Health
South Eastern Sydney
Local Health District

Integrated Care: the way forward in NSW

Integrated Care Forum

Wednesday 26th March 2014
Stamford Plaza, Sydney Airport

A NSW based forum for senior executives representing NSW Health, Local Health Districts, Medicare Locals and Non-Government Organisations to explore and develop local actions on Integrated Care, with expert subject matter presented by keynote speakers representing international and local perspectives on care integration.

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Video recordings of the proceedings from the Forum are available on the SESLHD YouTube channel at http://www.youtube.com/user/SESLHD

SESLHD website

SESLHD YouTube channel

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Introduction

Dr Greg Stewart, Director of Operations, Ambulatory & Primary Health Care SESLHD

There is a manifest need for better integrated health care. Both in Australia, and internationally, policy makers, managers and clinicians are grappling with the development of appropriate models to achieve better integration of health care across the spectrum of health care provision; i.e. from population health and prevention, to primary health care, and across secondary and tertiary care. Linked with this agenda is the broader need for better integrated health and social care.

Integrated care is very well defined in the NSW Health Integrated Care Strategy as:

> *"…the provision of seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health, in partnership with the individual, their carers and family. It means developing a system of care and support that is based around the needs of the individual, provides the right care in the right place at the right time, and makes sure the dollars go to the most effective way of delivering healthcare…"*[1]

A key policy issue for Integrated Care is an appropriate and robust strategic framework to guide the health system and its managers and clinicians in the provision of better integrated care. The English NHS "House of Care" model (page 8) draws together key elements of Integrated Care in a well-defined and practical way. SESLHD and GP NSW were pleased to be able to invite the architect of the House of Care, Dr Martin McShane, Director Domain 2 (Improving the quality of life for people with long term conditions), NHS England National Commissioning Board, to contribute to a one-day forum on Integrated Care. SESLHD and GP NSW extend their sincere thanks to Novartis for their support in bringing Dr McShane to Australia and in the publication of this report.

Ultimately, the implementation of Integrated Care at local level requires a series of enabling elements, best described by The King's Fund (page 17). How on-the-ground practitioners can use these elements and frameworks such as the House of Care to implement integrated care at local level was the core question addressed at this Forum. We asked the "Monday morning" question: "What can and will I do, back in my workplace next Monday morning, to achieve better integrated care".

The answers to this question provide a local way forward for Integrated Care in NSW.

[1] NSW Health (2014), *Integrated Care Strategy 2014-2017 Information Sheet*, available: http://www.health.nsw.gov.au/integratedcare/Pages/default.aspx

Integrated Care Forum – Program

Wednesday 26th March 2014 Stamford Plaza – Sydney Airport, Cnr O'Riordan & Robey Streets, Mascot 2020	
Time	**Item**
8:30-9:00	***Arrival and Registration***
9:00-9:20	Welcome - Gerry Marr, Chief Executive SESLHD and Lewis Kaplan, CEO GP NSW Introduction and purpose of day - Dr Norman Swan (facilitator)
9:20-9.50	Speaker: Prof Kathy Eagar, Director, Centre for Health Service Development, University of Wollongong Title: "Community Health and Primary Care in NSW – current state"
9.50-10:40	Speaker: Dr Martin McShane, Director Domain 2 ('Improving the quality of life for people with long term conditions') NHS England National Commissioning Board Title: "Building the House of Care"
10:40-11.00	Plenary Q&A session facilitated by Dr Norman Swan
11:00-11:30	***Morning Tea***
11:30- 12.10	Table work – allocated tables. "Do we need disruption to create a new integrated care model or can we build on the current system?" Feedback - facilitated by Dr Norman Swan
12:10- 12.45	Speaker: Dr Nigel Lyons, Chief Executive Officer, Agency for Clinical Innovation Title: "What will a successful Integrated Care system in NSW look like?"
12.45-1:30pm	***Lunch***
1:30-2:00	Speaker: Mike Brooke, Director, Outcome Services Title: "Harnessing the key drivers of interaction effectiveness in integrated care"
2:00 –2:10	Setting the scene for afternoon workshop - Dr Norman Swan
2:10-3:10	Table work – in geographic clusters, to discuss three issues: 1. What is happening in your local area? 2. What immediate steps will you take to progress Integrated Care locally? 3. What system issues need to be addressed?
3:10-4:00	Table feedback; consolidation of key issues identified; implementation steps facilitated by Dr Norman Swan
4:00-4:30	***Afternoon Tea***

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Integrating care – the journey towards integrated care

Lewis Kaplan, Chief Executive Officer General Practice NSW

If a viable health system with patient-centred, integrated care at its heart is not created, then patients, clinicians, budget holders and Australian society at large will have been let down by the system. While there is general agreement and now sufficient evidence that this is the right way forward, the implications of the changes needed to current clinical practice are not well appreciated on the ground. For example, the evidence-based guidelines for the prevention and management of cardiovascular disease were significantly changed in 2012 but their implementation by clinicians at all levels remains patchy.

There is a powerful argument that the response to these challenges is not to seek ways to cut services and access to services, but rather to seek new ways to deliver health care, new ways to cut duplication and improve communications, new ways to empower patients and front-line staff.

It is timely that the recent National Commission of Audit recommended that:

> *Detailed work is required to examine opportunities to improve the efficiency and effectiveness of Australia's health care system over the medium to longer term. The Commission recommends the Minister for Health be tasked with developing options to reform Australia's system of health care.*
>
> *The Minister should report to the Prime Minister in 12 months' time on progress and a preferred way forward.*[2]

In the NSW context, it is also timely that the NSW Minister for Health has announced an integrated care investment strategy with a 4 year commitment of $120M. It was very pleasing that this funding was protected from any cuts to the NSW budget as a result of Federal Budget announcements.

System change is needed to ensure that the tools to deliver integrated care are available, accessible and readily understood. Adopting the changes will also require major cultural and behavioural shifts which are much harder to implement and measure. The pre-conditions of change include a sense of urgency that the current ways of doing things are no longer appropriate or viable. While this message is being articulated by leaders such as our health ministers and leading health policy academics, clinicians are often too busy working in their particular silos to appreciate that these messages are for them as much as for the managers who try to control their budgets.

Capacity and time are required to train people at all levels to embrace the changes needed, be it in adopting new IT solutions, learning and applying patient self-management skills or re-calibrating clinical practice to become patient – rather than service – centred.

While clinical independence is a sound concept that has been fiercely defended by professional groups, it should be practised within a context relevant to current and future illness paradigms. Thus, open debate is needed around how well the current fee-for-service model supports clinicians who wish to practise medicine that delivers appropriate outcomes for people with chronic and complex diseases.

The SESLHD-GP NSW Integrated Care Forum explored these critical issues.

