Central Coast Integrated Care Program
Formative Evaluation: Technical Paper
March 2018

Prepared for the Central Coast Local Health District
About the CRRMH

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and is a major rural initiative of the University of Newcastle and the NSW Ministry of Health. Our staff are located across rural and remote NSW.

The Centre is committed to improving mental health and wellbeing in rural and remote communities. We focus on the following key areas:

- the promotion of good mental health and the prevention of mental illness;
- developing the mental health system to better meet the needs of people living in rural and remote regions; and
- understanding and responding to rural suicide.

As the Australian Collaborating Centre for the International Foundation for Integrated Care, we promote patient-centred rather than provider-focused care that integrates mental and physical health concerns.

As part of the University of Newcastle, all of our activities are underpinned by research evidence and evaluated to ensure appropriateness and effectiveness.

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<tr>
<td>ACI</td>
<td>Agency for Clinical Innovation</td>
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<td>CCAPI</td>
<td>Central Coast Alternate Pathways Initiative</td>
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<td>CCLHD</td>
<td>Central Coast Local Health District</td>
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<td>CCMARC</td>
<td>Central Coast Multi-Agency Response Centre</td>
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<td>DET</td>
<td>Department of Education and Training</td>
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<td>FACS</td>
<td>Department of Family and Community Services</td>
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<td>FRS</td>
<td>Family Referral Service</td>
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<td>FRS in Schools</td>
<td>Family Referral Service in Schools (sometimes referred to as FRS, or FRSIS)</td>
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<tr>
<td>GP</td>
<td>General Practice/Practitioner</td>
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<td>HETI</td>
<td>Health Education and Training Institute</td>
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<td>HNECC PHN</td>
<td>Hunter New England Central Coast Primary Health Network</td>
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<td>LHD</td>
<td>Local Health District</td>
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<td>NWPOC</td>
<td>North Wyong Proof of Concept</td>
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<td>PC</td>
<td>Primary Care</td>
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<td>PHN</td>
<td>Primary Health Network</td>
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<td>SES</td>
<td>Socio-Economic Status</td>
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<td>WWICCP</td>
<td>Woy Woy Integrated Care Coordination Pilot</td>
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Summary

Introduction: This paper presents the findings of a formative evaluation of the Central Coast Integrated Care Program (CCICP). There is no universal definition of integrated care but integrated care is understood to entail: person-centred care (i.e. care takes into account the individual’s needs, values, preferences and their own understanding of health/illness); co-ordinated care around individual needs to overcome fragmentation of service delivery; improved quality and cost-efficiency of care which necessitates a population health approach; and service innovation that is organised to meet the needs of the people involved (patient, carer, family member or population).

The program: The Central Coast Local Health District (CCLHD) was appointed as an integrated care demonstrator site by NSW Health in 2014 and awarded approximately $18.5 million in funding over four years (2014-2017) to further their pre-existing relevant initiatives. The CCICP implemented a plan structured around three target populations and an enabling architecture to support these streams. The target populations were: vulnerable youth and children, vulnerable older people and people with chronic and complex conditions. The components of the enabling architecture included: population health approach (including assessing population health needs and risk stratification), outcomes-based commissioning, co-design, information sharing technology, and multiagency Accelerated Implementation Methodology training. The CCICP involved working with health and social care partner organisations, in a coordinated person-centred fashion with a community/primary care focus.

Aims: As this was a formative evaluation the main aims were: to provide a description of the CCICP, chronical how the work had been implemented taking into account what had affected progress and to consider what evidence there was that advances towards integrated care had been made.

Methods: A mixed methods case study approach was adopted. The Project INTEGRATE framework was utilised to aid understanding of the complex and comprehensive nature of integrated care and to help assess progress. A review of documents, informant surveys (n = 27) and informant interviews (n = 23) were used to collect data. Key stakeholders that were invited to participate in surveys and interviews were identified by the CCICP core team. Descriptive statistics were used to analyse quantitative data and qualitative data and used a combination of content and open thematic coding.

Findings: This evaluation described an ambitious integrated care program involving three target populations that took an innovative approach to overcome service delivery challenges. Some gains, as defined under the Project INTEGRATE framework, towards integrated care are evident but the CCLHD still has some way to go. The context under which the CCLHD was engaged as a demonstrator site was not the same context under which they had to operate. This changing landscape created difficulties for the CCICP. Internally four key areas were identified that could act as variously as barriers or facilitators: leadership, staffing/personnel, communications/relationships and service gaps/needs. Greatest gains have been in collaboration and cooperation between service providers. The most notable gaps were in the areas of routinely involving service users in their care plans, ensuring the buy-in of service provider staff and electronic information sharing.

Conclusion: It appears that there is a need for greater attention on the needs of staff. Achieving the cultural change, communication channels and well-functioning relationships necessary is difficult in one organisation but this a multi-organisational context. Further, unless leaders are vigilant there is a risk that gains made towards integrated care could be lost as the focus on integrated care may dissipate in a transition to business-as-usual. Continued progress is only likely to be possible if supported by appropriate government supports and funding structures.

Limitations: The perceptions of key stakeholders with an incomplete view had to be relied on. The implementation has had a short time to run for the hoped for gains to be achieved.
1 Introduction

This technical paper describes a formative evaluation of the Central Coast Integrated Care Project (CCICP). An evaluation commissioned by the Central Coast Local Health District (CCLHD). The paper supports the Evaluation Report [1] which examines the lessons learned and makes recommendations. This paper has a greater focus on how the evaluation was conducted, the data analysed and the conclusions drawn.

1.1 Integrated care

The concept of integrated care has been traced to Ancient Greece where there was already a concern that care provided did not treat the whole person. The current concerns appear to have originally been stimulated by the World Health Organisation’s Alma-Ata Declaration on Primary Health Care of 1978 [2]. Internationally, recent reforms of health systems aimed at better integrative care have been driven by increasing health care costs as populations age and increasing numbers of people with chronic and complex conditions [3].

Integrated care has become a dominant strategy for increasing health system performance [4]. Goodwin, Stein [2], while recognising that there are many definitions, concludes that in practice integrated care has come to mean: care with a person-centred focus; co-ordinated care around individual needs to overcome fragmentation of service delivery; improved quality and cost-efficiency of care which necessitates a population health approach; and service innovation that is organised to meet the needs of the people involved (patient, carer, family member or population). Person-centred care takes into account the individual’s needs, values, preferences and their own understanding of health/illness [5]. Hence, integrated care aims to improve access, quality and continuity of treatment, reduce fragmentation of services and improve health outcomes, as perceived by the consumer, through service innovation [2, 5].

There is no formula for the provision of integrated care. For Borgermans, Marchal [3], delivering integrated care is about focusing on what the service user wants, taking big innovative steps, ensuring staff have the appropriate skills, taking a broad view of what wellbeing means, creating effective implementation strategies, compatibility with the context and monitoring of outcomes to ensure aims are being met. Importantly, much depends on, for example, the context of the health system in which it is being delivered [3] and is likely to vary according to the aims of the initiative and the groups being targeted. It is notable in a comparison of initiatives from different countries by Wodchis, Dixon [6] that there was much variation in the degree and type of integration. Some involved full organisational integration of health and social service providers, while others entailed cooperation among independent health services. On the other hand, commitment to make supporting organisational changes such as pooled funding was considered necessary. Furthermore, there were some commonalities in the experiences of these initiatives, which included the transition not being easy and that it took time to create an enabling environment and be able to see benefits. The involvement of service users in both in design and care planning is also generally accepted as an imperative to meet person-centred care objectives. Certainly, in Europe involving service users in service policy, design and evaluation is considered crucial [3]. Moreover, particularly successful examples of integrated care in Scotland [7] and New Zealand [8] involved extensive community consultations.

Integrated care has been posited as an important potential strategy for achieving the triple aim of: improving the experience of care; improving the health of populations; and reducing per capita costs of health care [9, p. 759] and more recently includes a fourth aim of improving the experience of the health workforce has been suggested as a “quadruple aim of healthcare” (Figure 1), acknowledging that the triple aim goals cannot be achieved without, or at the expense of, the workforce [10].
1.2 The Australian health system and integrated care

The provision of health care in Australia is fragmented, with services delivered by multiple public and private providers funded by a mix of federal and state government and private sources with varying goals and responsibilities. Furthermore, complexity and overlap result in services funded by one source having implications for services funded by another without their being common accountability to foster improvements in collaboration and efficiency. For example, downstream expenses incurred in state funded hospitals require upstream interventions by GPs and other health service providers in the community, many of whom do not fall under the jurisdiction of the state health authorities. Improved discharge planning for patients transferring from acute (state funded) to post-acute or rehabilitation settings (mostly federally funded) improve post-discharge care, avoiding readmissions and so improve unit and system efficiency and result in a better outcome for the patients.

Moreover, service funding is generally activity-based utilising fee-for-service arrangements which reward the quantity of services provided rather than the quality. As such these funding arrangements tend to overlook the population health needs and disincentivises collaboration that focuses on service user needs and outcomes. For example, efficiencies gained by better primary care may result in reduced hospitalisations which may in turn lead to budget restrictions due to reduced hospital activity. Thus perverse incentives apply which may result in unintended penalties for good practice.

On the other hand, the public provision of universal healthcare under Medicare in Australia has achieved many care advances and for providing an excellent public health service, via its public/private system [11]. Australia’s great advances in terms of care, population health and other areas of healthcare, over the last quarter-century have been noted in international comparisons [12]. Schneider, Sarnak [12] find that Australia performs badly in regards to equity of service provision compared to other high-income countries. Hence, there are significant problems, particularly in the areas of equity, access, sustainability and efficiency, which are causing problems for the healthcare system overall. These problems require solving if the public provision of healthcare is to be
maintained to a high, sustainable and equitable standard, both now and into the future. Similar points and issues are also active in the private provision of healthcare in Australia, with similar and connected problems. Analogous problems have been noted in other healthcare systems across the developed world – particularly in the United Kingdom and United States [12].

1.3 Integrated care in NSW – appointment of demonstrators

The goal of the NSW government has been to improve the health of the NSW population, in a way that is both sustainable and equitable. This goal is hindered by the lack of integration in the healthcare system overall. It is thus hypothesised that improved integration of public healthcare will make the public system more sustainable, more equitable and better able to pursue the goal of public healthcare in both NSW and Australia overall.

The NSW Government strategic plan presented in NSW 2021 [13] outlined two health goals and a related Family and Community Services goal:

- Keep people healthy and out of hospital.
- Provide world class clinical services with timely access and effective infrastructure.
- Better protect the most vulnerable members of our community and break the cycle of disadvantage.

The NSW State Health Plan supported these goals, by advocating a whole of government approach to the integration of health care. The expressed aims of the plan was to enable NSW Health to be: ‘person-centred’; ‘respectful and compassionate’; ‘integrated and connected’; ‘providing the right care in the right place at the right time’; ‘based on local decision making’; ‘providing a whole of society approach to health promotion and prevention’; ‘characterised by strong partnerships’; ‘innovative’; ‘financially sustainable’; and ‘fostering a learning organisation’ [14]. NSW Health committed to $180 million over 6 years (2014 to 2019) to an integrated care strategy a key part of which were three LHD demonstrator sites; namely Western NSW, Western Sydney and Central Coast [15]. The Central Coast LHD, and the other demonstrator sites were funded approximately $18.5 million over four years (2014-2017) ($50.6 million between the 3 demonstrator sites).

The NSW Health Demonstrator initiative determined that the selected local health districts would work in partnership with PHNs and other health agencies in the primary care, not-for-profit and private sectors to develop and progress approaches to integrated care to address the coordination and provision of services for service users in full understanding of local factors. Moreover, the three selected Demonstrators would network with each other and with NSW Health’s state-wide agencies and “pillars” including the Ministry of Health, Agency for Clinical Innovation and eHealth NSW, to ensure that lessons learned in one site could be implemented elsewhere. The strategy would adopt a system-wide approach that was informed by local priorities, with the aim to transform local health systems in a way that makes integrated care sustainable into the future.

1.4 Central Coast context

The Central Coast LHD served an estimated population of approximately 345,000 in 2017 [16]. The Central Coast of NSW lies just north of Sydney and covers an area of 1681 km²[17]. The main health service issues and needs identified for the Central Coast LHD are:

- increasing hospital attendances and admission rates in hospitals operating at or over capacity,
- increasing burden of chronic disease and obesity, and
- higher proportion of aged, vulnerable youth and people living with chronic and complex conditions [18].

In addition to the political and policy context and impetus for integrated care outlined above the Central Coast was well placed to undertake the demonstrator site role. Prior to the demonstrator opportunity, the Central Coast LHD had run several initiatives aimed at better care integration. Moreover, the Central Coast LHD has a defined geography and service footprint, with one LHD, one Medicare local (at the inception) which incorporated into the Hunter New England Central Coast Primary Health Network (HNECC PHN), one Aboriginal Health Service...
(Yerin Aboriginal Health Service Inc.), a well-established GP collaboration unit, and good links with the Department of Family and Community Services (FACS) and the Department of Education and Training (DET).

Furthermore a key CCLHD strategy document, Caring for the Coast strategy, describes five key priorities highly relevant to the vision of the integration of care and align closely with the quadruple aim of healthcare [19]. They also acknowledge the role of partnerships in meeting health needs into the future. These priorities are:

1. Our patients – Provide the best practice care to ensure patient safety and satisfaction
2. Our staff – support and develop our most important resource and provide a safe and rewarding workplace
3. Our resources – use resources effectively and efficiently
4. Our community – invest in better health by promoting a healthy lifestyle and available health services
5. Our future – develop strong and effective partnerships to meet the community’s health needs

1.5 The Central Coast Integrated Care Strategy Implementation plan summary

As part of their bid to be an integrated care Demonstrator, the Central Coast agreed to undertake a number of activities and approaches to better integrate care on the Central Coast. The Central Coast Integrated Care Strategy Implementation Plan 2014 (p.13) suggested that the core components would include 3 objectives:

1. Developing a commissioning function jointly governed between the LHD and the then Central Coast NSW Medicare Local (now HNECC PHN), taking in a whole of system approach to the region’s health and social needs, working with stakeholders in prioritising target populations, service design, resource allocation and contracting.
2. Enabling an integrated care system architecture that would be person-centred and allow movement towards anticipatory care for people with higher needs (away from system-initiated reactive care).
3. Catalysing change in models of care for three key target population groups:
   o vulnerable young people,
   o vulnerable older people, and
   o people with chronic and complex conditions.

In line with NSW Health’s expectations for demonstrator sites, innovation and learning were adopted as underlying principles. Hence, initiatives were explored and trialled and their ability to augment integrated care outcomes in the Central Coast context was considered. Necessarily, therefore, the CCICP took a flexible implementation approach with lessons learned from initiatives whether or not they were found to make a useful contribution to meeting integrated care goals.

Moreover, this work as a demonstrator site was conceived in CCLHD as the formative work for a ten-year vision to transform the care system on the Central Coast. It is clearly summarised on p4 of the Central Coast Integrated Care Strategy Implementation Plan 2014 and reproduced in Figure 2.

1.6 Major contextual changes during CCICP

It should be noted that the context that the CCICP was implemented changed over time and these events and changes impacted the trajectory and tempo of implementation (see Figure 3). Funding for the CCICP arrived in October 2014 and the CCICP leader, Anthony Critchley, was appointed. The rest of the CCICP team was appointed in April 2015, when the business of implementing the CCICP plan began in earnest, thus it is best considered that the implementation period began in April, 2015.

The major partner in the originally planned work was the Central Coast Medicare Local which then underwent a transition to the Hunter New England Central Coast Primary Health Network (HNECC PHN) in July, 2015. This involved a change in focus, broadening scope from primary care and general practice support to a commissioning function and work in low and moderate intensity mental health services and suicide prevention. For the CCICP
it also meant that its new partner organisation had a responsibility far beyond the boundaries of the Central Coast. The Central Coast Medicare Local had a footprint concurrent with Central Coast LHD, of 330,000 people spread across 1686km² and the new HNECC PHN serviced three times as many people (1.2 million) over an area more than 78 times as large (133,812km²) [20].

Figure 2: The Central Coast Integrated Care Strategy Summary 2014

Another key partner in the CCICP, the Department of Family and Community Services (FACS) underwent a restructure in September 2016, which resulted in some staffing changes and the loss of key contacts and historical knowledge, thus a slowing of momentum of work with this partner.

Numerous changes in the way the CCICP has been led and managed have occurred with the Central Coast LHD undergoing a restructure in July 2016. Then in August 2016 Matt Hanrahan took up a new position elsewhere, leading to the appointment of a new CEO (Andrew Montague). Furthermore, in February 2017, CCICP’s leader Anthony Critchley was seconded to the role of Mental Health Director in the Central Coast LHD. At this point, Michael Bishop stepped into the acting CCICP leadership role from his previous role as Business Integration Manager, a function that was then backfilled by Sarah Wilcox.

At the State-level, Minister Jillian Skinner - who had instigated and overseen the integrated care Demonstrator initiative retired in February 2017 and was replaced by the Hon Brad Hazzard, who notably was previously the
Minister for FACS. Also, the original Demonstrator funding window that ended on 30th June 2017, with a further extension to 30th June 2018. Furthermore, internally the CCICP focussed on moving successful integrated care projects to “business as usual”, without the certainty of further dedicated funding beyond that window. There was concern expressed by stakeholders that the Ministry of Health was assessing integrated care in a more narrowly constrained light (enhanced chronic disease management for example) and as such, the focus of work on the Central Coast could be undervalued by omission.

Figure 3: Timeline – Major contextual changes during CCICP
2 Methods

2.1 Evaluation purpose and approach

This formative evaluation of the Central Coast Integrated Care Program (CCICP) was commissioned by the Central Coast Local Health District via a competitive tender process. A formative evaluation is: “a rigorous assessment process designed to identify potential and actual influences on the progress and effectiveness of implementation efforts” [21, S1]. Thus the aim of this evaluation was to provide a detailed assessment of the implementation of the CCICP in the context of Central Coast strategies and priorities, to identify successes and problems and make short and medium term recommendations (recommendations are addressed in the Evaluation Report (Dalton et al., 2018) regarding how the program interventions can be adapted or improved to better meet the CCICP aims. To this end, a case study approach was adopted. According to Thomas and Myers [22] “Case study is about viewing and studying something in its completeness, looking at it from many angles and attempting to understand the interconnectedness of the elements comprising it” (p. 15). The outcomes of the CCICP activities are being assessed by a number of other evaluations.

This evaluation applied co-design principles with dialogue between CCICP partners and researchers throughout the process and sought to achieve a shared understanding of the dynamic context of the program, and the barriers and enablers for the various interventions.

The agreed evaluation methodology utilised the Project INTEGRATE framework [23] a validated international framework of integrated care. The mapping of the activities of the CCICP to the dimensions of Project INTEGRATE [24] enabled assessment of the breadth of CCICP activities and comparison with international exemplars.

Integrated care endeavours are by definition complex, thus we need suitable frameworks that can anchor and aid our understanding of the complex and comprehensive nature of integrated care processes. The Project INTEGRATE framework, is based on a four year study on examining best practice for integrated care in Europe [23]. The Framework provides an evidence-based understanding of the key dimensions and items of integrated care that were associated with successful implementation. Moreover, the different framework dimensions and items were seen to be both relevant and important in different country-contexts and to different disease- and condition-specific population groups. Thus, the framework provides a conceptual basis for reflecting on the design and implementation of integrated care programs [24]. These dimensions are outlined in Research questions

The evaluation asked the following key questions:

1. What is meant by integrated care in the context of the CCICP? Is this meaning common to other integrated care initiatives internationally?
2. What are the objectives of the CCICP? How do these objectives compare to other integrated care initiatives internationally?
3. What are the key components of the intervention, including its management, roles of professionals, organisational changes and supporting systems?
4. What are the characteristics of the groups being targeted?
5. What role did the context play in the implementation (facilitator, barrier)?
6. What were the key barriers to deployment? What were the key facilitators? How were they overcome or strengthened, respectively?
7. What has been the impact on professionals and other stakeholders in terms of added value and costs incurred?
8. What indications are there that CCICP has affected consumer experience, care outcomes and cost-effectiveness of care provision?

Figure 4, with the sub-elements outlined in Appendix A - Project INTEGRATE dimensions and sub-elements.
2.2 Research questions

The evaluation asked the following key questions:

9. What is meant by integrated care in the context of the CCICP? Is this meaning common to other integrated care initiatives internationally?
10. What are the objectives of the CCICP? How do these objectives compare to other integrated care initiatives internationally?
11. What are the key components of the intervention, including its management, roles of professionals, organisational changes and supporting systems?
12. What are the characteristics of the groups being targeted?
13. What role did the context play in the implementation (facilitator, barrier)?
14. What were the key barriers to deployment? What were the key facilitators? How were they overcome or strengthened, respectively?
15. What has been the impact on professionals and other stakeholders in terms of added value and costs incurred?
16. What indications are there that CCICP has affected consumer experience, care outcomes and cost-effectiveness of care provision?

![Figure 4: Key Dimensions of Integrated Care from the Project INTEGRATE Framework](image)

2.3 Evaluation design

A mixed methods approach to the evaluation was taken which employed three methods of data collection. 1/ Project documents related to the activities of the CCICP from 2014 to 2017 were reviewed. 2/ a broad group of key informants were invited to complete an online survey and 3/ a more focused subset of these informants were invited to take part in an in-depth semi-structured interview. The key informants to be invited to take part in the survey and interviews were identified by the CCICP team.
Document Review

De-identified data, primarily drawn from project documents such as needs assessments, planning documents, narrative and annual reports, thought pieces (such as literature reviews) and presentations pertaining to the CCICP work were provided to the research team by the Central Coast LHD and the Hunter New England Central Coast Primary Health Network.

Documents were firstly reviewed and information was extracted that was relevant to describing the CCICP intervention. Data from the documents was used in the initial case study description of the CCICP. The document review findings are summarised in Section 3. Document review findings were verified and refined with the CCICP team.

Key Informant Surveys

A total of 60 key informants were invited to participate in an online survey (on the REDCAP platform). Key informants included those from the Central Coast LHD, Hunter New England Central Coast Primary Health Network, General Practitioners, government and non-government agencies, and consumer and carer advocacy groups who were involved in the delivery of the CCICP.

Questions were structured around the Project INTEGRATE framework. However, the normative integration dimension was not included as this was not part of the original [23] paper. Informants were asked to indicate their level of agreement (using a 5-point Likert scale: strongly agree, agree, neither agree or disagree, disagree and strongly disagree) with a statement representing each sub-element of each dimension (see Appendix A). For example in relation to person-centred care: ‘Service users and care professionals work together to obtain and understand basic health information to make appropriate health decisions.’ Informants were also invited to provide additional commentary on each dimension in an open text box.

The survey was administered in the period August to September, 2017. A 44% response rate was obtained with 27 surveys being completed. There was representation across the three streams 48% (n13) and enablers program 14% (n4), with the majority of informants 37% (n10) involved in the overall CCICP program and not specific to one or more streams. Informants were primarily from the Central Coast Local Health District (62%) (n17), the rest were spread across outside organisations, including Hunter New England Central Coast Primary Health Network, government and non-government agencies and General Practitioners (37%) (n10).

Survey responses to the sub-element statements were analysed by calculating the percentage of informants ageing, disagreeing and not knowing. In addition, to gauge overall progress towards each Project INTEGRATE dimension the survey results for each dimension were scored one (strongly disagree to five (strongly agree) and the mean calculated. Open text qualitative responses were coded by looking for key themes. Analysis of this data informed the findings for research question three: What are the key components of the intervention, including its management, roles of professionals, organisational changes and supporting systems? The survey findings are summarised in Section 4 along with the interview findings.

Key Informant Interviews

Staff from the Central Coast LHD, Hunter New England Central Coast Primary Health Network, General Practitioners, government and non-government agencies and consumer and carer advocacy groups who had direct involvement with the CCICP (or one of its projects) were invited to participate in a key informant interview. In-depth, semi structured interviews were conducted face-to-face or over the telephone. Interviews ran from around 30 to 90 minutes; each was audio-recorded and transcribed verbatim. In order to protect the identities of informants quotes in this report are presented without any identifying information.

Questions were aimed at gaining an in-depth understanding of the context, activities and experience of those involved in various aspects of the CCICP (see Appendix B for the interview guide). A total of 51 informants were invited and 23 participated in the interviews. Interviews were conducted in the September and October, 2017.
Analysis of this data was approached by first sorting the data according to the research question to which it was relevant. This included sorting data relevant to the dimensions of the Project INTEGRATE framework. Thematic open coding was then used as a second step in the analysis. NVivo was employed to aid management and coding of data. Analysis of this data informed the findings for all research questions. The interview findings are summarised in Section 4 along with the survey findings.

2.4 Ethics approval

Ethics approval for the evaluation was granted by the Hunter New England Human Research Ethics Committee (approval 17/06/21/5.01) and site-specific approval obtained. This ethics approval was recognised by the University of Newcastle (ref no. H-2017-0218).
3 Brief overview of the Central Coast Integrated Care program from document review

This section presents the findings of the document review, providing an overview of the CCICP in brief. A more comprehensive description of the CCICP can be found in the CCICP Evaluation Report [1]. The CCICP is a complex, multifaceted intervention within three target population streams with more than 40 initiatives and enabling projects of different scale (see Appendix C), priority and maturity undertaken thus far. Below describes the key activities undertaken by the CCICP during their time as a demonstrator site.

3.1 CCICP strategic implementation plan

The Central Coast LHD incorporated the NSW Government and NSW Health goals and aspirations, creating a ten-year vision for transforming the system of care for its population so that:

1. Care is person-centred
2. Care is a seamless and comprehensive continuum
3. Care results in an effective outcome that is desired by the person
4. Care is efficient

This work began with the demonstrator project, the CCICP. The Strategic implementation plan summary is reproduced above in Figure 2.

3.2 CCICP framework

The CCICP assembled a core team, to work in collaboration with key partners in the Central Coast LHD and with external partners including HNECC PHN, the GP Collaboration Unit, NSW Ambulance, ACI, FACS, DET, the Family Referral Service (run by the Benevolent Society). A governance structure was established which included key stakeholders to guide and oversee the program. The reporting and governance arrangements for CCICP includes a monthly governance meeting, with membership including: the Chief Executives of both the Central Coast LHD and the HNECC PHN, the district Director of FACS, several senior staff related to the CCICP and a GP representative. Regular governance reports are tabled at these meetings track CCICP milestones, overall program progress. Projects were subject to their own tracking reports and the CCICP also reported on mandatory measures to NSW Health, with 12 predetermined measures and 12 negotiated measures.

