Implementing Integrated Care for Older Persons in Ireland

Early stage insights and lessons for scale up
“Our family’s recent experience with the Integrated Care Team was amazing. It was way more than we ever expected. It was holistic and it was great that we didn’t have to go off chasing people but to watch it all unfold in front of us.

What was brilliant was that when my mother was in hospital we were involved in the daily progress and when my mother arrived home, they arrived home with us.

The integrated care program really helped us, especially allowing my mother to stay at home for as long as possible.”

Vincent Delaney, Carer, CHO9
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td>Our Team</td>
<td>5</td>
</tr>
<tr>
<td>Background and Context</td>
<td>8</td>
</tr>
<tr>
<td>What are the ingredients for integrated care?</td>
<td>16</td>
</tr>
<tr>
<td>What did we do and how did we do it?</td>
<td>24</td>
</tr>
<tr>
<td>What difference has it made?</td>
<td>42</td>
</tr>
<tr>
<td>What have we learned?</td>
<td>66</td>
</tr>
<tr>
<td>References</td>
<td>74</td>
</tr>
<tr>
<td>Appendix 1 – Glossary of terms</td>
<td>76</td>
</tr>
<tr>
<td>Appendix 2 – Workforce Planning</td>
<td>77</td>
</tr>
<tr>
<td>Appendix 3 – Key deliverables of 10 Step framework</td>
<td>79</td>
</tr>
<tr>
<td>Appendix 4 – Utility of 10 Step framework</td>
<td>80</td>
</tr>
</tbody>
</table>
In Ireland, as in many other countries, we are living longer and better lives. This means we have to make changes now to ensure we can provide well planned, well co-ordinated care for older people when and where they need it.
Foreword

We are delighted, as co-chairs of the Integrated Care Programme, Older Persons (ICP OP) to witness the publication of this document which sets out the learning from implementing integrated care for older persons over the past 3 years. ICP OP was conceived of in 2015 under the joint sponsorship of the Social Care Division and Clinical Strategy and Programmes Division. The growing awareness of the need to change the service model and the ambition to deliver integrated care was captured through the development of the ICP OP 10 Step Framework. This provided a conceptual map, outlining the vision and the key ingredients that needed development. The development of Noras’ story provided a means of communicating that ambition. It is testament to the work of the leaders on the pioneer sites that we now have 13 pioneer areas established within 2 years, with over 65 staff directly recruited through ICP OP support. None of this would be possible without local clinical and managerial leaders having the courage to go the extra mile and to them we are indebted.

Whilst these teams are at various stages of development there has been an opportunity to learn from the initial phase of designing and testing the model. The document sets out the challenges encountered, actions taken and impacts made. The final part addresses recommendations for moving from pioneer or demonstrator sites to mainstreaming the integration of care for older persons. Many important lessons have emerged that have implications for scaling up integrated care in the context of emerging Community Health Networks set within the context of implementing Slaintecare and indeed the realisation of universal health care.

Dr Siobhan Kennelly,  
Clinical Lead, ICP OP

Mr. Michael Fitzgerald,  
Older Person Strategy and Planning
1 in 5 will be over 65 by 2031. For patients over 85 years, approximately 600 acute hospital presentations can be anticipated per 1,000 population.

Up to 25% of older people in Ireland live with frailty. A further 45% are at risk of being pre-frail.

Up to 40% of those waiting in Emergency Departments for more than 24 hours, are aged 75 and over.

50% of Acute Hospital delayed discharges require Nursing Home Support or a Home Care Package.

13 Pioneer sites have been established by the Integrated Care Programme for Older Persons between 2016-2018 and 60 multidisciplinary posts developed utilising €4.2m funding.

ICT solutions were initiated. Devices issued to 100 staff across 8 CHO’s/HGs and a case management platform tested.

A partnership with Age Friendly Ireland was initiated to provide a mechanism for service user and carer engagement in the co-production of integrated care

Age attuned pathways data (service structure and care process indicators) were developed to measure integrated care with an older persons dashboard under construction.

New community roles were initiated (community geriatrician, case managers, health and social care professionals) and supported candidate Advanced Nurse Practitioner (ANP).

What difference has it made?

**National Data Sample**

- Over 6,050 new referrals into Integrated Care teams.
- 3,530 Comprehensive geriatric assessments carried out.
- 49% of patients seen within 7 days of referral.
- 7 pilot sites have established a team hub. 5 more have plans underway.
- 42 cANPs specialising in older persons care are aligned to the integrated care pilot sites.
- 1,200 trained in frailty education by NCP OP.

**Local Data Sample**

- 1,082 annual bed days saved in 1 pioneer site using a day hospital for crisis intervention.
- 3% re-admission rate where early supported discharge implemented (national average is 10.8%, range 9.8-15.4% within 28 days).
- 34% reduction in LoS (>85yrs).
- 24% reduction in re-admission (>75 yrs).
PJ Harnett
Programme Manager Integrated Care Programme Older Persons

PJ Harnett has worked in a variety of roles in healthcare over the past 34 years before becoming the National Programme Manager for the Integrated Care Programme Older Persons. This included working in clinical practice, senior managerial and service improvement and development roles locally and nationally. Originally qualifying as a Mental Health Nurse he holds a Masters in Nursing, Masters in Healthcare Management and is currently undertaking a PhD in implementation of change in Healthcare systems with a specific focus on integrated care.

Jennifer Hardiman
Service Improvement Manager Integrated Care Programme Older Persons

Jennifer Hardiman has worked in clinical and managerial roles for 30 years in the NHS in the UK prior to her current role as Service Improvement Manager for the Integrated Care Programme Older Persons. She initially trained as a Nurse and Midwife, and her senior management roles have been varied across strategy, planning and operational management. Jennifer has a special interest in older people and primary care and has experience of leading large scale projects, service redesigns and care pathway redevelopments. She led on the development and implementation of an integrated care service across North East London in 2010.

