more appropriate care for them and their families.

1.9.3 The Steering Group members completed questionnaires and recorded their overall approval with progress, and their suggestions for extending the programme to a wider national forum, and having a more comprehensive engagement with service users in the future.

1.9.4 Line Managers were invited to workshops, and evaluations showed that they were beneficial meetings for discussing management challenges and changes that needed to be made in order for them to facilitate their staff working in teams to work in an integrated way.

1.9.5 Team leaders completed evaluation forms at the end of each action learning set, and more fully at the end of the programme. Overall the responses were highly positive. The benefits of being within the programme were felt with regard to

- Motivation,
- Working arrangements
- Benefits to patients and families.

- Team leaders valued being part of the ICON network,
- Attendance at the Action Learning Sets

1.9.6 Team leaders proposed that the following actions would further enhance the implementation of the ICON models

- More preparation for the next phase
- Increased support for teams as a whole,
- A formal appreciation of the time commitment required.

1.9.7 The patient experience was evaluated through case studies and interviews. These illustrated the change in their care with the ICON programme. The simplification of the process and coordination of health professionals improved the efficiency of the arrangements and minimised the number of consultations with patients and clients reducing duplication and increasing efficiency. One of the key observations was the value of involving patients/clients in all levels of the process thus ensuring that care was fully integrated and more patient-centred.

1.9.8 The ICON project team had an assessment of the programme through discussion and appraisals. The project has been under continuous review, and research has been undertaken throughout the process in order to compare and contrast the experience of the programme with other international programmes of integrated care.

1.10 Discussion

1.10.1 The discussion section in this report pulls together the process, outcome and evaluation and appraises the programme overall. The programme has been judged to be successful in meeting its initial objectives. The programme widened the experience of integrated care throughout the organisation, and allowed for the further development of the component parts as identified in the ICON diagrammatic model. The programme allowed for the testing of the model and refinement of aspects of integration. 18 teams have been involved in ICON Phase 3, with team membership growing by 15 staff, from 141 to 156, during the programme. Phase 3 of the ICON programme has helped in raising awareness of the systems and processes that need to be in place in order to support and facilitate integrated working. The team leaders have been working on the "Standard Operation Procedures" and their guidelines, using material and support form the ICON project team. Particular progress has been made in producing leaflets, developing a single file, agreeing an information sharing protocol and adopting outcome measures.

1.10.2 Team members' understanding of the potential for integration increased, and enthusiasm for pursing this agenda gained a momentum, with staff recognising a significant culture change. It was noted that for some of the teams, the changes they were making appeared to be slight initially, but the impact felt was significant. It has also signalled the way to progress integrated care, involving all stakeholders within the team and the network.

1.11 Recommendations

1.11.1 The recommendations are themed into three sections:

- Structure,

- Process
- Evaluation.

1.11.2 The recommendations lead to proposals for Phase 4 of the ICON programme, building on the strengths of Phase 3, and developing areas that now need specific attention. The recommendations also take into account the new structures of the HSE. The report recommends that Phase 4 represents the final phase of the ICON programme, and should be designed to enable integrated care to be adopted into the organisations as a fundamental way of working. In order to achieve this, it is proposed that the Phase 3 teams continue to be supported, and that a new programme of teams is invited to form Phase 4, organised around primary care teams in geographical areas. It is recommended that Phase 4 incorporates a strong training and briefing element, so that the learning is ongoing through a robust education and professional development programme. Phase 4 would run from January 2006 to June 2007, during which time there would be intensive work to extend integrated care throughout the organisation through the PCT networks and additional implementation sites. The ICON team would produce a resource pack, and carry out a series of briefing and training courses for trainers and managers. Therefore by the end of the next phase, it would be possible to consolidate the work and transfer this to the management structure.

1.12 Conclusions

1.12.1 This report concludes with a statement from the Chair of the Steering Group, who states that that good progress has been made in Phase 3 to further integrated care across the organisation for the benefit of patients, staff, the service and the organisation. The objectives set at the beginning of the Phase have been met, and in some cases have exceeded expectations.

1.12.2 Phase 4 should take this further, and with the inclusion of more specific outcome measures, the benefits should be highly demonstrable. The next phase should achieve the objective of the Steering Group, which is *"to make integrated care our way of working."*

2 INTRODUCTION

2.1.1 The Health Services Executive Midland Area (HSE MA) formerly Midland Health Board (MHB), now has been pursuing a programme of integrating care since the autumn of 2002. A Steering Group was established, chaired by the Assistant Chief Executive, and terms of reference agreed. The group was formed with the remit of addressing the problems of fragmentation, lack of coordination and duplication in health and social care services. The extent of these problems had been reinforced through the multiplicity of requests for ICT solutions. Rather than address the information technology issues directly, the Group recognised the need for a fundamental review of service delivery, planning and management. The Group wanted an inclusive and "bottom-up" process to be undertaken with respect to ways of improving the way that services worked together for the benefit of the patient. In this respect, the programme was led by the needs of the patient, and designed by those working with clients and patients.

2.1.2 This report describes the first two phases of the programme as an introduction to ICON. The report then describes the work of Phase 3 with the 18 implementation teams. The evaluation of this phase has led to recommendations for Phase 4 of the ICON programme.

2.1.3 The report references supporting documents such as reports, papers, published material and other additional material. The references are coded and have been compiled as a database. This database may then be used as a resource to be accessed through the next phase of the programme. The coding references are listed in Appendix D.

3 CONTEXT

3.1 Introduction

3.1.1 The priority being given to integrated working in the HSE Midland Area is in keeping with the local, national and international agenda for health and social care services.

3.2 International

3.2.1 There is a global phenomenon in health care, and this is the quest for integration. This is a declared national priority for many countries, with the World Health Organisation promoting and funding this area of work[1]. There are significant programmes devoted to integrating care where countries are collaborating, such as through the European Union[2].

3.2.2 A working definition of integrated care has been given by the World Health Organisation[3]. "*Integrated Care is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency".* This definition describes the characteristics of integrated care, and also defines integrated care in terms of its desired outcome. Integrated care covers inter-professional, multi-disciplinary and multi-agency care. Therefore the integration is across professionals and agencies in both health and social services. The integration focuses on primary and community care, although takes into account the whole system.

3.3 National

3.3.1 The Health Service Executive (HSE) in Ireland has given a key reason for the fundamental reform of health services was to ensure that that service users receive the same high quality service, wherever they lived. The new Chief Executive for the HSE, Professor Brendan Drumm, has cited as his top priority as "integrated clinical and administrative teams." He states in his September 2005 newsletter[4] that *"integrating the team-working concept …as a fundamental part of the organisation's culture will be the major challenge."* He describes the current system as cumbersome and inefficient, and states that "*team working should be at the heart of the reform*."

3.3.2 The HSE has stated that integration would be achieved through a strong corporate commitment, devolved decision making, clinical and service governance and effective performance management systems. The HSE has said of the reforms that *"important to the process will be integrated care pathways and care planning."* The HSE records that it recognises that appropriate incentives need to be built into the system to ensure that the objectives are met.

3.3.3 The Primary, Community and Continuing Care (PCCC) Directorate is responsible for the provision of Primary Care as well as community based health and personal social services. These services aim to support, maintain and promote the health and social

[1] Office of Integration for WHO, Barcelona
[2] Fifth Framework Programme funding Procare and CARMEN
[3] WHO European Office of Integrated Care
[4] HSE Health Matters CEO Message Simplifying Access and Delivery (Ref W004)

well-being of individuals and their families. The HSE has recorded that this is achieved through a partnership approach with individuals, families, communities, health and social care providers, including Acute Hospital Services and other statutory, non-statutory, voluntary and community groups to ensure the delivery of person-centered, needs led, integrated services.

3.3.4 The PCCC services are described by the HSE as varied and complex and comprise of a wide range of services including services for older persons, children's services, disability services, mental health services and general practice. The PCCC model is person centred, with the individual service user, their families and their communities will be involved in the planning and design of services in their area. The HSE Director of Primary, Community and Continuing Care has recorded that the establishment of the HSE offered a unique opportunity to address whole system integration, and that that opportunity could not be ignored.

3.3.5 The HSE has stated that effective corporate and service planning are key to the success of the HSE, with the development of business plans with user/community participation. The model for PCCC was informed through mapping current individual service user journeys. This process identified a number of difficulties that clients face in accessing and receiving services. Feedback highlighted that people were *'fitted into an available service rather than the service being customised for their needs'*. It also highlighted multiple points of contact with repeated history taking and a system where the availability of services was dependent on *'your own ability to seek out a service'*. The main message from the staff regarding user journeys was that people want to be involved in their care planning and delivery and want to have local accessible services, delivered by professional staff who work together to make the best use of resources.

3.3.6 The ICT Directorate, which provides information and communications technology services within the Executive, and also to external service providers who provide health and social services, has a focus on enabling integrated, person-centred service delivery though the provision of relevant patient care information and increasing effectiveness, efficiency and economy of ICT operations.

3.3.7 In the HSE National Service Plan 2005[5] the introduction by the Chief Executive Officer states *"Planning for health is not just about health and social services, it is about working with others, in partnership, to improve the overall health of the population. It is also about early interventions, reorientation of services from hospital to primary care, about safe, effective, efficient and integrated care delivered in a timely manner. Planning must also be supported by research and development programmes, by evidenced based decision making and above all by a commitment to respond to the choices and preferences of service users."*

3.3.8 A key objective in the national service plan is to develop an integrated service governance framework for the health services. Another key objective is to enable integrated, person-centred service delivery though the provision of relevant patient care information.

[5] Health Service Executive National Service Plan 2005 (Ref W002)

Figure 2 - National Context

3.3.9 This section has demonstrated that the HSE MA ICON integrated care programme is in alignment with the international and national agenda.

3.3.10 The national and international context for this programme is the priority being given to integrating care. ICON is unique amongst international programmes in that it provides a structured approach to facilitating integrated care, and has been developed in an inclusive way across the organisation across client groups and services.

3.3.11 A statement from Professor Drumm summarises the HSE position.

"I am absolutely confident that with organisation wide team-working, which works very well in many health services in other parts of the world, we will be able to greatly enhance patient care and increase job satisfaction."

4 BACKGROUND

4.1.1 The resources and structure to support this project have included the Steering Group of Senior Managers, a project team of two dedicated staff with administrative support, and external management consultancy, Tribal Secta.

4.1.2 As a preliminary to Phase 1, the Steering Group commissioned a discussion document on integrated care[6] that drew on research and good practice internationally, and provided a reference point for all participants in the programme. The document described models, systems and structures typically in place to support integrated working, and related this to the national context.

4.1.3 Phase 1, from January to June 2003 had three objectives in the formal agreed brief. The first was to develop an integrated care model, which led to the creation of ICON. The second was to identify high level data needs with regard to ICT to support integrated working. Finally the brief was to manage change. The phase incorporated a range of methods to engage with stakeholders, including workshops, questionnaires, interviews and conferences. The process generated enthusiasm, and was distinguished by the fact that it was built on existing good practice, designed on the needs of patients and clients, and was aiming to improve the quality and accessibility of services. The diagrammatic model created of "Integrated Care One Network" showed the component parts of integrated working, and enabled a shared understanding of the definition and elements of integrated care. Once the model was designed, champions emerged from the participants who were prepared to give presentations to other staff and care providers in a programme of roll out that involved over 750 people. The report on this phase[7] provided recommendations for future work to maintain the momentum of change using the ICON model as a structured approach to support multi-disciplinary, multi-agency and inter-professional working.

4.1.4 Phase 2 ran from the autumn 2003 to June 2004 and was used to further develop integrated care utilising the ICON model8.

4.1.5 The objectives of this phase were to further develop a project plan and road map, to finalise the definition, and to test and develop the ICON model with teams, and develop a stakeholder engagement strategy. The Phase also had the objective of developing an ICT specification9, and to develop a framework and protocol for information sharing10.

4.1.6 The five year road map11 was developed based around 8 themes: communication and ICT, collaborative advantage, clinical and social care governance, comprehensive services, clinical, care and support staff, clinical effectiveness, consultation and change management. A project plan with milestones and timescales was agreed as a guide.

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[6] Secta Report to MHB "Integrated Primary and Community Care" December 2002 (Ref D001)
[7] Secta Report to MHB "Developing a Model for Integrated Primary and Community Care in the Midland Health Board" June 2003 (Ref R002)
[8] Secta Report to MHB "ICON Phase 2" May 2004 (Ref D003)
[9] Capita ICT Specification 2004 (Ref D009)
[10] Information Sharing Framework and Protocol 2004 (Ref D016)
[11] Secta MHB 5 Year Road Map – Milestones 051203 (Ref D004)

4.1.7 The Stakeholder Engagement Strategy12 provided principles and guidance on working with all those who have a stake or an interest in the service and also gave tools and a matrix to be used as a self-assessment checklist.

4.1.8 Two implementation sites were nominated by the Steering Group where the model would be tested and developed. They were supported in this phase to develop the components of their care management system. The Primary Care Team in Portarlington was one of the ten national PCT pilots which provides primary care services to a population of 10,000 within its local area. The Early Intervention Team for Children with disabilities aged 0-6 in Mullingar is a specialist service for children, with developmental delay.

4.1.9 These teams agreed their priorities following an assessment by the ICON team. The teams chose to focus on their referral and assessment processes, how they shared information, the potential for a single file, and how to facilitate and support teamworking. The implementation sites provided useful material about the challenges and potential of integrating care and documentation produced provided a framework for future teams. This included Information Sharing Framework and Protocols, "Your Care Record[13]" single file[14], individual care planning[15], and a generic care pathway.[16] The work on care pathways for referrals was helpful in mapping the service connections. A protocol for measuring outcomes was also provided as a guide to teams[17].

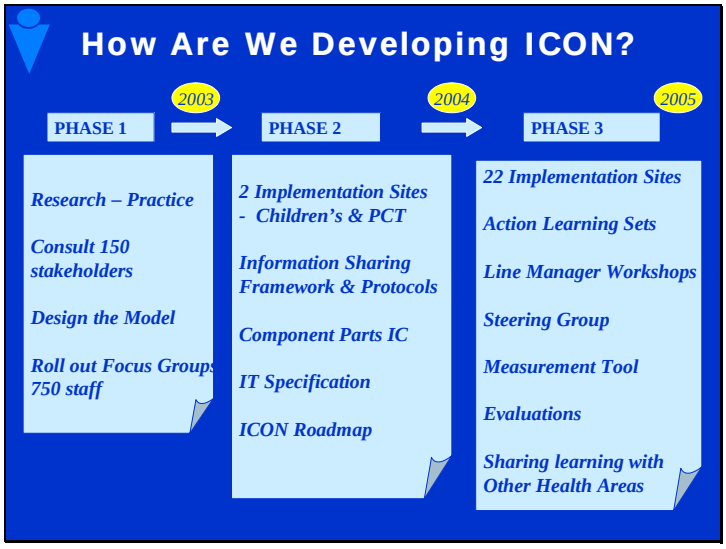
4.1.10 Within this phase an ICT specification for integrating primary and community care was developed in full consultation with staff and stakeholders and is subject to ongoing review and validation in the context of national procurement for an ICT system.

4.1.11 The recommendations in the Phase 2 Secta report included the need to develop an ICON Resource Pack, and to pursue further implementation sites within Phase 3.

[12] Secta Developing a Strategic Framework for Stakeholder Involvement April 2004 (Ref D005)
[13] ICON Information Sharing Protocols and Your Care Records. Ref (D006)
[14] ICON Single File Protocol (Ref D017)
[15] ICON Care Planning Protocol (Ref D018)
[16] ICON Generic Care Pathway. (Ref D007)

[17] ICON Measurement of Outcomes 2004 (D019)

Figure 3 - The 2 Phases of ICON)



5 PHASE 3 DESIGN

5.1.1 The ICON Steering Group reviewed progress on integrated care using findings from the Secta Reports on ICON Phase 1 and 2 in June 2004, and developed a plan for Phase 3 using the evidence from the evaluations to date. A seven point plan[18] was developed by the Project Team on potential steps in the Phase 3 programme, supported by a paper setting out strategic tasks identified in the road map which assisted the planning process.