[2] Commonwealth of Australia (2014), *National Commission of Audit* – Recommendation 18, available: http://www.ncoa.gov.au/report/phase-one/part-b/7-3-a-pathway-to-reforming-health-care.html

Setting the Scene

Gerry Marr, Chief Executive SESLHD

There are clear examples of integrated care occurring worldwide, such as the Integrated Diabetes Care Project originating from Dundee but now covering the whole of Scotland. The challenge of integrated care is to shift the balance so that as much as possible, care is provided at home and in the community. A Scottish example is apposite – in recognition of the important relationship between health and social care, the Public Bodies (Joint Working) (Scotland) Act 2014 received Royal Assent on 1st April 2014. The intention of the Act is to maximise every opportunity for patients and families to improve their health and social care outcomes through integrating the delivery of health and social care services[3].

The greatest asset in anyone's circumstances or illness is themselves and as such, the system needs to design, plan and think conceptually that the patient and the family are the major assets in this drama of their lives and illness. Systems are beginning to recognise and address the whole issue of 'self-management', support, anticipatory care and rehabilitation. The conceptual idea of an asset-based approached is becoming dominant.

The challenge is to scale up this approach very, very quickly. The economic and demographic challenge is that health systems in western countries will need to move to a scale never seen before. The integration of care is key to addressing this challenge.

Culturally, communities have been trained to be dependent on doctors and nurses with the currency of healthcare provision measured by the number of beds as opposed to the resources required (the clinicians). What needs to happen is to empower communities to equip health professionals to be retrained as coaches, to deploy skills of personal intervention. The notion of energising the community is important – people will continue to be suspicious if they don't see any real resources being transferred from the acute setting and will view what is said as simply rhetoric.

It will take a different way of thinking to shift investments to the primary care setting while maintaining and managing the acute setting. A fundamental rethinking of how to transform and transfer care into the community is required. Financially, the level of waste and significant variation in our system will allow the release of resources to make the transitional investment into primary and community care, without sacrificing the acute setting.

[3] Public Bodies (Joint Working) (Scotland) Act 2014 (asp9)

Integration on the ground – NSW community health, primary care and beyond

Professor Kathy Eagar, Director Australian Health Services Research Institute, University of Wollongong

International evidence shows that the stronger the primary care sector, the better the care system and the more affordable it is, and the better the patient experience. Australia needs to return to the approach of integrating health and social care. While integration is at the level of the patient, it is also about integration of and between the various levels of the system:

- Structural
  - Commonwealth/State; Public/Private/NGO; hospital/community, etc.
- Policy
  - health/aged care/disability (Scotland is integrating these whilst Australia is dis-integrating these)
  - health subsets – acute/subacute/primary/mental health, etc.
- Funding
  - Funding/purchasing/commissioning/paying/subsidising, etc.
  - Population need (capitation)/service activity/outcomes
- Transactional, e.g. IT platforms and systems, electronic medical records
- Cultural

The National Health Reform Agreement (NHRA) signed by COAG on 31 July 2011 identified the biggest problem in the Australian healthcare system to be the lack of integration. The solution was to split the system into 5…:

1. Hospitals – State responsibility with the Commonwealth now contributing its share on an activity basis.
2. Private sector primary care – Commonwealth responsibility via MBS.
3. "Aged Care" including Home and Community Care (HACC) for people >65 – Commonwealth responsibility. At the Commonwealth, the Department of Health and Ageing has now been split with Ageing now part of the Department of Social Services.
4. Disability services – State responsibility under the original agreement however, the NDIS has now superseded this.
5. Community health, population health and public health – State responsibility with no Commonwealth funding. Community health may not have a future with the current lack of incentives.

The (short-term) incentive for NSW is to close whatever it can (bar public health and hospitals) on the basis that:

- The Commonwealth can fund/subsidise private medical and allied health services, aged care, NDIS, etc.
- Private insurers and consumers can pay for the rest – Australia now has one of the highest consumer co-payment rates in the world.

In order to effect real change, NSW needs to learn and apply Leutz's Laws of Integration:

1. You can integrate some of the services for all the people, and all the services for some of the people, but you cannot integrate all of the services for all of the people.
2. Integration costs before it pays.
3. Your integration is my fragmentation – not all patients need/want their care to be integrated; priorities for integration are those with chronic conditions and those who are at risk.
4. You cannot integrate a square peg and a round hole.

5. The one who integrates calls the tune.
6. All integration is local.

These lead to two further rules:

a. Implementation is always local and has to fit the context.
b. As a corollary, larger policies should facilitate rather than dictate the structure and pace of local action.

Both Laws 5 and 6 cannot be (completely) right. Policies at the state level need to create opportunities for integration locally rather than drive and determine them.

Four priorities for NSW are to:

1. Maintain and extend the commitment to decentralisation as the system is always quieter and happier when it is localised.
2. Favour capitation and needs-based funding over fee for service and activity based funding. International evidence should be used to develop smart blended and mixed payment models.
3. Optimise the use of IT and promote information sharing, i.e. 'collect once, use often' (NSW and National Coordinated Care trials).
4. Support a well organised and resourced primary and community care sector.

Key evidence to measure success

- Peripheries of Excellence[4] as this is where care will be integrated. This does not just mean Centre of Excellence.
- Linked up providers through cultural and transactional integration.
- Smooth patient journeys
- Decision-making (both policy and practice) routinely informed by evidence
- A health system that we can afford to pay for – if we do not better integrate care and promote a primary care approach, we will have a health system that is not sustainable into the future.

[4] Tudor-Hart, J in Maynard, A and Chalmers, I (eds) (1997). *Non-random Reflections on Health Services Research: On the 25th anniversary of Archie Cochrane's Effectiveness and Efficiency*. BMJ Publishing Group, London. Available: http://www.nuffieldtrust.org.uk/publications/non-random-reflections-health-services-research

Building the House of Care

Dr Martin McShane, Director (Domain 2) Improving the quality of life for people with Long Term Conditions, NHS England

Long term conditions (LTCs) are a major and growing challenge, moreover the emergence and challenge of comorbidities is testing health and care systems. It is estimated that 70% of all health and social care costs in the National Health Service (NHS) are consumed by LTCs.

A shift in the approach to people with LTCs is now occurring, from the doctor/clinician being the only expert, to appreciating the potential of the patient as a knowledgeable and involved participant in their own self-care. Carers must also be recognised as a huge asset in the management of LTCs. A further consideration is how communities can be activated in managing LTCs (see Figure 1).

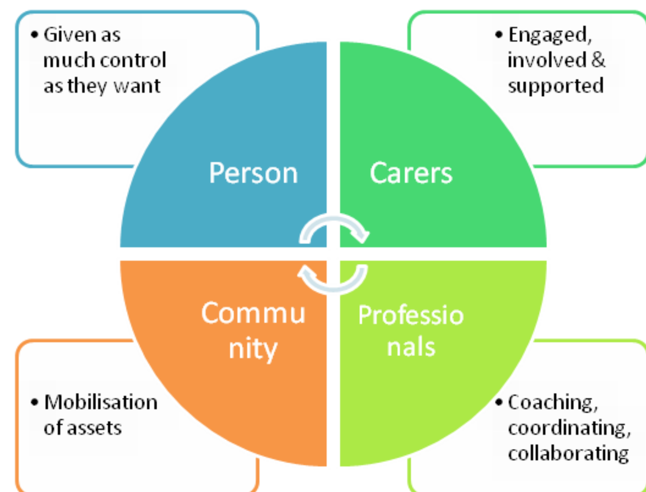

Figure 1: Stakeholders in addressing the challenge of LTCs

'Self- care' does not mean abandoned care. Self-management is about giving people as much control over their health care as they want. This is linked to the concept of patient activation. This approach is not one that health professionals are universally trained in. Likewise, the right incentives and levers do not exist to support this concept so that it becomes sustainable and its benefits realised. Patient activation measurement and how it can be used by clinicians to influence their clinical approach is being piloted in the UK. The intent of patient activation measurement is to help determine where the locus of control is – some patients will want to be actively involved in their care while others will simply want to be told what to do. This is about understanding the level of ownership that each individual wants to have of their health care and personalising care accordingly.