Des Mulligan
Service Improvement Manager Integrated Care Programme Older Persons

Des Mulligan has had a varied career in the public and not for profit sectors, having commenced his career in the Department of Social Protection. He then managed employment services before joining the Alzheimer Society of Ireland as a Regional Manager in 2002 working for the next 12 years developing services for people living with dementia. He was a project lead on a number of projects funded through organisations such as CAWT and Dormant Accounts. He was project lead for one of the original four Genio funded Dementia projects that was based in Mayo. Des has more recently worked as a General Manager of a nursing home in Sligo that was part of the Sonas Group Homes.

Dee Conroy
Project Manager Integrated Care Programme Older Persons

Dee Conroy has over 20 years experience in the delivery of large-scale complex projects in both public and private sectors in Ireland and abroad, with particular expertise in Healthcare, Infrastructure design and Construction. Immediately prior to joining the Integrated Care Programme for Older Persons in 2016, Dee’s predominant focus was on the implementation of wide scale service improvement initiatives in Acute hospitals across Ireland. Dee is a Chartered Engineer with a higher diploma in Computer Science as well as postgraduate qualifications in Project Management, LEAN six Sigma, Change Management, Entrepreneurship & Innovation.

Dr Siobhán Kennelly
National Clinical Lead Integrated Care Programme Older Persons

Dr Siobhán Kennelly (grad RCSI 1998) is consultant geriatrician in Connolly Hospital & CHO9 and honorary clinical senior lecturer, RCSI. She has been National Clinical Advisor in Social Care with HSE since 2015 and within that role has been clinical lead on the Integrated Care Programme for Older Persons. Her clinical and research interests include the care of older patients in community settings including residential care, the development of integrated care pathways in older person’s services and end of life care.

Belinda Buckley
Administrator Integrated Care Programme Older Persons

Belinda Buckley has worked as a Project Manager with many years experience across different industries in public and private sector organisations. Belinda was Marketing Manager for the Temple Bar Development Project for 9 years upto 2000 and managed marketing plans and initiatives. Belinda has diplomas in MII marketing management and RHS Diploma in Horticulture and a qualification in Lean Green Belt (healthcare).
Background & Context
Background

The vision that underpinned the Integrated Care Programme, Older Persons (ICP OP) sought to support older persons to live in their own community by providing timely access to health and social care that allowed older persons to receive the right level of care, in an appropriate location, ideally at primary care level. ICP OP had four key objectives:

- Supporting Older Persons to live well
- Enabling Older Persons to remain in their place of residence by providing secondary care in the community
- Providing integrated Intermediate Care (Hospital/Community Care)
- Supporting older persons in residential Care

In addition to these objectives, the other task to be addressed by ICP OP was to generate insights into the process of implementation in shifting the model of care away from an acute centric model. These insights would in time inform how best an integrated care model could be scaled up and embedded as the norm as outlined in fig 1.1.

Figure 1.1: ICP OP Programme stages

This document is a requirement of the NSP (2018) and reports on the ‘lessons learned’ from the implementation of the Integrated Care Programme, Older Persons (ICP OP) from 2015-2018. It initially sets out the ‘as was’ situation, (policy, demographic and service context) and describes the ‘actions taken’ (programme initiation, implementation and impact). Finally, it outlines the insights (lessons learned) and makes recommendations for scale up which has relevance for national and local leadership in relation to delivering systemic change.
Policy

A number of reports highlighted the need to shift health and social care provision away from episodic, acute hospital care to anticipatory care nearer to people’s homes, especially for the population living with long term complex care needs. This strategic vision recognised that efficiency gain in acute care is necessary but not sufficient to address the changing demographic profile, (HSE 2015-2017).

In this context, the absence of a government strategy that endorsed integrated health and social care as a policy response meant that the desired reform was not mandated. Whilst a number of age related policies were in situ, none specifically referenced integrated care until the publication of the Slaintecare Report (GOI 2017) (see fig 1.2).

The reform of Community Healthcare Organisation, referred to as the Healy Report (HSE 2013, p2.) found; “People experience difficulties in ‘navigating the system’ due to both complexity and scale of present arrangements. What must be improved is how these parts fit together so that the services are integrated and people can move smoothly through the system”. As a consequence, it recommended that; “Staff must be organised in a way that enables joined up team work, responsive to the assessed needs of the local people”. This and other strategic reports provided a roadmap whilst the development of the ICP OP 10 Step framework offered a means of implementation of integrated care for older persons.
The over 65s Population is expected to reach 1 million by 2031.

There are 47,000 people living with dementia in Ireland expected to rise to over 130,000 by 2041.

### Community

1 in 5 community dwelling older adults are living with frailty (Approx. 118,000 older persons)

In a 12 month period older adults living with frailty:

- Will spend 15 days in hospital in a 12 month period.
- Are on 6 medications.
- Will visit their GP on 7 or more occasions per annum.
- 40% of people living with frailty live alone.
- 96% have two or more chronic conditions.
- Comprise 55% of PHN caseloads.

### Acute Hospitals

- People aged >65 and over occupy 54% of acute hospital inpatient beds.
- Almost 30% of older people admitted to acute hospitals have dementia (and have longer stays in hospital).
- People aged >65 account for 90% of delayed discharges from acute hospitals.
- People aged >75yrs spend 3 times longer in ED than those <65.
- 35% of patients over 70 admitted to hospital show functional loss at time of discharge when compared to pre-hospital admission. This increases to 65% for 90 year olds.

### Residential Care

- Demand for Residential Care is expected to increase by 50% by 2030.
- Demand for Home Support Services is expected to increase by 40% by 2030.

### Falls

- 1 in 3 over 65’s fall annually
- 60,000 older adults require medical attention a year for falls
- 51% of patients have a ‘low fall’ of less than 2 metres resulting in a major trauma
- The average age of a person who breaks their hip is 80 and over two-thirds are female
Demography

In Ireland, life expectancy for women aged 75 has increased by 29% (1993-2013) and for men by 39% in the same period (Eurostat, 2016). Within the next twelve years, the >65 population in Ireland is anticipated to grow by 60% and the >85 population by 95% (See fig. 1.4). This means that by 2031, there will be one million people over the age of 65 in Ireland.