The CCICP consisted of three streams with enabler activities supporting these streams (see Figure 5). Each stream represented one of the target populations.

Figure 5: Central Coast Integrated Care Program Overview
3.3 Enablers

The work on particular population groups was supported by efforts to build an enabling infrastructure for integrated care via a variety of cross cutting projects, some applied broadly, others in small tests.

Population health approach

A population health approach lies at the heart of the CCICP. Vulnerable groups were identified by need, disadvantage, and likelihood to be high users of health services in the future. The original implementation plan proposed using risk stratification to select people (and cohorts) most at risk of future hospitalisations and likely to benefit most from a targeted more intensive approach to health care, such as care planning. To do this, the Central Coast undertook to develop a risk stratification model informed by a detailed diagnostic assessment of the three target populations.

Outcomes-based Commissioning

Outcomes-based commissioning places the emphasis on the achieving the desired outcomes for the service user when commissioning services. The CCICP tested outcomes-based commissioning in the context of NGO-provided care coordinators for a population of vulnerable older people in the North Wyong region (North Wyong Proof of Concept Project).

Co-design

Co-design, that is the involvement of stakeholders in service design, has been used to varying degrees. For example, substantial consultation and workshops were undertaken for both care coordination and shared care planning in the vulnerable older people stream but less so in the chronic and complex stream. In the vulnerable youth and children stream, there was much engagement and dialogue with stakeholders and to a lesser extent with the young people involved.

Information sharing tools

A key enabler of integrating care is the ability to share information safely and securely amongst care professionals. The CCICP undertook a number of projects to improve information sharing. Identifying, selecting and enabling a shared care planning system was a key goal for the CCICP. Extensive consultations with different stakeholders led to a clear understanding of the needs from varied perspectives, for example: GPs, health service and NGOs and residential aged care facilities. Notably there was considerable desire for timely connectivity to existing IT systems within general practice, health services and the NGO sector. Several options were considered known as ComCare, Patchwork and Go-Share (currently being trialled in the chronic and complex stream) but an IT platform that could deliver all of these needs has not yet been identified. Shared care planning work was deferred in order to prioritise work on other objectives.

Multiagency Accelerated Implementation Methodology (AIM)

The CCICP identified a lack of workforce change management skills as a key barrier to successful program implementation. Not having a common language across partner organisations (and internally) and managing resistance to change were two key issues experienced. An evidence review identified that joint training in the use of a consistent framework and change management approach would support effective interagency work. The CCICP embraced the Accelerated Implementation Methodology (AIM). AIM is an internationally recognised change management methodology was supported by the Agency for Clinical Innovation (ACI) and the Health Education and Training Institute (HETI) for NSW Health staff to practically assist with project implementation. Prior to the introduction of AIM training, as part of the AIM process, a commissioned analysis of readiness for change was conducted (an analysis of implementation history assessment by the facilitator Don Harrison). This flagged the likely difficulties for implementation given the Central Coast LHD profile. These included a top-down compliance culture, reinforcements that did not align with behaviour changes (more reward for staying the same), resistance to change, high turf guarding, the absence of common goals across the system. These results...
were similar to the rest of NSW Health. This analysis also helped prepare the CCICP team regarding their approaches.

The CCICP chose to trial multi-agency AIM training with its partner agencies (beyond NSW Health) to build capacity to deliver collaborative change, with 97 staff trained in 2016. Importantly, the two-day training sessions were delivered purposefully as cross-sectoral training to groups containing a mix of LHD and partner agency staff, including HNECC PHN, FACS, DEC, NSW Ambulance and the Family Referral Service (the Benevolent Society). Feedback from the training was overwhelmingly positive and further training was delivered in 2017, with more planned for 2018.

**International evidence and experts**

From the inception of the CCICP, the team have drawn upon evidence and international experts in integrated care to inform planning, implementation and review of progress. This has included attending and presenting at numerous conferences including the first World Congress in Integrated Care in Sydney in 2014, the second World Congress in Integrated Care in Wellington New Zealand in 2016, the 1st Asia Pacific Conference on Integrated Care in Brisbane, November 2017 (with four abstracts presented pertaining to the CCICP) and hosting international experts such as Dr Nick Goodwin, CEO of the International Foundation for Integrated Care in 2014, 2016 and 2017. Furthermore consultants were used to assist with the preparation of several work pieces including Price Waterhouse Coopers for the risk stratification work.

### 3.4 Vulnerable youth and children

A detailed diagnostic assessment of the children and young people population on the Central Coast was undertaken to inform the case for building a risk stratification tool to identify the vulnerable youth cohort. Considerable challenges were faced in the ability to collate data from multiple partners into a person-history dataset, thus this approach was not further developed. It was decided that the narrow focus on the relatively few young people who were attending hospital was not likely to yield as high a benefit as going upstream into the early intervention space, seeking to identify vulnerable youth via other means and connecting them to services earlier, with a particular focus on connecting to general practice and enabling referrals to flow on from that nexus.

The stream, therefore, focused on working with partner agencies in schools. The key partner agencies included the HNECC PHN, Education and FACS and integrated approaches were attempted through working via:

- **Family Referral Service in Schools** – an early intervention program working with children and their families to address health and social vulnerabilities by connecting with services and supporting children to engage in learning.
- **Central Coast Multi-Agency Response Centre (CCMARC)** – the first NSW co-located child protection multi-agency. The aims being to: facilitate information sharing between FACS and the LHD, define health’s role in responses to child protection, and support multiagency quality initiatives that enable early intervention responses for children at significant risk of harm.
- **Out of Home Care Health Access (OHCA)** – integrated multi-agency which assess and manages the health needs of children and youth in out of home care. The aims being to: better understand the pathways into out-of-home-care, identify opportunities for improvements in service delivery integration and provide a more integrated approach to assessment and treatment of children and youth.

### 3.5 Vulnerable older people

The approach for the stream for vulnerable older people focused on testing the use of an outcomes-based commissioning approach (see Section 3.3).
The journey to developing and testing the North Wyong Proof of Concept (NWPOC) on care coordination is summarised in Figure 6.

In brief the steps taken were:

- **Risk stratification/population needs assessment**: a diagnostic assessment of vulnerable older persons was undertaken and substantial testing and modelling around which cohort characteristics could be best used for risk stratification. The key risk factors proposed to target care coordination were hospital admission or GP consultations in the last 12 months, age and multiple chronic conditions [25].

- **Co-design of models of care**: through extensive consultation with 60 community stakeholders, three workshops, two GP panels and numerous interviews care coordination was prioritised as the most effective option for improving health outcomes for vulnerable older people on the Central Coast.

- **Market assessment and creation**: to pioneer outcomes-based commissioning of care coordination services a tender and contract structure required considerable negotiation largely because of the entrenched procurement/commissioning requirements of NSW Health. Many cultural issues were addressed and much resistance to change was overcome. After two industry briefings, the response to the Expression of Interest (EOI) was substantial, with 20 submissions, ranging from GPs, NGOs and private providers, indicating a good market appetite to undertake this work on the Central Coast.

- **Commission/procure**: Nine of the interested organisations were invited to tender. A further two industry briefings were held and seven responses were tendered. Notably positive feedback from all responders was received regarding the engagement approach to providers.

- **Delivery management and monitor**: Two organisations were selected to enrol a total of 440 eligible older persons into the care coordination trials. Contracts were finalised in December 2016, with the trial beginning early 2017. Notably in the course of the trial this year, possibly attributable to a significant flu season, both providers acknowledged that they were unlikely to reach their targets. The contract conditions were renegotiated such that the Central Coast LHD took back some of the risk, setting more modest targets for a more modest reward while providing some secure base funding to both organisations.

- **Evaluation**: the trial in North Wyong is the subject of a separate evaluation pertaining to outcomes and health economic analysis.
It should be noted that this proof of concept has given the CCICP many rich lessons in the areas of: risk assessment and stratification of populations; ethics and privacy concerns; new ways to contract and procure services; the nature of the ongoing relationships with the contracted providers and creating safe spaces to allow innovation that adapts to and manages risk. Moreover, the use of the outcomes-based commissioning cycle has provided a better way to develop and improve models of care.

### 3.6 People with chronic and complex conditions

This stream built on, aligned and consolidated a number of existing projects that were amenable to inclusion in the CCICP. Notably these included the Central Coast Alternative Pathways Initiative (CCAPI) being developed by HNECC PHN, the Central Coast LHD and NSW Ambulance. CCAPI is a new care model which allowed for referrals of patients, where appropriate (low acuity cases), to general practice etc. rather than default delivery to emergency departments. The CCICP enabled better LHD involvement and a significant number of paramedics to receive appropriate training.

The Chronic Disease Management (CDM) Program was redesigned as the Woy Woy Integrated Care Pilot (WWICP) as the long running CDM program had drifted in scope. The redesign involved working closely with the existing team to refocus the model of care towards general practice. As with other change management activities, this met with resistance from a well-established team accustomed to their existing work practices. Relationship management and effective communication have been employed to overcome resistance. This work was undertaken in partnership with HNECC PHN and the ACI. Notably eight new Standard Operating Procedures (SOPs) have been developed to define appointment scheduling routines and standard duration of service and Go-Share is being trialled (see Section 3.3).
4 Findings

This section brings together, summarises and discusses the findings from the different sources for each of the research questions. More detailed findings for the survey and interviews can be found in Appendices D (survey) and E (interviews).

4.1 Meaning of integrated care in the context of the CCICP

The review of documents did not uncover a clearly stated definition of integrated care. However, the program vision and strategy suggests an emphasis on working in partnership other stakeholders to provide person-centred care that is efficient and effective. Importantly, it was intended that a whole-of-system approach was to be taken towards commissioning to meet the needs of the region’s social and health needs.

Findings from the interviews generally reflected the suggested definition within documents. For most interview informants integrated care meant multi-disciplinary and multi-organisational team work provision of person-centred care. In providing integrated care was also expected to improve the experience of service users and their care outcomes and empower the service user by improving their health literacy. Integrated care was also interpreted as effective and efficient care that met the needs of all individuals in the population. Practicing integrated care also meant for some informants a better work experience for the health workers. Integrated care was also understood to be the usual way and the way consumers expected the provision of care to be conducted. Two informants, on the other hand, interpreted integrated care only as a CCLHD organisational unit.

It should also be noted that a few informants perceived that there was a lack of a shared definition amongst the key stakeholders (i.e. amongst CCLHD staff, other service providers and the Ministry of Health). However, for one informant suggested what should be ultimately important is what the service user understand as integrated care.

4.2 Objectives of the CCICP

No clearly stated overriding objectives of the CCICP were found in the review of documents. The program vision, however, suggests the objective was to provide effective and efficient person-centred care. Moreover, the core components of the implementation plan could be interpreted as objectives these being: joint LHD and PHN governance approach to the meeting of the region’s health and social needs, provide an enabling system architecture that would allow better person-centred delivery of care and care prevention, and innovative models of care for the three prioritised target groups. Furthermore, innovation and learning can also be understood as objectives.

The interview findings suggested uncertainty about the overall objectives among informants. Seven informants, when asked about the objectives of the CCICP, said they did not know what they were, that they had been lost or the work they were involved in did not have integrated care objectives.

Other informants did identify objectives, these fell into seven main areas:

- provision of health services (providing efficient and effective care, wrap around services and holistic care, meeting the needs, requirements and objectives of the service user, identifying needs and those at risk and reducing hospitalisation frequency and length),
- working with multiple service providers (shared decision making, care planning and assessments, referral pathways, and working with social services (e.g. FACS and education) as well as health services such as ACCHOS and GPS),
- measuring performance (data collection and analysis),
- commissioning services (including testing of outcomes-based commissioning of NGOs),
- fulfilling Ministry requirements,
- testing of innovative approaches, and
- moving integrated care to a ‘business-as-usual’ mode.
4.3 Key components of the intervention

The introduction and the document review provides a detailed description of the CCICP. Here we focus on the Project INTEGRATE dimensions and the progress achieved towards sub-elements of those dimensions as key components. It is our understanding that progress towards these key sub-elements or components are the most important aspect of the intervention.

Person-centred care – service user engagement and empowerment

This dimension of integrated care refers to the ability to empower and engage people in improving their health and wellbeing and to become actively involved as partners in care.

In general the survey and the interview responses suggested the delivery of person-centred care was more aspirational than actual. The interview narratives provided illustrative examples of the sub-elements where the CCICP had performed most strongly and were silent on the sub-elements where there was least certainty about performance.

The majority view of informants (>80%) in the survey findings was that the CCICP was affecting a move towards person-centred care (particularly in the areas of health literacy promotion (70% agreement) and user decision making (59% agreement), although on average only half agreed that sub-elements of person-centred care were being achieved. Generally, however, the survey results reflect a great deal of uncertainty about whether or not the sub-elements of person-centred care were being practiced.

In interviews, the different sub-elements of person-centred care being practised were discussed in relation to the different streams: promotion health literacy in the vulnerable older people stream; user empowerment/self-management in the chronic and complex stream; and involving the consumer in shared care planning and decision-making in the in the vulnerable youth and children stream and the vulnerable older people stream. Only for the vulnerable youth and children stream was it suggested that these person-centred initiatives were being practised as a result of the CCICP. Moreover, while examples of person-centred care could be given doubt was expressed that it was being routinely achieved.

However it is notable that: while narratives would suggest care planning was about what was best for the consumer the voice of carers and consumers involved appeared to be missing from conversations. No illustrative clear examples of carer support under the CCICP was forthcoming in the interviews; a process suggesting consumers were able to provide feedback on that would enable enhancements made to their own individual experience to improve their own quality of care was not mentioned; and neither was consumers having access to their own health care records.

Clinical integration – care coordination around people’s needs

This dimension of integrated care refers to how care services are coordinated and/or organised around the needs of service users.

The survey and interview responses suggest that while there have been some achievements in the area of clinical integration, there is still more to be done in this area. Interview narratives generally reflected areas of strength identified in the survey and were less clear on areas where survey informants’ progress was more doubtful.

Most survey informants (>80%) agreed that the CCICP had contributed to clinical integration although fewer than half agreed that clinical integration was being achieved. The majority (78%) agreed that professionals working together was being achieved. There was also good agreement that care coordinators were ensuring continuity of care (59%) and professionals proactively manage the needs of service users (59%). The results for other sub-elements were less clear.

Reflecting these achievements perceived in the survey, interview informants when discussing shared care planning referred to it in the context of multidisciplinary care teams or working with other service providers to
plan and provide care. Furthermore, the vulnerable older people stream and the chronic and complex stream were described as having been set up to have clearly defined care coordinators. On the other hand, the vulnerable youth and children stream reported a more flexible arrangement that utilised the most appropriate person for the case. Case management in which professionals worked together to meet the needs of the consumers was also apparent in all three streams.

Interview informants mostly spoke about transition of care in relation to discharge from hospital. A new model of discharge planning had been trialled and found to work well. However, it appeared that service providers in the vulnerable older people stream were not necessarily being included in the planning of their clients entering hospital. This limited application of transition planning may go some way to explain why only a minority of survey informants (37%) agreed that this was being achieved.

A single point of entry was the most contested clinical integration sub-element with 59% agreeing and 26% disagreeing it had been achieved. A central intake system, was mentioned in interviews although it was recognised by one informant not to directly part of the CCICP. Moreover, it was thought that there were still improvements to be made in this area.

The survey and the interview findings concerning whether partners in care were following defined care pathways to help understand and direct the process of care integration were unclear. Most survey informants (>50%) were unable to agree or disagree. In interviews, some informants talked about following referral pathways and clear guidelines for how providers should operate but did not discuss this further understanding and directing the process of integrated care.

In interviews, there was no mention of volunteers nor the community in relation to their involvement of coordinating people’s care needs. However, it should be noted that interview questions did not cover these areas. The majority of survey informants were unable to agree or disagree that this sub-element was being achieved.

### Professional integration – existence and support of teams/networks

*This dimension of integrated care refers to the existence and promotion of partnerships between care professionals that enable them to work together (e.g., in teams or networks) and so promote better care co-ordination around the needs of the service user.*

The averaged combined scores indicated that more survey informants agree that sub-elements of professional integration were being achieved than any other dimension. In addition, 74% agreed that the CCICP had contributed to this progress. Evidence from interviews of progress towards professional integration was less clear and to some extent contradictory.

There was good agreement amongst survey informants that care professionals shared accountability and responsibility for care outcomes (70%), work in inter- or multi-disciplinary teams (67%), and have a long term commitment to integrated care (63%). On the other hand in interviews, while working in multiple agency and multi-disciplinary teams was an established part of all three streams there was no evidence at neither the project management nor the front-line care level that these teams shared accountability and responsibility for care outcomes. Interview informants discussed sharing of information, shared care planning, coordination and consultation but their narratives suggested that individual care professionals took either overall responsibility or responsibility for their part of the care plan. Moreover, the resistance of some staff to changes under integrated care and the linking of this with that these staff feared their role being taken over (see Section 4.6) suggests that these staff were not recognising and enacting shared responsibility and were not ready for nor committed to integrated care.

Most survey informants (56%) agreed that there were formal agreements in place that supported collaboration. On the other hand, a large proportion (40%) were uncertain of whether or not they existed. This may indicate that there were formal agreements but that the agreements were not supportive of collaboration or that survey
informants were unaware of whether they existed or not. Narratives of interview informants revealed that some formal agreements had been put in place outlining the roles and responsibilities for care and the collaborations of different organisations’ staff and that service providers were working under agreed protocols or guidelines. How supportive these protocols or guidelines were of collaboration among the professionals was not discussed as no informants commented on the effect on the collaborative process. However, commitment to integrated care partnerships were apparent in nearly all interview informants’ narratives. Interview informants expressed not only their own personal commitment but referred to the commitment of those they were working with and leaders within the LHD.

A great deal of uncertainty was expressed in surveys in regards to ongoing multi- and inter-professional training and education with over half of informants neither agreeing nor disagreeing with the statement (just 37% agreed). The uncertainty might have been whether the training was of a continuous nature. Certainly in interviews, some informants mentioned some training and education that they had received, run or that had been provided for care professionals. It was not clear, however, that training and education was continuously supported as informants mainly reported training related to first involvement in the CCICP. Initial training and education opportunities mentioned included AIM, outcomes-based commissioning training, training for paramedics in triaging and managing low acuity call-outs and work area information being supplied. However, a few informants also mentioned attending integrated care conferences. One interview informant suggested GPs needed to be assisted to stay abreast of current information indicating that type of continuous education was currently lacking.

Organisational integration – joined up service delivery

This dimension of integrated care refers to the ability of different providers to come together to enable joined-up service delivery (that helps to then support professional and clinical integration).

There was a good level of agreement among survey informants that the CCICP had contributed to organisational integration. Even so, only half agreed, on average, that sub-elements of organisational integration were being achieved. Similarly in interviews there was some evidence of progress towards organisational integration.

Over half of survey informants (56%) agreed that there were shared set measures to monitor outcomes. In interviews, the most referred to performance measures for the vulnerable older people and the chronic and complex streams was reduction of unplanned hospitalisations and bed days. For the outcomes-based commissioning of the vulnerable older people stream the outcome that was of interest was reduced unplanned hospitalisations. Hence, this was a shared measure between the LHD and the service providers involved. In regard to the vulnerable youth and children stream, it was common for interview informants to comment how difficult it was to measure performance of this stream. However, one interview informant commenting on the vulnerable youth and children stream revealed that an evaluation was planned and that a common reporting strategy had been devised for the organisations involved.

The existence of collective incentives to support integration was also agreed upon by most (56%) of survey informants. However, in interviews, Incentives supporting integration were mentioned by only directly mentioned by two informants. One was in regard to the outcomes-based commissioning of the vulnerable older people stream in which there was a clear monetary incentive negotiated to reduce unplanned hospitalisations. However, the reduction hoped for had not been achieved and therefore the incentive was lost. Nevertheless, it was thought that the motivation for service providers to take part in the scheme was a potential monetary surplus. The second informant reflected on the lack of incentive in the vulnerable youth and children stream to work with families. Even so, it was apparent from narratives that the incentive for most informants to work in the integrated care space was to improve care and consumer experience and outcomes.

Only just over half (52%) of survey informants agreed that care organisations had shared strategic objectives and written policies and procedures. The narratives of interview informants suggested that any shared objectives were pre-existing; that is coincidental rather than negotiated between organisations. Hence,
organisations became involved due to mutual aims that could be served by working collaboratively. However, four interview informants perceived a lack of clarity of what was being agreed. It appears then that these informants were either unaware of or did not think formal agreements stipulated what was to be done and why. Conversely, other informants reported that level a Memorandum of Understanding and partnership agreements had been signed. Moreover, it was clear that the CCLHD perceived that the formal agreements they had with other organisations had not been sufficient. Seven interview informants mentioned a proposed ‘alliance’ between the LHD, the PHN and possibly other organisations. These informants understood that the alliance would clarify joint objectives, better promote integrated care between primary and secondary healthcare professionals or at least signal a long-term commitment of these organisations to integrated care.

Survey informants were, overall least certain about whether there was shared governance as over half (56%) neither agreed nor disagreed with the statement. In interviews some informants discussed a governance committee that appeared to involve LHD and PHN. These informants reported that findings of evaluations and monitoring were reported to this governance committee. It was not clear, what role the committee than had in orchestrating integrated care improvements.

Systemic integration – enabling platform

This dimension of integrated care refers to the ability of the care system in providing an enabling platform for integrated care at an organizational, professional and clinical level (e.g. through the alignment of key systemic factors such as regulation, financing mechanisms, workforce development and training).

Systemic integration is complicated and difficult to separate from organisational integration since the organisations involved are components of the system. Moreover, systemic integration largely sits outside of the control of the CCICP (although the CCICP may have some influence due to being part of the system) and not a primary concern of most informants. Nevertheless, most survey informants (67%) agreed that the CCICP had contributed to systemic integration. However, no sub-element of systemic integration received the agreement of at least half of survey informants that it had been achieved. This translated to the overall perception of progress towards systemic integration being supported by only about one third of survey informants. Open-text survey responses were overall reflected lack of progress. As systemic integration was not a primary concern to the informants it was not directly pursued in interviews. Even so, informants’ narratives point to systemic or key contextual issues especially when they resulted in significant barriers or facilitators.

The use of a common set of measures and outcomes to monitor and assess performance is related to the sharing of measures discussed under organisational integration. Most survey informants (around 50%) were non-committal about a common set of measures being implemented and only about one third agreed with the statement. Interview narratives indicated the reduction in hospitalisations measure of performance was imposed by the NSW Ministry of Health imposed as were other measures that needed to be reported on regularly. One interview informant suggested that these measures were negotiated. However, it was also apparent in interviews that the chronic and complex stream was constrained in what they could do due to having to meet Ministry indicators. Furthermore, it was suggested by some interview informants that the measures reported to the Ministry were not relevant or did not always fit well with integrated care work. Alternatively, interview informants also discussed the CCLHD identifying their own milestones, executive governance setting performance goals, nominating additional local performance measures to report to the Ministry or just generally collecting data about what was happening on the ground. It is apparent then that the local performance measures are not common systemically shared and that those measures that are shared (i.e. those imposed by the Ministry) lack relevance to integrated care. Moreover, the Ministry measures were reported to be largely activity-based when an outcomes-based approach was understood to be more conducive to promoting integrated care. Furthermore, the fragmentation of the health system into Commonwealth and State run sectors (see also Section 4.6) was perceived as resulting in relevant measures of performance not being commonly accessible.
Most survey informants (around 50%) also did not agree or disagree with the statement that the care system has financing and incentive arrangements directly promoting integrated care; only about one third agreed with the statement. In interviews, the NSW Ministry of Health was recognised as supporting integrated care through funding and thereby providing a mandate. Nevertheless, regulations that the Ministry imposed appeared to restrict what the CCICP were able to do. It was reported that initiatives had been blocked and the services and care it was possible to provide was restricted by rules. The short-term nature of the funding was also pointed to as being problematical in interviews; that the funding would end had implications for the retention of staff that had key roles in maintaining programs and continuing progress. The interview narratives highlighted an expectation was that the work would become ‘business-as-usual’ and the costs of integrated care absorbed into the LHD’s usual operational budget. There was a general understanding that to bring about the changes needed to embed integrated care as business-as-usual was a long-term strategy. Several interview informants perceived that the project was not far enough developed to continue without designated funding and perceived there was a danger that the gains made would be lost and learnings forgotten. The short-term nature of funding and the perceived impact of this barrier is discussed further in Section 4.5. The uncertainty expressed in surveys might, therefore, be due to a perception that the rules tied to the funding mean that while ostensibly being for integrated care failed in the end to promote it and that the designated funding was due to end.

Similar numbers of survey informants agreed (just under 40%) with the statement that national/regional policies support and promote multi-sectorial partnerships and person-centred care, as who were able to offer no opinion. There has been a change of Health Minister since the commencement of the project. The change in Minister and other changes of staff within the Ministry were perceived by interview informants to have resulted in attitudes, and therefore regulatory frameworks that were not as well aligned with innovation and bringing about changes towards integrated care. Furthermore, it was reported in interviews that the Ministry itself was lacking integration with different departments not being able to work with each other which made it more difficult for the CCICP to operate across portfolios. Conversely, the NSW Premier’s Priorities were considered to have allowed the CCICP to work with organisations falling into other portfolios; although a state strategy was seen as expensive and difficult to address. The different legislation for the different government departments was understood by interview informants as challenging. Furthermore, the issues around privacy legislation and lack of clarity amongst staff of what could be shared failed to meet the needs of integrated care despite relatively recent changes (see Section 4.6). Moreover, it was understood that internal policies restricted information rather than encouraged sharing.

That there was adequate investment in the workforce to support the goals of integrated care was disagreed with by more survey informants (48%) than agreed with it (19%). The picture from interviews was more nuanced. In interviews, the short-term funding of the project and service provision was indicated as working against being able to ensure an adequate workforce. Short-term funding was perceived to have resulted in recruitment difficulties. Nevertheless, the effectiveness and competency of those working in the CCICP (see Section 4.6) suggests, at least in the short-term, there had been adequate investment. In the longer term, it was also perceived that the LHD could be investing more in getting the workforce ready to undertake integrated care work. In relation to this kind of investment, interview informants mentioned that a Medical Research Institute with a focus on integrated care was being planned for the Central Coast. It was anticipated that the Institute would promote integrated care through influencing graduate workers.

