

Response to consultation paper Health System Integration in Queensland – consultation paper 6

Background

General Practice Queensland (GPQ), on behalf of its 17 member divisions of general practice, provides the following response to the *Health System Integration in Queensland – A joint consultation paper*. This feedback is based on:

- Consultation with Queensland divisions through a variety of mechanisms including the Queensland Divisions Forum and the Queensland Divisions Network Transition Group;
- Consultation with key primary health care stakeholders (Queensland Primary Health Care Network);
- Feedback and input from the GPQ Board.

Framework for Service Integration

GPQ, through the Collaborative Research Hub, has identified a Framework for Service Integration which incorporates 12 key elements to support the development of a strengthened primary care system¹. These elements are as follows:

- Integrated Governance Models
- Collaboration and Partnering
- Population Health & Service Planning
- Infrastructure Development
- Workforce Utilisation – Models of Care
- Integration Across Sectors
- Engagement Model – Strategies (clinician, consumer & community)
- Training and Education
- Funding Models and Sustainability (New organisations need time and stability to build capability, trust, culture and systems to be sustainable, McDonald et al., 2006)
- Innovation – Research and Development, Knowledge Sharing, Evidence Based Practice
- Performance Measures – Key Performance Indicators (Performance Framework – accountability, UK System)
- Change Management – leadership, advocacy, education, behavioural and cultural change

The above framework can be used to:

- assist in the identification of potential key elements missing from a Primary Health Care Organisation (PHCO);
- be utilised by both PHCOs and Local Hospital Networks (LHN) to look at what can be done collectively to address and respond to areas of unmet need;
- address issues of safety and quality (timeliness and effectiveness of care), information transfer (connectivity and continuity), and governance and collaboration;

¹ Armstrong, K. (2010) Framework for Service Integration: Elements to support the development of strengthened primary care system in facilitating coordinated, cross sector services. Presentation at the GPQ Division Forum, October 15, 2010, Available at http://www.gpqld.com.au/page/Partnershipss/Collaborative_Research_Hub/

- establish high level service planning including mapping, the use of data collected , and service re-design.

More information on the integration framework; 'Framework for Service Integration: Elements to support the development of strengthened primary care system in facilitating coordinated, cross sector services' (Armstrong, K. 2010) is available at http://www.gpqld.com.au/page/Partnershipss/Collaborative_Research_Hub/.

Key Messages on achieving an integrated health system in Queensland

- The Queensland Divisions Network strongly advocates for explicit approaches to drive integration between LHNs and PHCOs; whether through investment, structural mechanisms (such as Service Level Agreements, Partnerships or shared performance targets) or incentives.
- Fragmentation occurs within as well as across sectors; for example in relation to the Queensland Health Population Health planning and Health Promotion Functions which do not sit in District Health Services. These areas seem to have been omitted from the discussions around integration, but it is imperative that these health planning and promotion functions are included in integration discussions.
- Although the integration paper focuses on areas which will support system integration, strategies to deliver on the second of three primary objectives of the National Health and Hospitals Network² need to be identified. That is:

“Changing the way health services are delivered, through better access to high quality integrated care designed around the needs of patients, and a greater focus on prevention, early intervention and the provision of care outside of hospitals.”

- Integrating elements of the healthcare system provides the opportunity to³:
 - enhance the quality, efficiency and responsiveness of care (transition to and from hospital, pathways between services, seamless care, equity of access, service gaps – health outcomes);
 - improve the quality and safety of patient care (transfer of care – critical feedback loop – community to hospital and home again);
 - ensure key systems are consistent, including standard treatment protocols, IM/IT systems;
 - create the potential for economies of scale (GPLO workforce); and
 - reduce the workload burden of health professionals through supporting a coordinated, integrated collaborative service delivery model (with team based models of care, defined and agreed roles).
- PHCOs and LHNs will play a key role in developing the primary-secondary care interface through supporting⁴:
 - information management systems;
 - decision support systems;
 - disease registers;
 - coordinated shared care networks;
 - coordinated care teams;
 - links between specialists and programs;

² [http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/report-redbook/\\$File/HRT3-overview-pt1.pdf](http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/report-redbook/$File/HRT3-overview-pt1.pdf)

³ Armstrong, K. (2010) Framework for Service Integration: Elements to support the development of strengthened primary care system in facilitating coordinated, cross sector services. Presentation at the GPQ Division Forum, October 15, 2010, Available at http://www.gpqld.com.au/page/Partnershipss/Collaborative_Research_Hub/

⁴ Armstrong and Kendall, 2010; ; Harris et al., 2009; Naccarella et al., 2010a; Zwar et al., 2007

- coordinated liaison officer support roles; and
- collaborative evaluation methodologies and aligned data collection tools.