This is perhaps the biggest challenge in health care: changing the nature of the conversation/consultation around how care is provided. Not enough attention is given to the mindsets of individuals based on their beliefs and values – any proposed changes will fail if these are not respected and addressed. A fundamental change is needed in the interaction between professionals and patients. As noted by Professor Chris Ham[5], hospitals and health care systems operate as an 'inverted pyramid of power' – it is not the Chief Executive who makes the decision to commit resources, rather it is the professional on the front line. Unless this is respected and these professionals are involved in changing the system and the approach to LTC management, then the necessary change is unlikely to occur.

In effecting the best possible return on investment for healthcare, it is important to recognise that value needs to be measured where value equals quality [6]divided by cost. There are 3 ways of improving value:

- Improve quality while maintaining cost
- Maintain quality while reducing cost
- Increase quality while reducing cost.

[5] Ham, C (2003). Improving the performance of health services: the role of clinical leadership. *The Lancet, vol 361 no 9373,* pp1978-1980

[6] Quality is defined as safe, effective care, providing a positive experience.

Current measures are not good at tracking value throughout the system -this needs to change so that proactive, anticipatory care for LTCs is properly valued and invested in for people with LTCs.

A new system approach to care needs to be developed. The dividing line between General Practitioners and Specialists has grown. As such, a 'care gap' has emerged with more and more complexity to manage in the community. The expectation has been that GPs will take on the provision of the medical cover in this care gap on top of everything else that they have always done whilst specialists continue to become more and more specialised. To address this populations need to be risk stratified and the services that are needed to provide the level of care for each level or segment of risk can be developed to shift from a traditional hospital focussed system of care to one that has appropriate community based services.

While most other industries listen to the voice of the customer, it is apparent that this is a practice that has only recently developed in health care. People with LTCs are interested in a person-centred and coordinated model of care. This would incorporate the individual's goals/outcomes, good communication, information, informed decision-making, care planning, managed transitions and appropriate crisis care. Four components need to be in place for this to occur:

1) Engaged, informed and empowered individuals and carers
2) Organisational and clinical processes to draw down all the best evidence available
3) Health and care professionals working in partnership – with each other and with patients
4) Commissioning – this needs to be used to create the right framework so that the other 3 components can be in place. This is not merely about contracting and procurement, it is about understanding the needs of the community and wider population health needs. From this, the levers, tools and contracts that need to be utilised can then be developed in order to address these requirements systematically.

The metaphor of the 'House of Care' (see Figure 2) has been identified to represent this approach in the NHS[7]. No one component on its own will address person-centred, coordinated care. Without any of these components, the 'House' will collapse.

The 'House' also supports continuity of care:

- Informational continuity
- Management continuity – the levers and incentives to support continuity
- Relational continuity – someone who can be the patient's guide and advocate

Figure 2: The House of Care model, NHS England

If the House of Care is implemented, then it is highly likely that the cost of care in the NHS can be reduced. Furthermore, in order to support the development and implementation of integrated health care, the system should only do at a national level what can, should and could be done at a national level (i.e. create an enabling framework). It is a responsibility of local health economies to design the appropriate solution within their culture and context to allow the interaction of professionals and the individual in the House of Care.

Big gaps currently exist in the health system; this will need to change. The benefits and value of investing in social care need to be better understood. The general hospital will need to be shrunk and specialised services centralised. Primary care needs to be expanded and integrated with other community based services to support the capacity and capability to meet the challenge of LTCs.

[7] *Enhancing the quality of life for people living with long term conditions – The House of Care,* NHS England, www.england.nhs.uk/house-of-care/

What will a successful Integrated Care system in NSW look like?

Dr Nigel Lyons, Chief Executive NSW Agency for Clinical Innovation

The patient's perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to 'impose the patient's perspective as the organising principle of service delivery[8]

What is the 'burning platform' for change in the NSW system? The reality is that the current focus on ABF reflects a need to provide clarity on activities and costs across all components of a patient's care. This entails a focus on technical efficiency initially but will enable improved allocative efficiency as we make changes through better models of care, such as integrated care. We need to ensure that we remain focussed on improving patient experience and outcomes at the same time as ensuring efficient resource utilisation.

The system always needs to be anchored by the patient/consumer perspective. We tend to redesign the system based on what we think the patients' needs are, rather than listening to their concerns and experiences, and we do not currently go far enough to address those barriers and challenges in the system. There is a need to get better data to monitor and plan and we also need better information about outcomes – these are not measured well and not agreed on. This leaves the impression there are no systems to monitor outcomes. Data and measurable outcomes are very important for integration as are information systems. In order to make integrated care happen at scale and pace, The King's Fund has identified 16 key lessons from experience[9]:

1. Find a common cause
2. Develop a shared narrative
3. Create a persuasive vision
4. Establish shared leadership
5. Understand new ways of working
6. Target services and user groups where the greatest gains can be made
7. Bottom-up and top-down – this needs to be enabled in order to create a clear vision of what the objective is
8. Pool resources
9. Be innovative in finance and contracting
10. Recognise that 'no one model' exists for the development of integrated care in NSW
11. Support and empower users of the health system
12. Share information and develop and effectively utilise information infrastructure for this
13. Workforce and skill-mix changes
14. Specific measurable objectives
15. Be realistic, especially about costs
16. Coherent change management strategy

In essence, integrated care needs to remain person centred. Prevention needs to be emphasised with a reliance on self-management by the patient and/or the carer.

Integrated person-centred care is best managed by systems of care that:

- Emphasis prevention
- Rely on self-management by the patient and/or carer.

International best practice suggests that integrated care systems are most commonly led by the primary care sector and are most effective when there is pooled funding and a single budget holder. However, there is no magic bullet and the people at the local level are those who will make a difference.

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[8] Shaw, S, Rosen, R, & Rumbold, B (2011), *What is integrated care?* (Nuffield Trust, p7) from Lloyd, J and Wait, S (2005), *Integrated Care: A guide for policymakers* (London: Alliance for Health and the Future)

[9] The Kings Fund (2013), *Making integrated care happen at scale and pace*

[Harnessing] Key drivers of interaction – Effectiveness in integrated care

Mike Brook, Director, Outcome Services

The experiences of patient journeys are now well recognised as an important source of guidance in improving healthcare systems. In listening to these experiences, their perspectives may not always be aligned with their clinical providers - as an example, a psychiatrist treating a patient with schizophrenia may regard "recovery" as being an absence of symptoms, whereas a patient themself may see "recovery" as a compromise of coping with an everyday life that includes symptoms of schizophrenia that are ever-present, but manageable.