The involvement of all stakeholders was agreed on by nearly half (44%) of survey informants, however, around a third disagreed with this statement. Stakeholder involvement is apparent throughout the interview findings. Of note however, co-design of the approach for the vulnerable youth and children stream was mentioned by interview informants. On the other hand, there was no evidence from the interviews that service users had been involved in the design, implementation and evaluation of the programs and policies. However, the document review findings suggest some young people have been involved in relation to the vulnerable youth and children stream. Moreover, representatives from consumer and carer advocacy groups were invited to participate in surveys and interviews in this formative evaluation.
**Functional integration – effective data and information communication**

*This dimension to integrated care refers to the capacity to communicate data and information effectively within an integrated care system.*

In surveys, functional integration was the dimension where there was the least agreement that the CCICP had contributed to its improvement (just 44% of informants agreed). More survey informants disagreed than agreed about all the sub-elements except for one where agreement and disagreement was equal. Survey open-text responses were particularly critical of progress in this dimension. Hence overall the average scores suggested more disagreement (around 40%) that there had been progress made towards functional integration than agreement (<30%). These survey results were reflected in interviews where progress towards functional integration appeared limited.

The same percentage of informants agreed that a uniform service user identifier was shared among care organisations as disagreed (37% for both). In interviews there was no evidence in the informants’ narratives that a single service user identifier was being used between different care organisations. However, a direct question was not asked.

More survey informants (29%) disagreed that communication of data and information between care professionals and service users is effective (just 19% agreed). Similarly, most survey informants (52%) disagreed that shared care records enabled information sharing (>20% agreed). In interviews lack of compatibility of IT systems among service providers was considered a major barrier to communication of data and information and sharing care records among organisations (see also Section 4.6). Interview informants explained local decisions meant that the CCLHD and the CCICP were not using IT systems adopted by others. For example, it was reported that initially there had been an intention to commission a digital ‘shared care planning’ platform but after extensive researching the needs of stakeholders and options a decision was made not to go ahead. The resource intensive process and slow progress in other demonstrators led the CCICP team to purposefully halt this trial in favour of focussing resources on the outcomes-based commissioning trial. Other interview data suggested that the CCICP similarly found the Patchwork platform used by FACS was unsuitable for the needs of the project. On the other hand, it was also reported that there were plans and work being done that may help to rectify the incompatibility of IT systems to some extent. Firstly there was work being done within the CCLHD to improve communication with the PHN. Secondly, the My Health Record initiative of the Commonwealth Government was anticipated to alleviate some of the problems (but only relevant within the Health system). The other major barrier to communication and sharing care records perceived by interview informants, was the fear of sharing information due to privacy concerns (see Section 4.6).

Only about a quarter of survey informants (26%) agreed that decision-support systems were available to assist decision-making between professionals and service users; whereas a third (33%) disagreed. In interviews, there was little evidence to support progress towards this sub-element. Further, as noted under person-centred care and clinical integration above, decision-making tended to be among service providers and often did not include service users.

**Normative integration – common frame of reference**

*This dimension of integrated care relates to cultural elements – the extent to which different partners in care have developed a common frame of reference (i.e., of vision, norms, and values) in support of the aims and objectives of care integration.*

Only interview data is available to access progress towards normative integration (see Section 2.3). Interview informants’ narratives conveyed some gains in normative integration but that there was also more to be done in this area.
The extent that the vision of person-centred, holistic care was shared among interview informants was covered in Section 4.1. In brief, person-centred care was found to be a major defining feature of approximately two-thirds of informants. It is not known (and it was not asked about in interviews) how extensive this vision would be among the workforce involved in providing integrated care under the CCICP. Despite the lack of commentary, it is possible to surmise that a collective vision of holistic care was at least communicated through the population health approach adopted and the choice of the three streams.

Interview narratives’ suggest a key premise underlying the implementation of the CCICP appears to have been an emphasis on population health management with the aim of improving care for the specific population groups described by the three streams. Moreover, the interview data show that geographical areas were targeted where the greatest need was perceived and was supported by the extensive needs assessment undertaken at the CCICP inception. Interview informants spoke of risk stratification to identify which populations should be targeted in all three streams. Importantly, it was noted that a population approach rather than a disease approach was taken to care provision.

Informants’ narratives did not mention any efforts that had been made to build awareness and trust in integrated care services with local communities. It was perceived that it was unlikely that service users would notice changes made towards integrated care provision.

Interview informants perceived that at times leaders within the CCICP and CCLHD had failed to communicate clear vision and goals (see also Section 4.6). The lack of a consistently strong vision for the project was associated with changes in leadership in the LHD, the PHN and the Ministry. On the other hand more generally, given the praise they received (see Section 4.6) the members of the integrated care team had provided a clear vision for service providers to work towards. Therefore, given that leaders have not always been able to maintain a clear vision, there appears to be some way to go in regards to all stakeholders sharing a clear vision of integrated care.

Direct commentary on the degree of trust that partner’s in care have in each other’s reputation and in their ability to deliver effective care through collaboration was missing from the interview data and interview informants were not asked about trust. However, rather generally narratives were neutral or suggested respect for other service providers worked with when mentioned.

Overall perceptions of progress towards integrated care

The weight of opinion expressed in surveys is that there has been some progress towards integrated care. There was most agreement that there has been some progress in the areas of person-centred care, clinical, professional and organisational integration. Informants were, overall, uncertain that there has been progress towards systemic integration and generally perceived that functional integration has not been progressed. Figure 7 visualises this progress. The green line represents unanimous strong agreement that all sub-elements of integration have been achieved. Therefore the green line could be considered as aligning with a perception of full integration, at least in regard to these measures. The red line represents unanimous strong disagreement that all the sub-elements have been achieved. Hence the red line represents a perception of complete failure to integrate. The bold grey line represents overall uncertainty or neutrality in regard to the sub-elements. The survey findings are represented by the blue line (mean scores of sub-elements for each dimension).
When the level of agreement according to the mean scores of sub-elements for each dimension are considered, it is clear that there was a great deal of uncertainty among survey informants around progress towards the dimensions of integrated care, ranging from 35-40% (see Figure 8).

4.4 Characteristics of target groups

It is apparent from the document review that three populations were targeted by the CCICP activities: vulnerable youth and children, vulnerable older people and people with chronic and complex conditions. Rather than identifying youth and children to be included through hospitals as originally intended, the LHD worked with
schools and FACS. The vulnerable older people of North Wyong were used as a target population for a trial of an outcomes-based commissioning using NGOs already providing services for the aged in the area. People with chronic and complex conditions in Woy Woy were targeted which made use of a number of pre-existing programs.

The informant interviews revealed characteristics of the groups being targeted beyond the simple stream descriptions and why those groups were being targeted. The populations being targeted were understood to have with high levels of disadvantage and needs (low socio-economic population, older than most populations, high incidence of mental and physical health problems (frail aged), high levels of domestic violence, high alcohol and other drug abuse rates, high numbers of children in out of home care, high intergenerational unemployment, low private health rates, high smoking rates, poor ability to take care of their own health). The populations of North Wyong and Woy Woy were particularly understood to be at risk.

In regard to the vulnerable youth and children, the families as well as the children were understood to be part of the target population. The target ages for the vulnerable youth and children stream were understood to have expanded. It had started at 14 to 24 years, but the lower age limit had dropped to include primary school aged children and younger and those over school age had not been targeted as yet.

In regard to the vulnerable older people and chronic and complex care streams, these were no longer two separate streams as they had a great deal of overlap. The streams included people with two or more chronic conditions (e.g. diabetes, coronary artery disease, COPD) and were over 65 years (or younger for ATSI people).

There was some discussion around what was meant by ‘vulnerable’ for both young and older people by two informants but no clear definition was forthcoming.

4.5 The role of context in implementation

The role that context played in the intervention is best understood by looking at the informant interview data. The context referred to in interviews that played a role in implementation was mainly concerned with the restructuring that the health system had gone through, the commissioning and funding of the integrated care project and previous work done in the integrated care area, and the ability of the organisations involved to work with each other. In addition, the Central Coast was considered to have characteristics that made it suited for undertaking a trial for integrated care.

There were significant organisational restructures that had occurred since the outset of the project. Most significantly, Medicare Locals were overseeing the primary health care sector and Primary Health Networks did not exist. This restructuring had meant that there was a need to renegotiate how the LHD would work with the primary care sector. The building of the relationship with the Primary Health Network was seen as having taken some time. The restructure was also perceived as resulting in the project being less of a joint partnership than was originally envisaged. In addition, under funding reforms of the National Disability Insurance Scheme and My Aged Care block funding for services is being replaced by individual funding. It was understood that an individual funding model discouraged social care providers from being involved with integrated care initiatives.

Initially the integrated care agenda was seen as a 10-year strategy. This is important to note as this means that the Central Coast is only in the early stages of implementation especially given that the start was delayed by approval processes and recruitment of a suitable team. The Central Coast had a different starting point from other LHDs in that previous work had been done to co-locate state health services and general practice.

Due to the previous work they had done in the area of integrated care, the Central Coast was approached by the NSW Ministry of Health to undertake the project rather than submitting a tender. Moreover, the NSW Minister for Health had changed since that time. At the beginning the Ministry was not very clear about what their expectations of the project was. More recently, with the change of Minister, the Ministry has become more explicit but their current requirements do not necessarily match what has been done of the project in the early stages. The change has meant that the integrated care team were struggling to meet the demands of the current
Ministry. The current integrated care division of the Ministry were reported as being more risk averse and more concerned with short-term cost cutting than working differently than the initial guidelines had suggested. For some aspects of the project what was being implemented was, therefore, not necessarily recognised as integrated care. The shifting demands of the Ministry, therefore, has created barriers to implementation that needed to be worked around.

On the other hand, a recognition of a piece of legislation (referred to as 16A) was mentioned was perceived as meaning sharing of service user information was now more possible than it had been in the past. However, it was acknowledged, that service providers could still be reluctant to do so and it was considered by one informant that the rules were still not clear. There was a reported fear of sharing information due to privacy concerns amongst service providers and consumers.

The context of health funding and fragmentation of the health system was generally seen as a barrier. The fragmentation of the health system with State and Commonwealth jurisdictions, myriad organisations (government and non-government), specialist areas (e.g. mental health, drug and alcohol, domestic violence) and corresponding fragmentation of funding was also considered as making it a difficult area to work in to deliver integrated care. A pre-existing agenda, however, could help overcome those problems of fragmentation.

Funding, of course, was considered an enabler but there was concern about the short-term nature of the funding. In particular, there was concern for the long-term commitment to and sustainability of what already has been implemented as integrated care appeared to be moving to a ‘business-as-usual’ phase without designated funding. Importantly, current funding models were understood by one informant to discourage integrated care objectives (such as reducing hospitalisation) as money would be taken from another funding areas.

Leadership was seen as vital part of the context of implementation. Leaders at all the key organisations were seen as important, the LHD, the PHN and the Ministry. This will be discussed more in Section 4.6.

The location was also noted as a contextual influence. The health and social system operating in the Central Coast was seen as relatively distinct from those from those in Sydney and Newcastle, the adjoining areas which was understood as enabling a discrete trial. It was also understood that it was valuable to conduct the project outside of a major city. On the other hand, there was a perception that there was a shortfall of some vital services (GPs and social workers).

### 4.6 Key facilitators and barriers

The implementation plan and other documents revealed that a number of key enablers were attempted to facilitate the execution of the three streams: outcomes-based commissioning, co-design, information sharing tools, and multiagency AIM training. Moreover, a population health approach, international evidence and the advice of international experts were relied on to steer the direction of the project. Some of the facilitators or enablers, as they were referred to, were more successful than others. For example, AIM training was implemented to overcome the barriers of lack of workforce change management skills and lack of a common language and was reported to be working well. On the other hand, it was also apparent that information sharing technology to enable shared care planning has not been adequately addressed. Whilst the need to share information was recognised, tools such as Patchwork were found to be inappropriate. Outcomes for Go-Share do not, as yet, appear to be available. The eHealth application ComCare has found a use in the community supporting clinicians in situ to provide better care through access to health record data (even off-line).

The main barriers and facilitators were identified in informant interviews which could be grouped into four areas: leadership, staffing/personnel, communications/relationships and service gaps/needs. When barriers were commented upon it was rare for informants also to say how they were overcome. Possibly because informants would think of the vehicle for overcoming a barrier as a facilitator and refer to it in that way.
Leadership in was the most commonly identified facilitator of the project. Not only was it thought to be important but the early project leaders and key organisation leaders were often commented upon in an extremely favourable light. The LHD leaders brought to their positions, established and well-functioning relationships with key senior personnel in other organisations which was considered as a great asset to the project. These early leaders were also seen as facilitating the project by having a vision for and commitment to the project and for being supportive of an innovative approach. Conversely, informants some aspects of leadership had been missing over the course of the project. In particular, the vision and the goals for the project were not always clear to the informants. An aspect of lack of clarity early on, was attributed to the strong pre-existing relationship between leaders of key organisations that then did not formalise what they agreed to do. Moreover, during the life of the project, senior management of the key organisations including the Ministry had changed. It was considered four informants that the changes had resulted in aspects of the strong leadership that they had appreciated being lost. Management were considered to have a more “constrained view of integrated care is”, lack a strong vision for the project and to be more risk averse. They were understood to be less willing and able to negotiate a frontier pushing agenda. On the other hand, it was also noted that the new leadership had not been in place long enough to rebuild relationships. It must, however, be noted that overall the CCLHD leadership was viewed as facilitating rather than impeding deployment. In addition to the most senior members of staff in key organisations, several other individuals were seen as providing leadership that had facilitated operations and provided a leadership.

Staff and staffing arrangements had also played a key role in implementation. The resistance of staff to the changes required for integrated care being the most commonly identified barrier. Frontline staff and middle management were found to be resistant to new procedures and new technology. It was suggested that resistance was, in part, due to staff feeling that their work was being invalidated, or being taken over and, there was a perception of integrated care increasing their work burden. There was also a perception that people were resistant because of systems within health constantly changing which they referred to as change fatigue. This perceived constantly changing health landscape appeared to be related to a perception that led to integrated care risk being considered the ‘latest fad’. Furthermore, high staff turnover in various agencies including the Ministry, was considered to have posed problems for creating teams well versed and committed to integrated care. Similarly, the integrated care team being on short-term contracts was seen as a barrier to operations. Mainly because it made planning difficult, was a barrier to engaging people and meant there were regular unproductive periods. Recruitment of new staff could also be difficult for organisations. Most significantly, it was understood that implementation of the project had been delayed due to delay in recruitment of a suitable integrated care team.

Very much related to both the issues of leadership and staffing was the area of communication/relationships. In brief good relationships were thought of as a key facilitator of and poor communications a key barrier to implementing integrated care. Good relationships were fundamental for overcoming resistance to change and prompting an attitude of readiness for change. Relationships were understood to be built on open communication and clear strategies. However, poor communications acting as a barrier was also a strong theme. The main communication issues identified were: lack of compatibility of IT systems, lack of common understanding, and different workplace cultures of the various agencies involved. To address communications problems and to build common understanding, two initiatives were mentioned: the ‘day-in-the-life-of theory’ and AIM training.

The gaps in the system, both internally and externally, and the lack of process to take measures to identify those gaps was also identified as a key barrier. It was understood for example that there was a deficit in the numbers of GPs in Woy Woy and social care providers more generally. Associated with this, in the chronic and complex stream, was a failure to develop a good understanding of some of the work that was being done and the parameters in which they had to work. In contrast, the vulnerable youth and children the integrated care team had facilitated integrated care by working with the different agencies working together in an attempt to identify needs.
4.7 Impact on professionals and other stakeholders

The survey findings for the Project INTEGRATE dimensions (see Section 4.3) indicates that the CCICP has had an impact on professionals in regards to the way they work. However, the survey did not ask whether this came at a cost to professionals or provided them with added value. Only the informant interviews provide these types of insight. Negative, neutral and positive impacts on professionals and other stakeholders (excluding consumers) were identified by interview informants.

In relation to negative impacts, informants’ narratives mostly indicated that they had found working on the project stressful in some way. The demands of the project, the culture of the health environment, and the political environment contributed to the stress. Further, the transparency of communications was considered to open professionals up to increased criticism by exposing gaps and failings in clinical practice. In contrast, the role of the integrated care professionals was considered to be that of a “silent partner” meaning they were open to criticism due to their work bringing about integrated care being unrecognised. One informant, also talked about not feeling valued and not being listened to by senior management nor the Ministry. In addition, it was also thought that relationships with other LHDs had been undermined due to the way the CCLHD had received the funding (i.e. not by an open tender process). Other negative effects that the project had on professionals was discussed in Section 4.6 in relation to resistance of staff to the implementation. It was understood some had perceived the project as undermining their role.

The neutral comments largely reported on the project having no great impact on the way that the informants themselves carried out their roles; that the project tended to reinforce the way that they had worked in the past. On the other hand, one neutral comment recognised that the project did have potential to adversely affect staff and so the informant commenting had arranged regular debriefing meetings with their staff.

The positive impacts referred to were mostly in relation to professional development (through learning how to do things better, growth, increased skills, being challenged, and providing opportunities) and enabling career progression, building positive working relationships and increased job satisfaction. Furthermore, it was noted by some that the positives gained were associated with elements that made the work stressful. In addition, some informants felt that they had felt valued by the process and those that they were working with on the ground, and that clinicians were being better supported to work efficiently.

4.8 Effect on consumer experience, care outcomes and care cost-effectiveness

No data was available that objectively measured changes to consumer experience, care outcomes and cost-effectiveness. It is necessary, therefore, to rely on informant commentary for this evaluation.

Generally, it was considered too early to tell how successful CCICP had been in regards to affecting consumer experience, care outcomes and cost-effectiveness of care provision. However, most informants perceived some gains in the areas of consumer experience and care outcomes. All three streams were reported on positively in this light. On the other hand, two of these informants perceived that improvements could still be made. Further, it was noted that consumers were unlikely to notice any differences in their experience of care which may make the assessment of improved consumer experience difficult. Several informants mentioned that evaluations, with specific measures, of consumer experience and care outcomes were yet to be completed or that they were unaware of any results.

In regards to cost-effectiveness of care provisions informants were unable to point to any current evidence that the integrated care interventions implemented had been cost effective. It was also noted that improvements in cost efficiency may be difficult to prove because of the complexity of the overall costing system for health care, numbers were small, data collection was not always done, the complete array of health care the client receives is not taken into account, seasonal variations in service demand (e.g. due to flu cycles), and cost savings are often not likely to be seen for some time. This was seen as particularly true for the vulnerable youth and children stream. Furthermore, the reduced hospitalisation goal was seen as unrealistic for the chronic and complex
stream cohort. Too many of the clients were understood to close to their end of life and there was little the service provider could do to prevent them needing hospital care. Moreover, the suggestion that cost-savings should be the ultimate measure of success of the CCICP was questioned. The learnings gained from trialling various aspects of the project was interpreted as success, as was gains perceived in consumer experience and care outcomes.
5 Discussion

5.1 Meaning of integrated care in the context of the CCICP

Integrated care as understood by the informants and suggested by the program vision and strategy reflected the NSW Government goals and the approach advocated by the NSW State Health Plan. Integrated care was mainly understood to involve providing person-centred care in partnership with others that was effective and efficient. These definitions also are in broad agreement with what might be expected as fitting for an integrated care program according to Goodwin, Stein [2] understanding of integrated care. On the other hand, concern was expressed by some informants that not all key stakeholders shared a definition of integrated care. This is unsurprising to some extent given that there is not a universally accepted definition [2]. However, it does also suggest that the concept of integrated care perceived when demonstrator sites were engaged has not survived through changes in the NSW Ministry of Health. It also suggests that communication of concept could be improved amongst CCLHD staff and other service providers.

5.2 Objectives of the CCICP

There was some lack of clarity in the objectives of the CCICP in that no statement of clear overriding objectives were found. This may have been the reason that several informants were unable to articulate their understanding of what they were. Nevertheless, some objectives could be implied from the document review. Importantly, these implied objectives suggested working innovatively and in new ways aligning with the expressed aims of the NSW State Health Plan [14] by taking an innovative, whole of system approach and working in partnership to provide person-centred care delivery within a framework that encourages and allows learning. Where informants were able to identify objectives these largely fitted with the implied objectives from the document review and the NSW State Health Plan. The objective of fulfilling Ministry requirements identified may be at odds, on the other hand, given that narratives also suggested Ministry expectations had shifted with personnel changes.

5.3 Key components of the intervention

In regards to the key components of CCICP as they related to the Project INTEGRATE dimensions, informants overall perceived that the CCICP had resulted in some gains towards integrated care. Some gains in person-centred care and clinical, professional and organisational integration were noted while acknowledging the need for continued effort.

Survey informants overall perceived person-centred had been advanced but uncertainty about whether sub-elements of person-centred care was being practiced. These results were echoed by the interview narratives in that example of person-centred care were related but there was uncertainty about whether these practices had become routine. Most notably, there was little evidence that individuals were being truly engaged in their care. The voice of carers and consumers appeared to be missing apart from some examples in the youth and children stream. Person-centred care appeared overall to be being interpreted as meeting the array of needs of the client as the service providers saw them rather than as the client saw them. As person-centred care is understood to be the focus of integrated care [2, 5] advancements in this area are of particular importance and, to some extent, a test of the advancement of other dimensions. Alternatively, three of the initiatives compared by Wodchis, Dixon [6] also did not engage service users in their care planning.

Clinical integration was also perceived to have been progressed by the CCICP. The advancements made towards working within multi-disciplinary and multi-organisational teams was the dominant theme of the data collected in general. Indeed, shared care planning was clearly understood by most informants as meaning working with other disciplines and organisations rather than working with the client. A single point of entry with a single assessment is a core component of other examples of integrated care initiatives [6] but informants had varying
perceptions of what was happening in this area. As integrated care is specifically aimed at overcoming fragmented service delivery [2] the improvements observed in cooperation and coordination among service providers demonstrate essential progress.

The CCICP was seen by survey informants as having resulted in most gains in relation to professional integration. Nevertheless, the evidence for progress was mixed. In interviews while sharing of information and care and working with other professionals was discussed it was not apparent that responsibility and accountability was shared. Neither was it clear that supports fostering professional cooperation had been instituted. Moreover, resistance by some staff was noted although a high level of commitment to working in partnership was apparent among informants. Shortfalls in the professional integration area may be addressed by better provision of ongoing education and training which survey informants seemed very uncertain was happening. The need to garner the support of professionals is clearly articulated in the quadruple aim of healthcare [10]. Importantly, investment in all staff involved to enable them to develop the skills necessary for working in an integrated care environment is necessary [3].

The evidence of achievements in the area of organisational integration was also mixed, although there was a good level of agreement that the CCICP had contributed to the gains made. There was some evidence of organisational supports such as shared measures, shared objectives, incentives, policies and procedures. However, the application of these measures appeared to be limited as only half of survey informants on average perceived the measures were being implemented. Moreover, organisational cooperation appears to largely have come about due to mutual interests but a lack of clarity what was agreed was perceived. Notably, shared governance between the LHD and the PHN, despite being an implied objective of the CCICP was a particular area of uncertainty. Governance and organisational integration was clearly still a developing area as several interview informants talked about a proposed alliance between the PHN and the LHD. International evidence shows that the amount of organisational integration varies widely among initiatives and does not necessarily dictate their outcomes [6]. Indeed, Hérbert [26] considered the integration of providers under one organisation banner was not essential to the delivery of integrated care.

The influence of the CCICP on systemic integration is limited. However, deficiencies in the area of systemic integration made it more difficult for the CCICP to progress integrated care overall. There was a lot of uncertainty among informants about whether financing and incentive arrangements promoted integration of care. Moreover, the Ministry appeared to be sending mixed messages; on the one hand funding the CCLHD as an integrated care demonstrator site while restricting what the CCICP could action. The restrictions run counter to the aim of the NSW State Health Plan that seeks innovation and aims to foster learning organisations. The apparent contradictions may largely be the change in Ministry personnel who bring to their roles different priorities and perceptions of integrated care. The overall perception that there was inadequate investment in the workforce is a significant deficit. As noted when discussing professional integration the workforce is understood to be a fundamental pillar of healthcare [10]. There is evidence of attempts to involve various stakeholders including service users in service design, although the extent this has happened is questionable. The involvement of service users is perceived to be essential in the development of integrated services [3].

Survey informants perceived an overall lack of progress towards functional integration that had been brought about by the CCICP. The sharing of information and the platforms to do so appeared to be the major elements hampering progress in this area. It was apparent that the CCICP had struggled to find an appropriate IT system for the digital sharing of service user information despite having explored possibilities in the area. This area appears to be a common problem internationally as none of the initiatives compared by Wodchis, Dixon [6] had a fully enabled system for electronically sharing service user information.

Some progress towards normative integration was apparent, however, the picture was overall unclear. Mainly the interview narratives suggested inconsistency in regard to communication of a shared vision of integrated or person-centred care. As discussed in relation to clinical integration, person-centred care appeared to be commonly understood as coordinated care rather than catering for personal preference and choice. Nevertheless although this definition of person-centred care does not match the common interpretation in the
literature, it does appear to be a commonly held perception within the project. Moreover, the very design of the implementation suggests at least the intention to provide coordinated care. A failure, at times for leaders to communicate clear vision and goals were identified. It is widely accepted that changes involving cultures in the workplace are hard to bring about and take a long time to do. In the case of integrated care that involves an array of organisation both private and public (State and Federal) extra challenges can be anticipated.

Hence, while some gains are evident towards integrated care the CCLHD still has some way to go. Most significantly under the CCICP, service providers do not appear to be routinely engaging with service users in care planning to ensure the care delivered meets their perceptions of their needs. However, limited input by service users into service design did appear to be happening on occasions. Therefore, some advancements to a person-centred care have been made but the service user does not appear to be the foci as yet. It must be acknowledged, however, that the ideal of service-user oriented services are not easy to achieve in practice [7]. Nevertheless, important gains have been made in the building of relationships between organisations and professionals to work cooperatively and collaboratively that have helped and will continue to address the overcoming of fragmentation of service delivery. On the other hand, the most concerning deficiencies for enabling continued progress appear to be in the areas of investment in the workforce including ongoing education, and an electronic system to enable the sharing of service user information. Committed leadership is also likely to be needed to be sharpened to continue to build an integrated care culture. The CCICP, as noted in Section 1.6, had been operating for around two and a half years making it a relatively new project. As highlighted Mead [7] the changes needed to be brought about take time.