5.2 Objectives

5.2.1 The programme developed by the Steering Group focused on four key areas of work:

- Teams in implementation sites
- Governance
- ICT
- Education/research.

5.2.2 The overarching objective was to further integrated working across the organisation to the benefit of the patient, the staff, the service and the organisation.

5.2.3 The objectives of working with teams as ICON implementation sites were to widen the experience of working in an integrated way, to test and further develop the model and component parts, and to prepare for rolling out integrated care across the organisation.

5.2.4 The objectives of pursuing the governance agenda was to clarify with those responsible for planning, managing, delivering and monitoring health and care services which systems, processes and structures need to be in place for the programme and for integrated working in the longer term.

5.2.5 The objectives for the ICT agenda were to link with the whole system being developed across Ireland, and ensure that the specification from the ICON programme was incorporated into future solutions. There was also an objective of preparing staff for the introduction of an ICT solution by implementing interim software (the Measurement Tool) that offered a database and system of measuring integration.

5.2.6 The education and research agenda has been part of the ICON programme from the start. The objectives were identified with regard to being part of an international network of integrated care and pursuing a programme of education and professional development for staff. The Steering Group agreed that evaluation of ICON would be incorporated throughout the process.

Design of the Programme

5.2.7 The ICON project team put forward proposals for Phase 3 to focus on working with teams across the organisation, and on testing the model and the structured approach to integrating care. In order to agree the plan and identify teams, senior managers who formed the ICON Steering Group were asked to contribute proposals for sponsoring two teams each at a workshop held in June 2004. The criteria for the teams were

[18] Secta Operational and Strategic Tasks for Phase 3 – A Seven Point Plan. Ref D008

circulated in advance of the meeting, and the implications of becoming an ICON team were presented. The criteria had been drawn up following the learning from Phase 2 teams.

5.2.8 To be an implementation site, some or all of the following ingredients needed to be in place in each team.

- A designated team leader
- Clarity around team membership
- Regular team meetings
- Administrative support
- A designated budget
- Clear line of responsibility
- Delegated authority/empowerment
- Explicit links to service plans and targets.

5.2.9 Infrastructure considerations included:

- Accommodation offering co-location for teams
- Central filing location
- Access to ICT such as PC or laptop
- Network connectivity through email

5.2.10 Although not all teams would have all of this in place, teams that had some of the requirement could potentially maximise the benefits of being included in the ICON programme.

5.2.11 At the Steering Group workshop, all 22 teams were sponsored by a member of the Steering Group. Discussions on suitability with line managers and team leaders took place and issues arising were resolved by the sponsors before the sites came of board. The proposed teams covered a wide geographical area and a range of clinical and non-clinical services.

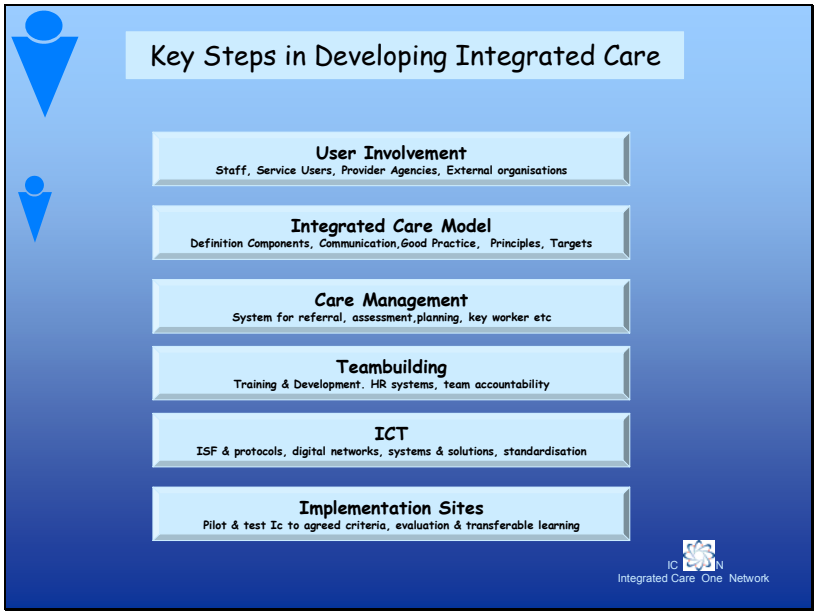
5.2.12 The presentation to the Steering Group[19] which was made as part of the preparation for the start of Phase 3 showed the findings from the work to date, and also a road map which included the key components of integrated care that future teams would be asked to develop. These included opening up the referral process, developing a common assessment, combining records into a single file, care planning, and measuring outcomes. Components also included developing an information sharing protocol, agreeing a strategy for engaging stakeholder and in particular patients and clients, and building up a directory of services. The programme of work would include team-building and addressing issues of HR and planning and would result in the creation of an ICON resource pack. It was noted that teams would give a priority to particular tasks or components within the programme according to their own agendas. Therefore there was not an expectation that teams would tackle all components in this

[19] Presentation Phase 3 Proposals for Teams June 2004 (Ref P001)

phase. The implications of supporting this programme were discussed at the start of the programme.

5.2.13 Once the teams were identified, a calendar of events to cover Phase 3 was drawn up and circulated to all relevant personnel. Workshops were planned with line managers across the organisation in order to prepare for the programme. The objective was to identify solutions for progressing integrated care within the 22 teams in implementation sites as nominated and sponsored by the Steering Group. 44 managers attended over three workshops, and a presentation[20] gave a briefing on the ICON programme and set out six key steps to integrating care; user involvement, integrated care model, care management, teambuilding, ICT and implementation sites.

Figure 4 - Key Steps in Developing Integrated Care)



5.2.14 The 6 key steps to develop integrated care were described as:

- User involvement
- Integrated Care Model
- Care Management
- Teambuilding
- ICT
- Implementation Sites

5.2.15 The outcome from the line managers meeting was a document[21] which identifies what helps and hinders integrated care. An action plan[22] was also created setting out steps that managers could take to facilitate team development and integrated care.

[20] Secta Developing a Structured Approach to Integrated Care September 2004 (Ref P002)
[21] ICON team “What Helps and Hinders” October 2004 (Ref D010)
[22] ICON team “Suggested Action Plan from Line Managers Workshops.” (Ref D011)

5.2.16 A programme of monthly meetings with team leaders were scheduled using an Action Learning Set (ALS) format. This formal method was chosen as it offered an opportunity for professional development of team leaders, and also for creating and sustaining networks across participants. Briefing on Action Learning Sets (ALS) was provided, and ICON team members familiarised themselves with the process in advance of the programme.

5.2.17 The identification of teams through the sponsorship, the briefing of line managers and the preparatory work with the Steering Group set the groundwork for the four elements in the launch of Phase 3.

6 IMPLEMENTATION TEAMS

6.1.1 18 teams in implementation sites which were sponsored by the Steering Group have been supported in the ICON Phase 3 programme from October 2004 to June 2005. Informal support has also been provided for continuity since the end of the programme. 4 sponsored teams have delayed their involvement with the programme.

Figure 5 - The 22 Implementation Sites)

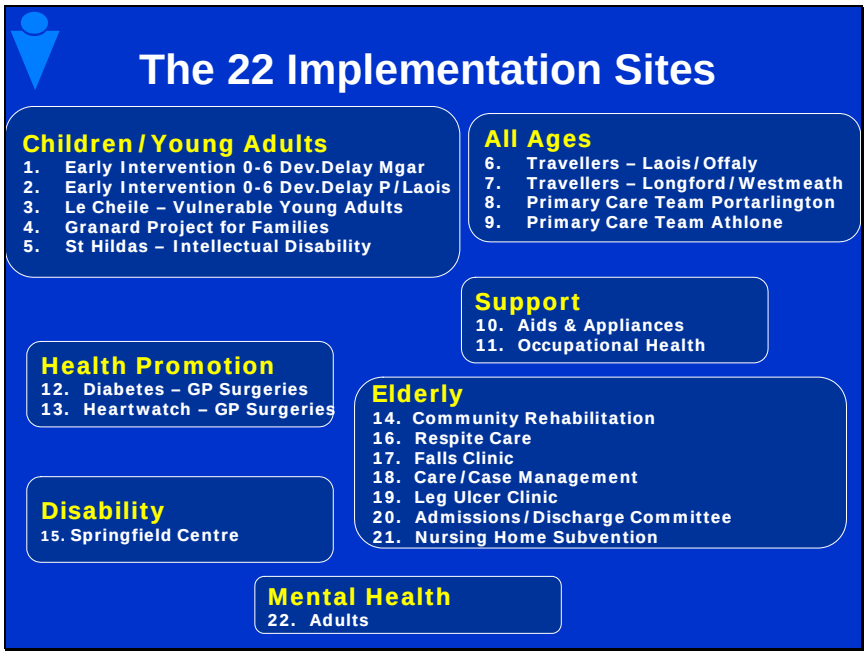


Figure 6

No.	22 TEAMS
A	Children/Young Adults
1	Early Intervention for ages 0-6 with developmental delay – Mullingar
2	Early Intervention for ages 0-6 with developmental delay – Portlaoise
3	Le Cheile – vulnerable young adults
*4**	*Granard project for families*
5	St Hildas – young people with intellectual disability
B	Older People
6	Respite Care

No.	22 TEAMS
7	Falls Clinic
*8**	*Care/case management*
9	Leg ulcer clinic
10	Admission and Discharge committee
11	Nursing Home Subvention
12	Community Rehabilitation Team
C	Disability
13	Springfield Disability Centre
D	Support
14	Aids and Appliances
15	Occupational Health for staff
E	Health Promotion
*16**	*Diabetes – GP surgeries*
*17**	*Heartwatch – GP surgeries*
F	Mental Health
18	Adult services
G	All Ages
19	Travellers – Laois/Offally
20	Travellers – Longford/Westmeath
21	Primary Care Team – Portarlington
22	Primary Care Team – Athlone

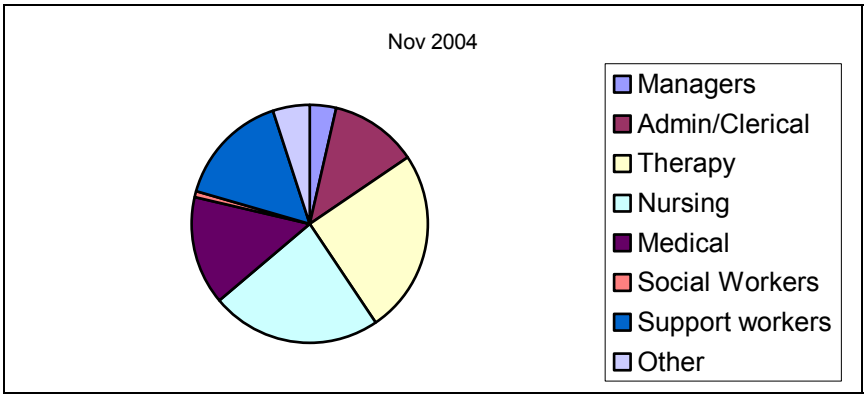
Table: ICON Implementation Teams Phase 3 in 2004/5

(Note those marked with a star have been delayed in participating fully in the programme)

6.1.2 A baseline assessment of the teams and their position on integrated care was carried out at the start of the programme.

6.1.3 This showed that there were 141 in the core teams, and many more staff and individuals that the teams interacted with across the health and social care network. Half the team members were either nurses or therapists.

Figure 7



6.1.4 The baseline assessment asked staff to record the systems that they had in place to support integrated working. These included their referral and assessment systems, care planning and client files. The assessment was repeated at the end of the process in order to track progress. (Appendix B) The ICON project team designed a programme of support for the team leaders that would enable them to introduce systems to support integrated care and also to manage the cultural change required for team working.

6.1.5 The main focus of support for the teams was through monthly Action Learning Sets for team leaders. A briefing paper on the management of Action Learning Sets was prepared as a guide[23]. In addition, ICON project team members have visited each team on several occasions to provide briefings on aspects of integrated care, discuss progress, provide training on the IT system for measuring integration (Measurement Tool), and respond to specific queries and requests.

[23] Secta "Action Learning Set Agreed Process" 2004 (Ref D012)

Figure 8 - How are we supporting implementation sites?

6.1.6 The support to the implementation sites included:

- ICON Project Team
- Phase 2 Team Leaders as mentors
- Sponsors and Line Managers
- Action Learning Sets
- Training and Development
- Measurement Tool
- Standardised Frameworks for Protocols
- Expert Advice

6.2 ICON Programme of ALS

6.2.1 The programme of monthly meetings is shown below. The meeting in February was replaced with attendance at the INIC conference in Dublin.

Date	Team Leader Presentation	ICON Team Presentation	Standard Operating Procedure (or Guide)
October 13th /14th	PCT Portarlington EIT Mullingar	ICON Progress Site Implications Measurement Tool	
November 17th /18th		International Integrated Care Team working and	

Date	Team Leader Presentation	ICON Team Presentation	Standard Operating Procedure (or Guide)
		networking	
January 12th /13th	Travellers Health Community Rehabilitation Team	Analysis of team working training	Information Sharing Framework & Protocol
February 14th & 15th		ICON presentation at INIC Dublin	
March 9th /10th	Admissions & Discharges Springfield Centre	International Network conference	Single File
April 13th /14th	St Hildas Centre for Learning Disabilities	Care Pathways	Care Pathway
May 11th /12th	Occupational Health	Stakeholder Engagement	Care Planning
June 8th	Leg Ulcer Clinic Aids & Appliances	Outcome Measurement	Outcome Measurement
June 9th	All	Evaluation Phase 3 – interim results	Display of Leaflets, SOPs and documentation

6.3 Action Learning Sets

6.3.1 The objective of the Action Learning Sets (ALS) was to *"share the learning on progressing integrated care within the ICON implementation sites, and to develop a support system for the 20 Phase 3 implementation sites and the 2 Phase 2 implementation sites."*

6.3.2 An initial ALS workshop was attended by over 25 participants. Those present were asked what they wanted to get out of being part of the ICON programme, and what they hoped to achieve with respect of benefits for the patient, the staff and the service. Many responded that they would value utilising a database in order to help manage their clinical workload. It was hoped that the Measurement Tool would facilitate this in

advance of the national system being implemented. The presentations at this launch of the ICON programme included an introduction and update on integrated care, the Measurement Tool, and the learning from the first two implementation sites in Phase 2. A plenary discussion on implications and priorities led to the creation of the programme.

6.3.3 It was agreed that the teams would be split into two groups for the purposes of managing the Action Learning Sets (ALS). One group incorporated teams that were concerned with care of older people. The second group was a general group, incorporating clinical and social care services for all ages and also administrative services. It was agreed that sessions would be run on two consecutive days, and that the teams would be brought together in the final learning set. The sessions would run from 9.30am to 1.30pm, with formal presentations and training in the first part of the morning followed by small group work after coffee. The group work would be structured on three key questions: what has been achieved to date with regard to integrated care (or since the last session), what were the plans for the next month, and were there any particular problems or issues that the small group could help with. Action plans for individual team leaders would be agreed at the end of each session. Each member would be given an allotted time to speak without interruption, and each member had a scheduled period of time to share with the group. The management of the learning sets would be that they would be confidential, non-judgemental, constructive and supportive as described in the briefing paper. The process is designed to enable each member to have dedicated time, and to encourage a supportive framework within the group.

6.3.4 The session was formally evaluated. The output from the session was a paper setting out the challenges, opportunities and support needs that participants had identified[24].

Monthly Meetings

6.3.5 The November workshops had presentations on the international context for integrated care, which provided information and resources[25]. Programmes for integrated care such as PROCARE and CARMEN were described, and the ICON programme assessed in this context. The presentation concluded that ICON was unique in its range, its diagrammatic visual representation of integrated care, and the way that the model was developed in an inclusive way. The focus on the international network was a prelude to the planned conference of the International Journal of Integrated Care which was being hosted by the MHB in Dublin, where ICON would be presented.

6.3.6 A second presentation was made on team working and networking, giving definitions and characteristics of teams[26]. This session was to provide a basis for discussion on how best to foster efficient and effective working within and across teams.