Another example might be our management of a hip replacement candidate, an area where demand is increasing and public hospital waiting lists grow longer. Not all waitlisted patients will have osteoarthritis as their sole health issue or even, highest priority - a common and more complex real-life scenario may demand recognition and management of multiple co-morbidities, including depression; associated medication side-effects contributing to excessive weight gain; onset of diabetes; all these in addition to their primary management diagnosis - their arthritic hip. Once this recognition of complex care needs occurs, multidisciplinary team-based care arrangements are required to address and manage these.

As a simple initiative to encourage clinicians to "see the person in the patient"[10], treatment accounts and perspectives from patients have been published along with an invited response from their treating doctor on their patient's views. These patient and doctor perspectives have highlighted examples where each party may not always have a view and understanding of agreed treatment plans and health priorities that are completely aligned. As one GP commented after looking through their patient's story: *"Is that what the patient thought I meant? I wonder why?"*

Acknowledging that multidisciplinary care approaches are increasingly required to manage complex need, it then becomes important to encourage health systems that support and promote these models. In our own research we have focused on attempting to develop our understanding of the interaction effectiveness between general practice, allied health and hospital services.

Our methodology used qualitative and quantitative research to obtain input from general practitioners, practice nurses, practice managers and a range of allied health professionals; working across eight different metropolitan and regional Medicare Local catchment areas. As well as rating practice support, education services and other core support areas, participants were asked to rate and comment on a range of aspects of their interaction across service sectors, including their local public hospital services.

From initial findings, three factors have consistently emerged as key drivers impacting this interaction, being *relationships*; *processes and systems*; and *information access*.

Relationship factors

The relative strength of inter-relationships were assessed using measures in three domains, including clinical recognition; feeling of inclusion in a treating team; and overall communication quality.

Clinical recognition was regarded as sub-optimal:

- by allied health professionals in rating recognition of their clinical contribution by GPs

[10] Lapsley, P (2012), *See the person in the patient, BMJ* 2012; 344:e2138

- by both allied health professionals and GPs in rating recognition of their clinical contribution by hospital services

Where clinical recognition between providers is sub-optimal, the benefits of collaboration will be regarded as less important and less likely to occur. Referrals for acute treatments were also less likely to occur, with accompanying increased treatment difficulties with some chronic conditions.

Feeling included as a member of the treating team was regarded as sub-optimal:

- by allied health professionals in the GP's treating team
- by both allied health professionals and GPs in the hospital services' treating team

The 'treating team' concept is still not embraced widely across the broader system of GP – Allied Health – Hospital services. Where providers are included in a treating team, then it more likely that there will be better information flow, shared decision making with team member contributions regarded as being valuable.

Communication quality was regarded as sub-optimal:

- by allied health professionals in their interaction with GPs
- by both GPs allied health professionals in their interaction with hospital services

Communication quality with hospital services was assessed by seeking ratings of patient admission advice, timing and quality of discharge information. Communication with GPs was rated on quality and ease of contact to discuss patients. As with clinical recognition and treating team inclusion, communication quality is another aspect of relationship strength that is likely to impact collaboration across providers.

Processes and systems

In looking at processes frequently used by GPs, allied health professionals and hospital services, a widespread lack of integration was described in many of these, that limits the effectiveness of interaction. A common example described was the process of referral where a wide range of systems and feedback quality between GPs and allied health professionals was described. Many GPs referred to an absence of feedback when referring a patient; conversely many allied health professionals admitted to being ignorant of what kind of referral feedback was most useful to a GP. Even where team care planning subsidies were available and a documented team care arrangement involving multiple providers put in place, allied health professionals described regular instances where patients were sent to them for treatment even when available subsidy levels were exhausted. Both groups were critical of the fragmentation in processes used to refer patients into the hospital system, with many hospitals still using unique referral requirements and processes across different outpatient services.

While eHealth is seen to be an opportunity to standardise some of these processes in terms of information consistency, all those involved (GPs, Allied Health professionals, hospitals, consumers) lag behind. In allied health professionals in particular, there is a widespread lack of awareness of how eHealth will benefit their clinical practice.

Information Access

As one of key factors impacting interaction effectiveness, information access across general practice, allied health and hospital services is sub-optimal and is impacted by:

- a delayed uptake of eHealth and PCEHR (person controlled electronic health record)
- fragmented access to hospital based information systems
- limited public hospital capacity to automate sharing information to non-GPs
- challenges in accessing timely information even within service areas

Opportunities to improve interaction/integration

As well as recognising these existing factors, a number of other opportunities to extend this understanding and improve interaction effectiveness exist including:

- *Freeing up / growing health care capacity* either at a state/national systems level; at a service level (eg in developing new multidisciplinary musculoskeletal treatment services); at a workforce level (eg in encouraging earlier referral to appropriate allied health professionals in acute treatment phases) and at a community capacity level (eg in ensuring consistent health promotion messaging is delivered across all provider contacts.
- *Improving health service performance* - through uptake of each of these capacity domains
- *Informing the development of quality improvement initiatives* (e.g. Health Pathways, Clinical Handover Redesign)
- *Understanding public hospital 'front-line' staff perceptions* about their interaction with GPs and allied health professionals as well as their own internal colleagues and services
- *Including consumer perceptions of health service/journey 'effectiveness'* in planning and service provision

Acknowledgement of participating Medicare Locals:

Inner West Sydney Medicare Local, Western Sydney Medicare Local, South Western Sydney Medicare Local, Northern Sydney Medicare Local, Sydney North Shore & Beaches Medicare Local, Nepean Blue Mountains Medicare Local, Central Coast NSW Medicare Local, Eastern Sydney Medicare Local.

Do we need disruption to create a new integrated care model or can we build on the current system?

Summary of morning table discussions

While most people have some understanding of what constitutes 'integrated care', this tends to be fragmented and not a common understanding. As part of the Forum's proceedings, discussion groups were formed to identify whether "disruption[11]" is required to create a new integrated care model or if the current system can be built on to improve integration.

Various types and levels of system 'disruptors' that may have an impact on the current system need refinement or stimulate a new model of integrated care were identified. It was noted that the health system (within NSW and Australia) is already in a state of disruption, currently due, amongst other things, to:

- Activity Based Funding
- The establishment and development of the Medicare Locals[12]
- The implementation of the National Disability Insurance Scheme
- Health reform generally
- The introduction of new models of care such as Health Pathways.

The discussion groups agreed that these factors were acting as catalysts for change but there was no certainty as to whether they are stimulating a new model of integrated care. Concern was also expressed that any disruption, caused by the best of intentions or not, might actually result in a more fragmented health system.