5.4 Characteristics of target groups
The groups targeted matched a population health approach in accord with Goodwin, Stein [2] understanding of the practice of integrated care. The vulnerable youth and children, the vulnerable older people and people with chronic and complex conditions streams were all targeting at risks groups with high levels of disadvantage and needs. The vulnerable older people and the chronic and complex streams closely align with the international impetus for integrated care delivery and with where most effort in the space appears to have been placed to date (see for example Hérbert [26]; Wodchis, Dixon [6]). The vulnerable youth and children stream targeted a group that does not appear to have received much attention elsewhere in regard to integration as it is now understood1. Hence, this is a particularly innovative area to be working in and the learnings are likely to be of great general interest. The long-term potential for improvement in outcomes and costs for this group is particularly exciting.

5.5 The role of context in implementation
The context under which the CCLHD was engaged as a demonstrator site was not the same context under which they had to operate. This changing landscape has created difficulties for the CCICP to negotiate. Three areas of change that had caused difficulties were discussed by interview informants.

Firstly, it was perceived by informants that the replacing of Medicare Locals with Primary Health Networks meant the rebuilding of relationships and the early level of agreement on partnership was lost. Such changes clearly impede progress but are likely to be overcome with time and good will. It appears good will is being shown with the informants talking about the creation of an alliance between the LHD and the PHN.

Secondly, changes to the Ministry was understood to have resulted in expectations for the work changing; with a move from a more open, flexible arrangement encouraging innovation to one that was more prescriptive. Truly innovative approaches that create very different ways of working have been recognised as an important factor in the development of integrated care [3]. The Ministry’s restrictions on what the LHD can do and expectation

1 In the 1970s children and adolescent health was a primary target of integrated care as it was then understood 2. Goodwin, N., V. Stein, and V. Amelung, What Is Integrated Care?, in Handbook Integrated Care. 2017, Springer. p. 3-23.
that reforms fit with old structures is likely therefore to impede progress. Moreover, the short-term nature of the funding and the expected move to ‘business-as-usual’ without designated funding has the potential to mean that any gains made are lost as the attention moves away from doing things differently.

Thirdly, the service funding arrangements under NDIS and My Aged Care in which payments go to individuals to choose where they spend it rather than the service providers was seen by some informants as discouraging service providers from working together. Theoretically this would seem a difficult area. On the one hand, this move could be seen as truly innovative and a step towards person-centred care because it allows the service users to make decisions based on their own preferences, values and priorities. On the other hand, the arrangement is ultimately market led and therefore likely to lead to a competitive environment in which service providers are disinclined to share information. Furthermore, it also has equity implications in regards to access of service users. In areas where there is low demand in terms of numbers because of geographical area or because of rarity of need, service users may still have no choice or no service available. Hence, to operate as an arrangement that promotes person-centred integrated care reforms at the system level are going to be necessary for progressing integrated care, a proclaimed aim of the both the Federal and State governments.

There had been changes to legislation (prior to the implementation of the CCICP) that allowed for greater sharing of information, although there appeared still to be some reluctance to do so. This demonstrates that government has a significant role to play in the facilitation of integrated care. However alone, legislation or policy changes are unlikely to be enough, work also needs to be done to foster changes in culture that translate into different ways of working.

The local CCLHD context was understood to influence the implementation. Notably, the CCLHD were already instigating changes to encourage integrated care which was thought to be the reason that they were selected as a demonstrator site. In addition, although the CCLHD was seen as a distinct geographical area and therefore well suited to a discrete trial some shortfall in vital services were also noted that would make integration more difficult. These differing circumstances make direct comparisons with other demonstrator sites and integrated care initiatives more difficult. The previous work in integrated care may also mean that it was more difficult for the CCICP to make further gains that were measurable.

Finally the general context of the fragmented health system and funding arrangements was also seen as creating difficulties. However of course, the fragmented nature of the health was the problem that the CCICP was aiming to overcome. It is interesting to note that that in Scotland where progress towards integrated care has been particularly successful, the Public Bodies (Joint Working) (Scotland) Act 2014 which required the creation of local boards jointly responsible for the provision of health and social services [7]. Similarly an initiative in Québec, Canada (the PRISMA model), has had success operates under a combined Ministry of Health and Social Services [26]. Such systemic changes at government level may well be necessary for real gains to be made at the local level.

5.6 Key facilitators and barriers

Some key facilitators were designed into the implementation plan in response to identified barriers. This approach along with the seeking of information from international evidence and advisors and the population health focus which sought to understand where need was greatest can be considered as important facilitators. This general approach taken was reflective of a learning organisation that NSW Health aimed to foster.

Interview informants identified four key themes regarding barriers and facilitators which are related: leadership, staffing/personnel, communications/relationships and service gaps/needs. The first three of which are very much related.

Leadership was the dominant theme. Good leaders were seen as having a clear vision and strong commitment to the project and were prepared to take risks in line with what was expected for an innovative project. More recent leaders were found to be more risk averse and therefore less appropriate as leaders for the project. The ability to build strong relationships with stakeholders was also understood as being an important attribute of
the leader. It was acknowledge newer leaders had not had time to fully develop relationships. The discussion of leadership largely concerned LHD management or those with direct involvement in the project. However, leadership can occur and is needed at all levels. It is clear that the state and federal government also have a role to play in leadership. Government directions and The NSW State Health Plan in particular have been a source of leadership in the pursuit of integrated care. Similarly, Borgermans, Marchal [3] finds that strong political and clinical leadership is a key feature of successful integrated care development.

As recognised by the quadruple aim of healthcare [10], the workforce is essential to success of healthcare. Having staff engaged and motivated to work towards the changes needed was identified as key facilitator. The will of the staff to implement changes was particularly important; being a barrier if they were unwilling or a facilitator if they were willing. It appeared in the CCICP that high staff turnover may have made this job more difficult. Short-term contracts for staff feed into the problem, acting as demotivators and resulting in periods of non-productivity even if they are otherwise willing. For staff to work in a more integrated way in collaboration with others the right environment must be created [27]. Working across organisations this is unlikely to be easy but leadership, communication and favourable workplace conditions would almost certainly be required to ensure staff that are positively oriented to the cause.

The necessity of good relationships was widely recognised and leaders were understood to be instrumental in making them happen. On the other hand, deficiencies in communications were also recognised often in the context of a system failure most notably lack of compatibility of IT systems for sharing of information, lack of common understanding and divergent workplace cultures. Some attempts have been made to alleviate these issues (e.g. AIM training to enable common understanding) but it appears there is still a way to go. However, none of these issues are easy to overcome and result in significant barriers. While the need for electronic systems for sharing service users’ data is often mentioned in the context of integrated care the literature does not tend to talk about the wider communications issues (see for example Borgermans, Marchal [3]; Wodchis, Dixon [6]).

Lastly, a failure to understand what was available locally and the parameters under which services needed to operate appeared to be barriers for the vulnerable older people and the chronic and complex streams. Clearly, program design needs to be feasible for the constraints set. This also suggests a communication problem, a lack of available data or lack of a process to enable gaps and constraints to be identified.

5.7 Impact on professionals and other stakeholders
The findings indicated that some professionals and other stakeholders involved in the CCICP were affected by it both positively and negatively; although other informants reported the project had not affected the way they worked. The CCICP had contributed to professional development but had also contributed to workplace stress. As yet, while the subject of the workforce and the skills needed by the workforce have been covered in the literature, there appears to be little discussion of the impacts on professionals working in an environment endeavouring to provide integrated care.

5.8 Effect on consumer experience, care outcomes and care cost-effectiveness
Generally it was considered too early to tell or there was too little evidence to comment on how the CCICP has effected consumer experience, care outcomes and care cost-effectiveness. Importantly in this regard, it was noted by Hérbert [26] that the move towards integration is likely to incur greater costs prior to cost-savings and improved outcomes being realised in the longer-term.
Conclusion

This evaluation has described an ambitious integrated care program involving three target populations. The organisational and systemic changes experienced have posed challenges for the implementation of the CCICP. Nevertheless, there is evidence of some good progress but also areas in need of attention. The evaluation is unable to comment on outcomes in terms of consumer experience, care outcomes and cost-effectiveness of care. This evaluation has taken place approximately two and a half years into implementation, hence the amount of progress that can be expected is limited because it is well recognised that the changes needed take time. Hence a long-term view is necessary.

The definitions of integrated care, the implied objectives and the population groups targeted comply with what is generally understood to characterise integrated care and the stated aims of the NSW State Health Plan which underpins what would be expected of CCLHD as an integrated care demonstrator site.

Components of the intervention have led to some gains towards integrated care delivery as defined under the Project INTEGRATE framework. The best gains have been made in the area of partnering and building of relationships between organisations that have led to improved collaboration and cooperation between service providers. The evaluation also shows that the CCLHD have taken innovative approaches to overcome service delivery challenges and have developed as a learning organisation in accord with the NSW State Health Plan.

The vulnerable youth and children stream undertook a particularly innovative working with a non-typical target group and working with FACS and education. Moreover, more engagement with service users in care planning and service design was apparent in this stream than the other two.

The test of outcomes-based commissioning in the North Wyong Proof of Concept is novel in the Australian context and has provided many rich lessons in this new way of working.

The most notable gaps identified are in the areas of routinely involving service users in their care plans, ensuring the buy-in of service provider staff and a common system for sharing service user information electronically.

The importance of leadership, good communication, relationship building and cultural transformation has been highlighted. These are very much related to the gaps identified. Going forward to maintain the momentum of what has already achieved leadership able to communicate a shared vision, build and promote relationships and engage the workforce in the task, much if which is understood to be difficult, and thereby build an appropriate cultural environment. It appears that there is a need for greater attention, therefore, on what the staff need in order for them to deliver the services required. Furthermore, research that investigates how implementing an integrated care program affects staff is warranted.

Achieving the cultural change, the communication channels and the well-functioning relationships necessary is difficult enough for one organisation. The difficulties involved in the multi-organisational context of integrated care cannot be underplayed.

Further, unless leaders are vigilant there is a risk that gains made towards integrated care could be lost as the focus on integrated care may dissipate without a dedicated project and funding and in the transition to business-as-usual. It would be all too easy for the focus of much of the service delivery to slip from the integrated care imperative. Moreover, it appears the encouragement for innovative change necessary is being lost.

The CCLHD can only do so much without the systemic supports that government need to instigate only so much can be achieved. It is desirable that the compatibility of various funding structures with integrated care objectives are considered.

It is plain, then that much of what needs to happen for good functional integration is not under the control of the CCLHD. Other organisations need to play their part and the government needs to commit to providing systemic support and funding. The CCLHD has a role in advocacy and leadership to meet these aims.
7 Limitations

This evaluation is largely reliant on the perceptions of key stakeholders. Few of these stakeholders had insights across this large and ambitious project. Even the senior managers were not in their posts for the entire length of the implementation to date.

Furthermore, the evaluation was carried out approximately two and a half years into implementation. The project implementation time was not very long compared to the amount of time likely to be necessary to see the kind of results and benefits hoped for.

8 References

11. Australian Centre For Health Research, Evaluating health outcomes in Australia’s health care system. 2007.
18. Central Coast Local Health District, Central Coast Integrated Care Strategy Implementation Plan, N. Health, Editor. n.d.
Appendix A - Project INTEGRATE dimensions and sub-elements

These tables elaborate on the integrated care dimensions and sub-elements [24].

<table>
<thead>
<tr>
<th>1</th>
<th>Person-Centred Care</th>
<th>Service user engagement and empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Health literacy</td>
<td>Service users and care professionals work together to obtain and understand basic health information to make appropriate health decisions.</td>
</tr>
<tr>
<td>1.2</td>
<td>Supported self-care</td>
<td>Service users are empowered to self-manage the symptoms, treatments, physical, social, emotional, and behavioural consequences of living with long-term health</td>
</tr>
<tr>
<td>1.3</td>
<td>Carer support</td>
<td>Caregivers are supported in a way that builds their capacity of caring and managing the burden of their care relationship.</td>
</tr>
<tr>
<td>1.4</td>
<td>Shared decision-making</td>
<td>Service users are actively involved in decisions about their care and treatment options.</td>
</tr>
<tr>
<td>1.5</td>
<td>Shared care planning</td>
<td>Service users are actively involved in establishing a holistic care plan, which encompasses health and social care aspects of treatment.</td>
</tr>
<tr>
<td>1.6</td>
<td>Feedback</td>
<td>Service users are supported to give regular feedback on quality and continuity of care received.</td>
</tr>
<tr>
<td>1.7</td>
<td>Health data access</td>
<td>Service users have access to their own care records.</td>
</tr>
</tbody>
</table>

This dimension of integrated care refers to the ability to empower and engage people in the improvement of their health and wellbeing. The approach supports a wide range of ‘service users’ (e.g. patients, people living with frailty or physical disabilities, carers, etc.) to become actively involved as partners in care.

<table>
<thead>
<tr>
<th>2</th>
<th>Clinical integration</th>
<th>Care coordination around service user needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Multidisciplinary assessment and plan</td>
<td>Professionals and providers work together to undertake care assessments and planning.</td>
</tr>
<tr>
<td>2.2</td>
<td>Care coordinator</td>
<td>Named care coordinators ensure continuity of care to service users over time.</td>
</tr>
<tr>
<td>2.3</td>
<td>Care transitions management</td>
<td>Co-ordination between professionals and providers enables seamless care transitions for service users across settings.</td>
</tr>
<tr>
<td>2.4</td>
<td>Case management</td>
<td>Professionals work together to proactively manage the needs of defined service user groups (e.g. case management with precise inclusion criteria).</td>
</tr>
<tr>
<td>2.5</td>
<td>Single point of entry</td>
<td>There is a single point of entry for service users when accessing multiple services from different professionals/providers (centralization of referrals).</td>
</tr>
<tr>
<td>2.6</td>
<td>Community involvement</td>
<td>Volunteers and the community are actively involved in coordinating care around service users’ needs.</td>
</tr>
<tr>
<td>2.7</td>
<td>Integrated care pathways</td>
<td>Partners in care follow defined pathways to help understand and direct the process of care integration.</td>
</tr>
</tbody>
</table>

This dimension of integrated care refers to how care services are coordinated and/or organised around the needs of service users.
### 3 Professional integration: Existence and support of teams/networks

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<tbody>
<tr>
<td>3.1</td>
<td>Shared accountability</td>
<td>Professionals recognise and enact shared accountability and responsibility for care outcomes.</td>
</tr>
<tr>
<td>3.2</td>
<td>Collaborative agreements</td>
<td>Formal agreements exist to support collaborative working between care professionals.</td>
</tr>
<tr>
<td>3.3</td>
<td>Inter- and Multi-disciplinary teamwork</td>
<td>Care professionals work in inter-disciplinary or multi-disciplinary teams with agreed roles and responsibilities.</td>
</tr>
<tr>
<td>3.4</td>
<td>Continuous training</td>
<td>Multi- and inter-professional training and education is continuously supported.</td>
</tr>
<tr>
<td>3.5</td>
<td>Collaborative attitude</td>
<td>Care professionals have a long-term commitment to leading, developing and delivering integrated care in partnership with others.</td>
</tr>
</tbody>
</table>

This dimension of integrated care refers to the existence and promotion of partnerships between care professionals that enable them to work together (e.g., in teams or networks) and so promote better care coordination around the needs of the service user.

### 4 Organisational integration: Joined up service delivery

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<tbody>
<tr>
<td>4.1</td>
<td>Performance assessment</td>
<td>Care organisations participating in integrated care use a shared set of measures and indicators to monitor outcomes and performance.</td>
</tr>
<tr>
<td>4.2</td>
<td>Incentive schemes</td>
<td>Collective incentives (shared gain) exist between care organisations to support care integration.</td>
</tr>
<tr>
<td>4.3</td>
<td>shared strategic goals and policies</td>
<td>Care organisations have shared strategic objectives and written policies and/or procedures to promote integrated care, including Service-Level Agreements and Memorandums of Understanding (inter-organisational strategy).</td>
</tr>
<tr>
<td>4.4</td>
<td>learning and quality improvement</td>
<td>Care organisations regularly engage staff in a process of joint learning and continuous quality improvement</td>
</tr>
<tr>
<td>4.5</td>
<td>Shared governance</td>
<td>Care organisations have shared governance and accountability mechanisms to ensure that they are formally interdependent to deliver integrated care.</td>
</tr>
</tbody>
</table>

This dimension of integrated care refers to the ability of different providers to come together to enable joined-up service delivery (that helps to then support professional and clinical integration).
<table>
<thead>
<tr>
<th>5</th>
<th>Systemic integration</th>
<th>Enabling platform</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1</strong></td>
<td>performance assessment</td>
<td>The care system uses a set of common measures and outcomes to monitor and access performance.</td>
</tr>
<tr>
<td><strong>5.2</strong></td>
<td>regulatory framework</td>
<td>The care system aligns its regulatory framework with the goals of integrated care.</td>
</tr>
<tr>
<td><strong>5.3</strong></td>
<td>Financing and incentive arrangements</td>
<td>The care system has financing and incentive arrangements that directly promote the provision of integrated care.</td>
</tr>
<tr>
<td><strong>5.4</strong></td>
<td>Proactive policies</td>
<td>National/regional policies pro-actively support and promote multi-sectoral partnerships and person-centred care.</td>
</tr>
<tr>
<td><strong>5.5</strong></td>
<td>workforce</td>
<td>The care system has invested in an adequate workforce in terms of the numbers, competences, and distribution of key staff to support the goals of integrated care.</td>
</tr>
<tr>
<td><strong>5.6</strong></td>
<td>stakeholders involvement</td>
<td>All stakeholders (e.g. service users, professionals, managers) are actively involved in the design, implementation and evaluation of integrated care programs and policies.</td>
</tr>
</tbody>
</table>

This dimension of integrated care refers to the ability of the care system in providing an enabling platform for integrated care at an organizational, professional and clinical level (e.g. through the alignment of key systemic factors such as regulation, financing mechanisms, workforce development and training).

<table>
<thead>
<tr>
<th>6</th>
<th>Functional integration</th>
<th>Effective data and information communication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6.1</strong></td>
<td>single common identifier</td>
<td>A uniform patient/user identifier is shared between the different care organisations.</td>
</tr>
<tr>
<td><strong>6.2</strong></td>
<td>stakeholder communication</td>
<td>The communication of data and information between care professionals and service users is effective.</td>
</tr>
<tr>
<td><strong>6.3</strong></td>
<td>shared decision making</td>
<td>Decision-support systems are available and foster shared decision making between care professionals and service users.</td>
</tr>
<tr>
<td><strong>6.4</strong></td>
<td>shared care records</td>
<td>Shared care records (e.g. single electronic health record) enable data information to be shared for multiple purposes (e.g. needs assessment, performance management and evaluation).</td>
</tr>
</tbody>
</table>

This dimension to integrated care refers to the capacity to communicate data and information effectively within an integrated care system.
<table>
<thead>
<tr>
<th>7</th>
<th>Normative integration</th>
<th>Common frame of reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>vision</td>
<td>Existence of a collective vision on person-centred holistic care (i.e., not disease-centred)</td>
</tr>
<tr>
<td>7.2</td>
<td>population health management</td>
<td>Collective practice puts emphasis on population health management aiming to improve access and care experiences as well as outcomes of specified populations</td>
</tr>
<tr>
<td>7.3</td>
<td>social capital</td>
<td>Building awareness and trust in integrated care services with local communities</td>
</tr>
<tr>
<td>7.4</td>
<td>leadership</td>
<td>Presence of leaders with a clear and common vision of integrated care</td>
</tr>
<tr>
<td>7.5</td>
<td>shared vision</td>
<td>All stakeholders (e.g. professionals, managers of organisations, services users) share a clear vision of integrated care</td>
</tr>
<tr>
<td>7.6</td>
<td>trust</td>
<td>Partners in care have a high degree of trust in each other’s reputation and their ability to deliver effective care through collaboration</td>
</tr>
</tbody>
</table>

This dimension of integrated care relates to the extent to which different partners in care have developed a common frame of reference (i.e., of vision, norms, and values) in support of the aims and objectives of care integration.
Appendix B - Stakeholder interview guide

Organisational involvement
Please tell me about [name of organisation]’s involvement in the Central Coast Integrated Care Project. Within the Central Coast Integrated Care Project, how have your organisation’s relationships with other stakeholders been managed? What support is there for organisations to implement the Project?

Personal involvement
Please tell me now about your own involvement in the Central Coast Integrated Care Project - how you became involved and what your involvement has been. Please describe the characteristics of the group or groups your work, in relation to the project, is targeting. How has your involvement in the Central Coast Integrated Care Project affected you?

The Project
Integrated care means different things to different people, what does it mean to you? What do you perceive are the aims of the Central Coast Integrated Care Project? What do you see as the fundamental components of the Central Coast Integrated Care Project? As a result of the Central Coast Integrated Care Project, what do you perceive has changed for service users? How do you perceive the care provision is approached under the Central Coast Integrated Care Project? What specifically is being done that wasn’t being done prior to the implementation of the program? What, if any, potential benefits do you perceive arise from the Central Coast Integrated Care Project? What, if any, potential downsides do you perceive arise from the Central Coast Integrated Care Project?

Facilitators and barriers
What, if anything, do you think has facilitated the implementation of the Central Coast Integrated Care Project? How have these facilitators been strengthened? What do you think may have retarded the implementation of the Central Coast Integrated Care Project? How have these barriers been addressed?

Measures of success
How is the project being monitored? How is this information being used? How successful do you think the Central Coast Integrated Care Project has been?

The future
What do you perceive the future will be for the Central Coast Integrated Care Project?

Conclusion
Would you like to say anything else about the Central Coast Integrated Care Project that hasn’t already been covered?
Appendix C - CCICP sub-projects by type as mapped January 2017
Appendix D – Key informant survey findings

The surveys provided information about informants’ perceptions of the progress that the CCICP had made towards the different Project INTEGRATE dimensions (see Appendix A). These findings are relevant to research question three (see Section 2.2).

D.1 Person-centred Care

It was agreed by more than 80% of informants that the CCICP had contributed to improving person-centred care (see Figure D1). When viewed by sub-elements, there was clear agreement on contributions to health literacy (70%), user decision making (59%), to a lesser extent user empowerment (52%) and caregiver support (44%), with less clear agreement on user participation in care planning (41%), user feedback (44%) and access to own records (41%).

Figure D1: Perceptions of Person-Centred Care

Of the thirteen free text responses given, five expressed uncertainty on commenting on the whole CCICP, six shared a nuanced view, acknowledging gains either in policy intent, small scale improvements and achievements (e.g. within projects/streams), whilst acknowledging that there was work yet to be done in this dimension. Two reflected on the difficulties of achieving change, that whilst there were pockets of achievement, it had not yet spread.

The Central Coast Integrated Care Program has done well in improving Patient-Centred Care and the CCLHD Caring for the Coast Strategy enables this. There is still much room for improvement in this area.

The Central Coast Integrated Care program has been more of a test-bed for integration methodologies, trialled on a small scale. As a result, the contribution of the program to improved delivery has been extremely limited. In specific programs, it has achieved good results, but these have not been expanded across the broader patient population of the Central Coast at this point.
D.2 Clinical integration

It was agreed by more than 80% of informants that the CCICP had contributed to improving clinical integration (see Figure D2). When viewed by sub-elements, there was clear agreement that providers worked together (78%), to a lesser extent on continuity of care to users (59%) and to the proactive management of needs by professionals (59%), with less clear agreement on seamless care transitions (37%), partners following defined pathways (30%) and single point of entry (59%, but with 26% disagreement). There was neutrality/lack of knowledge over the contribution of volunteers in care coordination (67% neither agree nor disagree).

![Figure D2: Perceptions of Clinical Integration](image)

Fourteen responded to free text on clinical integration, of which seven discussed the positive impact, all of these were qualified with recognition that more work needed in this dimension. Five acknowledged lack of spread and one discussed a perceived failure to fully understand role of GP and practice staff.

...in my experience, most services are reactive and unplanned except for the most complex patients, and very few services have strong integration of the patient in decision making and planning processes. The integrated care program has only addressed these in very limited groups of patients, and whilst the outcomes from those trials are good, the impact has not been felt widely and most patients have been unaffected by the program.

Not everyone needs integrated care. Again, there are pockets in the LHD where this happens well. I think there is a limited understanding of what GPs do, and can do (and practice staff), as well as other services.
D.3 Professional Integration

It was agreed by 74% of informants that the CCICP had contributed to improving professional integration (see Figure D3). When viewed by sub-elements, there was clear agreement on contributions to shared accountability (70%), inter- or multi-disciplinary teams (67%), long term commitment (63%) and that formal agreements existed (56%). To a lesser extent, informants agreed that professional training was supported (37%, with 56% neither agree nor disagree/don’t know).

![Figure D3: Perceptions of Professional Integration](image)

Of the thirteen free text responses, nine were positive, five had were nuanced with acknowledgements of limitations to date, that more work needed to be done, that there were pockets of good work, though a lack of spread. Two informants had not seen evidence of difference.

Some acknowledged that some of the improvements lay beyond the control of the CCICP.

*A number of issues for Child Protection and Out of Home Care work are state wide and while ICP was able to implement improvements locally some of the improvements required for integration require state leadership i.e. Ministry of Health and FACS.*

Others expressed conflicting views of the value and role of primary care and GPs.

*Integrated care has strongly advocated for the role of GPs and NGOs in the health care economy.*

*Within the LHD, there are pockets of strong integration between services and between professions, however very few of these consider the primary care sector as part of the team.*
D.4 Organisational integration

It was agreed by 74% of informants that the CCICP had contributed to improving organisational integration (see Figure D4). When viewed by sub-elements, there was agreement on contributions to shared measures and outcomes (56%), collective incentives (56%), and shared objectives (52%). To a lesser extent, informants agreed that shared governance existed (41%), though this was not disagreed with, rather the majority neither agreed nor disagreed (56%).