6.3.7 A team working training day was held for team leaders in January 2005, in response to the evaluation forms and requests raised in the ALS. The session provided team leaders with experience of using techniques and tools to facilitate team working. Team leaders recorded a high level of satisfaction with the day[27]. When asked whether they were unhappy with any aspect of the day, one participant recorded *"Absolutely not!"*

[24] Action Learning Sets "Challenges, Tasks and Support Needs" Oct 2004 (Ref D013)
[25] International Integrated Care 131204 (Ref P003)
[26] Teamworking and Networking Nov 2004 (Ref P004)
[27] Team working Evaluation January 2005 (Ref E003)

Comments that were made that illustrate the value of the day included: *"Made me think about the skills I have. Gave me tools to identify skills of other team members."*

6.3.8 A general point that was made was consistently, as shown in this quote "*Everybody on the team is important. All need to work together."*

6.3.9 The January workshops followed on from the team-working training. The presentation was analysing the training day, and reflecting on the learning. Presentations were also given by the team leaders for Traveller Health and Community Rehabilitation. These illustrated the importance of building on good practice, and the team effort required in order to achieve the tasks agreed. The workshops also addressed the development of a Standard Operating Procedure (SOP) on Information Sharing, which was led by team leaders who had already undertaken this task. Advice on how to create the document was shared, and help offered.

6.3.10 In the team leader's evaluation of the learning sets to date [28] all team leaders said that the session met their needs, and one participant recorded that *"Learning sets & information from other sites are invaluable."* Another team leader stated that the session enabled them to *"Focus my attention - times and structure in my head where we are going."* The small group work was considered to be particularly valuable*. "Discussing in the learning sets what has been achieved and what to be done. This allows exchange of valuable information."*

6.3.11 In the learning sets in March presentations were given by the Admission and Discharge Team and the Springfield Disability Centre. One of the team leaders led a discussion on how to develop the Standard Operating Procedure (SOP) for a single file. Tribal Secta made a presentation on the learning from the international conference in Dublin.

6.3.12 The presentation for the April set was Care Pathways, and the subsequent discussion led to an agreement that care pathways were a critical tool for managing the interfaces across disciplines, sectors and agencies in the service. However it was concluded that addressing the development of care pathways was an ambitious task, and one which would need wider support than could be offered from the ICON team. Therefore it would be referred to a later phase, and teams would be provided with appropriate guidance and support. The team leader from St Hilda's Centre for Intellectual Disabilities gave a presentation on person-centred planning, which was considered to be applicable for all services.

6.3.13 The May ALS included a presentation on Stakeholder Engagement which focused on the Stakeholder Framework document, and practical tools for assessing and managing the engagement of stakeholders. The group discussed ways to enhance the involvement of service users, and drew particularly on ladder of participation (Arnstein.) The team presentation was from Occupation Health, which described the extent of the team, relationships across the organisation, and the workload which exceeded 6,000 clinic attendances a year.

6.3.14 The June ALS represented the final workshops in the ICON Phase 3 programme. The two groups of teams, (Elderly and General) were joined together for a plenary session for this last workshop which was scheduled over a two day period. Presentations

[28] ALS Evaluation January 2005 (Ref E006)

included one from the Leg Ulcer Clinic and from Aids and Appliances. A presentation on Outcome Measurement was made, and this was used to prompt a discussion on appropriate measures for each team and how to determine patient benefit from a change in practice.

6.4 June Final Workshop – June 2005 "Celebrating Small Steps"

6.4.1 The final workshop was entitled "Celebrating Small Steps", to signify that each team had made progress in furthering integrated care. In some instances although the steps taken may have been considered to be small, the impact had been significant. The last day provided an opportunity to "showcase" the work that had been carried out, and display boards were filled with examples of work completed. This included leaflets on services, referral pathways that mapped the work of the team, consolidated documentation that streamlined versions into a simplified form, improved communication systems with stakeholders, and input from people who use the service all of which are available from the ICON Team.

6.4.2 The team leaders gave a presentation on the work they have done to implement ICON and were supported by having some or all of their team members present at the event. Each team concentrated on three main achievements they had made during the programme. Along with the team members, the audience included line managers and Steering Group Sponsors. The Steering Group Chair congratulated all of the teams involved and acknowledged that the implementation of integrated care is a journey which is best taken in small steps. The event marked the conclusion of the phase, and each team was awarded an ICON Certificate of Achievement.

6.4.3 The team leaders worked with their teams to identify the three key benefits of being in the ICON programme, and presented their findings as described above[29]. Themes emerged and are summarised below.

6.5 Benefits to Patients

6.5.1 The teams stressed the fact that services were now more organised around the patient. *"I feel that staff are working together to help."* The staff also feel that the patients have more information on the services. *"The leaflet is more user-friendly for the client."*

6.5.2 The service provides better continuity and choice. *"The stress is lessened for families"* Access to services has also improved. One patient stated that it is *"easy to get referred to another service – I feel that staff are aware of my needs."*

6.5.3 There is reduced duplication in the service. On team member recorded that *"details that may appear insignificant to the service user do not need to be repeated (such as demographics) This gives the client confidence in the system."*

6.6 Benefits to Staff

6.6.1 The staff have emphasised the improvement in team working stating that there is "improved collaboration between health professionals and staff, and a more efficient use of therapists and other staff members' time." Staff also recorded that there was an

[29] Summary of Presentations to "Celebrating Small Steps" conference June 2005 (Ref: D020)

"improved definition of roles and responsibilities of various professionals which has lead to increased cooperation between these professionals."

6.6.2 Staff in teams have noted the reduction in duplication, such as recording patient details and in the number of separate appointments for patients. "More clinical time for patients" "There is a greater use of resources." Staff note their appreciation of the opportunity to recognise and build on good practice, and to review the services. "Encourages reflective practice"

6.7 General Benefits

6.7.1 The ICON programme enabled staff in 18 teams to relate to each other, and in particular connect through their team leaders through the Action Learning sets. *"The Department is no longer working in isolation."* We now have *"multi-disciplinary working towards a common goal."*

6.7.2 There has been progress made in increasing awareness of person-centred care. *"There is a client focus from the point of receipt of referral to placement."*

6.7.3 The application of the ICON model as a structured approach to integrated care is appreciated. *"ICON is highly visual. Demonstrates how integrated care can improve care to clients."*

6.7.4 Overall, the feedback by team leaders and teams was very positive. An assessment of the evaluations is given in more detail later in this report.

7 RESEARCH AND DEVELOPMENT

7.1 Introduction

7.1.1 The ICON programme has been informed by national and international research, and has been built on an evidence base and good practice. Within the programme there are three key areas where this is being directly addressed: International Conference, Publications and Evaluation, and a Masters Module being made available through academic partners.

7.2 International Conference

7.2.1 The ICON team presented a paper to an annual conference of the International Journal of Integrated Care in Birmingham in February 2004[30] with a supporting paper[31]. Following this the HSE MA (then MHB) offered to host the 2005 conference in Dublin which was accepted. The Health Services Executive hosted this on 14th and 15th February and the event was well attended and considered to be stimulating and informative. The ICON Steering Group made an undertaking to commit resources in terms of management time and finance in order to manage the organisation of the conference. A presentation on progress on ICON was made[32]. A report on the conference and themes emerging from it was prepared by Tribal Secta and shared with the Steering Group and team leaders[33].

7.3 Publications and Evaluation

7.3.1 The ICON programme incorporates evaluation and review on a continual basis, and opportunities have been sought to publish papers in order to disseminate the learning. An article by the ICON project team describing the ICON case study was published by the Journal of Integrated Care in the Spring of 2004[34] and a follow up to this has been published in the Summer of 2005[35].

7.3.2 The ICON project has been incorporated as a case study to a research study for a PhD currently being undertaken by one of the Tribal Secta Consultants, Helen Tucker. It is registered with the University of Warwick. Support in principle for the research and evaluation was given by the Steering Group, and terms agreed with the Assistant Chief Executive and Chair of the Steering Group. Supervision of the research project by Dr Frances Griffiths has provided additional input to the appraisal of the project from an academic perspective. Access to university resources in terms of library resources and recent studies has been beneficial.

7.4 Masters Module

7.4.1 The Steering Group gave a commitment to supporting professional education and development, and building on the learning on integrated care. In keeping with this, the group invited Professor Geoff Meads from the University of Warwick to give advice on

[30] ICON IJIC Birmingham February 2004 (Ref P009)
[31] Developing a Structured Approach to Furthering Integrated Care for the Population of the Midland Health Board, Republic of Ireland (Ref R001)
[32] ICON INIC Dublin February 2005 (Ref P010)
[33] INIC conf February 2005 (Ref P012)
[34] JIC ICON August 2004 (Ref R002)

developing a formal course module on integrated care at Masters Degree level. The notes of the meeting[36] illustrate the decisions that were made in terms of shaping the course objectives, content and management. The presentation to the Steering Group on the 10th January 2005 provided an outline of how the course may be developed and what the course might contain[37]. The slide shows the creation of a specification from HSE MA, which is then further developed with lecturers from the University. The potential content of the modules included concepts and context for integrated care, learning from international experience, models of governance, outcomes, innovation and evaluation. The University of Warwick has submitted the course through its accreditation system, so that when the HSE MA wants to take up this course, it is open to them to do so.[38] Professor Meads advised on the benefit of pursing a local academic partner in addition to distance learning through a University such as Warwick, and this is being pursued. The National University of Ireland Galway has requested that the ICON project be included as part of the programme of training for its Diploma in Primary Health Care Management.

7.5 Health Innovations Award

7.5.1 The first HSE National Award for innovations in health has been launched this year, with awards being made in October 2005. The initial submission[39] resulted in the ICON programme being short-listed to a final of 40 projects. The more detailed submission has been successful[40], and the project has been further shortlisted to a final of 19 submissions. The project has to demonstrate compliance with the 7 criteria listed below. A strong research and evaluation programme, an evidence base, and transferable learning are key features of the ICON programme.

Criteria for Health Innovations Award

- Research/assessment feasibility
- Effective leadership
- Strong planning and coordination of implementation
- Effective management
- Evaluation & improvements to meet stakeholders' needs
- Evidence of success, sustain results
- Potential for replication

7.5.2 The initial application in May 2005 made the case for ICON being an innovation as the extracts from the initial submission and the detailed application illustrate.

7.5.3 "The innovation is the structured approach to furthering integrated care in primary, community and continuing care using an inclusive process which is evidence-based, focused on a diagrammatic model of integration. This approach is novel. No other model in any other country has approached the development of integration on an organisation-wide basis, covering all clients groups, clinical and administration services

[35] JIC ICON March 2005 (Ref R003)
[36] Masters Module Course Design (Ref M001)
[37] Presentation on University Course to Steering Group (P020)
[38] Masters Module University of Warwick (Ref M002)
[39] Health Innovations Award May 2005 (Ref D014)
[40] Health Innovations Award Round 2 July 2005 (Ref D015)

across a wide geographical area. ICON is a structured approach to furthering integrated care, designed and developed in an inclusive way, engaging key stakeholders at each stage."

7.5.4 The submission in July 2005[41] summarised the project in the following way. "The ICON Project has enabled over 130 staff in 22 teams to improve the way that they work together to provide care. ICON has raised awareness of the benefits of integration across the organisation, and provided a culture for innovation and best practice. The ICON model was designed and developed by staff in 2003 as a way to improve integration of care for Primary Community and Continuing Care (PCCC) across disciplines and agencies. Benefits have included improving patient access to services, clarifying referral processes, simplifying assessments, managing care jointly and formalising systems for sharing information. Teams have had support and training from the ICON project team, and a network of support has been established through action learning sets. Patients and carers have expressed an increased confidence in the service. The learning and challenges from ICON are being shared locally, across Ireland and internationally. There is commitment to build on the momentum and progress integration further."

7.5.5 One of the key messages regarding the programme has been *"always keep the client at the centre and respect clinical best practice while challenging custom and practice".*

[41] Health Innovations Award Submission July 2005 (D015)

8 INFORMATION COMMUNICATION TECHNOLOGY

8.1 Introduction

8.1.1 The driver for the review of health and social care services was prompted by the fragmentations in the system brought out through the ICT systems. The many and varied requests for ICT solutions demonstrated that staff were not working in a joined up way. Rather than address this through the technology, the organisation decided to review the services and encourage more coordination and integration through the development of a model of care. As progress was made on joint working, the requirements for integration could be reflected in the specification for an ICT system. ICT would than support and facilitate shared working, rather than dictate the need for it. A specification was developed with full consultation in Phase 2 of the programme, and has been used to inform the work nationally with regard to an ICT solution for acute hospitals as well as PCCC.

8.1.2 This section looks at three key areas for ICT. The first is the Measurement Tool, which was designed by the ICON team as an interim measure for teams. This provides a database, reference guide, and a tool for self assessment of levels of integration at team and client level. This section also looks at the work being carried out on digital networks, as well as the over-aching work on the ICT strategy for PCCC.

8.2 Measurement Tool

8.2.1 As part of the ICON Integrated Care One Network project, there was a need to measure levels of integration at both team and client levels, within the ICON implementation sites. The Measurement Tool developed in Microsoft Access has been designed to support sites in recording their client base along with supporting them in measuring levels of integration within the teams. Within the ICON project there are a number of components to developing integrated working and this tool supports this process with a number of guideline templates based on Microsoft Word which helps teams develop their own suite of guidelines/protocols for their specific areas of service delivery. These document templates are stored within the Measurement Tool folder and are accessible from either within the Measurement Tool application or within Microsoft Word. Templates included are The Information Sharing Protocol, Your Care Record, Single File, Common Assessment, Care Pathway, Outcome Measurement & Care Plan. Other documents include Developing a Strategy for Stakeholder Engagement and the Information Sharing Framework to further support teams. This Measurement Tool does not purport to be an IT solution for Primary Community & Continuing Care.

8.2.2 There are two distinct levels of data capture:

- Team Level
- Individual Client Level

8.2.3 At the Client level data such as demographics, next of kin, and components of integrated care, core, network and agencies involved in the provision of care to the client can be captured. Further information on common assessments, interventions and appliances issued can also be recorded.

8.2.4 The Assessment Team Level details those parties involved in delivering the optimum care based on the requirements from the Patient/Client level assessment.

8.2.5 The system supports the components of the ICON, Integrated Care One Network data gathering process. The database is a menu driven system developed in Access 97 and Access 2000. Data is entered into the system using a series of user forms.

8.2.6 A Reports section is included within the application and this enables the user identify progress being made at both team and client levels along the continuum of integration. The reports clearly demonstrate the number of clients with single files, common assessments etc. The application further supports the identification of staffing shortfalls in service delivery and assists in the management of appliances issued to clients.

8.2.7 A Measurement Tool Manual has been developed and will be available online within the application. Training will be arranged for both Team Leaders & Clerical support and change requests will be managed on a three monthly basis if urgent.