Responses to questions posed in the paper:

What are the features of an effectively integrated health system in Queensland

- Clear patient and clinical information **communication pathways** must be demonstrable both across and within health sectors (e.g. between LHNs, between LHNs and PHCOs, between LHNs/ PHCOs and community/ aged care sectors).
- Access to **common data systems**, or data systems that communicate with one another, are key to planning. This is also necessary when monitoring key performance indicators/evaluation and identifying service gaps.
- **Shared key performance indicators** between LHNs and PHCOs could be a mechanism for ensuring that the two work together and have a greater understanding of primary and secondary health service provision.
- A coordinated approach to **population health and service planning** is required. This could include developing consistent frameworks/methodologies for application at the local level. A model of collaborative population health and service planning should be driven by shared ownership of KPIs and shared accountability.
- Investment in **strategies to drive integration** across sectors as has been seen in overseas models.
- Input from Consumers should be a cornerstone of local integration partnerships, with investment in **consumer involvement**.
- **Consumer satisfaction** with providers/services; measurement of health quality and complaints, etc. should be fundamental.
- Before planning and/or developing new services, LHNs and PHCOs should work together to assess **quality and efficiency** of current services. Service planning should reflect how and when this process has occurred.
- **Clarity about the role and function of sectors** within the health system. Currently there is confusion about the competencies and capacities of General Practice within the hospital sector and a lack of understanding of how the primary care sector can support the hospital sector.
- A health service in which **consumers are central** to service planning, delivery and governance.

What principles in the paper are supported and what other ones need to be considered:

All principles in the paper are supported. The Queensland Divisions Network suggests the following principles for further consideration:

- The inclusion of Carers in principle 1 as they often access services on behalf of consumers.
- In underpinning effective integration of primary and secondary health services the Divisions Network suggests a principle explicitly focusing on integration mechanisms within and across sectors.

Integration of Indigenous primary health care services and enhanced services for marginalised and/or disadvantaged individuals and groups.

As well as the integration issues pertaining to the Community Controlled Sector (which are covered satisfactorily in the paper), changes will be needed to improve the health of other marginalised or disadvantaged groups.

These changes require a focus on:

- Targeted preventive health initiatives;

- Community development to build individual and community capacity;
- Social inclusion and access and equity;
- Service delivery settings and models designed around 'hard to reach' people; and
- Working with other government and non-government organisations and stakeholders, e.g., transport, housing, income support.

Boundaries and alignment

- GPQ and the Queensland Divisions Network support, in principle, boundary alignment between LHNs and PHCOs.
- Boundary alignment alone will not facilitate integration between LHNs and PHCOs enabling appropriate management of patient flows; pathways between services; smooth transitioning to sub acute care; equity of access and service gaps⁵. In order to achieve these aims a **strategic approach to, and investment in, integration** is required (see features of an effectively integrated system above).
- Forced alignment of health service provider boundaries with LHNs reduces flexibility. LHN boundaries are necessarily reactive to population health stresses and not proactive in advance of population growth, due to the high capital asset nature of tertiary and acute services.
- The planning of primary care services requires flexibility to meet changing demand through population mobility and demographic change. It is less reliant on large hubs of service (such as a hospital) and the planning imperatives are significantly different.

Governance, Representation and Engagement

Representation

- Funding should be provided for **consumer representation** on Governing Councils and/or structures under the Councils, giving Consumers equal status to other Governing Council members.
- The concept of having 'shared Director' positions on the Boards of LHNs and PHCOs is very problematic from a governance perspective. A better way to achieve integration between the organisations is to establish joint governance structures such as combined planning committees, combined clinical governance committees and combined community engagement committees. Otherwise, having specific "reserved" seats on Boards will lead to a concept of 'representation' which is not compatible with the legal duties of Directors on Boards.
- Clinician engagement: clinician engagement mechanisms such as Clinical Councils should be common to and shared between the LHN and PHCO and must include General Practitioners.
- Consumer engagement: community engagement mechanisms such as Community Councils should be common to and shared between the LHN and PHCO.
- Directive versus local variation: Queensland Health will need to strike a balance between being prescriptive enough to ensure that LHNs have appropriate structures in place (eg community engagement mechanisms) so that engagement is not simply tokenistic, whilst still allowing for local variation. A staged approach might be useful whereby local variation is allowed, reviewed and then perhaps more uniform approaches required once appropriate models are established.

What aspects of governance need to be integrated across LHNs and PHCOs to benefit the broad range of consumers?