![Figure D4: Perceptions of Organisational Integration](image)

Of the twelve free text comments, nine were, with seven providing qualifying observations of limitations such as small cohorts, success within certain programs, lack of spread, knowledge of agreements for some not others. Three responses clearly outline lack of knowledge regarding this dimension. There was acknowledgement of shared objectives, agreements and MOUs, some for incentives and measures.

One acknowledged that the CCICP had been successfully built upon existing partnerships, but that these had been challenged by disruptions and restructures, but had continued to work on these and was future focused.

*The Central Coast Integrated Care Program has successfully built on existing partnerships which has been difficult to achieve given the disruption from the restructures occurring within Hunter New England and Central Coast PHN (previously Central Coast Medicare Local), Department of Family and Community Services (expanding from a local Central Coast office to include Hunter and New England) and an internal CCLHD Executive restructure. This involved having to engage and build solid relationships with new stakeholders/sponsors, while maintaining the momentum of the Program. The Organisational Integration will be further built on with a formal Alliance Partnership model implemented between the key partners.*
D.5 Systemic integration

It was agreed by 67% of informants that the CCICP had contributed to improving systemic integration (see Figure D5). When viewed by sub-elements, 44% agreed that there was stakeholder involvement in design, implementation and evaluation. Other sub-elements were represented with uncertainty, a majority of neither agree nor disagree responses for policies that support multi-sectoral partnerships (37% agree), financial arrangements (33% agree), and framework aligned to integrated care goals (33%). Informants disagreed with investment in adequate workforce (48% disagree, only 19% agree).

![Figure D5: Perceptions of Systemic Integration](image)

Of the eleven free text responses, three were positive but with qualifications, from lack of knowledge to more negative assessments. All eleven statements are critical of progress in this space, three of which explicitly acknowledge barriers from state and national policies and funding regimes are hindering progress towards systemic integration.

*The biggest issues remains the impact of federal funding decisions and frameworks that talk about integrated care but create disintegration. The second biggest issue is that Ministry of Health sees Integrated Care as chronic disease management between state health providers and GPs only.*

Two highlighted communication issues – perceptions and time restrictions. One acknowledged gaps in workforce skill and competencies to support integrated care, whilst another stated that current staffing levels did not always meet demand for both service user support and communication processes.

*CCICP is very time sensitive and time consuming and consequently some patients will fall through the gaps due to current staffing levels not always being able to meet demand for patient support & communication processes.*
D.6 Functional integration

It was agreed by 44% of informants that the CCICP had contributed to improving functional integration, another 44% indicating that they neither agreed nor disagreed (see Figure D6). When viewed by sub-elements, there was as much agreement as disagreement on uniform user identifier (37% each), there was much uncertainty around effective stakeholder engagement (52% neither agree nor disagree, only 19% agree) and decision support (41% neither agree nor disagree, with 26% agree). There was clear disagreement on contributions to shared care records (52% disagree).

**Figure D6: Perceptions of Functional Integration**

Of the thirteen responses, one did not know enough to comment and the other twelve responses were critical of progress in this space, four specifically acknowledging no shared care platform, one perceiving the lack of a shared care trial as a missed opportunity for workforce readiness, another expressed frustration that despite the assurance that Central Coast would be a trial site for MyHealth record, this did not happen and one perceived a lack of commitment since these systems had not been implemented in response to demand. Only three comments contained positive feedback regarding processes being set up, some system improvements and better communications in some areas.

The IT patient management system is not fully integrated between departments within CCLHD and this limits the coordination and support to patients under the project as they are not always identified as being in the system. This then has a knock on affect to other providers of care i.e. GP/Community providers as they are not notified the patient is in hospital or being seen in the community by a CCLHD health professional.

D.7 Overall perceptions of CCICP’s contribution towards integrated care

However it should be noted that there was considerable uncertainty (neither agree nor disagree) among survey informants regarding progress towards the dimensions of integrated care overall, ranging from 35-40% (see the level of agreement according to the mean scores of sub-elements for each dimension Figure D7). However,
positive perceptions regarding the CCICP contribution towards the integrated care dimensions are evident (see Figure D8), perhaps indicating the stakeholders understand that progress and contributions have been made, but that maturity has not yet been achieved or spread sufficiently, reflecting the uncertainty represented in Figure D7.

**Figure D7: Perceptions of current state of integrated care in CCICP (August-September 2017)**

[Graph showing perceptions of current state of integrated care in CCICP]

**Figure D8: Perceptions of CCICP contribution to integrated care dimensions**

[Graph showing perceptions of CCICP contribution to integrated care dimensions]
Of the fifteen informants who chose to make a general comment, two were critical of progress including a lack of awareness of the good work of the CCICP, that was not well communicated, and the observation of difficulties in achieving a wide impact in a short time frame.

I am unaware of many projects/programs being widely implemented. Within CCLHD achievements and results have not been publicised widely. Regular project updates would have been a good method to keep the LHD up-to-date on results. I have not been made aware of any success stories but hopefully they have happened.

Five informants took the opportunity to make positive reflections on progress, from contributions of individuals and stream successes to personal reflections on skills and knowledge gained from experience.

Great structural improvement and change management systems. A good team of thinkers and doers.

The facilitation of relationships across all local health areas and sharing of information by the Integrated Care team has been invaluable in my role.

Seven informants took a nuanced view, outlining positives with criticisms, chiefly with respect more work to be done in the space, reflecting that the ambitious remit of the CCICP had left the program spread thin and lacking visibility. Two conveyed concerns regarding fit of social care angles with NSW Health goals.

CCLHD is making great inroads for 'integrating health' however there remains much work to be done in achieving truly integrated care for addressing clients bio-psychosocial needs... Service redesign or quality improvement does not necessarily equal integrated care.

The program had an ambitious remit and has struggled to gain traction outside the LHD and in some cases, in the LHD. Pilots of eHealth records, support for health pathways and better consultation with the broader system remains problematic. The team have worked hard to achieve buy in, in some projects, but in others, the lack of consultation has been challenging. Also, the visibility of the program with primary care and staff within the LHD has been limited, probably because of the large number of projects which have been initiated. That being said, partner organisations remain keen to partner and the awareness of the benefits of the integrated care and the work of the program may be realized in coming years.

I think it was a bold initiative, and challenging for many health workers as it questioned how we do business. There has been some great work. I think it has great potential. Especially with the establishment of the Research Institute, and linkages with local health professional 'schools'. A research focus on integrated care, and the practical application of integrated care through the LHD’s Caring for the Coast and its elements (patient = person-centred, community=population, resources= cost per capita). It has been difficult to quantify, as the social care and person-centred care approaches don’t fit well with the NSW Health hospital activity mindset. Also challenged by a near complete change of personnel involved with the program from the NSW Health perspective.
Appendix E - Key informant interview findings

The interviews provided information relevant to all the research questions (see Section 2.2).

E.1 Meaning of integrated care in the context of the CCICP

Care that involved teams of workers (17/23) was the predominant theme when informants were asked what integrated care means to them. Multidisciplinary and multi-organisational teams were referred to and the sharing of resources and information.

It means working together around a person and their needs regardless of who employs you. So the team that supports a person would be from Education, FACS and Health. It could be from any combination of services, government or non-government, but it’s about that we in fact see ourselves as working for that and with that person. That’s what integrated care means for me from a person-centred perspective.

I see a group of people from different organisations that meet, that auspice a joint team that’s sort of co-funded by everyone.

The second most common theme in regard to the meaning of integrated care was person-centred care (15/23). Five of these informants expanded this discussion to talk about providing a continuing care for patients as their needs changed or they transitioned from one care setting to another. While one informant spoke about the need to provide continuing care on discharge from hospital without talking about the care being person-centred. Seven informants who mentioned person-centre care also suggested that integrated care also meant improving the experience or outcomes of service users. One of these informants also spoke about empowering and increasing the health literacy of service users.

What I mean by that is it’s about the system is very driven and biased towards provider needs rather than the person’s needs and true Integrated Care is flipping that on its head and really looking at person and family-centred approach to how you deliver care for that person.

Well, for me, and I have to say having worked in health, having worked in the community and now working as a service provider manager, I can honestly say it’s about being able to support that person through the trajectory of their lifetime and being able to support them the way they are right here and now and being able to really touch base with the people who they need.

So for me it’s bundling all of those things together that basically means provided they’re coming together with their - you know, with their care specialisation or current skills to enhance the patient experience, to enhance the patient’s outcome and to ensure that there is an availability of care for a population.

Indeed for one informant, what the service user perceived as integrated care was what was ultimately important.

…but my point is when you’re trying to actually roll this out and sell it to people they’ve got to know, okay, it’s not good enough to say we’re going to integrated care, isn’t it wonderful. We’ve actually got to give them something that integrated care means to them.

In addition, to improving the experience of service users, two informants also understood integrated care to mean an improved experience for staff.

I think it is all about how it meshes together around the patient to improve patient - well, I suppose you could look at the quadruple aim around improved patient experience, improved patient outcomes, staff experience and within a cost-effective manner.

If you’re doing integrated care, you’re improving the patient experience, you’re improving the staff experience. If you’re caring for the patient, you should be doing person-centred care. Caring for your patient, you should be empowering your patient around health literacy and understanding the disease.
Four of the informants that talked about person-centred care did not mention the care being provided as a team. For some (8/23), integrated care meant effective or efficient care. For three of these informants this meant recording and analysing health care data. For another it meant making sure everyone in the population had their needs met.

Look, for me, and it comes back to the old - and it sort of does try it to me these days, but it's that old statement that's old and - right care, right place, right time and right price.

I'm sort of seeing integrated care as an entire pipeline of care that patients might go through. It's actually not a - not viewing it as different segments that operate independently. It's actually about making sure that we get an optimal combination of care along that pathway. So patients might need a little bit of this, a little bit of that but not something else and it's how do we actually best get that together, and, most importantly, making sure that we have primary care in that mix as well. So it's sort of like primary care as being the gatekeeper to come of the many other services which is the way that we are supposed to be doing it in Australia, but the way that our system is set up, that doesn't always quite happen like that. So that once a patient leaves primary care, they go off into another system of health care, and some of the things that occur there might be better off handled in primary care. So as an economist, to me the lack of integrated care is an efficiency problem and an effectiveness problem.

...if we can use that data to actually look at – well, why do people come back to hospital and really unpack that. I think we've lacked that at a local level, which is integration in itself, being able to really have people on the ground to look at the data.

...we'd come across a program that was fantastic, but it would actually see seven patients a week and it had already got to saturation point, and we'd say, "How do we convert this seven to 7,000?" So we would always take that population framework into how do we not dilute the patient experience or the patient outcomes, but how do we make sure that the 7,000 people that need this service in our community have access to it and not just the seven who are at the front of the line.

For four informants integrated care meant an approach that should be the regular way of conducting the business of caring. It was believed that consumers expected an integrated approach in which various providers worked together and shared information. Hence integrated care met consumer expectations. However, to do integrated care meant to challenge the boundaries because integrated care did not easily fit into the current mode of operation.

So it's elements of person-centred care, about empowerment, about teamwork, communication and how we can make sure that they become – they are reinforced in the way that we do our business. That's a really important component.

I've had this conversation with people outside of work, which was, you know, that your GP doesn't share your file with the hospital, and the hospital doesn't share your file with the GP, and you know, that's what we're trying to achieve. We're trying to make sure that we can share and we can provide the best care, you know, as a whole system on the Central Coast, not just separate agencies working separately and treating different things. Because really, as a consumer, and before I worked in Health, I had always just assumed that that had happened. So, you know, what I might be allergic to, and the GP knows, the hospital necessarily doesn't know.

Often you're on projects and you think "Well is this something that will continue?" and I look at this and go “It can’t not” because it - that it even has a label and that it's a, sort of, movement is actually a bit weird because it's such an obvious thing to do and I know - What it really says to me is actually integrated care is about challenging the boundaries and working out the right way, the best way, within I think a very difficult framework where we're especially in Australia constrained not only by different organisations but by separate funding pools that come from either federal or state.
Alternatively, another informant thought that not everyone who came into the health system needed integrated care all the time.

Integrated care is not for everyone, but everyone needs integrated care. So I think there’s a level of complexity or a level of need that says this person needs integrated care or this person doesn’t, or this person might not have needed it when they’re 40 but they might need it when they’re 60.

On the other hand, two informants spoke about integrated care as a distinct central coast organisational unit. It then seen as either something that was isolated from how the central coast usually operates or as a resource of support. It was also acknowledged by a third informant that by creating an integrated care unit there was a danger that integrated care would be seen as separate from regular operations.

Integrated Care is a resource within our district that helps support us in implementing quite significant system reform, I think. They’re there to support us, but they’re also there to help drive some of the process because the advocacy that they were able to do and the education they were able to do at executive level in the district, I would never have even had access to those people. This had higher level exec sponsorship, Integrated Care. So we were able to get attention on issues. Like child protection is such a small part of Health’s business, but it really should be a really big part of Health’s business because we’re involved in a child or a family’s life almost for their lifetime.

If you create a little integrated care unit and say we want to do integrated care and we want you to do it, well, everyone else will say: Well, hang on. There’s a unit there to do this, so why do we need to do it?

On the other hand, three informants considered that there was a lack of a shared definition of integrated care amongst CCLHD staff, other service providers and the Ministry of Health. This meant that what CCICP had achieved was not recognised. Moreover, the expectations of the Ministry were not being meant. For some integrated care appeared to mean cost cutting, for others that it ran counter to person-centred care.

That was the question we’d always get and we’d get that a little bit from the Ministry as well. ‘How is this integrated care for Health? You’re not dealing with chronic and complex conditions. You’re not trying to prevent hospital admissions now. You’re not dealing with the most costly of our patients at the moment, so why are you doing it and we’re paying you to do it?’

We certainly had a GP who is quite sort of emblazoned in my mind is that I still feel like your definition of integrated care is something you do to me rather than something you do with me.

The lack of a shared understanding of integrated care was perceived as meaning that some workers would not recognise that they were involved in integrated care.

I, sort of, think some of the people that I think I’ve worked with most successfully and they’ve really appreciated the work and, you know, been very, very open and thankful about it but I, sort of, think if I was an external person and I went back to them now and said, you know ‘What’s your integrated care done for you?’ I think they would probably turn around and say Ah no I’ve had very little to do with integrated care.

Moreover, the need for a shared definition was identified to enable integrated care to become part of the CCLHD’s business as usual was identified by one informant.

So what is it that we want to embed as principles, but how do we, for the person on the ground, convert that to behaviour? So actually if you’re working in it – if you are truly delivering integrated care, what does that behaviour look like for you as a nurse on the ward, for the podiatrist working in the community, for whichever example you want to pick up, what does integrated care actually look like behaviourally and what processes do we have in place that support that? …there’s a lot of change that’s needed, but, yes, it needs to come from the top down, and it needs to be understood and we need to have a definition that we all agree on.
Furthermore, it was anticipated by one of these informants that the definition of integrated care was likely to be subject to change overtime.

So, you know, because what is integrated care for us at any given time could change and I’m sure it will evolve and I think really we’ve got to just have this holistic, high-level look at things and say well, you know, how should it work because for the patient it’s all one thing, it’s about them and it’s what they meet on their journey.

E.2 Objectives of the CCICP

The objectives stated by informants fell into seven main areas: provision of health services, working with multiple service providers, measuring performance, commissioning services, fulfilling Ministry requirements, testing of innovative approaches and, more recently, moving integrated care to a ‘business-as-usual’ mode.

Provision of health services was the topic most often spoken about in regards to objectives of the CCICP (9/23). Generally this was in regard to providing efficient and effective care, wrap around services and holistic care, meeting the needs, requirements and objectives of the service user. However, identifying needs and those at risk and reducing hospitalisation frequency and length was also mentioned.

I think the aim was to see, well, what can we actually do to improve patient care, improve really those quadruple aims around the patient and really providing that right care in the right place at the right price. That was Matt Hanrahan’s mantra at the time. So, for instance, the LHD didn’t have to be the centre of all care, and we understood that. For instance, the vulnerable youth probably don’t even need to set foot into the LHD until they get sick, but we know that if we don’t care for them now, they’ll get sicker earlier later. You know, there will be more of them getting sicker earlier. And the same with the concept of having GPs providing that sort of care coordination and keeping people out of hospital.

So it really needs to be goal orientated for the patients. You know, what’s their goal? You know, our goal might be that, you know, they do this and that, but their goal might not be that at all.

The first one was the aged care component which was looking at reducing people’s presentations at emergency departments and looking at supporting people to reduce, you know, their trips and falls and their obesity and managing their health kind of requirements before they present at ED. And then the other part, which sort of sits in the integrated health care team but has taken a fairly different structure is the youth stuff, and some of the youth homelessness work... which is looking at early intervention in schools and utilising the FRS program to identify young people in families early in their kind of risk identification journey and provide wraparound services and support.

Four Informants discussed working with other service providers as an objective of the CCICP. This was in regard to shared decision making, care planning and assessments, referral pathways, and working with social services (e.g. FACS and education) as well as health services such as ACCHOS and GPS.

What we thought we needed on the coast was better integration around decision making and assessment of child protection reports and then better planning of referral pathways, more integrated referral pathways. So when I’m talking about integrated I’m actually talking about integrated across agencies.

So how do we identify them and how do we work out who they are and how to work out what their needs are. So that. It’s about not just looking at health care needs but actually looking at health and social care. So invariably we will have someone in the vulnerable population who turns up at the ED but actually it’s a social care issue that’s caused that rather than necessarily an exacerbation of their health.

Four informants saw performance measurement that included data collection and analysis as an aim of the CCICP. One informant believed this brought a different perspective to the work that enabled different ways of working. However, it wasn’t always perceived that anything useful was being done with the data collected.
Part of my role that I thought was to try and see how we could influence what happens in case mix and performance, see them – have them see a different approach to the data and see how, okay, that’s interesting. Have them exposed to people with slightly different skills and seeing what those skills might bring to their case mix and performance work, and so it was sort of cool that after having had our bio stats person spend a day or two a week working particularly in their space and then doing – our bio stats person doing an SQL course, and then to actually have one of the case mix people do an SQL course and the like. You know, that was a really small but really positive development, and I think an awareness amongst the management over there that – you know, data management skills, biostatistical skills are worth having in that performance and case mix because that’s where a lot of the number crunching data happens in the organisation. So I think that was a – for me that was an unstated, undocumented objective but one that was really important for the program.

...we didn’t really know what we were trying to solve by being up there. So we were collecting activity data but I’m not sure that it’s actually driving anything. The governance group that used to happen for that, I don’t think it happens anymore.

Five informants talked of commissioning of services as being an objective of the CCICP. Indeed, this was seen as a driver of the work. The project was used to test outcomes-based commissioning of NGOs to do work that had previously been carried out by the CCLHD.

Well I think improved integration with agencies and that sort of thing and the way they work, but the whole commissioning thing as well and commissioning not for profits, NGOs, to do some of the work that we used to do. I think they’re doing a lot of that.

It’s to test outcomes-based commissioning.

...we actually started to look at how do we commission services in a different way. So how do we pave for outcomes, not just for activity, and that was very exciting.

Fulfilment of contractual requirement was the key objective perceived by one informant.

So at one level the organisation’s responsibility is to fulfil its contract with the Ministry of Health. You could take a higher philosophical approach and say the Central Coast Local Health District, by virtue of the Health Services Act, has a role to protect and promote the health of the population, as well as deliver health services to people in need.

A CCICP objective, perceived by three informants, was innovation: to test approaches outside of the entrenched structures.

To date I think that we were given quite a strong message to be innovative in this space, to try new things, to be adventurous, to be prepared to fail, so that we were given that opportunity to, I suppose, to hothouse some ideas. What are some ideas? What are some different ways of doing this?

Notably, six informants perceived that the objectives had changed over time. Two of these informants believed that the objectives were no longer clear. However, others saw the main current objective as being the inclusion of integrated care into their regular business so that it was considered “business-as-usual”.

I guess it’s possibly broadening the scope from those initial vulnerable groups to more broadly, and I think this is with our new CE on board. You know, how do we move this from a series of smaller projects to influence how we do business more generally. You know, that’s an area of work that we’re currently – increasingly finding ourselves in.

However, according to one informant who was involved at the start of the project the objective was always to make integrated care ‘business-as-usual’.
The first piece was trying to socialise the concept of integrated care, and the other part that we were really trying hard to crack was how do you systematise integration? So you can do it at a program or service level, but we were looking at how do you actually make this business as usual in a systemic way?

Whatever the case, the CCICP was understood to had enabled the LHD to see a way forward in which integrated care may become and should become part of the normal way they do business.

I think what it has done, for me, that the Central Coast Integrative Care Strategy has - ...it was a project off to the side and had been through this funded period, but I think people have seen how it can be integrated into core business now and we can take those steps to actually make it core business, and people realised that it’s the principle of integrated care that needs to be integrated, so that everything we do start thinking about how do we integrate with all of the relevant services, whether they’re health, social service, and whether there in the public or non-public sort of setting.

A total of seven informants, when asked about the objectives of the CCICP, said they did not know what they were, that they had been lost or the work they were involved in did not have integrated care objectives.

I honestly can’t answer that and the reason I say that and I’ll be honest is because, so we had a plan, we threw the plan out, we've done some good work that was better than the plan. Now I don’t think we’ve got a clear strategic direction.

The objectives weren’t based around integrated care. I didn’t see any evidence of that. From memory I didn’t see anything about integrated care being part of the objectives whilst they were doing that.

E.3 Key components of the intervention

Here the evidence from the interviews is organised and discussed around the Project INTEGRATE dimensions to provide insights into key components of the intervention. Other key components have been discussed in the introduction (see Section 1) and the review of documents findings (see Section 3).

Person-centred Care: In general the interview responses suggested the delivery of person-centred care was more aspirational than actual. That person-centred care was valued and understood to be central to providing integrated care was reflected in informants’ descriptions of the meaning of integrated care to mean (see Section E.1). Often narratives would suggest the care planning was about what was best for the consumer but often the voice of the individual involved appeared to be missing from conversations.

...for me simply it’s around a true person-centred care to how you look after a person for their health and social care. What I mean by that is it’s about the system is very driven and biased towards provider needs rather than the person’s needs and true Integrated Care is flipping that on its head and really looking at person and family-centred approach to how you deliver care for that person.

Nevertheless, there were a few examples that informants gave that indicated some progress towards person-centred care.

In regard to care professionals working with service users to promote health literacy to empower their decision making around their health, only the vulnerable older people stream was mentioned (by 2 informants).

I think the other thing that the providers have really focused on is increasing the literacy of that population as well. So hopefully more understanding of ...what my chronic disease looks like? What are the things that work for me? What are the things that don’t work for me? What can I put in place in terms of self-management?

No illustrative clear examples of carer support under the CCICP was forthcoming in the interviews. Although three informants mentioned the importance of carers in relation to vulnerable older people and working with families. Further, working with families was seen as important for those involved in the vulnerable youth and
children stream. However, the expansions on why working with families was important and illustrative stories suggested this was mainly because the problems of the children were indirectly related to issues within the families.

...a 10 year old with autism who's in mainstream school but his behaviour deteriorated at school and at the same time the Principal was getting strange messages and emails at all hours of the day and night from his dad. His dad's a single parent and his dad is known to have mental health problems. It was clear that dad’s mental health had deteriorated. The Principal didn't know quite what to do except that he had the Family Referral Service worker in schools available to him, so he got her to meet with the dad and find out what was going on. The dad was clearly unwell. He’d missed a couple of GP appointments and his GP was away. He wasn’t known to us in Central Coast LHD but he was paranoid and his behaviour for his son was sort of a symptom of his mental health distress, I suppose.

In the chronic and complex stream some success was reported in relation to supporting individuals with diabetes to better care for themselves. Under the CCICP the reach of the self-management program was perceived to have expanded considerably.

...for something like self-management, which was a community-based program and we had a real problem with reach. So he [Anthony Critchley] helped us sort of unpack that and give us a new model to pin it on, which seems to be working a little bit better. You know it’s doubled its reach and created some capacity in the service by transferring that activity of other service providers within the community. So it’s really changed that body of work there.

In addition, service providers in the vulnerable older people steam had recognised some consumers needed a lot of help to be able to comply with preventative self-management activities. One informant described how they proactively worked to support consumers to attend a course and exercise sessions.

Patients that we do have some are a little bit self-motivated, but in the majority of circumstances - so, for example, there’s a great source prevention program, the Stepping On program. Six weeks - I think nearly everyone over the age of 65 should go to this. It teaches you - for example, if you do fall, how to get up off the ground, and an OT comes and a physio, but to get to that class. If you can’t drive, and public transport in the Wyong area is so difficult, you can’t get there. So our team actually drove people to the course. ...We’ve had to take people to hydrotherapy as well.

Just two informants talked about involving the consumer in shared care planning and decision-making. These informants were involved in the vulnerable youth and children stream and the vulnerable older people stream. The informant involved in the vulnerable older people stream suggested that this inclusion of the service user was the way that they normally worked. However, the informant in the vulnerable youth and children stream believed that the involvement of the student in question would not have occurred without the CCICP.

...sometimes when we’ve known that they’ve been really palliative, it’s about, okay, let’s talk about your advanced care plan. Let’s get your wishes down. So although it doesn’t reflect in the study itself, it actually has been really important for that person, and, as I said, we’re very person-orientated.

...the care plan that was written at that time was a bit different because there was a real emphasis on giving control back to the student. The care plan included actions for the student when they felt unsafe, where their safe place was, the words they would use to the teachers to say they need to go to that safe place, the teacher’s response. So then they would without concern they would let her go. They wouldn’t crowd her or chase her down to make sure she got there. They took the calculated risk to allow her to take responsibility for how she was feeling and that was a real shared care plan. It made significant difference to that young woman. That wouldn’t have happened if we hadn’t done what we’ve done.

Even so, despite having multiple stories of person-centred care, the vulnerable youth and children informant perceived that person-centred care had not been achieved in the stream on a regular basis.
We aren’t there yet with saying that we’re really doing person-centred care because we’re not always having the child or the parent or grandparent in the room yet and I think there’s still a level of bravery that our service providers need to take around really sharing the care, because they’re sharing the care with each other a little bit better at times, when it’s pointy end but they’re not sharing the care I don’t think enough with our parents and our students.

In relation to service users being supported to give feedback on the care they were receiving, some informants alluded to evaluations collecting consumer experience feedback (see Section E.8). This, however, was always in regard to general evaluations of services. A process suggesting consumers were able to provide feedback on that would enable enhancements made to their own individual experience to improve their own quality of care was not mentioned. Informants did not mention consumers having access to their own health care records.

