Integrated Care Programmes

Newsletter

Volume 1, Autumn Issue 2015

Developing an Integrated Care System for Ireland

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

IN THIS ISSUE

What is Integrated Care?

Integrated Care aims to join up our health and social care services, improving quality and putting patient outcomes and experiences at the centre of everything we do. It means changing the way that care is provided, so that people with complex needs can live healthier and more independent lives.

The HSE's Clinical Strategy and Programmes Division is leading a large-scale programme of work to develop a system of Integrated Care within our health and social care services. This is a long-term programme of change and improvement for our health and social care services, and will involve people at every level of the health service working together to create improved experiences and outcomes for the people in our care.

Integrated care has the patient perspective as an organising principle of service delivery. It is based on the principles of illness prevention, patient empowerment, multi-disciplinary cross-service care planning and delivery, where all health and social care services work together to provide a flexible network of care responsive to the changing needs of patients and their families. Achieving this will involve public and private providers, patient groups, clinicians and the voluntary sector - indeed all healthcare stakeholders.

How will this happen?

Five Integrated Care Programmes are being established:

- Patient Flow
- Older Persons
- Prevention and Management of Chronic Disease
- Children
- Maternity

These five areas will allow us to tackle the most pressing challenges in our health and social care systems, and improve outcomes and experiences for the greatest number of patients – and for our staff. Each of the five programmes will develop a framework for the management and delivery of health and social care services, and an implementation plan to be followed over the coming 2-5 years.

The Integrated Care Programmes aim to:

- Empower people with chronic disease, including older people, to manage their health and care needs with support, and to live independently in their own homes for longer.
- Engage and enable all clinicians to deliver the right care at the right time in a joined up approach, improving the end user experience of health and social care.
- Design and develop integrated and sustainable health and social care services for the future.

people will be served by collaborative, caring and co-ordinated health and social care services

Message from the Director

Welcome to this first issue of our Integrated Care Programmes newsletter which I hope you will find interesting and informative.

Integrated Care is one of Clinical Strategy and Programme Division's most significant programmes and our dedicated team is working together with all stakeholders to integrate health and social care services to improve and streamline care for people living in Ireland.

In this issue we provide an overview of what's happening in the Integrated Care Programmes, our priorities and our achievements to date. We also keep you abreast of what is planned for the future in this significant journey we are undertaking to a future with coordinated, person-centred care and support.

Your feedback is appreciated and will be acted on... from content through to your opinions and ideas.

Regards

Áine

Dr. Áine Carroll,
National Director for Clinical Strategy & Programmes

ON THE HORIZON

Integrated Care Conference 6th October Dublin Castle Printworks

'Making People-Centred Care a Reality'

Tuesday 6th October, 2015 marks our first Integrated Care Conference to be held in The Printworks, Dublin Castle. The theme of the conference is 'Making People-centred Care a Reality'.

We are privileged to have renowned international speakers from the World Health Organisation, International Foundation for Integrated Care and NHS participating in our conference. It also provides an opportunity to showcase our most innovative Integrated Care projects that are delivering improved clinical services and care for patients here in Ireland.

Invitations have gone out for the event which we expect will host some 500 delegates. Leaders, managers and key staff who are responsible for delivery of the National Strategy for Healthcare Reform will benefit from this conference.

5 Key Integrated Care Programmes

These ICPs will be established on a phased basis

- Patient Flow
- Older Persons
- Prevention and Management of Chronic Disease
- Children
- Maternity

Overview of Integrated Care Programmes and Workshop Feedback

Integrated Care aims to 'join up' health and social care and put quality patient outcomes at the centre of everything we do. The Five Integrated Care Programmes will work with the existing National Clinical Programmes, our Service Divisions, and other key enablers such as Finance, HR and ICT to ensure the correct business supports are available to deliver seamless patient-centred services.

Five Integrated Care Programmes are being established on a phased basis:

- Patient Flow
- Older Persons
- Prevention and Management of Chronic Disease
- Children
- Maternity

A series of Benefits Realisation workshops was held in late 2014 from which we gained valuable inputs for the ICPs.

In the following features, we provide a summary of the outputs from each of the workshops based on the contributions, feedback and inputs we received from workshop participants.

There were four workshops in total: Patient Flow, Older Persons, Chronic Disease, Children – the fifth ICP workshop for Maternity is planned for a future date. Each workshop was attended by a diverse and expert range of clinical and operational stakeholders, patient advocacy groups and patients all bringing significant experience and expertise within and surrounding the services provided by the HSE.

The objectives of the Workshops were to identify:

- **Potential benefits** to all concerned of an integrated model of care
- **Potential business changes** required to realise these benefits
- **A set of potential enablers or workstreams** that would need to be put in place

Read more below about each Integrated Care Programme and the outcomes from the Workshops.