Actual and potential disruptors were also identified in relation to sources of mechanisms of funding. Current funding settings are potentially more likely to result in more care being provided in acute care facilities. A positive disruptor would be to modify the current funding model to better enable a move towards integrated primary care and to reward the achievement of positive health outcomes. This is commensurate with current literature that suggests that this would be an appropriate method to ensure that funding is directed towards integrated care [see annotated bibliography pp14-21].

Other disruptors that have the potential to result in a greater stimulus to integrated care include:

- A focus on general practice and community based care
- Consumer identified and led health care planning and provision
- Increased and shared accountability across service providers and stakeholders.

For disruptors to be successful there was consensus that they need to be:

- Based on evidence and driven by data
- Focussed on motivating decision makers that the current system is unsustainable. In other words, focussed on creating a shared 'narrative' about the needs and benefits of an integrated system.

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[11] Christensen, C.M., Bohmer, R., & Kenagy, J. (2000). *Will disruptive innovations cure health care?* Harvard Business Review, available: http://hbr.org/web/extras/insight-center/health-care/will-disruptive-innovations-cure-health-care

[12] It should be noted that subsequent to the Integrated Care Forum on 26 March 2014, the Commonwealth Government announced following the Horvath Review that: the Australian Medicare Locals Alliance would not receive funding from 1 July 2014; Medicare Locals will cease to exist from 1 July 2015 and will be replaced by a system of primary health networks that will be responsible for the coordination and organisation of the primary health care sector across Australia. The exact detail of this new network is not yet known.

Progress with local integration

Summary of afternoon table discussions

For the afternoon sessions participants were grouped in geographical clusters to consider and discuss progress of integration in their local area, and to record current initiatives to address barriers and system issues. The following stimulus questions were discussed:

1. What is happening in your area?
2. What immediate steps will you take to progress integrated care locally?
3. What system issues need to be addressed?

Common themes raised across the groups were congruent with the earlier presentations and included:

- The need for more strategic and formal relationship building across the sectors – including alignment of Board goals, Chief Executives providing shared vision and management, shared key performance indicators, more common measures and shared accountability across all providers.
- Cultural change to educate and communicate integration messages effectively across the sectors both for staff and consumers. The aim is to provide greater engagement in service delivery and focus on the staff and consumer voice in health service redesign.
- Provision of incentives for general practice and primary care workers to lead and develop integrated care initiatives.
- System changes to support engagement of other sectors including NGO's and private industry.
- Tapping integrated care funds, avoiding competition and ensuring sharing of resources.
- Clinical engagement across sectors is critical. Whilst it was acknowledged that it is a work in progress, it is starting to gain traction through successful collaborative projects that include Partners in Recovery, Connecting Care and pathway models.
- Immediate steps need to include improving feedback loops about health service delivery to clinicians and consumers.
- Support for the "no wrong door" policy into health services – everyone should be aware of services and how to access them.

Conclusion

Dr Greg Stewart, Director of Operations, Ambulatory & Primary Health Care SESLHD

The summaries of presentations, discussions and literature in this report of the SESLHD / GP NSW Integrated Care Forum provide a rich source of information to assist implementation of integrated care at local level.

The NSW Health Integrated Care Strategy, Integrated Care Demonstrators and the Planning and Innovation Fund will allow practical application of models and frameworks for better integrated care in the NSW setting. Partnerships, particularly between Local Health Districts and Medicare Locals / Primary Health Networks are key to such implementation.

The outcomes of the wide range of projects under the Integrated Care Strategy, all with the intent of embedding integrated care into the NSW Health System, will allow ongoing consideration, review and implementation of Integrated Care models. The long term aim is to ensure that better integrated care is the default model of care for people with Long Term Conditions. This will include elements such as local risk stratification and client registration, use of patient activation measures, better models for patient self-management, innovative IT logistics including mobile Health technologies, anticipatory care and new models of patient-centred personalised care planning. Care coordination will be at the heart of the new model.

The implementation of these elements at local level is the challenge of health services in NSW, regardless of source of funding or Commonwealth/State boundaries.

Key references – Annotated bibliography
Prepared by Tom Chapman and Wei-Li Hume

REFORM: Delivering Integration at pace and scale.

Reform is an independent, non-party think tank whose mission is to set out a better way to deliver public services and economic prosperity in Britain. In October 2013 Reform partnered with Novo Nordisk to explore how policymakers can facilitate integration that benefits patients. The seminar was led by Bill McCarthy, National Director of Policy at NHS England.

This paper is the transcript of the discussion that took place and outlines some important key principles and opportunities to achieve integration at pace and scale and the main talking points of a roundtable discussion on the same.
Two key principles 1) Integration needs to be based around the needs of people, not organisational structures and forms; 2) Pilots can be the death knell. Don't wait and see what happens in other areas/pilots are an excuse to not do anything.

Six opportunities that are enablers to achieve integration: 1) Measure what matters (based on patient experiences and outcomes) 2) Commission for outcomes and with the right money; 3) Don't forget about the workforce and change management; 4) Integration will be different everywhere (and national policy needs to accept this); 5) Freedom around currencies and incentives; 6) Sharing information through better technology.

Some of the **themes to create impact were raised in discussion**: the need for better acceptance and adherence to change and change management with no option to opt out; focussing on the 'big wins' at a national level rather than the 'quick wins'; the need to explore different evaluative measures on financial gains; the need for standardisation of tools and measures of integration, the importance of data sharing; the need to build systems on relationships, not transactions; supporting carers; building a central vision around improving health and activating patients and carers; need for generalist doctors; increasing the acuity of care administered in the home; patient nominated clinical leads (not necessarily the GP).

This brief paper is a good précis of elements required for integrating care in the NHS, the elements of which could be replicated in the Australian system. Key enablers were succinctly provided to achieve integration in a timely way across the health system – with scale and pace.

http://www.reform.co.uk/resources/0000/1120/Delivering_Integration.pdf

The Kings Fund: Making integrated care happen at scale and pace

The King's Fund is an independent charity working to improve health and health care in England and leads the discussion in the UK for system wide change. This paper effectively summarises the steps needed to make integrated care happen with its clearly articulated points.

The paper outlines sixteen main points:

1. Find common cause with partners and be prepared to share sovereignty
2. Develop a shared narrative to explain why integrated care matters
3. Develop a persuasive vision to describe what integrated care will achieve
4. Establish shared leadership
5. Create time and space to develop understanding and new ways of working
6. Identify services and user groups where the potential benefits from integrated care are greatest
7. Build integrated care from the bottom up as well as the top down
8. Pool resources to enable commissioners and integrated teams to use resources flexibly
9. Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector
10. Recognise that there is no 'best way' of integrating care
11. Support and empower users to take more control over their health and wellbeing
12. Share information about users with the support of appropriate information governance
13. Use the workforce effectively and be open to innovations in skill-mix and staff substitution
14. Set specific objectives and measure and evaluate progress towards these objectives
15. Be realistic about the costs of integrated care
16. Act on all these lessons together as part of a coherent strategy

The paper notes that creating a hub to support learning and development is likely to be critical in success, as is accessing skills in service improvement to support rapid cycles of learning.