While many older people remain well, engaged and active well into later life and continue to make a major contribution to local communities and society (Beard et al., 2016), increasing age also brings an increasing chance of long-term medical conditions, frailty, dementia, disability, dependence or social isolation. Older persons with complex care needs are a cohort of patients considered ‘high cost, high need’ consumers. 5% of this population use 50% of health and social care resource (Blumenthal et al. 2017). People >65 currently occupy 54% of acute hospital inpatient bed days (DOH 2016) whilst people >75 spend 3 times longer in emergency departments than those <65. While older people are admitted to hospital for medical reasons, by the time their medical condition is stabilised, arrangements for their discharge become dependent on many other issues, including ability to undertake basic self-care, their social circumstances, the availability and access to home-care packages, and nursing home beds. For example, 35% of people aged >70 admitted to acute hospitals show functional loss at time of discharge when compared to pre-hospital admission (NCPOP 2012).

Based on current service models, the requirement for long term care placements is expected to increase by 50% in the next 12 years and demand for home care support is expected to increase by 40% (Health Service Capacity Report 2018). Both Acute and Community services are experiencing a significant gap between population growth and funding available. Capacity in community services to help older people remain well, manage crises and recover from acute episodes is hugely variable and inadequate to meet the current demand (See fig 1.5).
From a service user perspective, a study commissioned by Age Friendly Ireland in 2015 highlights that older people express reluctance to access services due to fear of waiting (in ED), lack of information, poor quality of care, uncertainty and difficulty in accessing care, insufficient home care and sub-optimal personal care. Cross cutting themes to emerge included poor communication between different parts of the system requiring older persons to impart information repeatedly and reflecting a lack of ‘joined up care’ (HSE 2015).

**Changing the service model**

The National Clinical Programme Older Persons (NCP OP) was established in 2010. It developed an Acute Care Model for Older Persons (NCP OP 2012) which articulated the elements of an inpatient and ambulatory pathway. An audit by NCP OP (30 hospitals) described the level of dedicated older person resource between 2011 and 2014. The audit concluded that, as the population of >65s in Ireland was growing, the overall number of available, dedicated older person staff (no=356.5) had decreased. Only 40% of Consultant Geriatricians were working exclusively with older persons with the remainder having other commitments (acute medicine, specialist stroke services, acute medical rotas). The corresponding decline in availability of health and social care professionals and specialist nursing roles undermined potential for service development in older person’s care. In addition to this, the data on older person service development between 2011 and 2014 indicated there was only a very small increase (n=2) in in-patient specialist geriatric wards and on site rehab facilities together with a reduction in off-site facilities. This coincided with the economic downturn.

The NCP OP survey did not focus on local community services (e.g. Home Help) or specific initiatives (e.g. falls programme) and reflected the disparate and localised nature of service evolution. However, we do know that there were no dedicated Older Person MDTs working in the community with a specific remit for the care of older persons at the time of the survey.
“I’ve changed my whole view on how people should be looked after. It’s about keeping people out of hospital where it’s safe and appropriate to do so. It’s looking at supporting people in the community in their own homes.

When a patient comes into hospital it’s about getting them on the right pathway and getting them through the system as fast as we possibly can. The sooner patients are up and out of hospital the better the outcomes. The fact that we have an Integrated Care Programme means we have a whole structure which brings the community closer to the hospital.”

Jo Shortt, Senior Project Manager, Saolta Group.
What are the ingredients for integrated care?
A focus on frailty

Frailty is “A medical syndrome with multiple causes and contributors; characterised by diminished strength, endurance and reduced physiological function that increases an individual’s vulnerability for developing increased dependency and/or death.”

(Morley et al, 2013)

The Irish Longitudinal Study on Ageing (TILDA) is a large-scale, nationally representative, longitudinal study on ageing in Ireland, the overarching aim of which is to make Ireland the best place in the world to grow old. The outcome of the study will enable informed decision making regarding the future planning of older persons services and the development of social and economic policies. 8,500 older people took part in the first wave of TILDA in 2009 and 2010 and in 2016 a further 6000 interviews took place.

Frailty is the most problematic expression of population aging. A minor stressor (such as an infection) in a fit older person (figure 2.1 green line) has a small impact on the individual who can return to normal functioning. However, a similar event in a person living with frailty may trigger a much greater impact (red line) and as a consequence are much more vulnerable to the possibility of not returning to independence.

Figure 2.1: Frail older people display lower resilience to minor stresses, e.g. Urinary tract infection.

It consequently has become an increasingly important construct around which complexity in older person’s care can be articulated. Ireland, in tandem with a number of other countries participates on a EU Joint Action on Frailty (O Caoimhe 2017). The Irish Longitudinal Study of Ageing (TILDA), highlights the scale of existing and projected health and social care demand through the service interface with Public Health Nursing (PHN) Services. This identified 24% of older adults (i.e. those >65yrs) as being frail. A further were 45% pre-frail with local variation in frailty between 17-28% (Roe et al 2016, p3).

Figure 2.2: Prevalence of frailty among community-dwelling older adults (>65) in Ireland: data from The Irish Longitudinal Study of Ageing

Risk stratification data on frailty (O Halloran 2017) indicates that 21.5% of community dwelling older people aged >65 and 33.8% of people > 75 are at high/very high risk. This has significant population planning implications for health and social care and public services. When translated into a local context, taking Waterford City Community Healthcare Network (70,000) as an example there are 10,219 people > 65 years of which 4,378 are...
>75yrs. Approx 1 in 5 (2,150) at high/very high risk with 1,444 people >75 at high/very high risk. This cohort will consume 54% of inpatient beds, spend 15 days in hospital, take 6 medications and visit their GP on 7 occasions in a 12 month period. Within that cohort 40% live alone, 96% have two or more chronic conditions and 31% have had at least 1 fall in the previous 12 months. This means investment in service design and care delivery has to be integrated thus avoiding a solution that only addresses a ‘community’ or ‘acute solution’. In that regard the alignment of care pathways and organisational structures (Community Health Networks) is essential.