Moreover, one informant was very unsure about the progress of person-centred care and, indeed, what would enable the dimension of person-centred care to be measured.

I’m still not sure that we’re really good at how we would say we are going with person-centred care. How do we have a metric for that, or what does that look like to be able to say we’re achieving high-quality person-centred care? What are the measures for that? That really make sense of it and we really nail it, but I’m not sure if we’ve nailed it yet.

Clinical integration: In line with the major theme identified in informants’ definition of integrated care, the dominant meaning of shared care planning among informants was working in multidisciplinary care teams or working with other service providers to plan and provide care. Nine informants in describing what happened in projects under the CCICP mentioned only sharing care decisions and planning among service providers. Working with other service providers occurred in all three streams.

It’s really, really crucial, and we like to coin the phrase “sharing the care”. So actually not just paying token consideration to that, but actually truly saying we are, we’re in partnership and we’re doing this together.

Furthermore, the vulnerable older people stream and the chronic and complex stream had been set up to have clearly defined care coordinators. On the other hand, the vulnerable youth and children stream had a more flexible arrangement that utilised the most appropriate person for the case. Most often care ordination was taken on by the FRSIS worker.

There’s no named person and that’s okay and we’ve steered away from looking for named care coordinators. We’ve actually looked at more the roles that are needed, what the person needed, who’s going to take the lead on these things. So you’re almost asking people to step up without calling them a Care Coordinator and be clear what they’re going to coordinate and what they’re going to do and who’s the best person to communicate with the family. Usually it’s the Family Referral Service Worker in schools for at least a period of that time and then they negotiate who that responsibility goes across to, depending on who’s in their care circle if you like.

Case management in which professionals worked together to meet the needs of the consumers was also apparent in all three streams. Indeed, case management and care coordination were seen as interlinked.

So the care coordination role, it’s new to some people and there’s that bit of a blur between what’s case management and care coordination. It’s definitely a key.

It was less clear if the vulnerable older people and the chronic and complex streams involved multiple provers carrying out assessments (the vulnerable youth and children stream clearly did).

Transition of care was mostly spoken about in relation to discharge from hospital. A new model of discharge planning had been trailed and found to work well.

So the idea is that they move from a model of care where the nurses wait and get a referral from a ward. What we found in our initial investigations was that that happened quite late in the patient journey, where best practice initiatives say that patients should be seen on day 1 for their discharge planning needs. So
that’s the model. The model now will be that the nurses are allocated to the ward. We’ve done a trial in two wards, two acute wards at Gosford, M6 and M4, and the trial outcomes were very good. So one of the plans now is to move up to Wyong and do it in a couple of wards up there, implement it in a couple of wards up there, and then eventually implement it across the whole LHD.

However, it appeared that service providers in the vulnerable older people stream were not necessarily being included in the planning of their clients entering hospital. They had to proactively seek information themselves when they heard from family members that their client was being admitted.

So when we’ve heard from family members, we’ve been able to phone through to them and say: Look, can you have a look on ComCare. When do they go into hospital? Can you give us any information? What sort of services do you think they’ll need? And then we’ve been able to help support them with their discharge planning, but we’ve also been able to start setting up processes perhaps for their loved one or whatever, if they’ve been a carer, for instance.

Four informants mentioned a central intake system, although it was recognised by one informant not to directly part of the CCICP it was still seen as being a component advancing integrated care. Moreover, it was thought that there were still improvements to be made in this area. The aim of this central intake was to aid referral pathways.

Theoretically that should, in the long run, make it easier patients and for referrers because for adult community services they should be able to contact one central intake number and access the service they need without having to know... ARC does that and ACAT does that and somebody else does that and whatever are the service criterions, so we manage that at the back-end. So, again, trying to give that seamless front at the beginning for the patient or the referer. We’ve struggled I guess – that’s not completed. It’s in progress, and I think there’s cultural issues, there’s logistical space issues, being able to house everybody you need for intake. There’s cultural issues in terms of – you know, people accepting that’s what it is and it’s no longer just community nursing intake, and then resource issues, being able to staff that because we’ve traditionally done our referrals to each individual service... I think gone to try to do centralised intake three times in my time with chronic disease programs and we get to a certain point that we never quite get there. So we’re further along this time around under the integrated care, but it’s still not quite there.

It was not clear whether partners in care were following defined care pathways to help understand and direct the process of care integration. While some informants talked about following referral pathways and clear guidelines for how providers should operate, informants did not discuss how that this could or did further understanding and direct the process of integrated care. Rather it appeared providers were just following protocols. In addition, there was no mention of volunteers nor the community in relation to their involvement of coordinating people’s care needs (interview questions did not cover these areas).

**Professional integration:** Evidence of professional integration was sparse. As discussed in clinical integration, working in multiple agency and multi-disciplinary teams was an established part of all three streams. There was no evidence at either the project management nor the front-line care level, however, that these teams shared accountability and responsibility for care outcomes. As discussed, sharing of information, shared care planning, coordination and consultation appeared to happen but individual care professionals appeared to take either overall responsibility or responsibility for their part of the care plan (see also the discussion under clinical integration). The systemic changes needed to instigate shared accountability had not been made.

Now what we have is we have the report comes in to the Multiagency Response Centre. They share the report with us and we then make a decision on what information is relevant to be exchanged. We now exchange that verbally because we have workers that are collocated with FACS. ...We exchange that information now at a point of assessment rather than post the decision being made. So the decision of whether or not a statutory response or some other kind of response might be required for a family, we’re now exchanging information that informs the decision making process. We made changes of where the
staff were located for example. But we didn't deal with the recurrent funding and the way the positions are structured and who they account to, who line manages them and what's the structure around them and that sort of stuff. We made the kind of surface changes to get it functioning.

Moreover, the resistance of some staff to changes under integrated care and the linking of this with that these staff feared their role being taken over (see Section E.6) suggests that these staff were not recognising and enacting shared responsibility and were not ready for that change.

There was some evidence, on the other hand, that some formal agreements had been put in place outlining the roles and responsibilities for care and the collaborations of different organisations’ staff. Narratives of informants indicated that service providers were working under agreed protocols or guidelines.

What we did was we came up with basically just an operations manual for each of the agencies that were sitting in the service and really what's happened is.

…the coordinators are adhering to a process and that process is I've received the referral and I'm going to contact the client within seven days. I'm going to see the client within two weeks and I want to refer that information back to the GP or see them within three weeks. Whatever those operating procedures are, they're working towards that.

How supportive these protocols or guidelines were of collaboration among the professionals is not known. No informant commented on their effect on the collaborative process.

Some informants mentioned some training and education that they had received, run or that had been provided for care professionals. It was not clear, however, that training and education was continuously supported as informants mainly reported training related to first involvement in the CCICP. Initial training and education opportunities mentioned included AIM, outcomes-based commissioning training, training for paramedics in triaging and managing low acuity call-outs and work area information being supplied. However, a few informants also mentioned attending integrated care conferences and one that GPs needed to be assisted to stay abreast of current information.

One of the key things I think also is just that ongoing education. We have provided the GPs with a lot of education on my aged care and on what services are out there as well, and I think that that would be something that - if the study goes further, that that would be able to be built upon because really - but they are also, firstly, for the education of what's available out there for their patient, and they are so time poor that they don't actually always recognise that there are other things.

Commitment to integrated care partnerships were apparent in nearly all informants’ narratives. Informants expressed not only their own personal commitment but referred to the commitment of those they were working with and leaders within the LHD.

I want to see the organisation go in an integrated care direction. I am hugely committed to that. I think that is the way to go. I think that's where we're going to get our best benefit for our community, …So it’s not necessarily a personal, vested interest in that, but if I was invited to contribute, I'd be really happy to do that.

We had a committed board, a Chairman who was supporting us all the way and that was critical.

Organisational integration: There was some evidence of progress towards organisational integration. One informant clearly perceived that organisational (and systemic) integration was not being done well.

So I think then there’s the organisational integration and the system integration is really significant and important because I don’t think we do that well and organisationally I think what it looks like is a better understanding of how we each do our business and how that overlaps, and how working together we can do it better. But also aligning some of those things like reporting mechanisms.
The most referred to performance measures for the vulnerable older people and the chronic and complex streams was reduction of unplanned hospitalisations and bed days. For the outcomes-based commissioning of the vulnerable older people stream the outcome that was of interest was reduced unplanned hospitalisations. Hence, this was a shared measure between the LHD and the service providers involved. Moreover, the objective of reduced unplanned hospitalisation, and as a result the measures, appeared to have come from the Ministry and so they were also shared by the Ministry. The use of Ministry designated measures will be discussed more under systemic integration.

In regard to the vulnerable youth and children stream it was common for informants to comment how difficult it was to measure performance of this stream. However, one informant shared that an evaluation was planned and that a common reporting strategy had been devised for the organisations involved.

In the youth space, I think they’ve probably struggled just a little bit more to figure out how they’re going to measure the outcomes. There some challenges in how do you measure the vulnerability because there’s a slightly different focus. It’s not really about reduction at ED presentation. It’s more around, I guess, the kind of youth, mental health, homelessness. A bit more of a holistic kind of view. So I think – yeah, for me, I’m a little bit less clear, but I think the program is a little bit less clear about how they’re going to measure that reduction or that improvement in practice.

…what we did was we came up with a shared way of reporting so that we were all reporting on the same sort of activities or the same sorts of things. I don’t know how it’s being evaluated because essentially that’s FACS. It’s actually going to be looked at I think by the Cross Agency Implementation Unit now which is sitting in FACS.

Incentives supporting integration were mentioned by only directly mentioned by two informants. One was in regard to the outcomes-based commissioning of the vulnerable older people stream in which there was a clear monetary incentive negotiated to reduce unplanned hospitalisations. As it worked out the reduction hoped for had not been achieved and therefore the incentive was lost. Nevertheless, it was thought that the motivation for service providers to take part in the scheme was a potential monetary surplus.

As an economist, I have a view as to what the incentives were, but is that actually, and this is the real world issue, is that what the providers thought they were signing up to? …They are both, even though I think they’re both not-for-profit organisations, a surplus is what they’re aiming for, and my understanding is that they were signing up to generate a surplus, that they would have actually come in at less and fewer bed days and then being paid that amount that they would receive for each bed day avoided, and the fact that they opted for not going into originally a risk-sharing agreement so that they attracted the full payment at the end of the program.

The second informant reflected on the lack of incentive in the vulnerable youth and children stream to work with families.

We haven’t been working with families in a really constructive way at this point and we’re still not in a way because health doesn’t look at the family. We do, but we don’t have connected records. We don’t have incentives for services to work that way yet. So they might ask about families but they’re not thinking really about their needs. Their primary client is the one in front of them with that disease or that issue, whether it’s the child or it’s the adult. They’re not really looking at what the whole family issues are.

Even so, it was apparent from narratives that the incentive for most informants to work in the integrated care space was to improve care and consumer experience and outcomes.

Any shared objectives appeared to be pre-existing; that is coincidental rather than negotiated between organisations. Hence, organisations became involved due to mutual aims that could be served by working collaboratively.

I think – in the very early phases there was discussions around the nature of the integrated care work and how what it might mean and who we might be working with, and it wasn’t hard to get some shared...
objectives with the primary health network in relation to aged care and chronic and complex disease management because those sorts of things are very much on the PHN’s agenda, so that was pretty straightforward. The youth health focus partly came about because the CE of FACS and our CE were at a workshop, or conference or event somewhere else and they sort of thought: ‘Wow. We could actually do something together in this space around youth health.’ So, again, it was a pretty alignment of the design to improve our culture to help vulnerable, young people on the Central Coast, and I think coming out of those interactions I think there was also earlier recognition that while FACS and Health are talking, you know, there’s quite a role for education, and so they were brought into the mould.

However, four informants perceived a lack of clarity of what was being agreed.

...our leaders agreed to it but they didn’t agree to what they’d agreed on and no one was there to witness the agreement. It was verbal. It wasn’t concrete. There wasn’t clear governance around it. It was a troublesome way to do business. We kind of had to make it work and we found ways to try to join, but we also learnt a lot about how hard it is when you force people into a room. You do a project but they’re not sure what problem they’re trying to solve.

I think you’ve got to understand also that a lot of this was driven by relationships as opposed to process. A lot of the discussions, a lot of the planning were about people who have worked very closely together, maybe friends, that sort of thing. ...but instead from putting together robust partnership structures, I think a lot of it was formed around - on the side conversation.

It appears then that these informants were either unaware of or did not think formal agreements stipulated what was to be done and why. Conversely, other informants reported that level a Memorandum of Understanding and partnership agreements had been signed.

So with the PHN we’ve got one overarching Memorandum of Understanding. It has about four or five partnership agreements that sit underneath it, but rather than managing a whole host of unconnected service level agreements, we’ve got an overarching one with - you know, the PHN, with FACS, with education and multiple service level agreements can sit under those things. So it actually formalises agreements at a higher level. So actually bringing that sense of that mentality into - it’s been really useful.

Clearly the CCLHD perceived that the formal agreements they had with other organisations had not been sufficient. Seven informants mentioned a proposed alliance between the LHD, the PHN and possibly other organisations. These informants understood that the alliance would clarify joint objectives, better promote integrated care between primary and secondary healthcare professionals or at least signal a long-term commitment of these organisations to integrated care.

...we’ve been talking with, particularly the Primary Health Network, we’re talking about forming a more formalised alliance, ...we see the PHN as the core partner and then we would see bringing in the other groups as partners, depending on the particular pieces of work, and that includes not only health providers or other sort of non-government organisations or private health providers, but also the more social component as well. ...The district has traditionally had a GP collaborative. Then on the side we’ve had the integrative care piece. Part of the alliance will be about... bringing it all together so that there’s not multiple different routes ...so that there’s no duplication. ...we will be bringing it in with core business and anything that we do going forward where we’re changing models of care or looking where there’s service gaps or ways in which we can do things better, we need to take that integrated care approach and it needs to be at the centre of what we do.

A governance committee that appeared to involve LHD and PHN was referred to in interviews. It was reported that findings of evaluations and monitoring were reported to this governance committee. It was not clear, what role the committee than had in orchestrating integrated care improvements.

Systemic integration: Systemic integration is complicated and difficult to separate from organisational integration since the organisations involved are components of the system. Moreover, systemic integration
largely sits outside of the control of the CCICP (although the CCICP may have some influence due to being part of the system) and not a primary concern of most informants, as such, systemic integration was generally not directly pursued in interviews. Nevertheless, the informants’ narratives point to systemic or key contextual issues (see Section E.5) especially when they resulted in significant barriers or facilitators (see Section E.6).

The use of a common set of measures and outcomes to monitor and assess performance is related to the sharing of measures discussed under organisational integration. As discussed above, the reduction in hospitalisations appeared to be a NSW Ministry of Health imposed measure of performance as were other measures that needed to be reported on regularly. One informant suggested that these measures were negotiated. However, it was apparent that the chronic and complex stream was constrained in what they could do due to having to meet Ministry indicators. Furthermore, it was suggested that the measures reported to the Ministry were not relevant or did not always fit well with integrated care work.

...we’ve got reporting measures to the Ministry of Health that we have just renegotiated for the next 12 months as well around our portfolio.

But the ministry KPIs and monitoring has been really aimed towards stuff that you can monitor like, you know, how many of this are you doing or how many that are you doing, nor so much we implemented something and we changed, somebody will say: It hasn’t always lent itself very well to what we’re doing.

It was acknowledged that integrated care objectives such as person-centred care was hard to measure.

Alternatively, informants also discussed the CCLHD identifying their own milestones, executive governance setting performance goals, nominating additional local performance measures to report to the Ministry or just generally collecting data about what was happening on the ground.

We’ve got an executive that’s – in governance at the moment that’s very keen on really owning the strategy and defining what we do and in giving us a clear set of goals to go and achieve. So that’s the space they’re operating in and they’re managing the risk of it all obviously.

[The Ministry], they’ve given us their own state – so 12 state performance measures, so that’s how many integrated care patients are you seeing, what percentage of patients have you seen this year or whatever. ...So they’re not relevant to us, but then we also had to nominate – as a demonstrator site, we had to nominate 12 further local performance measures, which we tried to rely – well, we tried to make them relevant to our strengths. Obviously we touched a lot on the family referral service in schools because it’s not something that the ministry or the other sites are focused on youth, so it’s definitely a unique piece that we’re working on.

It is apparent then that the local performance measures are not common systemically shared and that those measures that are shared (i.e. those imposed by the Ministry) lack relevance to integrated care. Moreover, the Ministry measures were reported to be largely activity-based when an outcomes-based approach was understood to be more conducive to promoting integrated care.

I find it incredible that the Ministry knows enough about this to actually be quite innovative in giving for health relatively large amounts of funding to the LHDs to do this but then they’re, sort of, not looking at it systemically... Because in the same time as they’ve funded integrated care, they’ve also moved more sharply towards activity based funding which would seem to me to be a very contradictory move.

Furthermore, the fragmentation of the health system into Commonwealth and State run sectors (see also Section E.6) was perceived as resulting in relevant measures of performance not being commonly accessible. However, one informant understood that changes were afoot that might enable a better monitoring of outcomes.

I hear things like the Feds are looking to provide some of the MBS data to the State, to try and link with hospital data, so I think that’s a really positive step, an indication of some willingness to try to come on board because – you know, in our project, the North Wyong Project, we are hoping that the evaluation
will pick up on GP activity for the intervention group and control group, so that we’re not just looking at it through an LHD hospital admission ED attendance plans, but also through general practice – to sort of see if we – if we improve coordinated care, does that increase business or decrease business in primary care.

The NSW Ministry of Health was recognised as supporting integrated care through funding and thereby providing a mandate but regulations that the Ministry imposed appeared to restrict what the CCICP were able to do. For example, the care strategies within the chronic and complex stream, a procurement activity, an off-site central intake centre.

As noted in Section E.5, there has been a change in Minister since the commencement of the project which had brought with it changing demands. The change in Minister and other changes of staff within the Ministry were perceived to have resulted in attitudes, and therefore regulatory frameworks that were not as well aligned with innovation and bringing about changes towards integrated care. Furthermore, the Ministry itself was reported as lacking integration with different departments not being able to work with each other which made it more difficult for the CCICP to operate across portfolios. Notably, the integrated care branch of the Ministry not provided the support one informant would have liked.

So I think the Ministry of Health …created a branch that was looking after Integrated Care and that should have been helpful but I haven’t found it very helpful largely because I think my work falls out of what they’re comfortable with. So a lot of my support has actually not come from that branch of Integrated Care. It’s come from the violence, abuse and neglect portfolios in child protection in the Ministry of Health because we’re doing such early intervention work around vulnerability that they’ve got a great deal of interest with us. So there’s been a great deal of support from them, financially across a couple of projects where we’ve needed some additional funds and some I guess air time. They’ve also been the ones that have promoted the project that we’re doing to the premier and to the Minister for FACS. They’ve actually been flying the flag quite significantly but not through integrated care. That’s been done not through the Integrated Care Branch. It’s been done through other branches of the Ministry. But the Ministry themselves is a bit disintegrated which is tricky because the Integrated Care team don’t – structurally they’ve moved so they’re in the same place as the child protection support but they don’t understand each other’s business. The other part of the work that I do falls very much into mental health. Mental health and Integrated Care don’t understand each other’s business.

Conversely, the NSW Premier’s Priorities were considered to have allowed the CCICP to work with organisations falling into other portfolios.

…the thing that’s helped me the most in that has been the Premier’s priorities strangely enough because they are the Premier’s priorities. So any state-based organisation has to work towards them. So if you align to those you can find the things in FACS that are supporting homelessness in young people that are working towards improving that. You can find them in Health and you can find them in Education. So, then you get a place of joining because it’s a Premier’s priority, not a State and Health, not a State Education, or a State FACS priority. It’s an everybody priority leading up to that Premier’s priority.

On the other hand, a state strategy was seen as expensive and difficult to address. The different legislation for the different government departments was understood as challenging.

An often reported downfall of the state strategy is that it’s very rigid, you know, it’s turning the big ship thing and it actually can’t support change and innovation very well because by definition it’s a state strategy. So if you want to change something you have to get everybody else on board or you have to pay for a hugely expensive change.

Our legislation is a bit different to FACS’s legislation and yet we have legislation that covers us all. So there were some barriers. There were some systems barriers that we had to try and overcome and get some work around. …We’ve done that okay.
Moreover, the services and care that it was possible to provide was restricted by rules. The period people could access services for and what could be provided to the consumer was restricted rather than being flexible according to need.

*And a lot of those services are funded to provide services for 12 weeks. So at the end of 12 weeks, if the families isn’t fixed or better or whatever, they feel like they can’t extend that because they’ve got to get the next family in.*

*So I think that was really challenging for all of us, and trying to understand and trying to get integrated care to understand that the Ministry of Health was still driving chronic care and what was going to happen there was still under a ministry model, so they really couldn’t effect that too much, nor the rehab programs.*

As discussed in Section E.6, the issues around privacy legislation and lack of clarity amongst staff of what could be shared still failed to meet the needs of integrated care despite relatively recent changes. Moreover, it was understood that internal policies restricted information rather than encouraged sharing.

*As an organisation we hammer home the importance of protecting privacy and confidentiality but we don’t do is talk about ‘What happens if you don’t share?’ or ‘What are the consequences if you’re not sharing?’ We talk about the consequences of oversharng and breaches and we vilify and discipline and people know about those examples of the people who’ve breached confidentiality and they should, but we don’t know on the other hand what happens where people don’t share information well and therefore the care is impacted, and what does that look like for the patients?*

Clearly funding provided by the Ministry of Health for the project promoted the provision of integrated care. However, that funding was short-term and was expected to end. This had implications for the retention of staff that had key roles in maintaining programs and continuing progress. The expectation was that the work would become ‘business-as-usual’ and the costs of integrated care absorbed into the LHD’s usual operational budget. There was a general understanding that to bring about the changes needed to embed integrated care as business-as-usual was a long-term strategy. Several informants perceived that the project was not far enough developed to continue without designated funding and perceived there was a danger that the gains made would be lost and learnings forgotten. The short-term nature of funding and the perceived impact of this barrier is discussed further Section E.5.

Other than the positive measures discussed above there was a lack of evidence in the informants’ narratives to suggest further proactive support at the national or regional level of multi-sectoral partnerships and person-centred care. The arrangement of health spending with Commonwealth and State responsibilities is also discussed in Section E.5.

In regards to investment in an adequate workforce to support the goals of integrated care the main factor working against that is the short-term funding of the project and service provision. Short-term funding was perceived to have resulted in recruitment difficulties and was understood not to be compatible with a business-as-usual objective for integrated care.

Nevertheless as discussed in Section E.6, many of the people working in the CCICP were appreciated for their effectiveness and competency. There was also confidence that learnings from the chronic and complex stream enabled the LHD to understand what was needed for the workforce and a willingness was expressed to invest in that.

*I think what we’ve learned can inform where we go to next within our organisation with the chronic disease workforce that we have and that’s a much more sustainable workforce and there’s an ongoing investment in that from the organisation. So there’s sustainability there, and we can actually improve the range of people they can work with and get better outcomes for our whole community.*

Conversely, it was also perceived that the LHD could be investing more in getting the workforce ready to undertake integrated care work.
It feels like there’s a whole sort of suite of, or there’s a whole set of individuals scattered across the organisation that if we pulled them a little bit tighter with our integrated care knowledge and those functions together, then you would create teams that could create real change within directorates and to support teams to make change because they need all those elements. They need the quality and safety, they need Integrated Care, they need leadership and culture, they need education and training. Those sorts of things need to come together to make the whole thing roll but I think we're going to lose our people.

A Medical Research Institute with a focus on integrated care was mentioned that was being planned for the Central Coast. It was anticipated that the Institute would promote integrated through influencing graduate workers.

...if we get the Medical Research Institute happening well, we’re in a really good position to influence the new graduates of different health programs that are happening on the coast, to really have this mindset.

The involvement of most stakeholders is discussed throughout the findings. Of note however, co-design of the approach for the vulnerable youth and children stream was mentioned by informants. Further, there was no evidence from the interviews that service users had been involved in the design, implementation and evaluation of the programs and policies.

**Functional integration:** Generally progress towards functional integration appeared limited.

There was no evidence in the informants’ narratives that a single service user identifier was being used between different care organisations. However, as Medicare numbers are required for Health users accessing services this number may serve that purpose, at least in the Health system. It is not clear from interviews, however, if this is how service users are identified within health organisations’ systems. Moreover, Medicare numbers are unlikely to be of any help when integrating social services.

As discussed also in Section E.6, lack of compatibility of IT systems among service providers was considered a major barrier to communication of data and information and sharing care records among organisations. This is a well-recognised problem within the Health system which appeared to have no easy solutions.

> We have a lot of barriers to even sharing communication across teams. The different numbers of different electronic systems means that someone’s care as a patient can be, they need say the Diabetes Service, the Paediatric Inpatient Unit and the Mental Health teams, but all of those three teams use different electronic systems. They have no reason to come together other than this one patient. They don’t know each other. They don’t need to know each other in other spheres and they find it really difficult to come together and to even be in the same room to plan care. So you end up with this sort of transactional referrals across services even within health. It's not sharing the care. It's not coordinated. That sort of approach just is, we're just not there.

Interview informants explained local decisions meant that the CCLHD and the CCICP were not using IT systems adopted by others. For example, it was reported that initially there had been an intention to commission a digital ‘shared care planning’ platform but after researching the options a decision was made not to go ahead due to lack of suitability.

> So early on... one of our deliverables was meant to be a shared care planning platform. There was a governance decision to not proceed, so Michael Bishop, who’s pretty IT savvy, did an environmental scan, I think is what you would call it, of the shared care planning platforms that were in place at the time. And he basically said none of them suit what we need at this point. We could proceed but the other two demonstrator sites, I believe, were failing at share care planning platform at the time so they decided not to go ahead.

The CCICP similarly found the Patchwork platform used by FACS was unsuitable for the needs of the project.
...the software was a piece of software called Patchwork ...FACS was trying to answer was that agencies need to understand who is involved in a child’s care and communicate more. They actually purchased at a state level this program and we were really pushing it on NGO providers and on Health to actually use. We came back to the table and said: I think there are two questions. One is: ‘Do agencies need to actually communicate more and who is involved in care’. But the second one is: ‘Does this software solve this problem?’ I said to the FACS manager, absolutely question one there’s a universal yes. You know, in order to protect kids, we need to know who is involved and communicate more ...and the answer to question two: ‘Does this software do that?’ The answer is an absolute no.