There is also an acknowledgement of: the need to improve payment systems to encourage innovation; being aware of regulation/governance demands and not inappropriately applying competition policy to health and social care; monitoring to focus on system performance not just organisational performance; alignment of outcomes for public health, health and social care.

This brief paper outlines a useful generalised toolkit of integrated care elements for high level executive implementation planning.
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf

The King's Fund: Coordinated care for people with complex chronic conditions

Based upon an analysis of five UK-based case studies of care co-ordination programmes for people with long-term and complex chronic conditions, this report examines key lessons and markers for success in the 'how' of care co-ordination that might be transferable to different contexts and settings.

The 5 co-ordinated care program reviews were:

1) Consultant-led, community-based palliative care provision for terminally ill patients in their homes
2) Community-based specialist mental health and wellbeing services for people with mild to moderate mental health problems
3) Consultant-led, community-based home care for patients with advanced dementia
4) Community-based multidisciplinary teams co-ordinating care for older people
5) Community-based integration of health and social care services for complex case management

In terms of the process of care co-ordination, there are several factors that appear to be important and these are usefully stratified into design factors on a: personal level; clinical and service level; community level; functional level; organisational level and a system level.

The report clearly outlines that there has been an important lack of evaluation and measurement on which to judge the performance of care co-ordination programmes. This lack of evaluation is deemed a fundamental weakness; far greater attention is required to measure, evaluate, compare and reflect on performance.

The paper also reports in detail on lessons learnt from implementing care co-ordination under different contexts and settings. It takes time for programmes to mature; models of care cannot be transported between locations without a process of localisation; programmes flourish at the neighbourhood level with close working relationships between the multidisciplinary team; operations can be scaled up under the direction of an umbrella organisation; needs to be a quality improvement strategy rather than a cost saving strategy; disengagement of GPs is an issue; strong links need to be established with secondary care; care co-ordination models tend to work better when operating as fully integrated provider teams with a degree of operational autonomy; there is a key necessity for alignment across the political, regulatory, organisational, and professional spectrum towards common goals, too much reliance is placed on the local leaders to make change happen.

A good comprehensive analysis of current programs looking at what's working and lessons learnt. A good resource for managers focusing on health system change and implementation plans to look at how teams were constructed to provide integrated care, with the components broken down into table form for direct comparison.

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf

The King's Fund: Delivering better services for people with long-term condition – Building the house of care

The 'house of care' is how this report has described the elements of a co-ordinated service delivery model built on learning gathered from a number of sites in England. The report was built on the collective learning identified through workshops and individual interviews with representatives from programmes that are successfully partaking in collaborative care planning and effective self-management support in the UK

The key elements of the house of care are:

1) **Personalised care planning:** collaborative personalised care planning at the centre, as the basis for everything else.
2) **Engaged informed patients:** through seeking a person's views and providing personalised information, then, building in time for reflection and discussion.
3) **Professionals committed to partnership working**.
4) **Organisational processes**: e.g. more support in admin and task-based roles to free up clinicians for the necessary longer consultations; incorporating patient goals and action templates into the shared electronic record.
5) **Responsive commissioning:** prioritising resource allocation at a macro/District level, by aggregating the common needs highlighted in the personalised care plans at the micro level.

*****All these elements are linked electronically via decision support tools and shared IT systems.

This report outlines the resources required to provide the house of care as above, and also provides illustrative case studies from the UK to give examples of how these elements are working.

A good descriptive report to compare health services in NSW with the widely discussed UK model. Comparisons of the similarities and disparities are provided while allowing gaps to be identified clearly. This paper gives a good picture for managers and clinicians of person centred care and its components.

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

Institute for Public Policy Research: Towards whole person care

With the scent of reform for the NHS in the air, Bickerstaffe examines the components of what is seen to be the important major change required - a shift towards 'whole person care'.

Bickerstaffe argues clearly that the focus of the health care system should be on whole person care with:

- a long term investment mindset
- incentives for the achievement of collaboration
- the effective use of technology
- a flexible workforce.

There is sufficient interest and a groundswell of support for health care services to be integrated and as such, the appropriate action should be taken before such interest and support wanes to be replaced with cynicism. To this end, for change to occur there needs to be clarity around the understanding for the terms 'integration', 'coordinated care' and 'joined up services'. The case for moving towards whole person care also needs to be put clearly:

- one third of people in England have at least 1 chronic condition
- the lack of coordination amongst health and care services is a cause for frustration
- while the NHS is a highly ranked service for effective care and efficiency, it bottoms out when it comes to providing patient centred care.

Bickerstaffe proposes 4 factors as necessary to the delivery and management of integrated systems:

1. A long-term investment mindset
2. Aligned incentives for collaboration
3. Effective use and implementation of technology
4. A flexible workforce that can work across the traditional divides between health and social care.

Throughout the report, Bickerstaffe argues that the person receiving the care should be the focus of whole person care, not the system.
The key recommendations reiterated clearly here are:

- a single point of contact for all care needs
- access to other people with the same condition who can provide peer support
- online access to personal health and care records and the ability to share these
- personalised care plan covering health and social care
- the option of a personal budget, where this is helpful.

These look to the components of what the ideal health system should comprise however, as noted in the paper, there is much disruption taking place in the NHS and it is likely that any formative and constructive changes will not occur for some time.

Bickerstaffe's report provides salient comment on the need to address health system change through focusing on the individual. Due to the similarities of the NHS and the NSW Health system this paper provides a useful critique and suggestion as to the direction that such change and innovation should take.

Institute for Public Policy Research (IPPR): Towards Whole Person Care
http://www.ippr.org/images/media/files/publication/2013/11/whole-person-care_Dec2013_11518.pdf

Nuffield trust: Evaluating integrated and community-based care

As a result of the increasing and current interest in optimising how care is provided for those with long term conditions and/or multiple morbidities, there is a plethora of attitudes and approaches to how such care is delivered. This report reviews and critiques the approaches to providing integrated health care and offers some key lessons.

From consideration of the approaches taken to provide integrated health care, the authors offer 9 points to consider in further efforts of integration:

1. Significant time and resources are necessary for planning and implementing large-scale service changes. Returns on such a major investment cannot be expected in a short period of time as this is an unreasonable expectation (results will not match the political cycle).
2. The proposed intervention should be clearly defined as well as what it will achieve and how. It should then be introduced.
3. The expected outcomes should be clearly defined along with periodic milestones. 3 critical factors in achieving agreement on the outcomes are: support and engagement of GPs; effective project management; enough time for the proposed intervention to recruit eligible patients and demonstrate impact.
4. Generalisability and context are important for any intervention.
5. Size and time are important when demonstrating the feasibility of a significant change - this is akin to the 'chicken or the egg' conundrum.
6. Impact measures should not be confined to hospital use and cost.
7. The process of implementation is just as important as the intended outcome - prudent planning and implementation will allow tweaks to be made so that the implementation stays on track.
8. The best models for evaluation should be considered.
9. Effecting organisational and structural change will not necessarily bring about the desired results.