Service (re)design that focuses on population need

Planning for Health (HSE 2018) and the ESRI Projections for Demand in Healthcare (ESRI, 2017) highlights the demographic changes taking place currently, projected changes and consequent implications for service planning. Whilst population data in Ireland indicated a youthful population relative to other EU countries, closer analysis recognised compression of morbidity and a rapidly growing older population with consequent demands (DPER 2014, 2017). This requires earlier, more proactive approaches that will promote interventions that enable longer periods of health in ageing societies and reduce social isolation and co-morbid disease. Service design heretofore has taken place in ‘design silos’ with each provider of health and social care addressing institutional pressures. This did not accommodate multi-morbidity and longitudinal care needs that require planning care across multiple providers and settings.

Figure 2.3: Population Planning workshop with pioneer sites Oct 2017
Integrated Care Programme for Older People - Key Elements of an integrated service
(Pathway elements implemented on a phased basis depending on local resources in place)

**Home**
- Primary Care Team (PCT)
  - HH with knowledge and education re Frailty
  - PHN who can identify frailty, can support family with care and can link with GP/case manager/ANP/community intervention teams
  - GP who can manage above with PCT and support patient and family

**Primary Care**
- Health Promotion, Maintaining health, wellbeing & nutrition
- GP/PCT management
- Out of hours GP care
- Medication management with local pharmacist
- Carer support
- Home Care/ Home help
- Reducing Social isolation
- Information on local services
- Local day service Social opportunities
- 3rd sector Community support
- Telehealth
- Supported self management

**Ambulatory Care**
- Integrated Care Hub (MDT/Day Hospital), Single Point of access
- Case manager who links with community services, mental health team, palliative care services and Acute hospital
- Rapid access clinics. Early Diagnosis, CGA (SAT). Post diagnostic supports

**Acute Hospital**
- ED frailty at the front door
  - Timely access at crisis point. Divert/reduce requirement for acute hospital admission. Case manager as point of access at times of crises for Person in community. Community hospital admission if required. Front door response to frailty in Ed, FITT team, CGA(SAT). Early engagement with integrated care team.

**Inpatient**
- Specialist Wards for Older People with Frailty (SGW) staffed by multidisciplinary teams and gerontologically trained nursing, medical and HSCP staff.
- Comprehensive Geriatric Assessment.
- Early Supported Discharge for admitted patients.

**Residential Care**
- Supports for Person in long term care. Links with Acute hospital team, (ANP,CNS, Geriatrician). Integrated care team Single Point of contact for Nursing home

**Domiciliary care**
- Domiciliary follow up by MDT
  - Early Supported Discharge
  - Early review in Day hospital post discharge
  - Support via Case manager post discharge
  - Community intervention team, increased home care via primary care team
  - Home care package/home help, Links with voluntary sector

**Rehab**
- Access to inpatient and outpatient rehabilitation with supported assessment, therapies and clinical support.
- Governance & Training to support ICP implementation and sustain

What are the ingredients for integrated care?
**Bespoke Pathways**

There is evidence that integrated care pathways can reduce harmful outcomes and support transitions of care for older people (Silvester et al. 2014, Stewart et al. 2013). Bespoke integrated care pathways for older people living with frailty define best practices or essential care components & help determine locally agreed MDT practices with the goal of improving integration e.g. within or between primary, secondary and social care. They are useful in identifying ‘care deviations’ lower hospital readmissions, reduce Length of Stay (LoS) and improve quality, safety, efficiency & communication (Dubuc et al. 2013). As indicated by the NCP OP survey (NCP OP 2014), there was a very limited number of integrated care pathways in place prior to ICP OP. Figure 2.4 illustrates the key elements of an Integrated Service for Older Persons, with end to end Integrated care pathways in place.

**Workforce (Multidisciplinary Community Teams)**

The implementation of integrated care is significantly dependant on new community based, multidisciplinary roles (Woodchis et al. 2015, Goodman et al. 2012, Trivedi et al. 2013). This has been effectively implemented over the past decade in other jurisdictions (Gravelle et al. 2007, Counsell et al. 2006) and across a range of health and social care contexts with positive outcomes (Frazer et al. 2005, Harvey et al. 2017). In Ireland prior to ICP OP there were no community based MDTs in place who had a specific remit to support older people ‘ageing in place’.

Whilst there are many health and social care professionals in the community supporting the needs of older people, their capacity to deliver services to this population differs significantly in different areas depending on historical factors and resources. We know for example that access to public health nursing in some areas is dependent on GMS eligibility. Crucially prior to ICP OP there was no specific structure that enabled a cohesive team based approach to the management of health and social care needs of older people with access to both primary and secondary ambulatory care where this was needed. The development of this model was one of the key areas of development for ICP OP.

To bring Ireland in line with the European and Canadian norms of on average 1 consultant for every 6,250 people over the age of 65, Ireland needs to increase the number of consultant geriatrician posts to 117 by 2021, and 138 by 2026. 5.5 WTE clinical nurse specialists (CNS) were registered in the sub specialty of older age psychiatry and dementia and 6 WTE CNS in Stroke and Neurological rehabilitation (which is not explicitly for the older person) across the whole of Ireland. There were 4 WTE registered advanced nurse practitioners (ANP) exclusive to caring for the older person. No data existed on the number of dedicated HSCPs.

**Case Management Approach**

Whilst the specific model of case management for older persons is not definitive (Hopper et al. 2018), the use of a case management approach delivers superior outcomes over care as usual when set in a multi-disciplinary care network (Boult et al. 2013, Stokes 2015). The Clinical Case Manager role involves a senior practitioner working across primary and secondary care supported by the wider multidisciplinary team including specialists in gerontology and GPs. The aim of the role is to proactively identify older persons at risk, assess, plan and coordinate care between multiple providers. Whilst it’s possible that some services were adopting this approach, it wasn’t being systemically developed for community dwelling older persons or being supported as national policy. Whilst data wasn’t being collected one of the few known case management example in operation was in North Dublin (Kennelly 2015).
“An important aspect of integrated care is that the patient has complete trust in the information they are given and in the decisions that both the patient themselves and the care teams make about the patient’s care”.