- LHN Governing Councils and PHCO Boards should establish formal engagement protocols;

⁵ Health system integration in Queensland – A joint consultation paper

- Shared performance management frameworks;
- Clear governance mechanisms to support clinical governance, corporate governance and consumer and community engagement (as part of governance framework);
- Mechanisms to consult outside of the public health and primary care systems (obtain the views of NGOs and private-for-profit providers systematically and regularly); and
- Credible, timely and funded local patient/consumer involvement into strategic, operational and governance systems.

What other mechanisms could be established to facilitate involvement and engagement in governance processes?

Limited cross membership between PHCO boards and local hospital network boards may be one mechanism for promoting communication and integration and would be consistent with the commitment in the National Health and Hospitals Agreement to some common membership of governance structures where possible. A mechanism for achieving such cross membership would need to be established.

PHCOs are likely to have a skills-based board reflecting the range of functions of the organisation; multiple advisory and consultation mechanisms should be arranged to support the board and ensure strong engagement with the range of stakeholders.

In the context of PHCOs it is possible that each board would establish committees such as audit, risk and governance committees. It is probable that cross sector representation can be formally agreed on such committees. Committees established by the board of a PHCO may be advisory only, or have some degree of delegated authority to make decision. Terms of reference of board committees will ensure their role and responsibilities are clear

What features should be included in a formal engagement protocol between LHNs and PHCOs

- Joint consumer forum
- Data and information sharing agreements;
- Communications processes (internally and externally);
- Agreed patient information pathways;
- Formal integration strategies;
- Joint service reviews (efficiency and quality);
- Organisational roles and responsibilities,
- Performance indicators;
- Joint service integration performance measures (quality & safety, information transfer, collaboration, patient advocacy);
- Joint health planning mechanisms;
- Joint financial/funding arrangements;
- Joint appointment arrangement;
- Conflict of interest agreements;
- Mediation and arbitration processes;
- Dedicated roles to support PHCO – LHN interface (e.g. GP/ hospital liaison roles);
- Joint clinical governance forum (e.g., serious incident investigation); and

- Organisational under/over performance agreements.

Integration levers

Which of the levers will help achieve continuous and seamless care?

- Levers to integrate sectors to offer seamless care have to be explicit; this may be through a 'carrot or stick' approach. As well as incentives for models demonstrating coordinated care over time, there should be penalties or disincentives for those organisations/areas that are not able to demonstrate this.
- PHCO and LHN planning and delivering services together.
- Integration levers must be developed horizontally and vertically.
- Aligning boundaries and offering joint appointments (for example) on its own will not drive integration. Systematic, explicit and strategic incentives and disincentives must be applied.

Are different levers more important in different contexts (e.g., rural and remote, indigenous health, aged care)?

- Access and equity to health services for marginalised and / or hard to reach groups will require different approaches.

What current and possible barriers to integration need to be addressed?

- Lack of accountability on joint service integration indicators
- Significant cultural barriers ('us and them' mentalities, silos);
- Lack of understanding of the roles and responsibilities of each sector;
- Few or no consequences for poor performance;
- Duplication and ownership of services;
- Centralised decision-making processes in State health services (may continue to be an issue if not devolved);
- Funding mechanisms and sustainability; and
- Lack of evidence-based service planning in some instances.

Measuring performance and effectiveness

How could performance measures and reporting be used to enhance integration of service delivery?

- Performance measurement should be part of a cycle of quality improvement contributing to service planning and supporting investment/disinvestment in service delivery. This approach can be applied across services irrespective of service provider.
- Indicators which focus on wellness measures and patient journeys, navigating the system, communication pathways, collaboration and partnership and quality and safety indicators will reveal shortcomings in services, gaps in service provision and issues around integration.
- Current funding models are often based on short term outcomes/processes. Funding mechanisms could be developed, based on outcome measures and long term health gain. These could be structured to enhance integration processes, providing incentives for joint approaches to system improvement.
- In order to support collaborative approaches to population health and service planning across LHNs and PHCOs defined structures need to be identified/established/supported. This includes mechanisms to share data, debate key issues and prioritize areas of mutual interest. However joint planning doesn't necessarily mean that a joint plan is developed as PHCOs and LHNs will have different focus. A key focus could be the joint development of regional health improvement plans.

- Local joint planning (across interfaces) including consumer and carer input.
- Over the next few years indicators could be developed across sectors to enable cultural shifts to occur and develop a framework for health outcome performance indicators driving improvement over time.