Due to the importance of introducing effective and lasting organisational and structural change, the points offered by the authors are useful to consider. Significantly, these will provide useful addenda for the evaluation of any implementation that is introduced. Unfortunately, public and tangible results within the healthcare industry are often measured by the political cycle, so any certainty of long-term commitment and funding can only be assured where the government of the day has a clear majority.

As suggested by the report, formative evaluation will be an essential component of implementing change. With the current interest by the NSW Ministry of Health/State Government in effecting change in the health system through integration, the 9 key points will form a useful framework by which any implementation plan and can be evaluated. Many reports miss the important step of evaluation and don't provide evidence or analysis of the impact of changes in systems or effectiveness of care. A useful paper to complete an integration plan.

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf

The Lancet: Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

This paper examines the challenge that long-term conditions (LTCs) present to health systems around the world that predominantly address single-disease issues as opposed to multimorbidity.

This study, based on a national primary care dataset containing the records for a third of the population of Scotland, finds that individual diseases currently dominate the spheres of healthcare delivery, medical research and medical education. This focus is not reflective of the need for more attention to be placed on those with multi-morbidities.

Those with LTCs are more likely to be multimorbid with the additional association of age to multimorbidity. Additional findings... The majority of those who are multimorbid and those with who have physical-mental health comorbidities are younger than 65. Despite the strong association of age and multimorbidity, there are excessive numbers of young and middle-aged adults living in deprived areas who are multimorbid; this age group has the same prevalence of multimorbidity as those 10-15 years older who live in more affluent areas. Finally, mental health conditions are likely to be present for those who have a number of physical disorders. It was also found that women will have higher rates of multimorbidity and more mental health disorders than men.

Those who are multimorbid will be higher users of ambulatory and inpatient care than those without multimorbidity and they will be more challenged by fragmented care and medical error.

The findings of this extensive study are useful as they correlate with other multimorbidity studies from other countries that have also used a primary care/national population database set that include numerous morbidities and socioeconomic inequalities. The study is limited by the fact that there is no identified approach for the measurement of multimorbidity. However, the authors overcame this through utilising existing frameworks and identified conditions in the UK.

Importantly, there is evidence to support the case for building a strong primary care system for those who are multimorbid, in order that they can receive continuity and coordination of care.

Given that multimorbidity is an international experience, this paper provides useful comment for the investment and development of healthcare systems, training programs as well as research and clinical guidelines to place more emphasis on the importance of primary care. There is also a need for systems to reorient to ensure that the drug 'burden' required for multimorbid patients is coordinated for best practice.

Multimorbidity is the norm and no longer the exception for health systems. As such, the predominant single disease approach must be complementary and not singular in focus to the exclusion of multimorbidity.

http://ac.els-cdn.com/S0140673612602402/1-s2.0-S0140673612602402-main.pdf?_tid=bf45235e-9e6e-11e3-bd95-00000aab0f6b&acdnat=1393368604_8536b9fda14790a17d0c4ddff5a3d6a8

Australian Medicare Local Alliance: Improving integration of care – A discussion paper for Medicare Locals

Integrated care is a key reason for the establishment of the Medicare Locals in Australia. As noted by this discussion paper, the Medicare Locals are not able to address the fragmented state of the health care system on their own however, through partnership and collaboration, it is suggested that the needs of patients and communities can be addressed.

The paper uses the WHO definition of integrated care, in that it is the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money. As such, integrated care should be comprehensive, coherent, well-coordinated and patient/community centred. While integrating care services is something to be work towards, not all services will require a high degree of integration and achieving integration will not solve the problems of the health system. The point is also made that links should be created as this will create minimal disruption on clinicians and patients.

Overall, integrated care should be understood importantly as a tool to improve the quality of care for the majority of circumstances. Any benefits predicted from moving towards integration must outweigh the costs of implementation otherwise the process will fail before it has started.

It will also be important to identify and negotiate the barriers towards achieving integrated care:

- power
- tunnel vision
- autonomy
- time
- frequent changes
- different drivers
- scalability.

Integration of care to the patient or services to the community is the primary end goal and will necessitate the involvement of a number of stakeholders.

AMLA and UNSW have drawn on a range of resources and experiences from internationally recognised organisations. While this paper provides a useful point from which to start discussions, it is merely that. As there are planned changes to the National Health Reform system any progress that is made now will need to come from the collaboration of the key stakeholders in the relevant geographic area, i.e. the Local Health Districts in NSW and the providers of primary care in the community.

This discussion paper provides a starting point for discussion to take place between those who are involved in providing care in the primary care space. Unfortunately, much of these discussions will need to be reshaped or begin anew from July 2015. While Medicare Locals were funded to coordinate primary health care at the local level, they have subsequently been defunded with no real indication currently provided by the Commonwealth government as to the shape of the proposed Primary Healthcare Networks that will replace Medicare Locals.

http://www.amlalliance.com.au/__data/assets/pdf_file/0008/44639/20120619_rsc_Improving_integration_of_Care_Final.pdf

Attendees

FACILITATOR

Dr	Norman Swan

SPEAKERS

Mr	Mike Brooke	Director	Outcome Services
Prof	Kathy Eagar	Director, Centre for Health Service Development	University of Wollongong
Dr	Nigel Lyons	Chief Executive	NSW Agency for Clinical Innovation
Dr	Martin McShane	Director (Domain 2), Improving the quality of life for people with Long Term Conditions,	NHS England

ATTENDEES

NSW Health Organisations

Ms	Katherine Burchfield	Director, Integrated Care Branch	NSW Ministry of Health
Mr	Daniel Madeddu	Acting Deputy Director, Centre for Population Health	NSW Ministry of Health
Ms	Anne Robertson	Associate Director, Nursing and Midwifery Office	NSW Ministry of Health
Mr	Allan Loudfoot	Executive Director, Clinical Governance	Ambulance Service of NSW
Mr	John Feneley	Mental Health Commissioner	Mental Health Commission of NSW
Mr	Scott Thompson	Senior Advisor	Mental Health Commission of NSW
Dr	Amanda Walker	Clinical Advisor for End of Life	Clinical Excellence Commission
Mr	Michael Walsh	Acting Chief Executive	HealthShare NSW
Ms	Debbie Banovic	Chronic Care Project Officer	NSW Agency for Clinical Innovation
Mr	Daniel Comerford	Director, Acute Care	NSW Agency for Clinical Innovation
Ms	Regina Osten	Program Manager, Primary and Chronic Care	NSW Agency for Clinical Innovation
Mr	Chris Shipway	Director, Primary Care and Chronic Services	NSW Agency for Clinical Innovation
Ms	Linda Glanfield	ACI Co-Chair, Rehabilitation Network	Northern Sydney Local Health District
Dr	Jennifer Mann	ACI Co-Chair, Rehabilitation Network	Dubbo Private Hospital
A/Prof	David McKenzie	ACI Co-Chair, Respiratory Network	South Eastern Sydney Local Health District
Mr	Glenn Paull	ACI Co-Chair, Cardiac Network	South Eastern Sydney Local Health District
Ms	Linda Soars	ACI Co-Chair, Chronic Care	South Eastern Sydney Local