Bob Gilbert - National Chair of Older Person’s Councils
Mapping care resources

There were some excellent examples of mapping older person care resources at a macro level (Health Atlas) and local partnerships in action (e.g. Sth Dublin County Council Directory of Activities and Services for Older People https://www.dlrcoco.ie/sites/default/files/atoms/files/directory_of_activities_services_for_older_people_in_dlr_county.4248.pdf). This was once again initiated by committed national and local leaders. However, more often than not staff working in different settings (acute/community) and within different organisations (Health, Gardai, Community agencies, Local authorities) lacked full visibility of the range of services and how to access them. In addition, no mechanism existed to share this information to routinely map resources in order to fully leverage them.

User engagement

Person centred care is defined as care that is respectful and responsive to individuals needs and values, and partners with them in designing and delivering that care. A growing body of evidence indicates that a patient-centred approach to the design, delivery and evaluation of services brings benefits both to the patient and the organisation. Mental health services led the way in Ireland in terms of including users and carers in service redesign. Whilst the HSE had conducted a Listening to Older Persons initiative (HSE 2015), there were no mechanisms in place to ensure user feedback was practically used to inform service design.

Measurement of community interventions

Whilst a wealth of acute hospital activity data is collected there are very few ‘community’ equivalents, despite the fact the majority of funding is consumed outside of hospitals. The Qwikview system captures data on Home care and NHSS (€1.4b) which represents a significant % of the older person budget. However, the majority of care contacts and their impact are invisible to the organisation. To attempt to measure any qualitative or quantitative outcomes for any health care programme it is essential that reliable baseline data is drawn from an existing data source or easily obtained from a new data source.

ICT

With the exception of some national initiatives such as National Integrated Medical Imaging System (NIMIS) the ICT infrastructure was largely comprised of legacy systems that resulted in ‘silos of capability’ (HSE 2015). Clinical information systems have incrementally developed within acute hospitals whilst GP and Pharmacy systems stand outside the HSE systems. Within the community based service there is extremely limited capability with personnel using paper based systems, sharing desktop PCs and often not having access to email or hardware that allowed them to share information. Individual clinician, therapy and nursing disciplines in community teams have traditionally been keeping separate paper-based records for the same cohorts of patients.

Incentives to implement change

In circumstances where local services wanted to institute a change of model or develop a care pathway, the funding options open to them was through the traditional estimates process, research funding or philanthropy. All of these routes were problematic for various reasons. Apart from the practicalities of securing funding, the lack of funding specifically earmarked for service redesign meant that clinicians and managers could undertake local, time limited projects but were disengaged from systemic improvement.

Policy

The policy landscape (see page 9) addressed issues of importance to older persons. These policies benefit from government sponsorship and progress is formally monitored. In the case of integrated care, no such policy mandate was in existence. The implication of this meant that service managers and clinical leaders that were committed to this philosophy were doing soley based on personal commitment.
What did we do and how did we do it?
The Integrated Care Programme for Older Persons (ICP OP) was established in 2015 under a dual mandate from Social Care and Clinical Strategy & Programmes Divisions, HSE. The purpose of the programme was to design and test the establishment of integrated service design for older people across acute hospital and community services. Funding was allocated to initial sites based on operational pressures (e.g. ED waiting times). In the intervening period, ICP OP has been working with (13) pioneer sites nationally.

The timeline of developments are outlined in fig 3.1.

In order to ensure the approach adopted was evidence based ICP OP undertook two literature reviews. These focused on (1) the service design elements that offered the best outcomes for older persons (fig 3.2) and (2) the methods used to implement change at scale (fig 3.3).
The evidence for successful systemic change supports distributed, collective leadership (West 2014, HSE 2018). The approach adopted by ICP OP was deliberately ‘counter hierarchical’ in that it sought to adopt a servant leadership philosophy (see fig 3.3). This positioned ICP OP as supporting (serving) the needs of local leaders through its access to national enablers (resources or linkage to national initiatives) whilst trusting that they have the vision, capability and commitment. This is mobilised through constructive challenge and set within the ‘hard edges’ of the 10 Step Framework.

ICP OP initially funded the recruitment of 35 WTE posts nationally in 6 pioneer sites. They were selected based on an assessment of ‘readiness’ criteria where aspects of integrated care were already being developed locally. A further 5 teams were funded in 2017 and 2 more in 2018. There are now 13 sites in total with 60 funded posts. In addition, the development of candidate Advanced Nurse Practitioner (cANP) posts by the office of the Chief Nursing Office (DoHC 2017) has provided the opportunity for 61 cANP’s (43 in 2017 and 18 in 2018) in Older Persons to be strategically deployed. This strategic alignment has been amplified by cross border initiatives such as CAWT in Sligo.

The sites were established to test the model of integration with a case management approach. They are generally made up of around 6 team members including a geriatrician, case manager, physiotherapist, occupational therapist, social worker and administrator but some sites have included speech and language therapists, dieticians and pharmacists depending on their local demographics and needs.
A 10 Step Framework – ‘direction without dictat’

The ICP OP 10 Step Framework was developed to describe a series of key evidence based steps to implement integrated care. The framework is informed by 2 literature reviews (Harnett 2018) and Harnett and Kennelly (2018, in press) which reviewed international evidence underpinning both systemic change and integration of care for older persons. The development of a framework enabled change agents (locally and nationally) to share a common conceptual map on what ‘good looked like’. In doing so, it facilitated collective understanding of their respective clinical and organisational contributions. It also allowed for local design flexibility and innovation but these were set within common elements (evaluation, technology, funding). This recognises and builds on existing initiatives and binds them to an overarching ‘model’.

Guidance on the use and application of the framework was developed and launched in 2017, ‘Making a start in Integrated Care for Older Persons’ (2017). This methodology recognised that local resources, experience, people and geography differ from area to area and that a national model has allowed for this whilst some key elements are necessary to facilitate integrated care;

1. Older persons with long term complex care needs will have a single point of contact (case manager) who will help older people to access services when needed.
2. A multidisciplinary, community approach will be taken that provides a one stop shop for care coordination.
3. There will be clearly defined pathways allowing more patients to stay at home or get back home more speedily.