Integrated Care Programme for Prevention and Management of Chronic Disease

Valerie Twomey is the Senior Programme Manager for the ICP for the Prevention and Management of Chronic Disease

The World Health Organisation has stated that heart disease, stroke, cancer, diabetes, and chronic respiratory diseases are the biggest cause of premature mortality worldwide, with 82% of these deaths now occurring in low- and middle-income countries. It is estimated that 80% of chronic disease can be prevented, since so much is influenced by lifestyle choices and influences.

Irish data shows that the number of adults with chronic disease in Ireland will be around 40% of the adult population by 2020. With the prevalence of chronic disease, and with an ageing population comes increased challenges to the effective and efficient delivery of our healthcare services. Our programme aims to support improved prevention of chronic disease, and also improve the model for identifying and monitoring individuals at risk of developing chronic disease. Knowing where and when people might need health and social care services, would allow us to target health promotion, prevention and self-management strategies more appropriately.

Emerging themes from the workshop

Enablers	Business Changes	Potential Benefits
Integrated Model of Care	- New and improved structures for integrated care - Resources in the right location at the right time - Re-structuring of roles to allow for community outreach - Focus on and prioritisation of patients with chronic disease - Encourage partnership environment between patient and doctor/GP - Centralised repository access for self-care information	- Improvement of health for patients - Improved quality of life and death - Reduced incidence of chronic disease - Reduced risk factors - Reduction in multiple morbidity - Reduced burden of disease - Enablement and provision of self management support
Integrated Care Patient Pathways	- Reconfiguration of clinical pathways for patients with chronic diseases - Fair and equitable access for patients	- Improved coordination of care for right level of complexity - Defined pathways of integrated care - Improved access to diagnosis and early detection for patients as appropriate - Improved access to education and support/ information at the right time
Development of Disease Registers and Risk Stratification	- Chronic disease registers with a view to understanding who has the information - System that records the level of risk factors, pre-disease registers - Overarching set of patient level data - Risk stratification (short, medium, long term) - Introducing standard care plan process	- Access to shared information allowing shared decision-making with patients and staff
Supported Self-Management	- Patient managed at the most appropriate level of complexity	- Reduced hospital admissions - Reduced emergency department attendance - Reduced length of inpatient stay - Increase in early discharge - Reduced GP out of hours attendance

NEXT STEPS

Work has commenced on the following steps required to progress the Integrated Care Programme for Prevention and Management of Chronic Disease:

- Establishing the appropriate Programme governance arrangements
- Programme scoping to identify next 3-5 year priorities
- Developing and communicating the vision, mission and objectives for the Programme
- From the outputs of the benefits realisation workshop developing project plans for Workstreams
- Establishing the National Working Group for the Programme.

Integrated Care Programme for Older Persons

PJ Harnett is the Senior Programme Manager for the ICP for Older People.

The over-65 population is growing by approximately 20,000 each year, while the over-85s population (which places the largest pressure on services) is growing by some 4% annually. Older people with care and support needs should be provided with a continuum of services such as home care, day care and intermediate residential care to avoid unnecessary acute hospital admissions and have their required treatments and supports delivered within their local community at primary care level in as far as possible.

The workshop for the Integrated Care Programme for Older Persons was attended by a broad representation of internal stakeholders.

NEXT STEPS

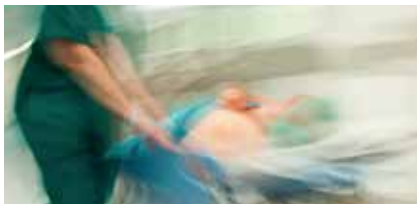
Work has commenced on the following steps required to progress the Integrated Care agenda for Older Persons:

- The initiation and design phase for an older persons integrated model of care will commence and be completed by the end of Q4, 2015.
- This will involve consultation with service users and carers (including representative groups) as well as service providers to inform the critical elements required to deliver integrated care for older people.
- Once agreed, the appropriate Programme Governance arrangements for the implementation and evaluation of the Integrated Models of Care.
- Outputs from the existing Clinical Programmes will be instrumental in further developing this ICP model.
- The Older Persons Working Group is to be established as a matter of priority. This is now in progress.
- Establishing the appropriate operating model to enable implementation and mainstreaming of the models of care across the health system in Ireland.

Emerging themes from the workshop

Enablers	Business Changes	Potential Benefits
Define the Model of care	- Refocus and resource services as per model	- Improved access to supports and services - Services and supports are delivered in the appropriate setting - Equitable access to standardised services and supports across the country
Proactive Approach to the needs of the Older Person	- Disease prevention - Service user education and enablement (incl.self-care) - Signposting - Case management	- Older persons remaining well for longer. - Older persons are aware of supports and services available to them - Increase in numbers of older persons having the skills to appropriately self-care
Develop Capabilities across the Care Continuum	- Direct access to diagnostics - Develop CIT - Leverage voluntary sector - Appropriate resourcing - Develop skills and competencies - Case management - MFTP	- Better health outcomes for older persons - Improved access to supports and services - Improved patient and carer satisfaction with services
Develop Clinical Care Programmes where gaps exist	- Fully Implement existing and new CCP's including recognised best practice initiatives	- Better health outcomes for older persons
Technology and ICT Technology	- Telehealth - Individual health identifier - Use technology for disease prevention - Sharing of Information across the care continuum (EPR)	- Better health outcomes for older persons
Intersectoral collaboration	- Develop capability	- Better health and social care outcomes for older persons

Integrated Care Programme for Patient Flow



Designing healthcare systems with effective patient flow is critical to the delivery of safe, effective patient care. Poor flow can lead to increased costs, poor quality and poor patient experience. Moreover, evidence links poor flow and suboptimal scheduling in healthcare to an increase in mortality, adverse events, readmissions and poor financial performance.