What measures will best indicate whether integration has been successful in the short/medium term

- Increased access to services;
- Improved continuity of care pathways
- Quality and timeliness of information across sectors (referrals/ discharge summaries);
- Safety measures (medication errors, transfer of patient information);
- Collaborative and partnership measures including governance;
- Evidence of joint service planning across sectors;
- Collaborative service delivery models;
- Uptake of electronic exchange of information;
- Policy measures supporting integration;
- Improved health outcomes:
 - Chronic disease risk reduction;
 - Hospital avoidance data based on intervention sites;
 - linked health data of records of general hospital admissions, morbidity and pathology to determine the rates of avoidable admissions/death for chronic conditions and the use of preventative screening or pathology (e.g. blood glucose, lipids, cancer screening)
- Efficacy and uptake of new practice measures (guidelines, pathways)
- Attitudes and practice change
- Joint quality reviews e.g. clinical audit of samples of patients ‘travelling’ across service sectors;
- Patient satisfaction, behaviour change, lifestyle modification, and;
- Participatory research evaluating impact of integration activity - utility and effectiveness of a systemic approach to practice change that crosses multiple sectors

Transformation change and innovation

How could what is learnt from implementation of the reforms and related innovations be shared across the state?

- Sharing through clinical networks;
- Agreement for funding in research and development for collaboration;
- Establishing Knowledge Networks in key priority areas;
- Knowledge Networks have a key role in policy and planning development, innovation and responsive decision making;
- Evaluation through learning communities (E.g. Communities of Practice CoP);
- Funding for research and development for PHCOs and LHNs and for some of this to be marked for collaborative work in innovation from each party to a shared goal or project;
- Best practice advice through clinical senate, governance committees or similar;

- Knowledge translation strategy;
- Information and marketing of successful strategies through cross sector communications (electronic etc.), and;
- Clinician education sessions.

Structures and support mechanisms

What are the state level governance or system enhancements that would enable the achievement of an integrated health system?

- Clinical senate;
- Building on clinical networks;
- Queensland Primary Health Care Network;
- Population health and epidemiology expertise;
- Data sources;
- Data on service usage, quality, relevance;
- Population health needs;
- CHIC partnerships;
- Partnerships with Universities, and;
- Specific training and education opportunities which can be accessed across sectors (e.g. ADTRU).

State level leadership and functions, including support for MLs

The Queensland divisions have identified the key functions required to support MLs at a state level. These functions include;

- Interface with state government and state health services, including primary health care services;
- Interface with state health as a future health service systems manager (performance, industrial relations, IT, support services etc);
- Strategic planning with state government and state health services (e.g. Queensland Government Suicide Prevention Action Plan);
- State wide liaison and consultation, particularly with primary health care stakeholders. Many primary health care organisations have no regional or local level representation. In Queensland, GPQ facilitates the Queensland Primary Health Care Network; a network of 45 stakeholder group representatives. This network demonstrates the need for ongoing wider consultation and communications on issues relating to improving the patient journey across statutory and NGO sectors; across health and social services to meet the growing expectation for improved service integration under the reform model;
- Support capacity and capability development in skills, knowledge and expertise including clinical and corporate governance and population health planning;
- Leadership, models of care and service Innovation; current statewide examples of developing innovative projects with consistent quality standards include:
 - *activate: mind & body* (improving the physical and oral health of people with severe mental illness);
 - General Practice Liaison (interface improvement, analysis and scoping);
 - Partners in Mind (mental health improvement between State health and primary care sectors);
- Shared business modelling e.g. human resources, finance

- Workforce planning, support and development;
- Statewide approaches to population health and service planning;
- Knowledge sharing, dissemination and information exchange;
- Project and program leadership;
- Research and development;
- Data and information sharing;
- Information Technology (e.g. secure messaging etc.);
- Securing investment from diverse funders to meet identified service gaps and population health needs;
- Program management and systemic models of care (e.g. practice nursing).

Next Steps

In order to develop an integrated health system in Queensland, it is imperative that the Transition Alliance clearly articulates the next steps following on from this consultation period. GPQ recommends the following next steps:

- The development of a vision for an integrated health system in QLD which is underpinned by broad consultation with a wide range of stakeholders.
- The development of an evidence-based integration framework for Queensland. This could be based on preliminary work undertaken through the GPQ Collaborative Research Hub (i.e. Service Integration Framework and the Service Integration Framework for General Practice Liaison Officers).
- To gain a broader stakeholder perspective, GPQ would suggest a stakeholder forum to seek input on and further develop the above mentioned integration framework. Ideally the developed framework would include both state level and local level evidence-based integration tools and would be driven by an ongoing consultation process.
- GPQ acknowledges that the development of such a framework will require resourcing and leadership. GPQ would be happy to take part in further discussion on the integration framework.