Figure 3.4

10-Step Integrated Care Framework for Older Persons

- Establish Governance Structures
- Undertake Population Planning for Older Persons
- Map Local Care Resources
- Supports to Live Well
- Person-centred Care Planning & Service Delivery
- Monitor & Evaluate
- Enablers
- Develop Services & Care Pathways
- Develop New Ways of Working
- Develop Multidisciplinary Teamwork & Create Clinical Network Hub
“The ICP OP 10 Step Framework gives us a template that will enable us to develop a whole network of care for older adults, but more importantly it allows us to integrate all of the various services within that network so that for the particular service user, the passage” from one point of care to another becomes relatively unobtrusive. It means that we can focus on their care rather than on the referral from one specialist to another and allowed us to use more effectively use the resources we already had”

Dr J Cooke, Consultant Geriatrician (CHO 5/ Waterford University Hospital)
The Integrated Care Programme, Older Persons (ICP OP) acts as an implementation agent at a whole system level as well as providing hands on support to enable local sites to develop integrated care in practice. ICP OP acts as a policy implementation conduit through collaboration and relationship building between different disciplines and agencies in local health and social care economies. This is a fundamental requirement of any transformational change.

A key tenet of the programme is to help advance local innovation, strategic thinking and ownership. This is achieved through the 10 Step framework for integration, tailored support and advice on implementation as well as practical tools, resources and evidence based research into the complexity of implementation of integrated care internationally.

ICP OP acts as a knowledge broker between sites in different locations around the country to ensure that projects are not established in isolation and that learning from implementation and evaluation can be shared, replicated and sustained at scale. The impact of the change is evaluated by the programme team to inform policy makers how the successful adoption of Integrated care at scale might work in practice.

The ICP OP methodology is outlined below in figure 3.5.

The ICP OP team shares core functions that supports redesigning older person services within a local health economy through implementing the ICP OP 10 Step Framework. This includes:

- Providing resources to develop community based teams and bespoke pathways
- Co-producing new care pathways through local process mapping and supporting subsequent implementation.
- Supporting the establishment of local governance groups (Acute Hospitals, CHOs and local partners).
- Facilitation of networking between pioneer sites, both formally (Networking Days) and informally.
- Supporting interpretation and implementation of the 10 Step Framework in practice nationally (input to policy and practice guidance (e.g. job descriptions, operational policy, practice guidance).
- Support sites though bespoke local workshops (e.g. care process mapping, population planning).
- Developing Partnerships with Age Friendly Ireland, business start-ups and Academia.
- Developing, testing and refining measures of integrated care.
- Evaluating (ICP OP impact and research into implementation).
- Testing and evaluating key integration enablers such as ICT.
- Providing national linkages to strategic and operational priorities (Winter planning, cANPs)

The ICP OP Team consisted initially of a clinical lead and managerial lead (2wte). This grew incrementally with the addition of 2 Service Improvement Leads (SILs), 0.8wte Project Lead and 0.6 wte administrative support.

An overview of the programme objectives and benefits are set out in fig 3.6.
3.6: Programme Objectives and Benefits realisation

**Situation**: An aging population with increased prevalence of frailty.

**Priority areas**: Focus on frailty.

**Enablers**:
- National governance approach
- ICP OP team
- Funding
- Framework
- ICT
- Service
- User engagement
- Evaluation
- Support
- Networking
- Comm

**Engagement**:
- Co-design with approach
- Users/carers
- Service providers
- ICT
- Finance
- Academia
- DOH
- MDT
- ED wait times
- Staff
- Satisfaction
- Community working

**Priorities**: Deliverables
- Population planning approach in use locally
- Map local care resources
- Bespoke pathways spanning community and acute care
- MDT adopting a case management approach
- Clinical network hub for MDT
- Engage Service users/patients in co-production
- Support older people live well in the community

**Impact**:
- Improved access to CGA
- Reduced institutional care
- Reduced hospital bed use
- Single point of contact for services in community
- Improved patient experience
- Improved care pathways
- Community and acute care settings
- MDT working
- Holistic needs addressed

**System benefits**:
- Move from hospital centric to community care model
- Population to service planning
- Single point of contact for services in community
- Clearly defined pathways across community and acute care settings
- MDT working
- Holistic needs addressed

**User/carer benefits**:
- Improved access to CGA
- Reduced institutional care
- Reduced hospital bed use (LOS for >75s)
- Improved patient experience
- Improved care pathways
- Community and acute care settings
- MDT working
- Holistic needs addressed

**GOAL 1**
- Manage resources in a way that delivers best health outcomes, improves people’s experience of using the service and demonstrates value for money.

**GOAL 2**
- Engage, Develop and value our workforce

**GOAL 3**
- Foster a culture that is honest, compassionate, transparent and accountable.

**GOAL 4**
- Provide fair, equitable access to quality, safe health services

**GOAL 5**
- Promote health and wellbeing as part of everything we do

**HSE Corporate Goals**
- Outcome & Impact
- Longer term benefits
- User/carer benefits

* Assumes full pathway in place in a local health economy.
Establishment of National Governance

The establishment of a National Working Group, Older Person (NWG OP, see appendix) comprising ICP OP, the National Clinical Programme Older People (NCP OP) and latterly Age Friendly Ireland, facilitated user input, clinical best practice, technical and practical support within each site. NCP OP had issued national guidance on an Acute Model of Care (NCP OP 2012). The implementation of this was not as widespread as desired due to a number of factors. NCP OP had a clinical design mandate but that did not have resources or a mandate to oversee implementation. The formation of a NWG OP brought the clinical design and implementation functions together. Subsequently, guidance documents to be issued which addressed the clinical design components of pathways (NWG 2017a, NWG 2017b, NCP OP 2017) as well as the overall design of integrated care (ICP OP 2017). It also allowed policy to be influenced and submissions to the Joint Oireachtas Committee on the Future of Healthcare in Ireland (SlainteCare 2017) by ICP OP 2017 and NCP OP 2107 helped ensure that integrated care was mandated at a policy level.