The goal of seamless patient flow across care settings is often thwarted by a lack of integration both within the hospitals and between hospitals, primary care and social care. Historical lack of capacity in the acute hospital system has led to bottlenecks in hospital admission for scheduled and unscheduled care. When this is combined with suboptimal coordination between hospital departments and services efficient patient flow is prevented.

NEXT STEPS

Work has commenced on the following steps required to progress the Integrated Care agenda:

- Establishing the appropriate Programme Governance arrangements for the development and implementation of the Integrated Models of Care
- Developing and communicating the vision for Integrated Care in Ireland
- From the outputs of the benefits realisation workshop develop plans to deliver the integrated models of care for each programme
- Establishing the working groups for each model of integrated care on a phased basis. The Patient Flow Working Group is to be established as a matter of priority.
- Establishing the appropriate operating model to enable implementation and mainstreaming of the models of care across the health system in Ireland.

Emerging themes from the workshop

Enablers	Business Changes	Potential Benefits
Clinical Leadership, Governance and Standards	- Service reconfiguration - enhanced & scalable models of care	Improve clinical outcomes for patients: - Standard quality care for patients
Patient Flow Planning and Pathway Management	- Integrated clinical networks supporting a performance culture	Timely & appropriate quality access to care for patients: - Improved ambulance turnaround and PET times - Improved 24/7 accessibility to non-emergency services - Reduced demand for ED
Patient Information	- 'Whole System' across approach to performance and reporting	Improved patient experience: - Reduced end-to-end waiting time (referral to treatment) - Equitable and transparent access (public/private)
Improved Resource Allocation	- Alignment of resource to patient demand all care settings	More efficient use of resource to match capacity to demand: - Reduced demand through HIQA threshold compliance - Improved 'first time' referral rates - Reduced AvLOS
Information and ICT	- Embedding professional standards	Improved staff morale

The Patient Flow Working Group is to be established as a matter of priority

Integrated Care Programme for Children

The 2011 Census report shows that there are over 1 million (1,035,817) children under 16 years in Ireland. Children 0-15 years now account for 23% of the total population, one of the highest in Europe. Overall, there has been a 16% increase in the 0-15 years age group since 2000, however, within the age groups, the increases vary quite a lot with the 0-4 year age group showing a 34% increase, the 5- 9 year age group has increased by 20% and the 10-15 year age group has increased by just 1%.

The rapid rise in the number of children under 4 years in this country is particularly striking. It has important implications for child health and acute paediatric services. It would be expected that the Irish health service would need to spend a greater proportion of its budget on children compared with other national health services who have smaller proportions of children. One would also anticipate that additional resources would have been put in place to deal with this additional quantum of children.

Healthy children need strong community paediatrics with immunisation, screening, nutrition and developmental/cognitive assessment. Ill children need a seamless acute hospital service. Children with care and support needs should be provided with a continuum of services such as day care and primary care to avoid unnecessary hospital admissions and have their required treatments and supports delivered within their local community at primary care level in as far as possible.

The mechanism by which an appropriate and effective continuum of care for children can be achieved is through the **development and implementation of an integrated model of care which is based around the specific needs of the child.**

Emerging themes from the workshop

Enablers	Business Changes	Potential Benefits
Define the Model of Care	Implement integrated Patient-Centred Model of Care and revised "patient" Pathway	Person-centred care and support: – Satisfaction with the entire patient service from patient perspective – Deliver support to family unit – Deliver care into the community – Educated and aware parents/families on appropriate care
Workplace Planning	Health Promotion and Prevention	Better health and wellbeing: – Decrease mortality and morbidity rate for children and family unit – Improve risk factor profile – Reduction in preventable accidents and disease prevalence – Increase activity & social activity for children with chronic disease – Right development for children into adulthood
Implementation and Change	Culture and Leadership	Access: – Prioritise and increase care into the community – Improve level of clarity on patient navigation flow – Children's access to healthcare for professional development milestones
Knowledge Management	Knowledge management	Value for money: – Reduce costs of care

Integrated Care for Maternity

The Integrated Care Programme for Maternity Services will be guided and informed by the recommendations that will be made following the review of maternity services which is currently underway nationally and the subsequent development of a national maternity strategy.

Any queries?

The Integrated Care Programmes will soon be online.

Visit our new web pages at www.hse.ie/integratedcare - a new information hub which will be a single source of all you need to know about the Integrated Care Programmes.

We'd be delighted to receive feedback from you at nationalcsp@hse.ie