Figure 9 - Measurement Tool Scope

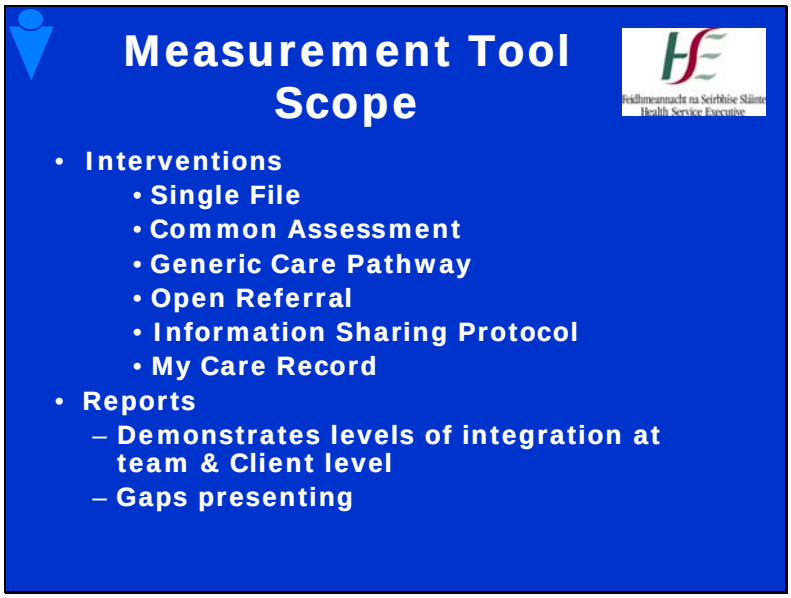
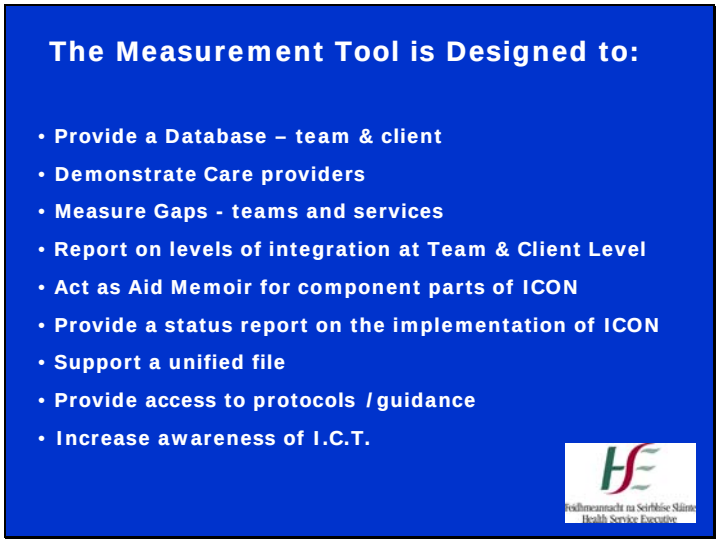


Figure 10 - Measurement Tool Design



8.2.8 The Measurement Tool was designed to:

- Provide a database – team and client
- Demonstrate care providers
- Measure gaps – teams and services
- Report on levels of integration at client and team level
- Act as an aide-memoire for the component parts of ICON
- Provide a status report on the implementation sites of ICON
- Support a unified file
- Provide access to protocols and guidance
- Increase awareness of ICT

8.2.9 The scope of the measurement tool is grouped under two main headings, interventions and reports.

8.2.10 Interventions:

- Single File
- Common Assessment
- Generic Car Pathway
- Open Referral
- Information Sharing Protocol
- My Care Record

8.2.11 Reports:

- Demonstrations of integration at client and team level
- Gaps

8.3 Digital Networks

8.3.1 The report on the digital networks for hospital and community stressed the need for integration of services supported by integrated information systems. The HSE MA (was MHB) took the opportunity of the commissioning of the "newest hospital in the world" to explore the latest technologies to support the whole health and social care service.

8.3.2 "Information is therefore an essential component to the network and the smooth travel of the patient/individual across the system as a whole. The network should facilitate information and care transfer across the piece.[42]"

8.3.3 "To be a successful implementation site for the national reform programme, the Tullamore hospital development needs as a matter of urgency to engage with its local stakeholders to identify the critical levers/priorities for change, to work through the

8.3.4 possible systems and processes to support the change and then to 'test them to destruction', to ensure that they facilitate rather than complicate the care giving process. In particular, local clinicians from across primary, community and acute care need to come together to give guidance on the parameters for an integrated care network and the requisite underlying pathways."

8.3.5 The learning from this exercise has helped in the recognition of the importance of the interfaces across sectors of health care, and the need to be primarily service-driven.

8.4 PCCC ICT Strategy

8.4.1 The vision for the ICT strategy for primary care incorporates integrated working:

8.4.2 "Patients will have access to an integrated care delivery service. This will include access to the right health and social care services when needed, in a convenient and appropriate setting, with access to the right professional. ICT will support, rather than intrude in, the relationship between the individual and professional. Transfer from one professional or organisation to another, when required, will be easy, organisational boundaries will be transparent.[43]"

8.4.3 The four strategy objectives in summary are:

- To provide PCCC care professionals and other staff with access to the information they need to do their jobs as effectively as possible
- To establish appropriate standards for both information and business processes to enable the effective sharing of information to support care delivery;
- To ensure the availability of integrated PCCC information systems to support co-ordinated and integrated service delivery models based around PCTs and other multi-disciplinary teams;
- To build on best practice and learning

[42] Digital Network for the Midland Health Board June 2004 (Ref W004)
[43] ICT Strategy for PCCC (Ref W005)

8.4.4 The strategy considers the requirements for an ICT system architecture and the necessary building blocks. The strategy for ICT PCCC needs to be considered alongside the ICON programme, as each informs the other.

8.5 Summary

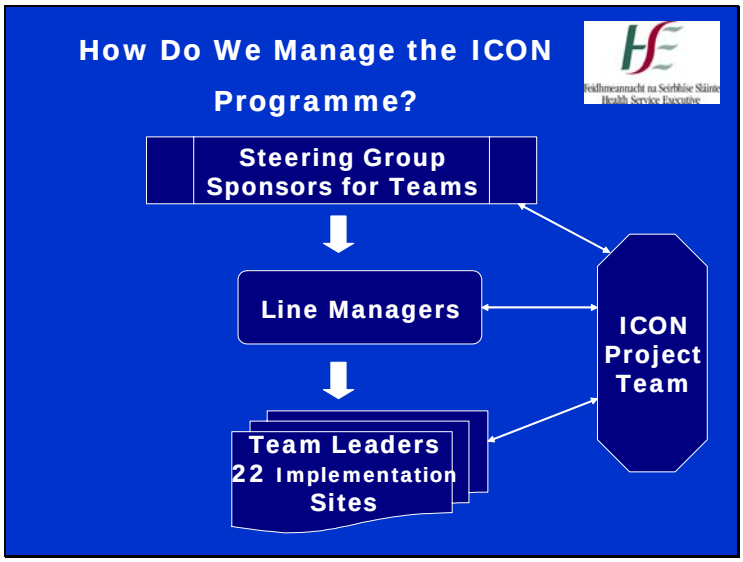
8.5.1 There are significant programmes of work being carried out nationally as well as locally to progress towards the implementation of an ICT solution. The Steering Group and ICON project team continue to contribute to this work, and continue to share the learning from the phases of ICON so that opportunities to maximise the potential for the systems to support integrated care are exploited at this critical stage.

9 GOVERNANCE

9.1 Governance of the ICON Programme

9.1.1 There are three levels of management of the project. The Steering Group has a remit to guide the project, the line managers have line management responsibility for the teams, and the team leaders provide the service delivery. The ICON project team has reported to the Steering Group, and worked with line managers and team leaders.

Figure 11 - The Management of the ICON Programme)



9.2 Steering Group

9.2.1 The project was governed by a Steering Group representative of senior management which covered all areas across Primary, Community and Continuing Care (PCCC.) This included Corporate and Clinical Governance. The Steering Group was a touch stone throughout the project to provide guidance, advice and a steer as to the direction the work should take[44].

9.2.2 Four meetings were held throughout the programme on the following dates: September 29th, January 13th, March 10th and May 12th. In between meetings there was regular contact between the Steering Group Chair and individual members of the Group and the ICON team.

9.3 Line Managers

9.3.1 Two sets of workshops were held for line managers. The initial group of workshops were held on September 27th, September 28th and October 13th and were attended by 44 line managers. The second set of workshops was held in the middle of the programme, on April 4th and April 5th and 25 managers attended these workshops. This process enabled those responsible for managing staff and services to contribute to the process, and discuss collectively how to adapt their management styles and systems

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accordingly. A strong theme was the need to devolve management and financial responsibility to teams as far as possible, and to support them in local decision making as far as possible.

9.4 ICON Project Team

9.4.1 The ICON team consisted of a Project Manager, Veronica Larkin, and an ICT Specialist, Martina Martin, as the key dedicated HSE MA staff for the project. During the programme, the secretary, Sandra Wrafter, joined the team. After a few months, a person to lead and support the integration of Integrated Care, Niamh Gibney, and an ICT advisor, Ian Hunt, became members of the team.

9.4.2 External management consultancy was available to the ICON team through Tribal Secta. A lead consultant provided continuity for the project, Helen Tucker, with Alison Kilduff and Emma Gibbard providing analytical support. Hugh Flanagan provided the facilitation for the team working training day.

9.5 Team Leaders and Team Members

9.5.1 The ICON programme involved 18 active team leaders, with teams involving 156 core team members. In addition there were network staff and associated staff. Four teams have delayed their involvement in the programme due to lack of staffing and time.

9.6 General

9.6.1 A structure for formal corporate, clinical and social care governance for the next phase of ICON needs to be agreed which reflects the new structure in the Irish health service.

9.6.2 Corporate governance systems need to reflect team working and team accountability, such as through service plans, targets, performance monitoring and professional accountability.

9.6.3 Clinical governance systems need to reflect trans-disciplinary working, so that teams are supported through risk assessments and their work is monitored through clinical audit and research.

9.6.4 Social care governance needs to reflect partnership working, and systems that facilitate service users to manage their care.

9.6.5 A framework for corporate, clinical and social care governance that is designed to support joint working and integrated care is a priority nationally as well as for the ICON programme.

10 EVALUATION

10.1.1 This section gives an overview of the outcome of evaluations with the key stakeholders. Phase 3 of the ICON programme has been evaluated at each stage and at each level as shown in the slide below.

Figure 12 - The Evaluation of the ICON Programme

10.1.2 The evaluations considered include:

- Patients and Clients
- Steering Group
- Line Managers
- Teams
- Team Leaders
- ICON Team

10.2 Patients and Clients

10.2.1 The impact on the care of individuals being supported has been assessed by the teams. Case studies have been provided by the teams, to illustrate the benefits and challenges of working in an integrated way, and how this affects the patient experience. (Appendix A)

10.2.2 Eight case studies for ICON implementation sites have been provided outlining the systems and processes before and after implementation of the ICON programme and also identified further challenges and learning. From the examples of patient experience emerged key themes around changes in systems and process. The case studies showed that the pathways before implementation was characterised by independent working with multiple assessments by different practitioners. However the pathways after implementation showed a change to multidisciplinary and multi-agency team working with a number of teams using common assessments and single client files. Joint clinical meetings are now held by teams to improve the coordination of their

work. The impact on clients and families include the identification of a key worker for clients who acts as a single point of contact along with clear information about information sharing. It has also resulted, in some cases, of clients being more involved in their own care planning with care being designed around their needs. There were also key themes that emerged around further changes and challenges, which included the need for standardised clinical documentation supported by ICT and a practical demonstration, increased use and expansion of the 'measurement tool'. The strongest message in the case studies is the change in the way the people who use the service and their carers and families are involved in their care.

10.3 Steering Group

10.3.1 The views of the Steering Group were extrapolated through a questionnaire at the end of Phase 3. (Appendix C)

10.3.2 When asked how members might progress integrated care further, suggestions included specific links to organisational objectives, links with corporate fitness structures including accreditation and audit, and shared learning. The suggestions all refer to embedding ICON within the structure and systems of the organisation. Critical success factors included commitment from managers, clear vision, good planning, good communication and ongoing evaluation. The responses in the questionnaire were generally positive about the programme and there were no proposals for a fundamental change. There were some contributions on how the programme might be extended, and the need for more engagement with people who use the service was stressed by members of the Group.

10.4 Line Managers

10.4.1 Managers were invited to put forward areas of work to be addressed and these included disseminating information widely on the ICON work to date, and sharing information on innovations and benefits within each of the teams. (Appendix C) Managers recognised that they had a responsibility to cascade information on a regular and systematic way. Managers recognised the importance of developing directories of services in order to support their staff and teams. Managers recognised their role in helping teams to have the appropriate environment and infrastructure for integrated care (accommodation, equipment etc.) They also recognised the need to fully involve teams in the creation and development of service plans and goals and to make sure that these incorporated integrated care. Managers recorded the value of administrative staff being part of the teams, and recognised the value of their contributions. Participants said that the workshop overall was highly beneficial in furthering an understanding of integrated care and its implications.

10.4.2 The workshops for line managers were positive and produced a clear steer for future development, both at a strategic and an operational level of focus. A high degree of commitment to integrated care was expressed, with a strong willingness to move the project focus of ICON into mainstream delivery. Both workshops discussed the requirement to communicate ICON much more clearly in terms of delivering national aspirations of integrated care and moving the focus from 'additional' activity to the way that care is routinely delivered. It was suggested that to do this well there is a need to

review learning and to systemise the forward approach and involve a more formal integration and utilisation of the manager's role and influence across individual areas of practice and operation.

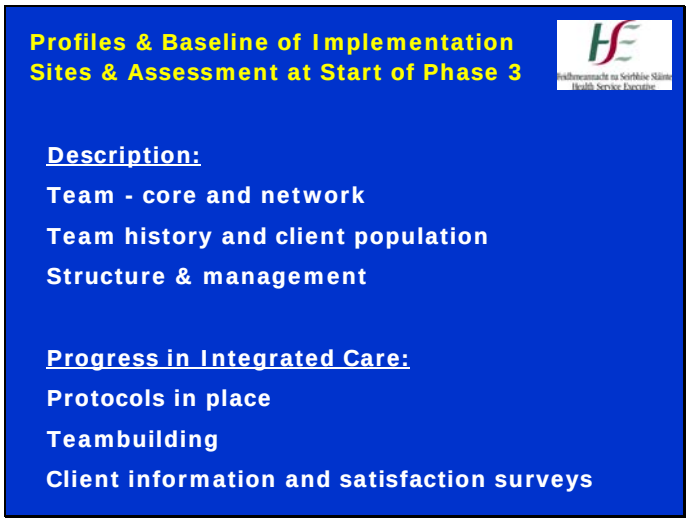
10.5 Teams

10.5.1 Questionnaires were completed for each of the teams at the start and end of the phase, enabling an assessment to be made of the progress made throughout the programme.

Figure 13 - Evaluating the ICON Teams

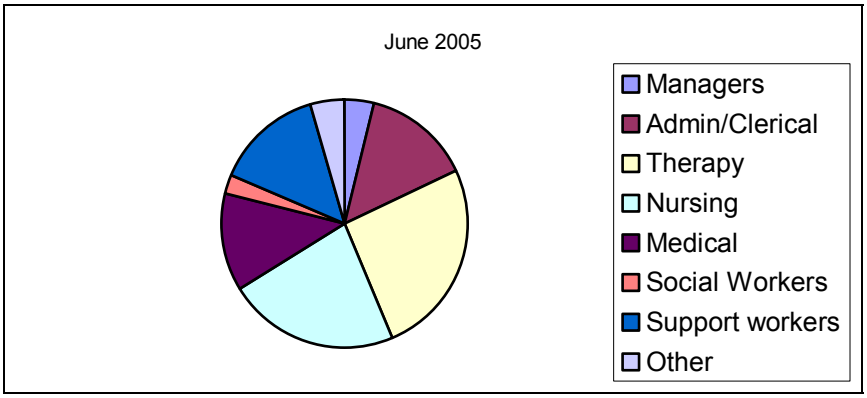
10.5.2 An analysis of the base line assessment and progress throughout the programme has been undertaken. (Appendix B) The ICON project team manager described the ethos of the learning sets and the approach taken to supporting team by stating that *"this is not a race to the finish but a movement along a continuum to ensure that services are moving towards greater integration"*

Figure 14 - Profiles and Baseline Assessment of Teams



10.5.3 The analysis in Appendix B shows that there has been an increase in the number of team members from 141 to 156 during the programme, with additional members being administrative, social work and therapists.

Figure 15



10.5.4 The analysis also shows that progress has been made in the teams formalising their processes, and in particular their protocols to support information sharing, the creation of leaflets and the adoption of outcome measures.

10.6 Team Leaders

10.6.1 Team leaders appraised the progress of the ICON Phase 3 programme in a number of ways. They completed evaluation forms at the end of each of the action learning sets.(Appendix C) They developed presentations to make to the rest of their group on how they were progressing with integrated care. The team leaders provided an evaluation on the training that they were given on team building. Team leaders completed assessment forms in the final workshop in June and made presentations to the group on the key benefits of being in the programme.

10.6.2 A SWOT analysis on the ICON programme by team leaders was carried out in the June workshop, and encapsulated some of the learning from the phase. The team leaders were asked what advice they would give to future ICON implementation site teams and team leaders, and this prompted some practical suggestions with regard to preparation for the programme, dedicated time, making sure of good attendance at the monthly ALS meetings and ensuring management support in order to get the best out of the programme.