Funding of front line posts

ICP OP has allocated €4.2m funding over the past 30 months. This was comprised of a mix of estimates funding (€2.5m in 2016), winter initiative funding (€650,000) and €1.1m (estimates) in 2018. This funding has exclusively gone into 65 front line posts (see appendix for local details) which are the foundation stone of a new model of integrated care delivery. This will target a population who require a case management approach. Local sites were encouraged to develop and submit business proposals for the development of older person’s services using the 10 Step Framework Approach. Local needs would dictate how the framework was adopted and an iterative approach to development was taken as a result. At the time of reporting there are 13 sites at various stages of maturity. 8 more sites have submitted a business case. This reflects the ‘pull’ effect created by ICP OP and remain pending until a strategic decision is made regarding scale up.

Figure 3.7: Site expansion timeline

<table>
<thead>
<tr>
<th>No. of sites</th>
<th>CHO 1 - Sligo</th>
<th>CHO 4 - CUH/MUH</th>
<th>CHO 6 - SVUH</th>
<th>CHO 7 - Tallaght</th>
<th>CHO 8 - OLOL</th>
<th>CHO 9 - Beaumont</th>
<th>CHO 5 - Kilkenny</th>
<th>CHO 5 - WUH</th>
<th>CHO 3 - UHL</th>
<th>CHO 9 - Connolly</th>
<th>CHO 9 - MMUH</th>
<th>CHO 5 - St Tipp</th>
<th>CHO 2 - UHM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CHO 3 - UHL</td>
<td>CHO 9 - Connolly</td>
<td>CHO 9 - MMUH</td>
<td>CHO 5 - St Tipp</td>
<td>CHO 2 - UHM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>21</td>
<td>13</td>
<td>6</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
What did we do and how did we do it?
Engagement with service users and carers

ICP OP, in partnership with Age Friendly Ireland, developed a process through which co-design of integrated care could be addressed. ICP OP organised national seminars and local workshops to mobilise this. A suite of guidance was developed; Service User and Carer Engagement in the Co-production of Integrated Care for Older Persons which set out the context for engagement at both a National and Local Level through the Age Friendly Cities and Counties Programme.

ICP OP produced two other sets of guidance; A guide for Local Steering Groups on a Co-production Approach to Service Improvement, and a draft Description of the role of an Older Persons Patient Champion. ICP OP adopted a ‘hands on’ approach with local service improvement projects that involve older people. In addition, ICP OP worked with the following national data collection initiatives;

- Your Service Your Say
- Your Voice Matters – The Patient Narrative Project
- QID Listening to Older Persons Workshops
- The National Patient Experience Survey

in order to translate this feedback into integrated care improvements on the ground.

ICP OP held a workshop on ‘Cultivating Patient Leadership within the Integrated Care Programme for Older Persons’ (Oct 2017). This event heard from a number of international speakers about their experience of developing patient leaders, and on using patient feedback to drive improvement in health services. The event was attended by key stakeholders including pioneer sites, NGO’s representing Older People, representatives from Older Persons’ Councils around the country, and Age Friendly Programme Managers from a number of local authorities. This workshop also engaged participants to get their views on what they felt was important in the description of the role of a Patient Champion within the Older Persons’ Programme. This feedback was used to update the draft paper on the Older Persons’ Patient Champion, and a leaflet was produced for the recruitment of interested citizens in March 2018.

A short video from the event can be viewed here [https://www.hse.ie/eng/about/who/cspd/icp/older-persons/news/](https://www.hse.ie/eng/about/who/cspd/icp/older-persons/news/)

ICP OP utilised data from national surveys to consult with older persons councils (3 of 4 completed) in order to plan four service improvement workshops with key personnel from four sites, (CHO9 Beaumont, CHO1 Sligo University Hospital, CHO 8 Our Lady of Lourdes Hospital, and CHO5 Waterford University Hospital. The target audience for these workshops is key personnel from the CHO and Hospital, older people from the area, staff from the local authorities whose catchment area was coterminous with that of the CHO, and third sector organisations representing older people. The outputs from these workshop are considered by the local steering groups and two service improvement projects will be initiated in each site, taking a co-production approach with older people.
Measuring the implementation and impact of integrated care is challenging on a number of fronts. This includes a lack of agreed metrics and a data collection process. At a more fundamental level the ability to track strategic change and attribute impact is a significant challenge when structures are not in place to facilitate this. The 10-Step Framework was offered as a shared conceptual map to support implementation. Community activity data was rarely captured historically and where it was captured it was patchy, inconsistent and not linked to strategic national aims, goals or improvements. The 10-step framework was developed to provide sites with a methodical foundation to support implementation within the sites; however there was no mechanism of measuring the sites against each of the required steps to chronicle their evolution.

A suite of indicators underpinning the 10 steps were developed to track fidelity to and the extent of implementation. These were aligned with the HIQA themes and standards for Quality and Safety. The rationale for collecting these measures was to enable the national ICP OP team and local sites to identify where progress against the 10 steps was delayed or blocked, see appendix 2. This enabled blockages to be escalated via the local or national governance structures. Where one site is clearly progressing at pace on a particular step it enabled the national team to share and disseminate good practice with other integrated care teams and share the learning. It was recommended that measurement be a standing item on each local steering group agenda.

Figure 3.8: Phase 1 Sites

What did we do and how did we do it?