In addition, it was understood that the CCLHD had implemented a different IT system to other LHDs NSW.

So in our work on the ComCare system – So ComCare’s quite out there because the rest of the state has got CHOC ...Central Coast made a decision to move to ComCare a little bit related to the integrated care strategy so it was better supporting our business needs. So it provides a point of care documentation. It’s just a bit more flexible and we have a bit more control over it.

On the other hand, there were plans and work being done that may help to rectify the incompatibility of IT systems to some extent. Firstly there was work being done within the CCLHD to improve communication with the PHN.

So I know the ComCare team were working on reviewing another system for eReferrals with the Primary Health Network. Hunter, I think, have implemented it so they were looking at whether that was successful. And the ComCare system, I think they’ve – they were setting up a trial between – so that they could communicate. I think discharge planning or something like that, between general practice.

Furthermore, the My Health Record initiative of the Commonwealth Government was anticipated to alleviate some of the problems. This will, nevertheless, only be relevant within the Health system.

The My Health Record will be I think a really good step in the right direction when it becomes opt out.

Moreover, improvements in electronic information sharing of care records was thought to still be some way off by one informant.

You know, we don’t have those cloud links between what happened in general practice and what happens here. I know we’re all waiting for the personally linked electronic controlled health record to really grow legs in terms of uptake and then use and then what can we actually all use it for, but I think we’re, like, ten years away from that personally.

The other major barrier to communication and sharing care records, was the fear of sharing information due to privacy concerns (see systematic integration above and Section E.6). There was little evidence of decision-support systems to foster decision making between professionals and service users. As noted under person-centred care above and clinical integration decision-making tended to be among service providers and tended not to include service users. There were some inclusion of service users in decision making in the vulnerable youth and children and vulnerable older people streams (see person-centred care above). In relation to the vulnerable youth and children stream, the system of care that CCICP appeared to have facilitated the inclusion of the service provider in the illustrative story. However despite the systems adopted, as also noted this inclusion of service users did not always occur in this stream. Moreover, in the case of the vulnerable older people stream the inclusion of service users appeared to be due to the attitude fostered within the service provider organisation rather than a system per se. The attitude may have even been particular to that particular worker.

Normative integration: Informants’ narratives conveyed some gains in normative integration but that there was also more to be done in this area.

The extent that the vision of person-centred, holistic care was shared among interview informants was covered in Section E.1. In brief, person-centred care was found to be a major defining feature of approximately two-
thirds of informants. It is not known (and it was not asked about in interviews) how extensive this vision would be among the workforce involved in providing integrated care under the CCICP. Despite the lack of commentary it is possible to surmise that a collective vision of holistic care was at least communicated through the population health approach adopted and the choice of the three streams.

A key premise underlying the implementation of the CCICP appears to have an emphasis on population health management with the aim of improving care for the specific population groups described by the three streams. Moreover, geographical areas were targeted where the greatest need was perceived. Informants spoke of risk stratification to identify which populations should be targeted in all three streams. Importantly, it was noted that a population approach rather than a disease approach was taken to care provision.

“We started the Family Referral Service in schools project with our partners and started to I guess look at place-based risk stratification. The place-based being sort of drawing a circle I guess around our learning community of primary schools and secondary schools and then starting to look at the health and social care needs of those populations.

…we didn’t strongly go down the disease approach of have you got this disease or that disease. We talked about maybe if you’ve got one or more chronic conditions, regardless of whatever they are, they may be an indicator of an underlying need, but we didn’t care what they were in some ways... You try to move away, a little bit, from the biomedical model because I think, particularly with aged care, there are recurring stories and there’s actually some literature and evidence that... if you take a person and subject them to sufficient stress, it will initiate a physiological process that will result in what we might consider to be organic disease and end up with someone being in hospital, and so the disease is just an expression of the underlying distress.

However, it was noted that the data available to the CCICP was not always sufficient to allow the outcomes hoped for to be achieved.

...because one of our approaches was to try and look at predictive analytics and look at risk stratification for people and trying to predict an unplanned hospital admission and therefore then try and avoid that, and what do we need to do to keep people out of hospital. So to do that you need a whole lot of data and it just highlighted the issues of the disconnect of data in the current system. So, that was a huge component that again we were attempting and it’s still in its embryonic stages, but attempting to address that from a person approach.

Informants’ narratives did not mention any efforts that had been made to build awareness and trust in integrated care services with local communities. As observed in Section E.8, it was perceived that it was unlikely that service users would notice changes made towards integrated care provision. It was thought 'integrated care’ was jargon that would mean little to the population. Even for those working in the area but not part of the integrated care team, the term integrated care was avoided for fear of under-selling the concept.

I don’t think it will ever be something that the larger population is terribly aware of or means much to them but it probably shouldn’t be.

In contrast to perhaps what the Ministry of Health may have been thinking, we haven’t been promoting integrated care loudly from the towers because ...it’s jargon and really... the elements of integrated care that are fundamentally more important than people understand... There’s communication with people who are not direct stakeholders but might be interested, and so for those it’s not immediately tagged as integrated care but more just about how we do business.

At times leaders within the CCICP and CCLHD had failed to communicate clear vision and goals. Moreover, it was apparent that while the Ministry provided some leadership by investing in and promoting integrated care the goals and vision suggested by the measures they imposed indicated the Ministry’s vision of integrated care did not align with that of the CCICP (see Systemic integration above). The lack of a strong vision for the project was associated with changes in leadership in the LHD, the PHN and the Ministry. On the other hand more
generally, given the praise they received the members of the integrated care team had provided a clear vision for service providers to work towards (see also Section E.6).

Yeah, whereas now we've actually got mechanisms where we're bringing our clinicians along with us. It's difficult to measure, very difficult to articulate but we are kind of leading the way of the new way for Health to operate in the child protection space.

Therefore, given that leaders have not always been able to maintain a clear vision, there appears to be some way to go in regards to all stakeholders sharing a clear vision of integrated care. In addition, it is apparent from the findings discussed in Section E.1 that not all stakeholders shared a perception of what integrated care was, and that not all service providers would be aware that the work they were doing would be classed as integrated care. Further, service users appear largely to have been left out of making decisions about their own care (see person-centred care); have not been engaged in design, implementation and evaluation of integrated care programs and policies (see systemic integration); and kept unaware of the moves towards integrated care.

Direct commentary on the degree of trust that partner’s in care in each other’s reputation and in their ability to deliver effective care through collaboration was missing and informants were not asked about trust. However, rather generally narratives were neutral or suggested respect for other service providers worked with when mentioned.

E.4 Characteristics of target groups

The interviews revealed characteristics of the groups being targeted beyond the simple stream descriptions and why those groups were being targeted. The Central Coast was perceived by informants as an area with “pockets of disadvantage”. North Wyong and Woy Woy had been identified as the main geographical target areas. The populations being targeted were understood to have with high levels of disadvantage and needs (low socio-economic population, older than most populations, high incidence of mental and physical health problems (frail aged), high levels of domestic violence, high alcohol and other drug abuse rates, high numbers of children in out of home care, high intergenerational unemployment, low private health rates, high smoking rates, poor ability to take care of their own health). Hence the population, and North Wyong and Woy Woy were particularly understood to be at risk. Amongst the groups targeted, it was perceived that there was high rates of avoidable hospitalisations and presentations which was straining the acute care facilities.

...from an acute perspective... we had a few pressure points and again, not unique but we were running it over 100 percent occupancy of our big acute hospitals. It was causing a whole lot of system issues and flow issues within our acute. We needed to unpack people who otherwise should have been managed outside of acute hospital that were unfortunately being managed in acute hospital.

In regard to the vulnerable youth and children, the families as well as the children were understood to be part of the target population. It was seen as important to work with the family, working through schools and FACS to start to address intergenerational issues (trauma, unemployment, drug abuse etc.) for longer term gains.

The focus is on looking at the whole family group because these kids and their issues are a symptom actually of a bigger picture. So if we’re going to treat that one symptom I guess it’s a bit like if you’ve got a brain tumour and you get a headache you don’t just treat it with Panadol. You’ve got to do something more significant than that that treats the root cause and it’s got to be on their terms because this is years of neglect. This is generations of neglect that we haven’t worked with families properly and that their experience and exposure has been kids being taken away by FACS often for the right reasons, but they are the kids that have been removed. Or FACS on their doorstep not providing support or health, providing a million referrals but not anything that they can actually physically do as in 'Well that’s great that you can refer me to that centre, but I can’t catch a bus there and I’ve got no car', so you may as well have not written a referral out.
It’s about targeting vulnerable families and communities within our population, but because this project is based in the schools it’s predominantly, yeah, for young people but not just mental health. So it might be - you know, whatever that family is going through, so you might have drug and alcohol, you might have domestic violence. If they’re Aboriginal, intergenerational trauma. So it’s a whole scope of different things. It’s just dependent on what that vulnerable family’s needs and requirements are. You know, you’ve got Family and Community Services involved in it as well, school counsellors, welfare counsellors.

Moreover, as CCICP has been implemented the target ages for the vulnerable youth and children stream had expanded. It had started at 14 to 24 years, but the lower age limit had dropped to include primary school aged children and younger and those over school age had not been targeted as yet. However, it was acknowledged that there was a need for young people over school age to be included in the stream. It was considered that it would take some years before it would be possible to implement a risk stratification process to identify those at risk post school from records during their school and younger years.

…if we looked at those people and had their permission to look back and did some data matching which our relationships would allow us to do within the next 12 months to two years I think, around formal agreements, we could data match and say ‘What did their school life look like?’ ‘What did their contact with us look like when they were in primary school and high school?’ because the records are really good in education for us to do that sort of thing and I think we would have an opportunity then to risk stratify and say there could be some patterns in that, that would help us to then apply to today’s kids and primary school students to say ‘Yeah, these are the ones we need to look out for.’ But we previously haven’t had the knowledge of what is on offer in the data in education and we also haven’t had the governance or relationships to even formalise that sort of data matching approach. So yeah, we haven’t done a great deal. But the other part also is that in our suicide data it’s indicating that the school leavers, so the transition from high school to work is a massive risk area for suicide and mental health for us. So that’s also an area that’s ready for us to do work in but we haven’t started working there, but we should be.

In regard to the vulnerable older people and chronic and complex care streams, these were no longer two separate streams as they had a great deal of overlap. The streams included people with two or more chronic conditions (e.g. diabetes, coronary artery disease, COPD) and were over 65 years (or younger for Aboriginal and Torres Strait Islander people). The inclusion of people in these streams who had got to the stage when they were requiring palliative care was seen as problematical by two NGO providers. The target outcome of reducing hospitalisations was considered difficult to achieve or that they were beyond the type of help anticipated within the project.

Then on the pilot we had a few palliative care people and probably some people that were a bit too far gone for this project to have benefit.

There was some discussion around what was meant by ‘vulnerable’ for both young and older people by two informants but no clear definition was forthcoming. Although there was some indications that Aboriginal and Torres Strait Islander people were considered among the most vulnerable.

So vulnerable older people. So the definition then has been what is vulnerability? We’ve been through a process defining geographically what geography we would work with, and that’s been the north-east Wyong geography, so the top-quarter, I suppose, of the Central Coast and then we’ve applied a re-stratification across that.

It’s about targeting vulnerable families and communities within our population, but because this project is based in the schools it’s predominantly, yeah, for young people but not just mental health. ...if they're Aboriginal, intergenerational trauma. So it’s a whole scope of different things. It’s just dependent on what that vulnerable family's needs and requirements are.
E.5 The role of context in implementation

The context referred to interviews that played a role in implementation was mainly concerned with the restructuring that the health system had gone through, the commissioning and funding of the integrated care project and previous work done in the integrated care area, and the ability of the organisations involved to work with each other. In addition, the Central Coast was considered to have characteristics that made it suited for undertaking a trial for integrated care.

There were significant organisational restructures that had occurred since the outset of the project. Most significantly, Medicare Locals were overseeing the primary health care sector and Primary Health Networks did not exist. This restructuring had meant that there was a need to renegotiate how the LHD would work with the primary care sector. The building of the relationship with the Primary Health Network was seen as having taken some time. The restructure was also perceived as resulting in the project being less of a joint partnership than was originally envisaged.

Well, the implementation plan - the initial application that the Ministry of Health had and the implementation plan were both developed prior to the PHN’s commencement. It was during the time when there were - the former organisation, which was the Central Coast Medicare Local. That change meant that there was a level of uncertainty on the LHC around how the program would work with the PHN going forward. ...Initially I thought that the program had a very strong joint approach to partnership; however, I had to modify that over time. It’s had more of an approach of being an LHD program with some assistance from that.

The dissolving of Medicare Locals and creation of Primary Health Networks went further than a name change. It was perceived that PHNs were less involved in primary care and were more of an agency for just commissioning services.

...certainly several GPs have said, and we had a meeting last week, and they were talking about it again, is that they don’t have an organisation just for general practice on the coast. ...and that’s something that they would really like for here because they don’t - their words: they don’t feel that the PHN is necessarily representing them anymore in the way that the divisions used to, and the Medicare Local less so, but still had a strong GP focus, whereas the PHN has got a different role again. ...And it’s more about commissioning other services - this is what they say, yes.

Possibly this aspect of greater joint ownership of the project is being addressed as five informants mentioned that there was now a move to create an alliance between the LHD and PHN where formerly there had been just an MOU. The purpose of the alliance to facilitate integration and avoid duplication.

...this is probably me just from a personal perspective of the relationship with the PHN, but this is where we’re looking at setting up an alliance. The district has traditionally had a GP collaborative. Then on the side we’ve had the integrative care piece. Part of the alliance will be about making - bringing it all together so that there’s not multiple different routes where, you know, they may be working in silos and duplicating... I think it’s consolidating work so that there’s no duplication.

In addition, under funding reforms of the National Disability Insurance Scheme and My Aged Care block funding is being replaced by individual funding. It was understood that an individual funding model discouraged social care providers from being involved with integrated care initiatives.

Not only did you have the Medicare Local going through significant reform, you also had social care providers going through a significant reform, not only with NDIS but also with My Aged Care, which was patient-centred care but also the funding chases - it’s moving from a block funding process to individually-funded processes. Those reforms meant that social care providers were a lot less willing because individuals - and this is the issue around one of those processes around integrated care is that per capita funding tends to allow for more integrated care, and so block funding is really a form of per capita funding
and it allowed for a bit more freedom of how these providers can discharge their duties and provide for a range of people, but when it's all individually packaged and Joe Citizen gets $50 for this and Mary Smith gets $80 for that, then that's all they provide.

Initially the integrated care agenda was seen as a 10-year strategy. This is important to note as this means that the Central Coast is only in the early stages of implementation especially given that the start was delayed by approval processes and recruitment of a suitable team.

It was always conceived to be, you know, the start of a 10-year journey … while New South Wales Health are claiming it was a four-year program, we only really had access to about two and a half years of that four years because the approval to undertake – to initiate the program was only really received in October 2014, which then meant – you know, you can get staff on, if you're lucky, by January 2015, which effectively only gives you two and a half years to deliver the program in its initial entirety, and then there’s been another year of funding that we’ve just started now, being September 2017.

An important aspect of context for the Central Coast was outlined by one informant. This informant described that the Central Coast had a different starting point from other LHDs in that previous work had been done to co-locate state health services and general practice. The CCLHD had already worked with Medicare Locals with shared funding arrangements and shared positions. The concern then for the CCICP was then to: “re-strengthen the ties with the new GPs that have emerged into the community because we’ve also seen a different profile of GPs where that holistic care is, I guess, less of a focus for a number of new emerging GPs than a quick turnaround of medical care.” This contrasted with other demonstrator site that had largely opted for adopting co-location for their projects. Hence, this meant that they needed to implement something along different lines. This was not a barrier per se, but in fact more likely to be a facilitator, however, it is likely to mean that direct comparisons with other demonstrator sites cannot be made. The previous work in integrated care may also mean that it was more difficult for the CCICP to make further gains that were measurable.

Due to the previous work they had done in the area of integrated care, the Central Coast was approached by the NSW Ministry of Health to undertake the project rather than submitting a tender. Integrated care had been identified as a ‘priority area’ of the then Minister, Jillian Skinner. At the beginning the Ministry was not very clear about what their expectations of the project was. More recently, with the change of Minister, the Ministry has become more explicit but their current requirements do not necessarily match what has been done of the project in the early stages. The change has meant that the integrated care team were struggling to meet the demands of the current Ministry.

So traditionally this was the Minister’s priority area. When Minister Skinner came in March, I think 2011, the integration and working with chronic and complex was a key focus of hers. Historically there would be a bucket of money. There’s be an EOI process or a tender process for most of the districts. You put in proposals and they’d pick three. That didn’t happen. In this instance for the demonstrators, the demonstrators were sort of chosen within the ministry and the Minister’s office based on opportunity, history, focus on integrated care etc. So it was sort of a negotiation point when we were identified as a possible demonstrator site and so a lot of work went into framing the context, framing the project, looking at what we could and couldn’t do.

Yeah, and the ministry changes even impacted significantly as well because our guidelines have changed so much, so, you know, given that there were no clear guidelines, or objectives, measures, whatever you want to say, there was nothing there are the beginning, often meant that we were, you know, come at with a two day deadline to get something together for them as soon as possible... They want something on this because the minister’s talking about integrated care, or something. So we’d often be thrown, you know, silly reporting deadlines, which we didn’t – you know, there was nothing clear.

Informants within the integrated care team spoke about being able to take an innovative approach to the project, to take some risks and to try working in a ‘different way. This is likely to be related to the loose initial guidelines. However, the integrated care division of the Ministry were reported as being more risk averse and
more concerned with short-term cost cutting than working differently. For some aspects of the project what was being implemented was, therefore, not necessarily recognised as integrated care. On the other hand, other parts of the Ministry appeared to be easier to convince (see quote below). The shifting demands of the Ministry, therefore, has created barriers to implementation that needed to be worked around.

That was the question we’d always get and we’d get that a little bit from the Ministry as well. ‘How is this integrated care for Health? You’re not dealing with chronic and complex conditions. You’re not trying to prevent hospital admissions now. You’re not dealing with the most costly of our patients at the moment, so why are you doing it and we’re paying you to do it?’ …We had to socialise the concept carefully and slowly because our leaders weren’t really totally across it. Whilst they started off wanting to be, the reality of what it looked like wasn’t so palatable… [The Ministry of Health] created a branch that was looking after Integrated Care and that should have been helpful but I haven’t found it very helpful largely because I think my work falls out of what they’re comfortable with. So a lot of my support has actually not come from that branch of Integrated Care. It’s come from the violence, abuse and neglect portfolios in child protection in the Ministry of Health because we’re doing such early intervention work around vulnerability that they’ve got a great deal of interest with us. So there’s been a great deal of support from then, financially across a couple of projects where we’ve needed some additional funds and some I guess air time.

It was also understood that the LHD’s innovative approach and the Ministry’s ways of working did not fit well together. The LHD had tried to do things in the integrated care space that conflicted with other Ministry of Health models which has meant they have pursued some wrong avenues.

I think it’s been really challenging because with the chronic diseases and the transition of that into integrated chronic care, we’ve been still held by the Ministry of Health in terms of what we needed to do. There seemed to be a sense that integrated care was coming in and going to do something new and beat and different, and what we did didn’t matter. So I think that was really challenging for all of us, and trying to understand and trying to get integrated care to understand that the Ministry of Health was still driving chronic care and what was going to happen there was still under a ministry model, so they really couldn’t effect that too much, nor the rehab programs. So I think there was a little bit of a misunderstanding and lost opportunity because there were things they could effect and things that they couldn’t, and I think we got too stuck in the things that they couldn’t effect.

What this also suggests, however, is that the Ministry operates in ways not compatible with integrated care and for integrated care strategies to be successful a whole of system approach is likely to be needed. One informant likened the changes needed to turning a big ship.

…it’s turning the big ship thing and it actually can’t support change and innovation very well because by definition it’s a state strategy. So if you want to change something you have to get everybody else on board or you have to pay for a hugely expensive change.

On the other hand, a recognition of a piece of legislation (referred to as 16A) was mentioned was perceived as meaning sharing of service user information was now more possible than it had been in the past. However, it was acknowledged, that service providers could still be reluctant to do so and it was considered by one informant that the rules were still not clear. There was a reported fear of sharing information due to privacy concerns amongst service providers and consumers.

So 16A freed up that process, whereas before we were the only ones who could ask information and we never gave information. But I think the other thing I think that’s happened is it’s taken a while for people to feel comfortable with it. I think people thought they’d be sued for breaking privacy legislation or whatever …I think we are getting closer and closer to the kind of shared information about families that will give us the intelligence to do this better, but we still have that cloud of fear about privacy and being overly involved in people’s information. So I don’t think we’re quite clear of that yet, and you still see that every day here. Anything the government tries to have a look at — you know, people are actively arguing
against. For us, those families can only benefit by us knowing the whole story. I know they’re fearful of us knowing the whole story, but we do need to know what all of the issues are in the family if we’re going to address that, and I don’t think there’s any other right solution. It’s just – it’s going to take time to get there, and a lot of people are going to have to change a lot of processes and reporting and monitoring processes and get through all the stuff about how we share information in order to do this.

I think similarly the privacy sharing. The legislation needs to come up to date. We need to get clear rules. We need to get – Sharing needs to not be an option. It needs to happen.

Related to how the NSW Ministry of Health operates, is the question of health funding and fragmentation of the health system. The fragmentation of the health system with State and Commonwealth jurisdictions, myriad organisations (government and non-government), specialist areas (e.g. mental health, drug and alcohol, domestic violence) and corresponding fragmentation of funding was also considered as creating barriers to integration of care.

...integrated care is about challenging the boundaries and working out the right way, the best way, within I think a very difficult framework where we’re especially in Australia constrained not only by different organisations but by separate funding pools that come from either federal or state.

Nevertheless despite this fragmentation, pre-existing shared agendas were seen as a facilitating factor.

...it wasn’t hard to get some shared objectives with the primary health network in relation to aged care and chronic and complex disease management because those sorts of things are very much on the PHN’s agenda, so that was pretty straightforward.

So really for us it was a bit of a no-brainer. It was just whether we were going to be successful because we knew that as a person-centred goal orientated type of organisation, we wanted to maximise each individual’s abilities.

Funding, of course, was considered an enabler but there was concern about the short-term nature of the funding. In particular, there was concern for the long-term commitment to and sustainability of what already has been implemented as integrated care appeared to be moving to a ‘business-as-usual’ phase without designated funding. Moreover, the declining funding and the foreseen lack of future funding was seen as an indication that integrated care was not being valued.

So I have some real concerns about when the resourcing drops off, the capacity to continue to stay in that, and – I mean, we’ve seen it time and time again. We’ve done lots of whole of government work in various fashions. We’ve done One Place, One Plan. ...we know as an agency ourselves that as soon as the resourcing drops off, the coordination and the management and the structural stuff starts to dwindle, and so I really think that that’s probably one of the key challenges for sustaining it. I know everybody kind of talks about embedding it into agency core business, ...

I think that we’re at a real danger point in Integrated Care here because I think there’s an understanding that Integrated Care funding will decrease and finish and we have to be ready to take it on ourselves or be saying that we’re moving to business as usual. My feeling is that in the conversations with the Ministry and the planning, we’ve taken a reductionist view in that planning. So we’ve gone from saying ‘Okay, well we’ve move from three stream managers to two.’ That shows that we’re moving to business as usual.

We’ll go one year’s funding at this amount and then the next year’s funding we’ll significantly decrease it by this amount. That shows that we’ll be business as usual. Actually that doesn’t. That just shows that you’re not going to pay for it. ...I think that’s really disappointing and that’s a very dangerous place for us to be at. I think it has real opportunities for the work we’ve created to just disappear and the momentum to just fade away. But, on the converse, the Chief Executive and his work with the alliance is hopeful because his signalling and his want to do it differently is really clear, but the planning and the operations
of that I don’t see that mirroring his vision. ...the funding isn’t the major issue. It’s what the funding means. So if you don’t fund something you don’t value it.

Importantly, current funding models were understood by one informant to discourage integrated care (such as reducing hospitalisation) as money would be taken from another funding areas. This transfer of funds made investing in hospital avoidance problematical for funding other programs.

So if I actually work really well and hard to reduce unplanned hospital re-admissions, the local district’s funding pool reduces. So if I’m actually saying I can actually stop these patients from coming into hospital for 500 bed days a year and let’s use that money to keep them out, when I’m very successful and keep them out for 250 days, that’s 250 days less money that the district has seized in a year’s time. ...when we do integrated care, the less money the district has available to do integrated care. ...You know, there was small pockets that you could actually reattribute to that, like hospital avoidance funding, but, again, they were smaller pockets of funding that could be applied and that would take money from other pieces that we were using - you know, that money for already existing programs. So it really didn’t help us at all.

Leadership was seen as vital part of the context of implementation. Leaders at all the key organisations were seen as important, the LHD, the PHN and the Ministry. This will be discussed more in Section E.6.

The location was also noted as a contextual influence. The health and social system operating in the Central Coast was seen as relatively distinct from those from those in Sydney and Newcastle, the adjoining areas. It was also understood that it was valuable to conduct the project outside of a major city.

I think the setting was also quite valuable. As a lot of my job is involved in health technology assessment, local context is really important. So understanding how some of these interventions work in regional and rural Australia, we’ll only ever know that if we conduct those trials, and this is a trial in rural and regional Australia, which this one is doing. So I think that’s given some pragmatic insights as to how these trials of integrated care are going to work in a real setting outside of major capital cities, so I think that’s been another factor. I think for the Central Coast, given their demographic profile, given the opportunity to conduct these trials, like they’re just far enough away from Sydney that we can actually have a reasonably not isolated geographical area, but it’s enough - we don’t have a lot of leakage in terms of people visiting hospitals outside of the Central Coast that we can actually - it’s a very good microcosm for actually conducting these kind of trials to see how they work.

On the other hand, there was a perception that there was a shortfall of some vital services (GPs and social workers). A shortfall of GPs was particularly noted in Woy Woy one of the areas of focus, which could be a barrier to altering people’s perceived habit of over using hospital services.