ICON Project Team

10.6.3 ICON project team members evaluated the programme through a SWOT analysis (Appendix C) The main strengths were considered to be the positioning of integrated care in the international and national agenda, the management commitment and the enthusiasm generated. The key opportunity was to expand the programme across Ireland, building up teams and networks around primary care teams as set out in the Primary Care Strategy. One of the significant weaknesses was the delay in the implementation of ICT systems to support integrated care. Threats and challenges may be a lack of time and attention to address the changes required.

11 DISCUSSION ON PHASE 3

11.1.1 The initial findings from the phase are that it is important to focus on three aspects of managing change when supporting such a programme namely process, culture and context. Some of the lessons learned are summarised below, and were shared in this format in the presentation made to the International Network of Integrated Care in Dublin, February 2005.

11.2 Process

11.2.1 The process needs to be clear and transparent, with agreed objectives, project plan, and very clear and reasonable expectations. In order to get buy-in at every level of the organisation, there needs to be an explicit understanding of the principles underpinning the programme, the likely impact in the short term, and the longer term vision. The diagrammatic nature of the ICON programme provided this information in an accessible and readily available format. The Governance structure provided clear accountability for the process, with regular reporting throughout. There is always scope to improve communication and dissemination of the project, and this is being carefully considered for Phase 4.

11.3 Culture

11.3.1 The engagement of the team leaders in the action learning sets enabled them to be supported in their own professional and personal development, and strengthen their ability to support the team through change. The training provided, such as in the team working training day and the training in the measurement tool was designed to equip them for the challenges of managing clinical and systems changes. The ICON team provided support and resources to support this process. The fact that the change was being supported at all levels gave a clear message about the culture change, and was designed to empower team leaders to take the management action necessary to facilitate and support change. The mentoring provided across the team leaders, particularly from the team leaders from Phase 2 proved to be particularly helpful. The cultural changes are complex and were focused on the ICON teams and services, although steps were taken to extend the impact through the many interfaces for each team

11.4 Context

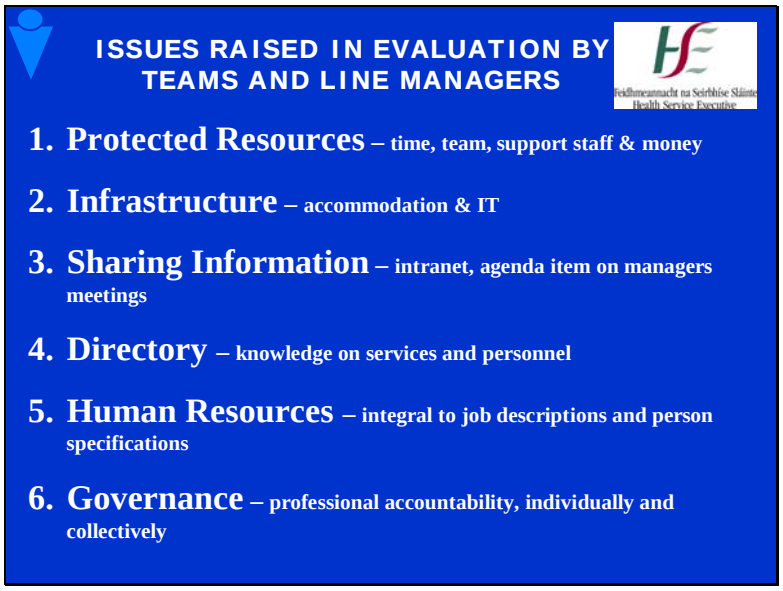
11.4.1 The context of major change in the health service in Ireland was a significant factor in the programme. The strength of the commitment of the senior management protected the ICON programme from some of the more fundamental instabilities that changes in structures and personnel can create. The fact that the programme was in keeping with the HSE agenda priorities helped support the work of Phase 3. A change management programme needs to be aligned to the organisational situation, and support the wider organisational aims.

11.5 General Findings

11.5.1 There were strong themes emerging from all parties with regard to factors that needed addressing in order to facilitate integrating care.

Figure 16 - Findings and Considerations

Figure 17 - Issues Raised in Evaluations



11.5.2 These issues include the need for protected resources, an appropriate infrastructure, a system for sharing information, a directory of services and staff, a strategy for human resources that reflects integration and a framework for governance.

11.6 Protected Resources

11.6.1 The most frequently referred to issue was the need for an allocation of time in order to address the changes that needed to be negotiated and implemented. For instance, the consolidation of all documentation into streamlined systems required time in order to carry out a documentation audit, review usage, redesign forms, consult, pilot and implement. Whilst the principle of improving levels of integrated working across staff and agencies may appear to be simple, it requires a reconfiguration of services delivery systems in order to support effective team working. Team Leaders led this

work as part of their role in heading up the team in addition to their existing clinical or administrative workload. Whilst it can be argued that the task was a legitimate part of their role, in practical terms there needed to be an allocation of time in order to create the new systems required and a clear understanding between management and staff that this was a priority. Resources that teams mentioned frequently were that of administrative, clerical or secretarial staff. Throughout the programme some teams made progress in negotiating some additional administrative time, and the positive impact of this was appreciated by teams concerned. Other resources referred to included finance, and the benefits of having a devolved budget to the team that effectively pooled the allocation for the work of the team. This was seen as a way of introducing greater flexibility to the team, and clearer accountability for working as a team.

11.7 Infrastructure

11.7.1 Some teams were hampered by the lack of adequate accommodation, facilities and equipment. Reviews of working arrangements by occupational health were instigated for some of the teams, where overcrowding and unsafe practices were a consideration. Any of these factors could reduce the effectiveness of the team trying to work in an integrated way.

11.7.2 The most significant single hurdle to the progress of integrating care was considered to be the lack of an ICT infrastructure and system. Currently many of the teams are recording their patient records manually, and only a few have computerised databases. This is limiting the access to patient information required by any team working with patients, particularly where the teams are not co-located or of there is a not a central filing system. There is a risk with the manual system that up to date information on clients is not readily available, and that support given by a multiplicity of professionals may not be coordinated. The team members appreciated the benefit of having IT systems that provided a care management system, recorded input by all professionals in a timely way, and was readily accessible through reporting systems.

11.8 Sharing Information

11.8.1 One of the challenges has been the need to pursue as many ways as possible to raise awareness of the ICON programme and ensure that it is taken into account in appropriate arenas. For instance, it has recently been suggested that ICON becomes a standing item on Senior Managers and LHO manager's regular meetings, so that it starts to be integral to the work of the organisation.

11.8.2 The ICON Steering Group and ICON Project Team have developed a multi-media approach which has included creating a video of ICON, distributing booklets, developing posters, publishing material and circulating information on conferences.

11.9 Directory

11.9.1 From the beginning of the ICON programme, the lack of a comprehensive, up to date and accessible directory of services has been noted as a limitation. Participants have pointed out that if they are not aware of the services and staff that are available within the organisation, they cannot create the links. A useful directory would include criteria for access to services, times that services are available, and what services are offered. The network created by the Phase 3 ICON programme has encouraged the creation of

directories of services around each of the teams, and the development of information leaflets and brochures for each of the services.

11.10 Human Resources

11.10.1 One of the challenges in team working and integrated care is the development and sustaining of teams or networks. Team leaders referred to the limitations of teams where the lack of a full complement of staff meant that existing team members were working less efficiently, as they were covering for other disciplines. A clear example of this was given in several teams, where there was a lack of social work input to the team. Teams also referred to the disruption that occurred to teams when there was staff turnover, and new members needed to be inducted into the team. There is a recognition that staff work within a number of teams, and that an effective programme for encouraging team working and integrated care is one that focuses on the individual and supporting a way of working that is appropriate for a range of situations with teams and networks. It is proposed that in the future person specifications and job descriptions will incorporate this ability to work as a team member in a person-centred way, appreciating the benefits of integrated care.

11.11 Governance

11.11.1 Factors impacting on integrated working include the overall governance of the organisation which is focused on personal and service accountability, rather than performance measures linked to team work. There is a concern from some professions within teams that their individual professional accountability might be compromised by working in accordance with team decisions. Also, that trans-disciplinary working may confuse the usual lines of reporting and accountability. The workshops raised suggestions that a clearer corporate, clinical and social care governance system would help provide a framework for integrating care. The framework could incorporate partnership working and networks.

12 RECOMMENDATIONS FOR PHASE 4

12.1.1 The evaluation and experience of Phase 3 has contributed to the design of the next Phase 4. Recommendations are grouped into three headings: Structure, Process and Evaluation.

12.2 Structure

Steering Group

12.2.1 The vital importance of management commitment, leadership and vision was stressed throughout the evaluations, and the need for a senior level forum operating at a strategic level has been of great value to the project. The continuity in the Steering Group has been another very helpful feature. However, there were practical difficulties in achieving a full attendance from such a large group of senior managers, and maintaining a focus with a membership of over 12 people.

- It is recommended that a Senior Executive Steering Group be formed with specific agreed terms of reference.

Local Management

12.2.2 The involvement of local operational managers such as line managers was highly beneficial, as they could support individual team members and help to address challenges and hurdles to integrated care. The matrix structure of the organisation organised into care groups and therapies has meant that many line managers may be involved in one team. The need for a management overview on a geographical basis was recognised.

- It is recommended that a Local Health Officer Management group be formed for the two geographical areas in order to manage the next phase of ICON implementation sites.

Teams

12.2.3 The identification of teams was through sponsorship by Steering Group members, and this had limited success in providing a structure of support within the organisation. The team leaders were supported by the ICON team through the action learning sets and other resources. Whilst the focus on the team leaders was considered to be successful, there were examples where other team members were not fully engaged or supported. Therefore, there is a suggestion that the design of the next phase involves more opportunity to work with the team as a whole.

- It is recommended that the support more formally extended to be available to teams as a whole, as well as team leaders.

Service Users

12.2.4 There are some examples of people who use the service, their carers and families being involved in the process. For instance some teams are working with consumer panels, children's services are involving parents more in the planning of care, and patients/clients are being asked their views through surveys and interviews. However, there is a general consensus that there is a need to involve service users more fully and more formally throughout each level of the programme.

- It is recommended that Phase 4 of the ICON Programme focuses more formally on person-centred care, and involves service users more fully in the programme at every level. It is proposed that a Stakeholder Group be established, involving representation from all those who have a stake in the service, such as through consumer panels and partnership Board.

Governance

12.2.5 An overarching requirement is for a framework for corporate, clinical and social care governance. This is being addressed on a national basis, and will provide a structure for the development of integrated care. It is critical that the systems in place, such as service planning and performance monitoring are tailored to team working. By redesigning the governance arrangements, some of the disincentives to collective working may be replaced.

- It is recommended that a governance framework be supported that covers corporate, clinical and social care.

12.3 Process

Implementation Teams

12.3.1 The value of identifying teams and supporting them as ICON implementation sites has proved to be considerable. It is given an opportunity to test and further develop aspects of integrated care with different services and client groups. The teams in the programme have started to develop appropriate protocols and systems to support this way of working, which can be transferred to other settings. There is more work to do within the teams as they continue to develop their new systems and protocols through consultation. The teams have tested integrated care, and faced the cultural issues of change management within a supportive network.

- It is recommended that Phase 4 continues with the programme of working with teams as implementation sites, continuing to work with the 18 active sites and attracting additional 20 or more teams.

Team Criteria

12.3.2 At the start of Phase 3, criteria for the selection were identified, building on the learning from Phase 2. It was noted that where teams had certain factors in place, they were most likely to benefit from the programme. This system of suggesting criteria could be continued, although purely a guide rather than a system of exclusion. In addition however, it was felt that the identification of teams around a primary care team on a geographical basis could offer the most constructive way to build networks of services. Therefore, this would be a major factor in identifying those teams that will be offered an opportunity to be part of the programme.

- It is recommended that the selection of teams be made on the basis of building up a network of services around a primary care team on a geographical basis.

Action Learning Sets

12.3.3 The evaluations demonstrated that team leaders found the regular monthly meetings highly valuable, and in particular found the format of the Action Learning Set to be very productive and supportive.

- It is recommended that monthly meetings using the Action Learning Set format be continued in Phase 4 with two groups of teams organised in geographical areas.

Training

12.3.4 Throughout the process, participants were asked their views on what further support or training they required. The request for team building training resulted in a full days training with external facilitators. The evaluation of this way was highly positive, and the day proved a useful reference point for the rest of the programme. In particular the Belbin exercise identifying team member characteristics was considered to be most useful.

- It is recommended that teambuilding training be an integral part of the programme, ideally scheduled as part of the preparation for the ICON programme or at an early stage of integrating care.

Measurement Tool

12.3.5 The Measurement Tool provides an interim solution to the lack of appropriate software in order to create and maintain a database and measure integration on a team and client basis. The system has allowed for self assessment of progress, and also to identify gaps in teams. Training was given on the tool. There has been a mixed reception to the system, and some concerns about the time taken to maintain it. However, improvements in the system with the addition of a reporting mechanism may enhance its usefulness to team members and the ICON team.

- It is recommended that the Measurement Tool be offered as a resource, with ease of access to protocols and information. The tool may be used as a database and a self-assessment system as teams find useful. The implementation of the system may be considered by each team according to their circumstances.

Care Management and Care Pathways

12.3.6 A care management system that meets national standards would provide the building block for integrated care. Care pathways that have been designed developed and agreed in a collaborative way across sectors, agencies and disciplines will also help in the management of care. The development of these systems is considered to be a major undertaking, and one where standards need to be set on an organisation-wide basis, if not nationally. Progress on these two areas would help in the management and coordination of people's care.

- It is recommended that work be supported in the adoption of a care management system, and the introduction of care pathways.

ICON Project Team

12.3.7 The team has consisted of two dedicated members of staff and a secretary, and this increased to include two additional staff members throughout Phase 3. An appraisal of the workload of Phase 4 is likely to suggest that this level of team will be required as a minimum to support an enlarged programme, particularly with ICT requirements. In particular, team members have valued the onsite support given by ICON team members which will need to be resourced in this next phase. ICON team members will need to be trained and supported so that they are fully conversant with all aspects of ICON, and able to work flexibly across the programme. The evaluations indicate that

there is a benefit to including external consultancy in order to provide independent facilitation and support.

- It is recommended that the ICON Project team be maintained and extended according to the agreed workload for Phase 4.

ICON Programme

- There has been some discussion as to whether the ICON logo and branding should be continued, or whether the programme should be absorbed into the organisation. The ICON identification is an advantage, as it enables a common understanding of the definition and component parts of ICON, provides a visual model of care, and enables a focus of attention on the programme. Disadvantages are that it may be considered to be excluding by those teams who are not within the ICON programme and yet want to pursue integration. On balance, it is suggested that the ICON be retained, but that Phase 4 represents the final phase of the programme by which time it may then be absorbed.
- It is recommended that the ICON model and branding be retained and utilised in Phase 4 which represents the final phase of the programme.

ICON Resource Pack

12.3.8 It has been recognised that in order to widen the scope of the ICON project, a readily accessible resource pack needs to be prepared that introduces the principles, components and benefits of integrated working. The resource pack would provide links to additional guidance and resources. Some of this material is within the measurement tool, and some information has been located on the website. However, teams have requested that this be prepared on disk and hard copy so that this may be readily shared. This will be particularly pertinent as the next phase moves into training and briefing for managers, staff and trainers.

- It is recommended that an ICON resource pack be developed.

12.4 Evaluation

Outcome Measures

12.4.1 Teams have contributed examples of benefits and outcomes from the ICON programme, such as through case studied, surveys and through the measurement tool It is recognised that more can be done to regularly and formally measure outcomes, so that benefits are quantified. An example of this is the reduced appointments that patients need to attend, as they are offered a “one stop shop” model of service. Outcomes in terms of improved health or swifter return to health because of earlier assessments and interventions may be another example.

- It is recommended that early in Phase 4 a set of outcome measures is agreed for each team, and data recording organised accordingly. Involvement of patients and clients in this process would be very beneficial to ensure outcome measures are appropriate.

Research

12.4.2 The ICON programme has been published in academic journals and papers presented at conferences. There is scope to increase the coverage in this next phase, and continue to raise the profile of the programme nationally and internationally. In

particular, support to team leaders and managers to write up their experiences for professional journals would also extend the message, and encourage shared learning.