		Network	Health District
Prof	Stephen Twigg	ACI Co-Chair, Endocrine Network	South Eastern Sydney Local Health District
Ms	Jane Graham	Service Manager, Rehabilitation and Aged Care	Calvary Health Care Sydney
Ms	Sue Hanson	Co-Chair, Palliative Care	Calvary Health Care Sydney
Ms	Kerry Stevenson	Director, Clinical Operations	Central Coast Local Health District
Ms	Carolyn Bailey	Director, Community Health Strategy	Hunter New England Local Health District
Ms	Susan Heyman	Director Operations, District Hospitals and Community Networks	Hunter New England Local Health District
Ms	Michelle Noort	Director, Integrated Care, Planning and Peformance	Illawarra Shoalhaven Local Health District
Mr	Gary Forrest	Executive Director, Clinical Operations (Custodial Health)	Justice Health & Forensic Mental Health Network
Ms	Jill Ludford	Director, Operations	Murrumbidgee Local Health District
Mr	Wayne Jones	Chief of Staff	Northern NSW Local Health District
Ms	Kim Field	Director, Primary and Community Health	Northern Sydney Local Health District
Mr	David Miles	Director, Planning	Northern Sydney Local Health District
Ms	Tish Bruce	Deputy Director, Ambulatory & Primary Health Care	South Eastern Sydney Local Health District
Mr	Tom Chapman	Chronic Care Redesign Manager	South Eastern Sydney Local Health District
A/Prof	Peter Gonski	Director, Aged Care	South Eastern Sydney Local Health District
Mr	Wei-Li Hume	HealthOne Project Officer	South Eastern Sydney Local Health District
Mr	Gerry Marr	Chief Executive	South Eastern Sydney Local Health District
Dr	Greg Stewart	Director of Operations, Ambulatory & Primary Health Care	South Eastern Sydney Local Health District
Ms	Nicole Wedell	Nursing Co-Director, Aged & Extended Care	South Eastern Sydney Local Health District
Mr	Justin Duggan	Acting General Manager	South Western Sydney Local Health District
Ms	Louise Dever	Director, Community Health	Southern NSW Local Health District
Ms	Jan Alford	Nurse Manager, Diabetes Centre	St Vincents Hospital Network
Ms	Ngaire Buchanan	Chief Operating Officer	St Vincents Hospital Network
Dr	Teresa Anderson	Chief Executive	Sydney Local Health District
Ms	Lou-Ann Blunden	Acting Director, Clinical Services Integration	Sydney Local Health District

Mr	Gerard Hyde	Executive Manager	War Memorial Hospital
Ms	Victoria Nesire	Operations Director, Medicine and Cancer Services, Westmead Hospital	Western Sydney Local Health District

Medicare Locals

Ms	Natalie Cook	NSW Medicare Local State Coordinator	Australian Medicare Local Alliance
Ms	Leanne Wells	Chief Executive Officer	Australian Capital Territory Medicare Local
Mr	Andrew Davison	Health Care Integration and Improvement Manager	Central Coast Medicare Local
Ms	Shona Dutton	Director, Population Health	Eastern Sydney Medicare Local
Ms	Jude Foster	Director, Primary Care	Eastern Sydney Medicare Local
Mr	John Baillie	Director, Primary Care	Hunter Medicare Local
Mr	Tony Maher	Director, Health Improvement	Hunter Medicare Local
Ms	Dianne Kitcher	Chief Executive Officer	Illawarra Shoalhaven Medicare Local
Ms	Amanda Jones	Multidisciplinary Care Coordinator	Inner West Sydney Medicare Local
Ms	Sheila Holcombe	Chief Executive Officer	Nepean Blue Mountains Medicare Local
Ms	Christine Howard	Executive Director, Population Health and Programs	Murrumbidgee Medicare Local
Ms	Narelle Mills	Manager, Aged Care	Murrumbidgee Medicare Local
Ms	Therese Greenlees	Clinical Services Coordinator, Northern Network	New England Medicare Local
Mr	Graeme Kershaw	Chief Executive Officer	New England Medicare Local
Dr	Dan Ewald	Clinical Advisor	North Coast Medicare Local
Mr	Vahid Saberi	Chief Executive Officer	North Coast Medicare Local
Mr	Ramon del Carmen	Chief Executive Officer	Northern Sydney Medicare Local
Ms	Cynthia Stanton	Director, Primary Care & Integration	Northern Sydney Medicare Local
Mr	Andrew Coe	Director, Primary Health Care Delivery	South Eastern Sydney Medicare Local
Dr	Wayne Cooper	Board Chair	South Eastern Sydney Medicare Local
Ms	Lynelle Hales	Chief Executive Officer	South Eastern Sydney Medicare Local
Mr	Rene Pennock	Chief Executive Officer	South Western Sydney Medicare Local
Ms	Kathryn Stonestreet	Chief Executive Officer	Southern NSW Medicare Local
Ms	Renee Hayden	Executive General Manager, Primary Health	Sydney North Shore and Beaches Medicare Local
Ms	Kris Hume	Chief Executive Officer	Sydney North Shore and Beaches Medicare Local

Ms	Donna Sedgman	Service Integration Director	Western Sydney Medicare Local

NGOs

Ms	Robyn Faine	Manager of Strategy & Policy	Alzheimers Australia NSW
Mr	Sturt Eastwood	Chief Executive Officer	Australian Diabetes Council
Ms	Henrietta Foulds	Regional Director, South Eastern Sydney, Community Services	Benevolent Society
Ms	Joanne Toohey	NSW Executive Director	Benevolent Society
Dr	Monica Robotin	Medical Director	Cancer Council NSW
Ms	Solange Frost	Senior Policy Officer	Council of Social Services NSW
Mr	Lewis Kaplan	Chief Executive Officer	General Practice NSW
Mr	Jeff Saul	Engagement Manager	General Practice NSW
Mr	Ian Sinnett	Board Director	General Practice NSW
Mr	Anthony Brown	Manager, Consumer Engagement and Policy	Health Consumers NSW
Ms	Betty Johnson, AO	Chair	Health Consumers NSW
Mr	Digby Hughes	Policy & Research Officer	Homelessness NSW
Ms	Julie Anne Mitchell	Director, Cardiovascular Health	National Heart Foundation
Mr	Stan Devine	Key Account Management	Novartis Pharmaceutical Australia
Mr	Jason Smith	Managing Director	Novartis Pharmaceutical Australia
Mr	Ryan Fletcher	Chief Executive Officer	Pharmacy Guild
Mr	Ben Dewar	General Manager	Vision 2020 Australia

Tertiary

Dr	Julie McDonald	Senior Research Fellow and Program Leader, Centre for Primary Health Care and Equity	University of New South Wales
Prof	Prasuna Reddy	Director, Centre for Rural and Remote Mental Health	University of Newcastle
Prof	Andrew Wilson	Director, Menzies Centre for Health Policy	University of Sydney