The Peninsular was identified as having a greater area of vulnerability, a lower socio-economic perhaps status amongst a certain demographic within the population. There was also a higher level of persons aged over the age of 75. There was a bunch of things going on. People not being able to appoint themselves a GP because their books were all closed. You know, it’s a relatively small area. There’s only so many GPs.

We could be doing – you know, making some savings and spending them somewhere else, but when we’re talking about a hospital that can’t get people out and they’ve still got people turning up in the ED – this is a very difficult message to sell and a very difficult environment in which to change.

Furthermore opposite to what was perceived as the Ministry of Health’s preference, the LHD was reluctant to promote what they were doing in the area as integrated care as it was thought that local stakeholders would not understand what this meant.

In contrast to perhaps what the Ministry of Health may have been thinking, we haven’t been promoting integrated care loudly from the towers because I guess that earlier – our earlier discussion about – you know, it’s jargon and really it’s what actually – it’s the elements of integrated care that are fundamentally more important than people understand, and in many cases delivering those elements of their work, or
delivering some of those elements in their work, or delivering – so there's been – there's communication between stakeholders. There's communication with people who are not direct stakeholders but might be interested, and so for those it's not immediately tagged as integrated care but more just about how we do business.

E.6 Key facilitators and barriers

The main barriers and facilitators were identified by informants which could be grouped into four areas: leadership, staffing/personnel, communications/relationships and service gaps/needs. When barriers were commented upon it was rare for informants also to say how they were overcome. Possibly because informants would think of the vehicle for overcoming a barrier as a facilitator and refer to it in that way.

**Leadership in was the most commonly identified facilitator** of the project (14/23). Not only was it thought to be important but the early project leaders and key organisation leaders were often commented upon in an extremely favourable light. The LHD leaders brought to their positions, established and well-functioning relationships with key senior personnel in other organisations which was considered as a great asset to the project. These early leaders were also seen as facilitating the project by having a vision for and commitment to the project and for being supportive of an innovative approach. In particular, Anthony Critchley was particularly appreciated for the support he had given staff and his ability to negotiate with various stakeholders at all levels to allow the project team to progress their work.

Like, we got to where we did and actually have achieved some very, very creative things because of that leadership, but that kind of – that connection from vision to defined goals, had that been there and been stronger and this is what you’re doing, we wouldn’t have had the creativity. We wouldn’t have had the benefit of the innovation, but we would have had the benefit of achieving as the mandate and pulling services in because they’re required to and those kind of things.

I guess, that commitment at a really senior level. So having the CEO and the DD and, you know, all of those kind of people commit to a bit of a vision at the start and then freeing up or facilitating their resources to be able and participate. That real high-level commitment type stuff and then prioritising it through line agencies certainly helped.

Whereas Anthony would go ‘You keep doing it, I’ll take the brunt of this for you’. So Matt and Kerry were very good at that as well. So the ministry – we’d cop a lot of that from the ministry 'Why are you doing this? You’re not delivering care', or ‘You’re not doing share care planning’, and you know, Matt and Kerry would talk them around. ...So just to have some solid executive sponsorship there was really good. ...So definitely having Anthony on was definitely a huge benefit. And Matt and Kerry, with a clear vision, they knew where we wanted to go, what we wanted to do, and they fully backed us. ...So that was huge, I think.

Conversely, informants some aspects of leadership had been missing over the course of the project. In particular, the vision and the goals for the project were not always clear to the informants. An aspect of lack of clarity early on, was attributed to the strong pre-existing relationship between leaders of key organisations that then did not formalise what they agreed to do.

So we started from the point of really strong relationships with primary care and we had probably really sympathetic leadership between Health and FACS because our two chiefs, the Director of FACS and the Chief Executive of the LHD at the start of this were two sides of the same coin. They operated in a very similar way. They had a good cordial relationship, they were very dynamic and they’re just very similar leaders. So they got along really well. But operationally there wasn’t much underneath that that helped us join. So we had good relationships but not really meaningful work. So we knew each other but we didn’t really know how to work together. So, I think the management of those relationships was problematic. Our leaders at that time would make promises to one another. One of those was a promise that we would be involved in the Central Coast Multiagency Response Centre which was a different model of care for
Child Protection and early response that we had previously seen in the state. That was a difficult partnership because our leaders agreed to it but they didn’t agree to what they’d agreed on and no one was there to witness the agreement. It was verbal. It wasn’t concrete. There wasn’t clear governance around it.

Moreover, during the life of the project, senior management of the key organisations including the Ministry had changed. It was considered by four informants that the changes had resulted in aspects of the strong leadership that they had appreciated being lost. Management were considered to have a more “constrained view of integrated care is”, lack a strong vision for the project and to be more risk averse. They were understood to be less willing and able to negotiate a frontier pushing agenda. On the other hand, it was also noted that the new leadership had not been in place long enough to rebuild relationships. It must, however, be noted that overall the CCLHD leadership was viewed as facilitating rather than impeding deployment.

I think the biggest area that we need to pick up on this now is around leadership, and I think also getting the - having the ministry on board with some of that aspects. Not that I was involved with it, but I understand it was a significant challenge getting - you know, having the ministry on board to move some of these more innovative things through, and the risk aversion was substantial and probably caused us, I’m guessing, a six- to 12-month delay.

In addition to the most senior members of staff in key organisations, several other individuals were seen as providing leadership that had facilitated operations and provided a leadership. In particular, Sarah Bradfield, Rachel Sheather-Reid and Taryn Gazzard were praised for the work they had done in their respective roles. When working with frontline staff having the perspective of integrated care experts who were outsiders to the discipline was considered helpful. Furthermore, the input provided by the international experts, Nick Goodwin, Anne Hendry, and Benedict (likely to be Robin Miller) was appreciated for proving a big picture perspective.

I think Sarah Bradfield in particular did an incredible job at articulating what they were and even fed some of that stuff back to the Ministry which was fantastic. But then actually having someone who leads those sorts of changes or really advocates for that kind of reform. It’s not something that I can necessarily drive I don’t think.

I think it was the very fact that they weren’t subject matter experts but they were integration experts which actually meant because I’m a subject matter – I’m embroiled in the work every day. I see the systems issues every day, but to actually have somebody who was able to have those more challenging, and I think the other thing is relationships. My relationships with my agency partners are critical for me to be able to do my work. To have someone who was independent of that be able to provide some leadership for all of us, that helps bring us along,

I should add that it was really good having Ann and Nick and Benedict - what’s his name? - one of the international experts come and speak with us and do workshops with us. I did get to go to those. They were really good, and I think it made us think about - beyond the day-to-day dramas and the day-to-day frustrations - you know, more widely we’re doing something that’s important.

Staff and staffing arrangements had also played a key role in implementation. The resistance of staff to the changes required for integrated care being the most commonly identified barrier (13/23). Frontline staff and middle management were found to be resistant to new procedures and new technology (especially older people). It was suggested that resistance was, in part, due to staff feeling that their work was being invalidated, or being taken over and, there was a perception of integrated care increasing their work burden. There was also a perception that people were resistant because of systems within health constantly changing which they referred to as change fatigue. This perceived constantly changing health landscape appeared to be related to a perception that led to integrated care risk being considered the ‘latest fad’.

So people didn’t want to engage when they didn’t feel like – what they were doing was seen as valid or important. I guess there was a sense that we were the doers, but we were already at capacity. You know, we were already on the floor doing everything we could, and we had integrated care saying, ‘Well, we’re
not a doer. We’re here to help you do it.’ But they didn’t stop to see what we were doing and to try and find where the quality improvement opportunities were, I guess. ...I think there was a little bit of concern from our care coordinators of they’re taking over our job, so there was just a little bit of hesitancy at the beginning and that and we had to really work hard to smooth that out and go – you know, they’re doing something different or doing something to supplement what we’re doing.

...back in the mid-90s it was health outcomes. Then it was collaboratives was the next thing, and then it was – you know, clinical redesign has got a bit of a hold at the moment. That’s great. You know, we have these cycles of this stuff, and the risk is integrated care becomes just one of those cycles that are just missed.

Furthermore, **high staff turnover** in various agencies including the Ministry, was considered to have posed problems for creating teams well versed and committed to integrated care. Similarly, the integrated care team being on **short-term contracts** was seen as a barrier to operations. Mainly because it made planning difficult, was a barrier to engaging people and meant there were regular unproductive periods.

I think our contracts have made it really difficult. So we’re all contracted workforce and we’re driving the projects. So for me I’ve been employed for the first – the first contract was for two years finishing in June last year and now contracted for another year. It might not sound like much because I’m used to working on a contract but when you’re working in partnership and you are driving something and people think you’re not going to be there, they slow down. You can’t make more meetings because you might not be there. You can’t make promises because you might not be there. That’s been really hard. So we had three months I think where right up until the 11th hour, I think it was right up until mid-June we still didn’t know whether we’d be continued. So, I really think we lost about three months of productivity. That’s really slowed us down and it will slow us down again even more. It’s going to start to happen again next year, around about March or April because people will be saying ‘Well what do we do when you’re not here?’ But the work won’t be finished and we won’t be ready to stop and we won’t have created positions to keep the work going. So I think that’s really had an impact.

**Recruitment of new staff** could also be difficult for organisations. Most significantly, it was understood that implementation of the project had been delayed due to delay in recruitment of a suitable integrated care team.

On the other hand, certain staffing arrangements were seen as pivotal to making aspects of the project work. For example, education had employed staff as ‘Network Specialist Centre Facilitators’ under the CC MARC initiative to facilitate the different agencies involved working together.

Very much related to both the issues of leadership and staffing was the area of communication/relationships. In brief **good relationships were thought of as a key facilitator of and poor communications a key barrier** to implementing integrated care. Relationships were considered key by about half of informants (12/23). Good relationships were fundamental for overcoming resistance to change and prompting an attitude of readiness for change. Relationships were understood to be built on open communication and clear strategies.

I think a lot of the success has been driven by relationships and building trust. I think that’s the enabler. That was my experience of working particularly with Anthony Critchley and Sarah, and Taryn Gazzard. ...they were really good at working with and referring to me as the ‘subject matter expert’ and bringing me on the journey. ...That stuff was really important. They didn’t at any time disregard or disempower me in the process at all. That was the stuff that I’ve just found – I’ve been in Health now for 10 years and this was my first experience of being valued in that way as a Subject Matter Expert looking at systems issues.

There wasn’t the, I guess, gate-keeping around information or disclosure. We were all very open and honest about practice and working at that fairly senior level, to be able to unpack stuff and go, ‘Yeah, look, we do this, but it doesn’t really work all that well’ and ‘We’re open to different ideas’, and, yeah, being able to kind of have that very open, frank conversation stuff. ...And the kind of transparency, I guess, where they were very open about the fact that they really weren’t quite sure – they got given a brief. They
really weren’t quite sure how they were going to go about the process in the practice, but worked kind of as a collective together to establish some of that. It was a very good kind of relationship establishment base.

However, poor communications acting as a barrier was also a strong theme. In relation to communications the perennial problem of lack of compatibility of IT systems was raised by eight informants. This was also related to the problem of information sharing discussed in Section E.5. Further, two informants discussed the inability of the team to find a suitable IT platform for shared care planning. Communications were also seen as being hampered by a lack of common understanding and the different workplace cultures of the various agencies involved. Communication was, importantly, something that the CCICP had not done well. It was acknowledged that a communication strategy had been missing but this appears to be something that is being addressed.

I think our information management systems make life really hard. You know, we don’t have those cloud links between what happened in general practice and what happens here. I know we’re all waiting for the personally linked electronic controlled health record to really grow legs in terms of uptake and then use and then what can we actually all use it for, but I think we’re, like, ten years away from that personally.

So just down to communication, another big thing. We didn’t do communication well ...we didn’t have a clear communication plan to begin with.

At the moment we’ve done a comms strategy and we’re just starting to work on the comms plan so we haven’t actually produced the plan.

As well as working on a communication strategy, two initiatives were mentioned in relation to attempting to address poor communications and to build common understanding. The ‘day-in-the-life-of theory’ and Accelerated Implementation Methodology (AIM) training and. The ‘day-in-the-life-of theory’ encouraged stakeholders to share exactly what they did in the course of their work. AIM was run as a component of the project to facilitate the building a common language, understanding of integrated care and a readiness for change. However, it was not seen as enough on its own; the need for building relationships through good communication was still thought necessary.

...we did this a couple of times before we created the-day-in-the-life-of theory, what we found was that people had a very different understanding. So people sort of said, well, this is how this X, Y, Z occurs. Other people would actually make assumptions of what that looked like from their own perspective, and it wasn’t until they actually got it right down to, well, what does that actually look like in practice that we actually got people to think, oh, when you say ‘assessment’, that’s what you mean. When we say ‘assessment’, this is what we mean. So for us maybe an assessment might have been a four-hour, comprehensive, detailed assessment in health, but for another service it might have been we’ve gone out to actually visit them and they want to be part of the program. So we’re trying to actually create a real common language around this stuff, and the only way I could crack that was by creating the-day-in-the-life-of piece... Because the language was really, really different across every entity.

The Aim training has certainly been an enabler. The creator readiness for people to change and also giving them some tools and skills. It has created at first a secret society and now a growing not so secret society of people who are hungry to make a difference and want permission to do it, as in ‘I’m looking for the opportunities.’ They’re not loose cannons. They’re actually operating within a good structure and recognising where they can make difference and recognising where they’re probably not going to make a difference, as in when to hold them and when to fold them, which preserves their currency and preserves their energy.

Once, again, you can train as many as you like, but actually there’s a mentality about doing stuff and, you know, jumping off a cliff, which you have to do when you’re implementing things, and if you don’t have that, then all you’ve got is a language for change without the mentality to go with it.
In addition some communications had clearly worked well. For example, the vulnerable youth and children the integrated care team had facilitated integrated care by working with the different agencies working together in an attempt to identify needs.

So through different funded sources like non-government organisations out there funded by FACS to do targeted early intervention, they didn’t know how to get into the school. They didn’t know what the school needed and the school didn’t know how to talk to them. So we became those relationship brokers, identifying the needs in the school and then identifying the right services who could support some of that as well as the services saying ‘Well we want to pilot this or trial that within a school environment’ and us matching them up with the schools.

The gaps in the system, both internally and externally, and the lack of process to take measures to identify those gaps was also identified as a key barrier. It was understood for example that there was a deficit in the numbers of GPs in Woy Woy and social care providers more generally. Associated with this, in the chronic and complex stream, was a failure to develop a good understanding of some of the work that was being done and the parameters in which they had to work.

I think the portfolio work for chronic disease really struggled in the role. They didn’t take the time to map what we currently did and then look at where the gaps were and what the opportunities might have been to integrate out into the community. They just kept coming in and, I don’t know, bombarding everybody with searches and – and there was things we couldn’t change. Like, we couldn’t really change our rehab program models and we couldn’t really change – we were changing our chronic disease in line with the Ministry of Health algorithms and things like that. So I think unfortunately that project worker spent too much time being – looking for shiny things, going how about this? How about that? Without actually understanding what it was that we did.

E.7 Impact on professionals and other stakeholders

Negative (5/23), neutral (6/23) and positive (15/23) impacts on professionals and other stakeholders (excluding consumers – addressed in Section E.8) were identified by informants. Only one informant suggested negative impacts without also commenting on a positive impact. Three informants made neutral and positive comments, and one made a neutral and negative comment.

In relation to negative impacts, informants’ narratives mostly indicated that they had found working on the project stressful in some way. The demands of the project, the culture of the health environment, and the political environment contributed to the stress.

Personally it’s pushed me to the edge a lot. I’ve never been so beaten at times by this work. I maintain a deep desire and commitment that Integrated Care is the way to go and I don’t have any doubts whatsoever, but I do feel pretty beaten by working in a culture where the rhetoric or the message is ‘change, change, change’ but the actual actions are ‘stay the same, stay the same, stay the same’.

...we were both very conscious of the tension between our everyday business and the demands on us and, you know, meeting what’s required of each of us in our own departments and then the attention to something like that, which we both think is really important, but I think the funding required and the time required gets underestimated all the time by people.

I think integrated care as an outcome is really lovely, but getting there is one of the hardest and ugliest pieces of work that I’ve ever done... You know, when I say to my colleagues in western Sydney and western New South Wales, their experience is exactly the same. You know, from feeling physically ill every time they had to present how far they’ve managed to get. It’s really hard work... The expectations with working within a political environment, where things - you know, so suddenly all of the focus went on to let’s change chronic and complex care. So you’re actually working within a very politicised environment.
Further, the transparency of communications was considered to open professionals up to increased criticism by exposing gaps and failings in clinical practice. In contrast, the role of the integrated care professionals was considered to be that of a “silent partner” meaning they were open to criticism due to their work bringing about integrated care being unrecognised. One informant, who was part of the integrated care team, also talked about not feeling valued and not being listened to by senior management nor the Ministry. In addition, it was also thought that relationships with other LHDs had been undermined due to the way the CCLHD had received the funding (i.e. not by an open tender process). Other negative effects that the project had on professionals was discussed in Section E.6 in relation to resistance of staff to the implementation. It was understood some had perceived the project as undermining their role.

The neutral comments largely reported on the project having no great impact on the way that the informants themselves carried out their roles; that the project tended to reinforce the way that they had worked in the past. Otherwise the integrated care work was seen as just a small part of their work or that people involved in the project had “put their reputations on the line”. On the other hand, one neutral comment recognised that the project did have potential to adversely affect staff and so the informant commenting had arranged regular debriefing meetings with their staff.

I think I already had that approach but I didn’t know what it was called. ...I’ve had lots of different roles, so I probably have quite a broader background than maybe some... So personally that might be just my experience rather than the experience of the role maybe.

I made it mandatory that all of my staff had to connect with me one on one for a monthly supervision session. So they each had to come for an hour once a month, and it wasn’t about where is your project up to. It was really about where are you up to, and that was a critical piece to hold that group together.

The positive impacts referred to were mostly in relation to professional development (through learning how to do things better, growth, increased skills, being challenged, and providing opportunities) and enabling career progression, building positive working relationships and increased job satisfaction. Furthermore, it was noted by some that the positives gained were associated with elements that made the work stressful.

I’ve grown my skills. It’s been the hardest struggle I’ve ever done. It’s grown my skills probably because it’s been the hardest struggle I’ve ever done. I’ve had to find ways to make it work. I’ve grown a huge amount in my ability to negotiate, to facilitate, to be brave, to manage resistance, heaps of that stuff.

I think I’ve clarified probably the direction that I’m going to go in within the organisation. So personally I think I’ve grown. You know, my understanding – I find it hard, I’ve come up as an admin person, a high level admin person, but essentially that’s what I am. And I’m transitioning to a project-y role. I’ve been transitioning for a while now to a project role. So I’ve grown in that aspect and I feel like early on, when I was doing exec support I thought there’s nowhere for me to go within the organisation.

...so for me it’s a great team, a wonderful working experience and the documentation that they produce is like best practice. You know, I come back here and say to our guys, ‘Look at this? Look at the program logic chart? Look at how they manage the project? How they manage the data? How they build the relationships?’

Now, you talk to social workers in that room and they think it’s a great benefit because we’re all sitting together and it’s a great team environment, all that sort of stuff.

In addition, some informants felt that they had felt valued by the process and those that they were working with on the ground, and that clinicians were being better supported to work efficiently.
E.8 Effect on consumer experience, care outcomes and care cost-effectiveness

Generally it was considered too early to tell how successful CCICP had been in regards to affecting consumer experience, care outcomes and cost-effectiveness of care provision. However, most informants (14/23) perceived some gains in the areas of consumer experience and care outcomes. All three streams were reported on positively in this light.

I think what’s changed with the project, the project that we’ve done, the Family Referral Service in schools I think has created an opportunity for case management of vulnerable families for a period of time at an earlier stage than they would normally come to our attention. So it means that for them they have someone who can walk the walk with them that’s not from a state-funded, state Health or a State Government organisation. They’re not from Education or Health or FACS, they’re from a non-Government organisation that can truly assess their needs, walk the walk with them on what they need to engage with Health or social care, to get what is important to them changed. So that for the service users, it builds a face in responsiveness and accessibility.

And I see the outcomes of it for these young people and vulnerable families and it’s just fabulous and it just continues to grow and the momentum continues to grow.

We never would have reached some of those sort of vulnerable populations. So there’s an immediate care benefit to people that received additional care, received additional phone calls, additional follow-up, additional services. Those things we did if – you know, the really basic stuff – you know, helping with aged care beds, those things designed to keep people out of hospital that actually helped the people that otherwise needed care because what we did was we freed up a bit of demand.

...there was a lady that was on a home care package, and she was in a retirement village. So she had meals provided from the village, and she had a lot of food intolerances and she didn’t like her meals. So this lady was 45 kilos when we had her on the service, and then when we went back to the organisation they said, ‘No. No. The guidelines say this.’ But we were able to go and have a discussion about the guidelines and help redefine the person’s care plan. So when somebody is having services from another organisation, when we signed the patients up on to the program, obviously they signed a consent which said we could freely discuss their information. So we are able to do those care plans and help build them and make sure they’re appropriate.

On the other hand, two of these informants perceived that improvements could still be made.

Interestingly a lot of the original impetus was also to link not only health services, so the hospital, the general practice but also to really try and get your social care providers into that space as well, understanding that we get a lot of social admissions or people who if we had just been able to implement quickly, the provision of social care - we could have provided them with better care in a better location.

Further, it was noted by five informants that consumers were unlikely to notice any differences in their experience of care which may make the assessment of improved consumer experience difficult.

So when we ask about patient experience, unless we ask, ‘Is it helpful to have [name of informant] at your general practice?’ They’re just going to say, ‘Yeah. My care is the same as always.’ So they’re the hard things that we haven’t been able to crack in terms of measurement yet without really leading somebody down to the answer that we need.

Several informants mentioned that evaluations, with specific measures, of consumer experience and care outcomes were yet to be completed or that they were unaware of any results.

In regards to cost-effectiveness of care provisions informants were unable to point to any current evidence that the integrated care interventions implemented had been cost effective. The only data referred to was for the work initially done with the ambulance service in 2015. A 5.6% improvement in the number of people going
to the emergency department was found. Since that time there had been some issues with analysing the data due to problems with reporting and different data being collected from the original data set. For the outcomes-based payment trial in North Wyong, the data was still with external evaluators. However, it was noted that analysis may be problematical due to the control and intervention groups possibly being too different.

...the issue that we’ve got coming out of the data at the moment leads me to suggest that the control group - sorry, it was the risk stratification that put people into the group and where they were allocated to the control and the intervention, and just some of the outcomes that we are seeing in terms of our primary outcome, which was bed days, that leads me to suspect the control group might be different in some way. We don’t know that yet because we haven’t done the granular analysis to actually look at the patients to see are they meaningfully different. So we all know that they had some common characteristics coming in, but there are some individuals in the intervention groups that are having particularly long hospital stays and we’re not seeing that in the control group.

It was also noted that improvements in cost efficiency may be difficult to prove because of the complexity of the overall costing system for health care, numbers were small, data collection was not always done, the complete array of health care the client receives is not taken into account, seasonal variations in service demand (e.g. due to flu cycles), and cost savings are often not likely to be seen for some time. This was seen as particularly true for the vulnerable youth and children stream. The requirement for short-term cost gains was seen as impeding what the CCICP could implement and led the inclusion of the vulnerable youth and children stream to be questioned.

So what we wanted to do was try and set up early on – that’s why we were trying to link with ...different universities and have a health economic analysis of the current model versus the new model and is it sustainable in the current system, and does it actually produce an economic return, because we were very conscious that we’re working with big government and they obviously have an interest in making sure that this is sustainable or has an economic return over a period of time. So that was important to have the foundations of that done too and that was difficult given that we can track costs down to the dollar but then you’ve got MBS, TBS, everything else that goes into the system plus personal contribution.

...well what happens with the piece of paper or the referral with the paramedic to the GP. Who’s going to collect all that and then who’s going to table it and who’s going to send it to integrated care and can we collect it? Actually when they were doing a work around in no longer identifying a low acuity protocol, it’s just that this person was cared for outside emergency but, no, pardon me, the protocol no longer became important. What was important was this person was not transported to hospital. That was the bottom line.

I think if you really do integrated care correctly and properly and you combine it with, sort of, best practice care I think your turn-around times for benefits and outcomes will be very long and therefore very hard to track. You know, as an example, you look at a project and they want to be able to report an outcome within two years which automatically rules out half of the things you might have done because – and then it points you to, you know – A good example is Rachel’s program. It points you to picking out the very pointy end people and then it becomes harder to prove that there’s a value because obviously the failure rate of those very unwell people is quite high naturally and you probably can’t influence a certain portion of it whereas if you didn’t have to have reportable outcomes so soon you could go for the lower acuity people who - where you’ve got more opportunity to change their trajectory.

Furthermore, the reduced hospitalisation goal was seen as unrealistic for the chronic and complex stream cohort. Too many of the clients were understood to close to their end of life and there was little the service provider could do to prevent them needing hospital care.

...we could see that there are some people, particularly those with respiratory and cardiac disease, that were on their end of life trajectory, and as a senior clinician I could see that having gone through the PROMS and the CCPS to say - look, you know, they’re on high priority. We do the very best we can, but
realistically it doesn't matter what we're going to do. It's going to end up in hospitalisation at some stage, and then, of course, you've got those that just fall over and break both their ankles and you can't do anything about that.

Moreover, the suggestion that cost-savings should be the ultimate measure of success of the CCICP was questioned. The learnings gained from trialling various aspects of the project was interpreted as success, as was gains perceived in consumer experience and care outcomes.

I actually also think that the North Wyong program has been a success because it's something that has never been done before. It's something new and different and innovative for New South Wales Health, and I think the success is trying something and realising it's not working but learning from those mistakes.

So I think that for me that is a success because it's a brave new world, and I was saying in a meeting just recently that - you know, I don't see it as a failure in any way, but what I would hope to see is that we can pick up around what worked well. So what I don't think - I don't think that the cost benefit analysis has come through as being - that is cost-effective, and that's fine, therefore we've got to understand, well, why isn't it cost-effective but what has been the impact on patients? Look, I suppose the other thing around the evaluation is this year has been the worst year for hospital presentations, so it probably hasn't made a drop on our hospital presentations because of the impact of just the year that we've done it in, so I think we've got to understand that. But I think even being able to get up at process, being able to develop the costing models and working with those general practices. I think you can take that away as a success and say, well, what parts of that do we want to replicate in terms of the way we work with general practice or whether we want to fund general practice.