- It is recommended that there is encouragement given to submitting papers for conferences and publication within professional and academic journals.

Evaluation

12.4.3 Evaluation of each stage of Phase 3 was built into the design of the process, and helped inform the planning for each step of the process. It is suggested that this system be continued, and team members prepared for the implications and benefits of ongoing review. Also that the study continues to be subject to the case study research material for the University of Warwick for this final Phase.

- It is recommended that the ICON programme continues to be evaluated and researched.

13 CONCLUSION

13.1.1 Phase 3 of the ICON programme has run for 9 months and its overarching aim was to further integrated working across the organisation to the benefit of the patient, the staff, the service and the organisation.

13.1.2 The evaluations, including the case studies, team leader presentations, questionnaires and interviews have demonstrated that progress has been made with the integration agenda, and benefits have been recorded. The presentations given by teams and team leaders at the "Celebrating Small Steps" day illustrated that each team had made some progress and that the awareness and understanding of integration had increased considerably. The programme now has a momentum, and will be well placed to proceed with Phase 4.

13.1.3 The programme focused on four key areas of work: implementation sites, governance, ICT and education/research.

13.1.4 The objectives of working with teams as ICON implementation sites were to:

- widen the experience of working in an integrated way
- to test and develop the model and component parts
- to prepare for rolling out integrated care across the organisation.

13.1.5 The implementation sites have been the central focus of this phase, and have achieved their objectives. Benefits in addition to those planned include the personal and professional development of team leaders and team members, empowerment of teams, and enthusiasm for making improvements to clinical services through multi-disciplinary and trans-disciplinary working.

13.1.6 The objectives of pursuing the governance agenda was to clarify with those responsible for planning, managing and monitoring health and social care services which systems, processes and structures need to be in place for the programme and for integrated working in the longer term. The work with the teams has highlighted the strengths and deficiencies in the current governance structure, The timing of the restructuring coming through the reforms means that any learning from this phase may be offered for the future structures so that integration can be supported and facilitated.

13.1.7 The objectives for the ICT agenda were to link with the whole system being developed across Ireland, and ensure that the specification from the ICON programme was incorporated into future solutions. There was also an objective of preparing staff for the introduction of an ICT solution by implementing interim software (the Measurement Tool) that offered a database and system of measuring integration. Work has also been carried out on proof of concepts for web-based services in three areas, namely the case history form, a referral tracking process and an obstetric card. The increasing appreciation of the way that an ICT solution could enhance the clinical management of services has been promoted through the programme. Teams and team leaders may be well placed to work with the new national solution once it is ready for implementation.

13.1.8 The education and research agenda has been part of the ICON programme from the start, and the objectives were identified with regard to being part of an international network of integrated care including publishing and disseminating findings from ICON and pursuing a programme of education and professional development for staff. The

Steering Group agreed that evaluation of ICON would be incorporated throughout the process. The richness of material coming through this phase has yet to be fully appraised, analysed, interpreted, validated and written up. However, the consistency of recording and the audit trail of events and documentation means that there may be a strong evidence base built up for pursuing integrated care and considering the transferability of this programme into a national agenda.

Final Thoughts by Chair of the Steering Group

13.1.9 The following extract is from the submission for the health innovation award[45], as the ACEO assessment of the project.

13.1.10 "The project is sustainable, as it is the aim of the ICON Steering Group and the organisation as a whole to make integrated care a way of working, and not a separate project. Integrated care must by definition be sustainable. Adopting a structured approach to facilitating integrated care, and supporting the processes and cultural change through a funded team has accelerated integrated working, There has been an investment in terms of financial support and time commitment, and this will continue as integrated working has gained a momentum within the organisation. It is hoped that over time the ICON Project will not be required as a separate initiative, but will have served its purpose in prompting new ways of working. The problems of fragmentation and lack of coordination across our increasingly specialist health care environment are significant, and need to be addressed. The groundwork that the ICON team have carried out should make future roll outs sustainable.

13.1.11 The innovation has had an impact throughout the organisation, and not only with the teams directly involved.

13.1.12 The work of the ICON team has meant that there is an increased awareness of what is meant by integrating care, and the use of the ICON diagrammatic model has been useful in that it illustrates the component parts of integration as well as the features, values and principles. The teams have shared their knowledge and learning with other teams that they are working with, so the roll out has started informally.

13.1.13 The main benefits to patients and carers have been drawn out through interviews and case studies, and are described as having a better understanding of the service, clearer about their role and the role of the team, and a simplified way of accessing and receiving services. For instance, common assessments by teams have meant that appointments for children with disabilities and their parents have been reduced, cutting down on travel time, inconvenience, tiredness etc.

13.1.14 The main benefits to staff concern personal/professional development and improved morale. The ethos of the project has been to build on good practice, and the project started with 19 presentations by staff on what they were already doing to integrate care. Phase 3, (two and a half years later) finished with 18 teams declaring the progress they had made through conference presentations. The sharing of issues, challenges and good practice within a network of support has been invaluable. Team leaders have stated that they feel empowered to address issues, work more constructively and openly with their teams, and to lead the development of the service. This is now prompting a review of the level of formal delegation to teams, including

[45] Health Innovation Award Submission July 2005 (D015)

delegated authority and finance. It is also prompting the organisation to look at the structure and systems organisation-wide, to ensure that they support t integrated working.

13.1.15 The benefit to the organisation is that there is a clear focus and a growing momentum for continual improvement in integration. During this time of major change with the health reforms, it is helpful to have such a positive project led by an enthusiastic ICON team. The central theme for integrated care is being person-centred, and therefore any changes must be in keeping with keeping the patient at the centre. The ICON project manager has described this ethos as *"keeping the patient at the centre whilst respecting best practice."* There are some challenges to the organisation arising from the project, such as a recognition that some teams are not being able to fulfil their potential because of practical difficulties such as co-location (lack of accommodation), lack of administrative support (reducing the appropriate use of clinical time) and resources (such as training budgets.) However, these issues have been helpfully clarified and are being addressed by them.

13.1.16 The benefits to health services generally are that all agencies and disciplines are joined together with a common purpose. The teams have included external agencies contractors, as well as HSE MA staff, and the project gives a forum for such staff to address how they improve services collectively. The conclusion from the project is that integrated working will not happen by accident, but with a clear programme of support much can be achieved.

APPENDIX A – CASE STUDIES

Case Studies - Client and Patients

Eight case studies for ICON implementation sites have been provided outlining the systems and processes before and after implementation of the ICON programme and also identified further challenges and learning. From the case studies emerged key themes around changes in systems and process. The case studies showed that the pathways before implementation resulted in independent working with multiple assessments by different practitioners. However the pathways after implementation showed a change to multidisciplinary and multi-agency team working with a number of teams using common assessments and single client files. Joint clinical meetings are now held by teams to improve the coordination of their work. The impact on clients and families include the identification of a key worker for clients who acts as a single point of contact along with clear information about information sharing. It has also resulted, in some cases, of clients being more involved in their own care planning with care being designed around their needs. There were also key themes that emerged around further changes and challenges, which included the need for standardised clinical documentation supported by ICT and a practical demonstration, increased use and expansion of the 'measurement tool'. The strongest message in the case studies is the change in the way the people who use the service and their carers and families are involved in their care.

Case studies provided by 7 of the teams and are examples of:

A) Coordination and communication

B) Information and Family Support

C) Multi-agency support

D) Key Worker with Multi-Disciplinary Team

E) Co-ordinated Care Planning

F) Support for Carers

G) Client-Centred Care – Inter-Disciplinary & Inter-Agency Working

H) Holistic Care

A) Co-ordination and Communication

a) Mildred

Mildred, aged 93 year old lady was being discharged from hospital. She has complex medical problems and lives alone. She requires ADL assistance from 2 carers. Prior to ICON the hospital staff will have alerted the GP, Public Health Nurse PHN) and Physiotherapist and each practitioner would have attended Mildred independently. Now the Admissions and Discharges Team has strong connections with the hospital medical, nursing and therapy staff, and has agreed a system of handover that provides assessment and continuity of care. The team jointly assess Mildred and the committee decide on appropriate services and care, involving the GP and PHN in the process. Mildred has signed a referral form and a Nursing Home Subvention form where she has formally agreed to her health and social information being shared appropriately between members of the team. Now Mildred has a key worker in the team so she has a single point of contact for her welfare. She is clear about how information is shared between the multidisciplinary assessment team and is informed of the outcome of Nursing Home Subvention. The team recognises the importance of clarity of information to the patient about the services being offered and their options. The team are also more aware of the support services available from other agencies, such as the Alzheimer's Society of Ireland and the Irish Wheelchair Association.

Admissions and Discharge Team

B) Information and Family Support

b) Emma

Emma is an only child who is 4 years old and has Down's syndrome. She has persistent respiratory problems. Prior to ICON the Area Medical officer referred Emma to all the professionals individually who in turn completed case history details, assessed and treated Emma individually and made onward referrals as required. The professionals met three times a year to discuss what Emma was receiving and how she was progressing. Emma would have received 7 case histories to complete, 7 assessments/review appointments and 7 reports.

Now Emma has one case history form, one assessment appointment and one report with all professionals working together. As part of preparation for a review, the nurse now visits the home to discuss any issues that her parents may have and any information they would like clarified on the day. Emma's EIT assessment review is scheduled over 2 hours and involves all professionals who agree a joint report. One of the team is the link worker who becomes the single point of

contact for care. The link worker goes through the plan with the parents and arrange for the plan to be signed by them. Emma's link worker is clear about how information is shared on his care, and her carers have signed a consent form to allow the sharing of information as stated in the Information Sharing Protocol. Parent training and home visits plays a more active part in her interventions. Emma parents have reported that they are have a better awareness of Emma's overall needs and feels that everyone is working together for their child. The team recognises the importance of involving the parents more, asking how they perceive the service, and informing them of the options that are available to them.

Early Intervention Team, Mullingar

C) Multi-agency Support

c) Patrick

A teenager, Patrick, who is experiencing difficulties in their life, ranging from problems at home, in school and socially, is referred to the Youth Support service. Prior to ICON the teenager would have been involved with various services (school completion programme, social work department, psychology department and Le Cheile) that may not have been working in an integrated fashion and may not be service user friendly.

Now the Le Cheile team develops practice to encourage professional/non-professional participation from service providers. More importantly systems are put in place to encourage client participation, thus to empower the client and ensure the client is receiving the service they want. This has resulted in the client developing a sense of control over their care. Professionals / Non-professionals involved have more insight into what the client is receiving in terms of service delivery. Service providers can support one another and compliment each others work "goals" while remaining client focused. This has resulted in the client developing a sense of control over their care. Professionals / Non-professionals involved have more insight into what the client is receiving in terms of service delivery. Also service providers can support one another and compliment each other's work "goals" while remaining client focused.

The team now recognise that services can no longer work in isolation of one another and to continue to do so would be to the detriment of the client. Integration means communication! Thus,

clients need to be aware that information will be shared. Service providers will have a responsibility to be "informed" and "inform" accordingly and service providers also need to be aware of their client "discharge" responsibilities. Also aspects of service provision are reported on / passed on, as the client develops and engages with other services, where appropriate and necessary). And where possible, there is a mechanism for re-referral or re-direction to other service providers.

Le Cheile, Youth Support Service, Portlaoise

D) Key Worker with Multi-Disciplinary Team

d) John

John is a 54 year old man who has had a stroke, and has returned from hospital for rehabilitation at home. His partner is his main carer. Prior to ICON the hospital staff would have alerted the GP, public health nurse and occupational therapist and physiotherapist to the fact that John was being discharged from hospital. Each practitioner would have attended John independently.

Now the Primary Care Team has a dedicated Team in Portarlington who will handle the majority of John's health care needs locally. They have regular clinical meetings where they can agree a multidisciplinary care plan and easily update each other on his progress. John has signed an enrolment form where he has formally agreed to his health and social information being shared as appropriate between Team members. John now has a key worker in the team, so has a single point of contact for his care. He is clear about how information is shared on his care, and has signed his care plan. It is clear how all of the professionals involved in his care play their part. The programme of therapy has been designed to suit his needs, with some shared appointments to avoid too many visits to the hospital. John has said, "The support I have had since returning home has been excellent, and my key worker always knows what is going on. I feel reassured that I can ring her if I am worried."

The team have developed a single referral sheet that all Team members can use for several Team services. This has reduced much paper work and duplication. The team recognises that there needs to be clarity of information to the patient about the services being offered and what their options and choices are is important. Also increasing the awareness of what others support and

services may be available from other agencies, such as the Stroke Association and the Irish Wheelchair Association.

Primary Care Team Portarlington

E) Co-ordinated Care Planning

e) Kathleen

Kathleen is a 75-year old widow who is currently a patient on Medical II, Midland Regional Hospital, Tullamore following a stroke. Kathleen had been living in rented accommodation prior to admission to hospital and she had no family, savings or assets.

Prior to ICON an application for subvention would have been received at the Health Centre, Tullamore. Financial assessment would have been carried out and on receipt of medical dependency report from Liaison PHN, entitlement to subvention decided. This would be followed by a letter issued to client/family informing of the rate of subvention payable.

Now Kathleen is referred to the Admissions & Discharges Committee and Medical, OT, Physiotherapy and Financial assessments are carried out. Medical staff on the ward would contact the Nursing Home Subvention Department to check progress on subvention application. The Bed Manager, Midland Regional Hospital, Tullamore would also contact this office to discuss if Kathleen can be placed in a private Nursing Home pending a bed becoming available in the Board's long stay units. Kathleen's case is discussed at the Admissions and Discharges committee meeting. Kathleen now has a key worker and is fully informed at all times about what the plan for her future care is. All staff are fully aware of each others roles. Staff in the hospital know they can contact the Nursing Home Subvention department at any time regarding a client and vice versa. Decisions regarding the client's future care are made following a multi-disciplinary assessment and client is discharged more promptly to the appropriate care setting.

Nursing Home Subvention-Laois/Offaly

Support for Carers

F) John and Mary

John and Mary are a married couple in the 60's who attend their local GP. John has been diagnosed with Alzheimer's for some years but Mary is finding it increasingly difficult to cope as his condition worsens. The GP has previously contacted the Public Health Nurse but now feels there may be a need for some Home Help. The GP makes referrals to a Physiotherapist, Occupational Therapist and Psychiatry for Later Life. Contact should also be made with the Alzheimer's Society who provides some services to John and Mary. After referrals have been made it is difficult for the client or the GP to co-ordinate care.

Prior to ICON the couple would attend their GP who refers by post to the relevant services. Each practitioner works independently of each other with no multi-disciplinary approach making life difficult for the client and the care providers. Now the GP brings John and Mary's case to a clinical meeting. They have enrolled with the Team and both have signed their consent to have relevant information shared with other team members. The GP can refer to Physiotherapy, OT, and Public Health Nurse at the weekly clinical meeting. The Community Welfare Officer and Social Worker also attend and are made aware of the couple's situation. A Team member takes it on board to contact the Alzheimer's Society and Psychiatry for Later Life and also contact John and Mary and make them aware what services will be provided and when. Progress and updates from all Team members involved in John and Mary's care will be given at subsequent clinical meetings. John and Mary also now have a single point of contact for their care through the Team. They are clear about how their information is shared and have given their consent. It is clear how all of the professionals involved in their care play their part. The programme of therapy has been designed to suit the needs of both John and Mary with a holistic and multi-disciplinary approach.

The team recognises that there needs to be clarity of information to the patient about the services being offered and what their options and choices are is important. Also increasing the awareness of what others support and services may be available from other agencies, such as the Alzheimer's Association.

Portarlington Primary Care Team

G) Client-Centred Care – Inter-Disciplinary & Inter-Agency Working

g) Gerry

A 15 year old boy, Gerry, who sustained an Acquired Brain Injury following a sporting accident requires the use of a wheelchair for mobilisation. The client is now ready for discharge from this National Central Hospital to the care of family and services in his own community.

Prior to ICON the social worker at the Central Hospital would have contacted the GP and physiotherapy, probably by letter, to notify them that the client was been discharged to their care. Each of the professionals who would have met the client would have assessed and delivered care to this transfer client independently and is isolation of each other. There would also be occasions where some professionals would have liaised with each other in care provision.

Now ICON has become an acceptable way of working at Springfield Centre to provide an integrated approach to the clients care. The medical social worker at National Rehabilitation Hospital and the Regional disability co-ordinator for Springfield Centre sets up a multidisciplinary, intra-disciplinary meeting, between both teams for a formal 'hand over'. Now the client and his parents are central to the meeting and the clients care progression was discussed in his and his family's presence. The client is met and involved in planned, holistic integrated therapy services. Because Physiotherapy, Occupational Therapy, Speech & Language therapy are based at the same work area i.e. Springfield, appointments could be arranged for the same day (where appropriate). Therapists will then be able to jointly assess and provide therapeutic interventions for the client.

Springfield Centre

Mullingar

H) Holistic Care

h) Brege

A mother, Brege, who cannot read or write, requires assistance for her son who has a medical disorder. The mother needed Domiciliary Care Allowance for her son and the public health nurse arranged to call to her home. The public health nurse prompted consultant clinic appointments, followed up on missed appointments and rescheduled them. The PHN also referred the family to the Community Welfare Officer for a car seat for their toddler, which they purchased after receiving the grant.

Integrated Care facilitated the transfer of information across professionals and improved the quality of health for this family as the MHB was a one stop shop which compensated for any literacy problems restricting the family's access to services at present. The following professionals were involved in the care of this family: Area Medical Officer, Dental Department, Community Welfare Officer, Tullamore Regional Hospital, Audiology Services, Crumlin Hospital for follow-up appointment and Community Health Workers from the Primary Health Project who brought out the appointments from Audiology and Out-patients and read appointment times to client.

Traveller Health Team – Laois/Offaly

APPENDIX B PROFILES AND PROGRESS OF TEAMS

QUESTIONNAIRE ANALYSIS

SUMMARY

The 18 teams in ICON Phase 3 involved 141 team members at the start of the Phase, and this increased to 156 members of teams by the end of the phase. New members included therapy staff, administrative staff and social workers. This analysis of progress of the 18 ICON Phase 3 implementation teams shows some progress in formalising and implementing the component parts for working in an integrated way. The study has demonstrated an increased awareness of what is required, and some progress towards priority areas of integrated care. Particular progress has been made in producing leaflets, developing a single file, agreeing an information sharing protocol and adopting outcome measures. However, it shows that within the short period of the Phase, from November 2004 to June 2005 many of the systems and ways of working are still being developed and that the teams will continue to need support to progress these further.

INTRODUCTION

At the start of Phase 3 the 18 active teams were asked to provide a sponsorship form of their profile. They were also asked to complete a questionnaire to determine their starting point with respect to the main component parts of integrated care. The questionnaire was re-issued at the end of the phase, to determine what progress had been made. The profiles described each team with respect to their membership, team leader, location, sponsor and contact details.

In the questionnaire eleven areas were assessed:

1. Cost Code
2. Referral procedure
3. Client Notes
4. Common Assessment
5. Reports
6. Information Sharing Protocol
7. Care Plan
8. Outcome measures
9. Team building
10. Patient Satisfaction Survey
11. Leaflets

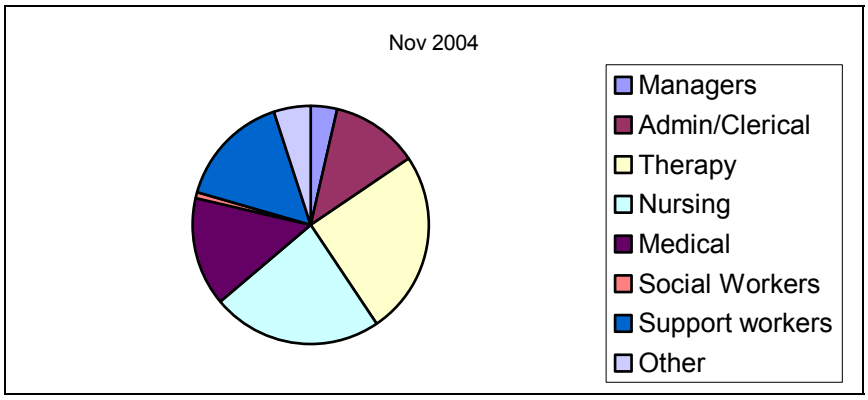
TEAM PROFILES

Start of Phase 3

The profile of team membership for November 2004 showed that nurses and therapists made up nearly 50% of the teams. Nearly 1 in 7 team members is a doctor.

Nov 2004 Team members	No.	%
Managers	5	4%
Admin/Clerical	17	12%
Therapy	35	25%
Nursing	33	23%
Medical	21	15%
Social Workers	1	1%
Support workers	22	16%
Other	7	5%
Total	141	100%

The pie chart below shows the distribution of team members by profession for November 2004.

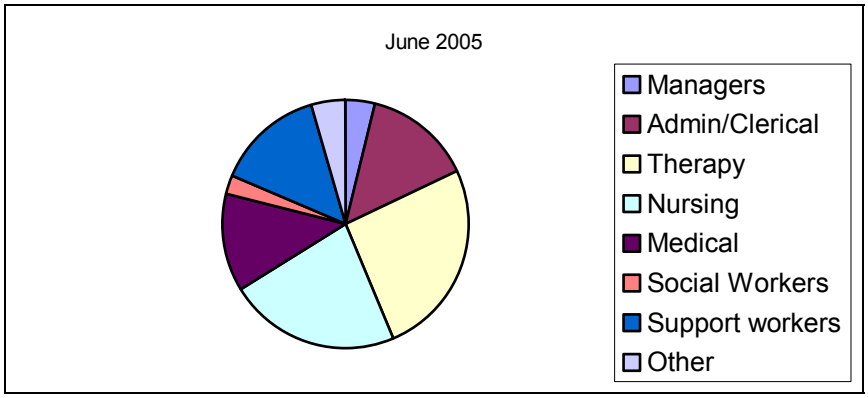


End of Phase 3

The team profiles show that nurses and therapists make up just under half of the team membership. Clinical staff, namely nurses and doctors, make up one third of team members.

June 2005 Team members	No.	%
Managers	6	4%
Admin/Clerical	22	14%
Therapy	40	26%
Nursing	35	22%
Medical	20	13%
Social Workers	4	3%
Support workers	22	14%
Other	7	4%
Total	156	100%

The pie chart below shows the distribution of team members by profession for June 2005.



Changes in Team Profiles

The teams have increased in size over the period of nearly 9 months by 15 members of staff.

Some teams made a successful bid for an allocation of additional administrative and clerical staff to assist with the work of ICON and an additional 5 staff were recorded. Some of the teams recorded additional therapists, which may have been the result of successful recruitment. A number of the teams have recorded that they require a social worker, and an additional 3 social workers were identified during this process.

The identification of the "core" team for each ICON Phase 3 team required a judgement to be made in each case, as some team members were sessional or called as required but were considered critical to the work of the team. In the event that regular team meetings included sessional staff, then they were recorded as "core." Some of the teams worked across large networks of health and social care professionals across the health service and voluntary agencies. These staff were not listed in the profiles, but were identified as key contributors to the service across the wider network. The team members profiled represent the core teams.

Team members	Nov-04	Jun-05	Difference
Managers	5	6	1
Admin/Clerical	17	22	5
Therapy	35	40	5
Nursing	33	35	2
Medical	21	20	-1
Social Workers	1	4	3
Support workers	22	22	0
Other	7	7	0
Total	141	156	15

QUESTIONNNAIRE RESULTS

Cost Code

At the start of the programme, not all team leaders knew whether their teams had cost codes. Once this was confirmed at the end of the programme, just over half the teams have formal cost codes. This issue was raised throughout the programme when factors as resource implications were raised such as for team building training and improved facilities. Devolved financial responsibility with a defined budget was suggested as a helpful mechanism for teams in developing integrated care.

1. Cost Code	Phase 3 Begin	Phase 3 End	Difference
Yes	8	10	2
No	7	8	1
Unsure N/A	3		-3
Total	18	18	

Referral Procedures

Teams described their referral procedures, which typically included self referral, referral through GP or social worker, and referral from other professionals. Most said that the referral process was clear and understood. Some of the teams have started to streamline their referral documentation, such as for the leg ulcer clinic. The traveller's team has recorded that *"we are working on a standardised form with team members."*

2. Referral Procedure	Phase 3 Begin	Phase 3 End	Difference
Yes	16	16	0
No	2	2	0
Total	18	18	

Client Notes

The response to this question about the maintenance of client notes elicited a variety of replies. Two thirds of the teams have described their progress towards a single file. This management of client records varies according to the type of service that the team offers. Typically the system that is described is that each professional keeps a file, but there is a system to consolidate this into a single file for patient management.

The team at Springfield describe that their records are *"separate but in accordance with policy."* The team for Le Cheile describes its system as "*each client has own file similar to social work."*

3. Client Notes	Phase 3 Begin	Phase 3 End	Difference
Yes	8	12	4
No	10	6	-4
Total	18	18	

Common Assessment

Teams have described their progress with a common assessment process. For instance, the Early Intervention Team for children with developmental delay in Mullingar has had training on using a common assessment tool (Bailey's.) The falls team are working to a common risk assessment. The team for mental health have developed and agreed a common assessment tool, but it has yet to be implemented. The aids and adaptations service uses a common form designed by OTs.

4. Common Assessment	Phase 3 Begin	Phase 3 End	Difference
Yes	10	11	1
No	8	7	-1
Total	18	18	

Reports

Most of the reporting carried out by team members is uni-disciplinary, although two of the teams recognise the need for both. Just under half produce multi-disciplinary reports. One of the teams, Le Cheile, working with vulnerable young adults, state that it would depend on what agencies were involved in the support plan.

5. Reports	Phase 3 Begin	Phase 3 End	Difference
MDT	5	6	1
Uni	11	10	-1
Both	2	2	0
Total	18	18	

Information Sharing Protocol

Five of the teams stated that they had information sharing protocols at the start of the programme, and this increased to 8 during the process. All teams are working on introducing this. The position is that when originally asked whether teams had an agreement about sharing information, some of the teams responded positively to this question. However, arrangements were typically informal, not bound by a framework, not monitored, and not to current standards. Therefore the scores in the questionnaire are misleading, in that there has been more progress in the awareness and formalisation of sharing information that the figures would suggest.

"There is a consent section in the assessment process."

"Being part of the ICON project has highlighted what needs to be developed for data sharing"

6. Information Sharing Protocol	Phase 3 Begin	Phase 3 End	Difference
Yes	5	8	3
No	13	10	-3
Total	18	18	

Care Plan

11 of the teams have care or support planning process. Not all of the services require a specific care plan, such as within the aids and adaptations team. The public health nurses working with travellers describe the creation of a care plan only when it is required. For instance, the care plan used for the traveller's service may be discussed with the travellers and agreed informally. The team record the system as "*verbally due to literacy problems."*

There has been work on a care planning process for the organisation as a whole and some of the teams have been waiting for this to be implemented, such as the Falls Team. The question asked of the team leaders was whether there was a care plan, and whether this was agreed with the client. *"We will be agreeing plan of care with client/carer with new plan."*

7. Care Plan	Phase 3 Begin	Phase 3 End	Difference
Yes	11	11	0
No	3	3	0
As required	3	3	0
Not applicable	1	1	0
Total	18	18	

Outcomes

Just under half the teams stated that they recorded outcomes at the start of the programme. An additional five teams are now recording outcomes, making a total of 66% of the teams.

St Hilda's service for people with intellectual disability describes their system of person centred planning, which has a system of agreeing outcomes with clients and monitoring progress with them.

Others describe continuous assessment in care plans, such as for the Respite Care team.

8. Outcomes	Phase 3 Begin	Phase 3 End	Difference
Yes	7	12	5
No	10	5	-5
As required	1	1	0
Total	18	18	

Teambuilding

The majority of the teams have not had a teambuilding training day for their team as a whole. Portarlington PCT has had two training days, and the Community Rehabilitation Team has had a training day during the programme, and wants to repeat this. Other teams have struggled to identify time and budgets, although in evaluation forms have identified the need for this.

Team leaders for each of the teams were invited to a teambuilding day, and had an opportunity to use some of the tools and techniques to encourage team working. This day was evaluated as successful, and team leaders expressed a view that they wanted to have an opportunity to have a training day with their team members.

9. Teambuilding	Phase 3 Begin	Phase 3 End	Difference
Yes	4	5	1
No	14	13	-1
Total	18	18	

Patient Satisfaction

Half the teams carry out patient satisfaction surveys. For instance, the mental health team has carried out a survey with the Irish Advocacy network. There has been a specific survey on dental services for travellers. One of the teams is considering focus groups as being more appropriate for the client group. The Springfield Centre has interviewed patients and families. One team states that *"clients are asked for feedback as part of their monthly review."*

The introduction of service user satisfaction surveys and other methods for monitoring service user satisfaction has been the subject of presentations and discussions within the teams, and assessed as part of an overall system of performance management.

10. Patient Satisfaction	Phase 3 Begin	Phase 3 End	Difference
Yes	9	9	0
No	9	9	0
Total	18	18	

Leaflet

Teams agreed that the promotion of their services, through leaflets, websites and other systems, was an important part of the process. It was agreed in discussion that there was a lack of information about available services, eligibility, access, service offered, staffing etc. Therefore a number f the teams undertook to create or update a leaflet advertising their services. Those that have developed leaflets during the programme include Portarlington PCT, admissions and discharge team and aids and appliances.

Other teams have their leaflets in draft and are consulting on the content and awaiting approval for production. The ICON team has been assisting with the development of these leaflets using a template as a guide to good practice.

11. Leaflet	Phase 3 Begin	Phase 3 End	Difference
Yes	11	14	3
No	7	4	-3
Total	18	18	

CONCLUSION

Over 150 staff have been involved in ICON Phase 3, and team membership has grown during the programme.

Phase 3 of the ICON programme has helped in raising awareness of the systems and processes that need to be in place in order to support and facilitate integrated working. The team leaders have been working on the “Standard Operation Procedures” and their guidelines, using material and support form the ICON project team. Particular progress has been made in producing leaflets, developing a single file, agreeing an information sharing protocol and adopting outcome measures.

The progress being made as shown in the analysis appears to be modest. However, it is noted that team leaders have expressed the view that they are much clearer about what needs to be in place, and are working on drafts to introduce these systems. It must be recognised that when these systems are introduced, there needs to be discussion, consultation and negotiation with all parties. Therefore time needs to be allowed for this process to take place, and the eventual signing off of the new documentation and systems.

This analysis shows that progress is being made, but that a longer period of time needs to be allowed in order for the full benefits of being in the ICON programme are brought to fruition.

RECOMMENDATION

It is recommended that the teams continue to be part of the ICON programme, and continue to receive support and assistance from the ICON project team.

APPENDIX C - EVALUATIONS

Introduction

Evaluations have been carried out with the key participants in the programme, including the steering group, line managers, team leaders, teams and ICON project team. The results of the analysis are summarised below.

Steering Group

The views of the Steering Group were extrapolated through a questionnaire at the end of Phase 3 which covered four themes

:

- Involvement of members of the group,
- Implementation sites,
- Integrated care
- Issues for the future[46].

Ten out of a potential twelve members completed the questionnaire. The two members who did not submit a questionnaire were a manager who has recently changed position, and a new manager who has recently been appointed. Of the 10 who responded, 8 managers have been on the group since November 2002 when it was first formed. This has provided continuity and consistency to the project. Most responded that they believed that the membership was satisfactory, although there were some suggestions regarding having clearer service user involvement. There were some reservations expressed about the attendance and contributions from members. 9 out of 10 believed that the frequency of meetings had been appropriate, and all said that the dissemination of information was acceptable (ranging from satisfactory to excellent). Proposals for the future governance included a PCCC board, a national forum and more local implementation groups geographically orientated. Additional membership suggested including Local Health Officers (LHOs), hospital representatives and service users.

The members were asked to describe their role as sponsors of their implementation sites, and 6 described it as supportive with advice. Some said that they were motivating and enabling. 2 members recorded that their input was limited due to lack of time. The most frequently mentioned support required for the implementation sites was ICT.

[46] Steering Group Questionnaire Analysis (Ref E001)

When asked how members might progress integrated care further, suggestions included specific links to organisational objectives, links with corporate fitness structures including accreditation and audit, and shared learning. The suggestions all refer to embedding ICON within the structure and systems of the organisation.

When asked about who is to be involved in integration, the general view was that everyone should be involved.

Critical success factors included commitment from managers, clear vision, good planning, good communication and ongoing evaluation. The members rated the progress of the sites they had sponsored. Of the 15, only 2 were recorded as slow to develop. The others were satisfactory to excellent. Where there were specific achievements the relevant factors were suggested to be management support and levels of commitment. Challenges and issues for sites were identified as being primarily ICT, lack of time, a need for administrative support and funding.

Members were asked their views on the selection of future sites and whether the criteria should change. Half of the respondents chose not to comment on this, or suggested that there should be no change. Others made suggestions with regard to having specific systems and resources in place, or improved preparation such as fully understanding the ICON principles before joining the programme.

The responses in the questionnaire were generally positive about the programme and there were no proposals for a fundamental change. There were some contributions on how the programme might be extended, and the need for more engagement with people who use the service was stressed by a number of members.

Line Managers

Line Managers were invited to two sets of workshops. The first was in September and October 2004 and was timed to coincide with the start of Phase 3. This workshop session was used as a briefing for line managers and an opportunity for them to discuss how the current management arrangements helped or hindered the integration agenda, and what they might be able to address to facilitate integration. The second set of workshops was held in April 2005, so that progress could be reviewed.

In the first workshop all line managers recorded that they enjoyed the workshop, and 93% felt that they had contributed to the project[47]. 43 out of the 44 participants felt that they had learned more about integrated care from the session and all but one participant recorded that the day helped them to identify benefits of integrated care. The facilitated group discussions between managers

[47] Line Managers Workshop Evaluation Sept & Oct 2004 (E001)

were considered to be the most interesting aspects of the workshop. 42 managers said that they were now more enthusiastic about the benefits of integrated care.

"I am always looking for opportunities. There are a lot of integrated work practices already in operation. There is already enthusiasm"

Managers were invited to put forward areas of work to be addressed and these included disseminating information widely on the ICON work to date, and sharing information on innovations and benefits within each of the teams. Managers recognised that they had a responsibility to cascade information on a regular and systematic way. Managers recognised the importance of developing directories of services in order to support their staff and teams. Managers also recognised their role in helping teams to have the appropriate environment and infrastructure for integrated care (accommodation, equipment etc.) Managers also recognised the need to fully involve teams in the creation and development of service plans and goals and to make sure that these incorporated integrated care. Managers recorded the value of administrative staff being part of the teams, and recognised the value of their contributions. Participants said that the workshop overall was highly beneficial in furthering an understanding of integrated care and its implications.

"Getting the understanding – the light came on!"

"Clarification of how ICON will work and how it can fit into any and all services."

The ICON Project Team invited Line Managers within the Board to a second half-day workshop held on the 4th and 5th April 2005[48]. The objectives for the sessions were to provide update on the progress of ICON implementation, across the Midlands and within individual sites, identify opportunities and challenges for implementing ICON; and to discuss next areas of development for the spread of integrated care.

The 23 Line managers who attended were asked to consider the opportunities and challenges for the implementation of ICON and to offer advice on the next phase of the process. These managers completed an evaluation form. All of the managers recorded that they enjoyed their participation in the group work and 96% found the session met their needs. One participant stated that they 'needed more basic information about the ICON concept and implementation in practical terms without the jargon'. Several felt that the session contributed to their understanding of the process generally and within their local area. A number of sessions within the workshop were identified as useful, with the majority identifying the session which enabled them to hear from other line managers and having the opportunity to discuss together. A few (13%) of the participants were unhappy with an aspect of the session stating that there was a need for more focus upon two way dialogue and facilitation than on presentations. Topics to be covered in future meetings included

local implementation and practical applications, reviewing and disseminating progress, impact and client feedback, clinical governance, accountability and 'moving from pilot status to embedding integrated care'.

74% of respondents stated that they learnt a lot more about the implementation of integrated care. However some people wanted 'more information on the development of new sites' and also stated that line managers were unclear as to the roles of other people within ICON'. Most of the participants (61%) felt that the session had helped identify more of the potential benefits and challenges of integrated care, however some stated that it had only helped 'a little' with comments around management, lack of time and resources. There were mixed opinions as to whether the session had helped to support them as a manager, either stating that it helped them a lot, a little or that it was not applicable. None of the participants stated that it had not helped them. The managers stated that they would endorse the values of ICON and encourage staff that integrated care is the way forward, provide protected time, information and training around ICON and integrated care.

'Puts integration of care under the umbrella of a standardised approach – ICON'

'Encouraged me to play a more active role in integrated care'

Participants identified a variety of aspects of integrated care that are going well within their service, including communication, referrals, standardised documentation including singe files and team building. There were also a variety of aspects that were deemed to be going less well and these included the development of SOPs, time for development, information on ICON and communication. The main theme identified in terms of support required over the next six months was the need for on-going training and support in the practical application of integrated care. There were a number of suggestions around the future development of integrated care, which included identification of additional implementation sites, dissemination of learning, re-branding of ICON moving it away from pilot status, providing adequate staffing to projects, agreeing referral pathways and streamlining services. Generally there was a view that there was a need for more sharing and communication.

"More days like to today – to help us to develop integrated care."

The workshops for line managers were positive and produced a clear steer for future development, both at a strategic and an operational level of focus. A high degree of commitment to integrated care was expressed, with a strong willingness to move the project focus of ICON into mainstream delivery. Both workshops discussed the requirement to communicate ICON much more clearly in terms of delivering national aspirations of integrated care and moving the focus from 'additional'

[48] Line Managers Workshop April 2005 (E002)

activity to the way that care is routinely delivered. It was suggested that to do this well there is a need to review learning and to systemise the forward approach and involve a more formal integration and utilisation of the manager's role and influence across individual areas of practice and operation. It was noted that the scale of operational change associated with the system reform agenda could pose a significant threat for the stability of further ICON development and the influence of the Steering Group will be required to ensure that appropriate linkages are made between ICON and other national areas of development.

Teams

Evaluating the ICON Teams

A questionnaire was designed by the ICON team the purpose of which was to measure the status of the teams in the ICON implementation sites at the beginning of the process and the same questionnaire would be used at the end of Phase 3 to measure changes which took place during the implementation of ICON Questionnaires were completed for each of the teams at the start and end of the phase, enabling an assessment to be made of the progress made throughout the programme. Questions in the initial base line assessment in November 2004 were asked again in June 2005 and covered the following areas:

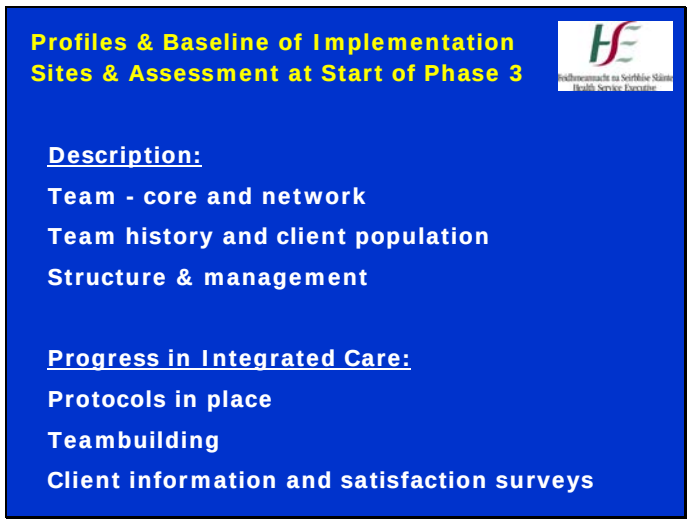
- Name of team, lead person and length of time in operation
- Cost code
- Client group, referral process
- Client records, single file and data sharing protocol
- Common assessment and Care Plan agreed with client/carer
- Outcome measures
- Team building training
- Patient Satisfaction survey
- Information Brochure

Sponsors were asked to complete a form which provided details of the membership of the core teams and the network teams associated with each implementation site. The form asked for details on:

- Client group, geographical area and service covered
- Team name, team leader and team address with contact details
- Team members by name, job title, contact details and ICT availability

This enabled an assessment to be made of how teams may have changed over the Phase.

Profiles and Baseline Assessment of Teams



An analysis of the base line assessment and progress throughout the programme is currently being undertaken. The ICON project team manager described the ethos of the learning sets and the approach taken to supporting team by stating that *"this is not a race to the finish but a movement along a continuum to ensure that services are moving towards greater integration"*

A SWOT analysis on the ICON programme by team leaders was carried out in the June workshop, and encapsulated some of the learning from the phase. The team leaders were asked what advice they would give to future ICON implementation site teams and team leaders, and this prompted some practical suggestions with regard to preparation for the programme, dedicated time, making sure of good attendance at the monthly ALS meetings and ensuring management support in order to get the best out of the programme.

Strengths	Weaknesses
Changing environment created	Teams and Team leaders needed more preparation prior to the ALS
Supportive	Teams need more administrative support for all the document review, database etc
Shared learning and shared experiences – understand other team challenges	Under-estimated time required
ALS cover all geographical areas	Need to reschedule time allocated for ICON
Monthly meetings offsite and "real" issues discussed at meetings	Some confusion over language – such as care pathway/referral pathway
ICON Project team support – on site visits appreciated	
Improved job satisfaction with an opportunity to reflect and review	
Opportunities	**Threats & Challenges**
Teambuilding training day was helpful – identified team members	Uncertainty in the reform process
Understanding team dynamics helps	Lack of resources – staff, time, money
ALS created protected time	The ceiling for staff employment inhibits the build up of teams
The pack of ICON material and guidelines was helpful	Branding of integrated care as ICON may be a problem
Public expectation of coordinated services – want to avoid duplication	ICON programme may be seen as excluding
The individual assessments of teams on sire?? by the ICON project team such as the baseline questionnaires	Integrated care has many guises – identifying models throughout the organisation
Building on good practice	
Consumer panels offer an opportunity for user input and providing an equitable service	
Meetings outside service environment creates opportunity for discussion	

Team Leaders

Team leaders appraised the progress of the ICON Phase 3 programme in a number of ways. They completed evaluation forms at the end of each of the action learning sets. They developed presentations to make to the rest of their group on how they were progressing with integrated care. The team leaders provided an evaluation on the training that they were given on team building. Team leaders completed assessment forms in the final workshop in June and made presentations to the group on the key benefits of being in the programme.

The overall response has been highly positive, with all team leaders citing benefits from being within the programme.

The ICON Shield that was completed at the end of the programme directed team leaders to identify four areas to comment on: personal, professional, administrative and developmental. Themes within the personal element included the importance of reflective practice and learning how much each site had in common with one another. As one team leader said

"I have felt challenged and have had to be innovative, motivational, positive and find solutions. I have enjoyed networking and making new friends and connections. This has encouraged me to be adventurous and change."

Themes on the professional development include a focus on evidence-based practice and the importance of team work/trans-disciplinary working. One team leader said *"We now have a more structured approach to delivering our service." "We are now more client-centred."*

With respect to administration, team leaders referred to the furthering of IT skills and the examination and review of forms for relevance and whether they are "client-friendly." Other administrative issues have been the importance of stakeholders and the need for ongoing evaluation.

Team leaders referred to the developmental aspect of the ICON programme such as not being afraid to ask for help when needed, developing more skills and the importance of team support. *"It just reinforces again that all new challenges/beginnings take time and have teething problems – but that with perseverance will succeed…….with patience and encouragement."*

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Overall the team leaders recorded highly positive benefits from the investment of time that they have made to being part of Phase 3 of the ICON programme.

ICON Project Team

ICON project team members evaluated the programme through a SWOT analysis – strengths, weaknesses, opportunities and threats. The outcome is summarised below. The findings on strengths and opportunities provide a strong platform for progressing the next phase. The team considered carefully the weaknesses and threats or challenges, and incorporated ways of addressing these where possible into their Phase 4 proposals.

The main strengths were considered to be the positioning of integrated care in the international and national agenda, the management commitment and the enthusiasm generated. The key opportunity was to expand the programme across Ireland, building up teams and networks around primary care teams as set out in the Primary Care Strategy. One of the significant weaknesses was the delay in the implementation of ICT systems to support integrated care. Threats and challenges may be a lack of time and attention to address the changes required.

Strengths	Weaknesses
International context – integration a priority and connections with international networks gave confidence	ICT infrastructure not yet in place – limits integration
National context – reform gave opportunity to re-evaluate	4 out of 22 teams did not take part – issues of opting out for this and future phases
Involvement in associated national programmes such as Digital Networks and PCCC ICT Strategy	ICON Project team may be considered too small for size and diversity of programme
Management and Leadership drive and commitment	Need to continually raise awareness of ICON throughout the organisation – such as more roll out sessions
Management continuity through membership of ICON Steering Group and Project Team	Risk that the programme is considered by some to be process driven and concerned only with documentation
ICON Management and Reporting structure clear, with explicit programme and objectives	Team leaders did not always take their whole team with them – focus of programme on leaders rather than teams
Line Managers support shown through engagement with workshops and support to teams	Steering Group attendance was low at times throughout the programme and input limited

Champions of integrated care through team leaders	Many team Leaders recorded limited contact with their Sponsors, so this element of support did not work well in practice.
Staff commitment as shown through attendance at ALS, workshops and roll outs	There was a variety of input from line managers to teams – some had very little contact or support. Need to formalise this more in the structure
Culture of empowerment, innovation and risk – “ask forgiveness not permission”	Measurement Tool was considered by some teams to be limited in its use and wanted more training and support in order to get more from it.
Evaluation built into programme	Measurement Tool reporting function not yet developed so benefits to teams and programme not yet felt.
Solution-focused approach encouraged for all involved.	Teams and team leaders wanted more preparation for the programme
ALS a strength - has enabled shared learning and support, with encouragement for reflection	Recognition that there is a need to reorganise and re-orientate services in order to work in an integrated way
Process supported professional and personal development of team members and others engaged in process	Lack of input at all levels by people who use the service – contrary to trying to deliver person-centred care
Programme size provided a variety of teams across services and geography which added to the learning	
Improved knowledge of services and staff with care pathways developed which is encouraging connections across a wider network	
Engagement with Consumer Panels, Partnership Board has been very constructive	
Programme well-documented, with evaluation built into process	
Connections with academic institution helpful, strengthening the evidence base for the programme	
Measurement Tool giving access to guidance and protocols helpful	

Starting to go beyond PCCC into hospitals	
Opportunities	**Threats & Challenges**
To roll out nationally, and develop the programme and the model further	Lack of time from teams limits what they can achieve
To improve links with other parts of the HSE on the Integration/ICT agenda	Integrated care being seen as an “add on” rather than integral
ICON programme gives permission to participants to create links with counterparts across the organisation	Integrating care being subsumed into wider agendas such as governance or quality
Midland Area in forefront of integration agenda	Industrial relations issues regarding staff changing roles and responsibilities
PCT structured to enable the development of teams and networks	Wider structural implications that are not addressed
Learning from each other – a structured programme that facilitates this	Funding restrictions for the programme, teams and services
Improvement to service to client, and learning of ways to further engage with service users	ICT could be a threat if time from ICON Project Team is diverted onto iSoft requirements and away from the wider programme
Opportunity to contribute to debate on structures and governance in line with integration	LHOs will be key – priorities not yet known
Appreciation of the different levels of integration – not all aiming for full integration	Integrating care not yet a requirement in HR systems - such as person specification, job descriptions etc.
Design care pathways to learn more about the service and interactions	Need to recruit appropriate people into the ICON Project Team that have the experience to offer teams
Support staff in teams to express what is needed to improve the service and enhance integration	Performance measures not yet linked to integration, and lack of clarity on the management and performance responsibilities
	If ICON widens nationally may slow down the pace and lose momentum

APPENDIX D – CODING REFERENCES

C	Case Studies	C001-C008
V	Vignettes	V001-V003
M	Course	M001 – M002
E	Evaluation	E001 – E006
W	PDF files	W001-W006
P	Presentations	P001 – P021
R	Publications	R001 – R003
D	Reports	D010 – D020