Development of Measurement Process

<table>
<thead>
<tr>
<th>Phase 1 Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Establish Governance Structures</td>
</tr>
<tr>
<td><strong>2</strong> Undertake Population Planning for Older Persons</td>
</tr>
<tr>
<td>Frailty Prevalence</td>
</tr>
<tr>
<td>11% Severely Frail (Very High Risk)</td>
</tr>
<tr>
<td>21% Moderate Frailty (High Risk)</td>
</tr>
<tr>
<td>36% Mild Frailty (At Risk)</td>
</tr>
<tr>
<td>32% Fit (Minimal Risk)</td>
</tr>
<tr>
<td><strong>3</strong> Map Local Care Resources</td>
</tr>
<tr>
<td><strong>4</strong> Develop Services &amp; Care Pathways</td>
</tr>
<tr>
<td>▪ Focus on Frailty</td>
</tr>
<tr>
<td>▪ Acute Care Pathways</td>
</tr>
<tr>
<td>▪ Ambulatory Care</td>
</tr>
<tr>
<td>▪ Rehabilitation</td>
</tr>
<tr>
<td>▪ ICPs for Falls, Dementia &amp; Nursing Homes Outreach</td>
</tr>
<tr>
<td><strong>5</strong> Develop New Ways of Working</td>
</tr>
<tr>
<td>▪ New roles including case management approach for long term complex needs In-reach and outreach</td>
</tr>
<tr>
<td><strong>6</strong> Develop Multidisciplinary Teamwork &amp; Create Clinical Network Hub</td>
</tr>
<tr>
<td>▪ Co-ordinate between care providers</td>
</tr>
<tr>
<td><strong>7</strong> Person-centered Care Planning &amp; Service Delivery</td>
</tr>
<tr>
<td><strong>8</strong> Supports to Live Well</td>
</tr>
<tr>
<td>Enable older people to live well in the community:</td>
</tr>
<tr>
<td>▪ Community Transport</td>
</tr>
<tr>
<td>▪ Social Activities</td>
</tr>
<tr>
<td>▪ Home modifications &amp; handy person</td>
</tr>
<tr>
<td>▪ Medication Management</td>
</tr>
<tr>
<td>▪ Shopping</td>
</tr>
<tr>
<td>▪ Harness Technology</td>
</tr>
<tr>
<td>▪ Support carers</td>
</tr>
<tr>
<td>▪ Information &amp; Advice</td>
</tr>
<tr>
<td><strong>9</strong> Enablers</td>
</tr>
<tr>
<td>▪ Develop workforce</td>
</tr>
<tr>
<td>▪ Align finance</td>
</tr>
<tr>
<td>▪ Information systems</td>
</tr>
<tr>
<td><strong>10</strong> Monitor &amp; Evaluate</td>
</tr>
<tr>
<td>▪ Track service developments</td>
</tr>
<tr>
<td>▪ Measure outcomes</td>
</tr>
<tr>
<td>▪ Staff and service user experience</td>
</tr>
</tbody>
</table>

Complete Underway Not Started
Care process metrics

When integrated care teams were first implemented in each of the pilot sites it was recognised that a standardised measurement process was required to record activity. There was no existing measurement framework in place in Ireland that would capture process, structural or outcomes measures associated with integrated care. As a consequence community activity data was rarely captured and interventions that enabled older persons to stay at home were invisible to the system.

Process measures were developed that captured referral information, activity/interventions and results such as discharge destinations and time on caseload. This comprised initially of 13 categories with 117 data elements captured against these categories (figure 3.9). Data was captured by all team members and submitted monthly per pilot site. After the first 6 months the process was reviewed and refined.

**Figure 3.9**

ICP OP Summary Sheet
3 Categories
13 Groups
66 Data Elements

**Referrals**

1. **Point of Referral**
   - 1. ED or AMU
   - 2. Day Hospital
   - 3. OP Dept.
   - 4. Inpatient
   - 5. GP
   - 6. PHN
   - 7. Other

2. **Re-Referral**
   - 1. Re-referral within 30 days of discharge from ICR

3. **Age Profile**
   - 1. Aged 65-74
   - 2. Aged 75-84
   - 3. Aged 85-94
   - 4. Aged 95+

4. **Gender Profile**
   - 1. Male
   - 2. Female

5. **Complexity of Referral**
   - 1. High
   - 2. Medium
   - 3. Low

6. **Active Caseload from Prior Periods**
   - 1. Total

**Activities**

7. **Direct Contacts**
   - 1. Geriatrician
   - 2. Case Manager
   - 3. Physiotherapist
   - 4. Occupational Therapist
   - 5. Pharmacist
   - 6. Clinical Nurse Specialist
   - 7. Registrar
   - 8. Speech & Language Therapist
   - 9. Dietician
   - 10. Medical Social Worker
   - 11. CNM2

8. **Location of Direct Contact**
   - 1. Home visit
   - 2. Emergency Department
   - 3. Community day hospital
   - 4. AMU
   - 5. Rehabilitation unit / hospital
   - 6. Long term care
   - 7. Others not listed

9. **Indirect Contacts**
   - 1. Geriatrician
   - 2. Case Manager
   - 3. Physiotherapist
   - 4. Occupational Therapist
   - 5. Pharmacist
   - 6. Clinical Nurse Specialist
   - 7. Registrar
   - 8. Speech & Language Therapist
   - 9. Dietician
   - 10. Medical Social Worker
   - 11. CNM2

10. **Intervention Types**
    - 1. CGA (with SAT)
    - 2. CGA (without SAT)
    - 3. Care & treatment plan developed (MDT)
    - 4. Review of care plan and actions (MDT)
    - 5. Implementation of actions within care & treatment plan (direct contact)

**Results**

11. **First Direct Contact with new referral**
    - 1. 0-24 hours
    - 2. 24-48 hours
    - 3. 2-7 days
    - 4. >7days

12. **Discharge from Integrated Care Team (episode of care)**
    - 1. 0-1 week
    - 2. 1-2 weeks
    - 3. 2-4 weeks
    - 4. 4+ weeks

13. **Discharges from Integrated Care Team (Destination)**
    - 1. Long term care
    - 2. Transition care
    - 3. Rehabilitation unit
    - 4. Acute hospital
    - 5. Living at home with community support
    - 6. Deceased
“What’s really powerful about ICP OP is that they allowed us to identify gaps in local services. That has really empowered us and has led to a huge amount of enthusiasm and passion in the team. We have been given the autonomy and licence to do what we think works on the ground. We are now meeting regularly as a group to together plan services and identify gaps. ICP OP enabled us to implement locally”

Dr. Emer Ahern, Consultant Geriatrician (CHO5 St. Lukes Hospital Kilkenny)
Information Communication Technology (ICT) is recognised as a key enabler of integrated care (Protti 2009, Goodwin 2015, Winthereik and Bansler 2007). The ability to share information relating to patient care across health and social care systems is an essential component of MDT working and case management. Significant deficits exist in this information sharing due to a lag in the development of the e-health record. In order to facilitate and test information sharing models at local level, a core component of ICP OP activity was to enable ICT development at sites to develop this capability.

ICP OP worked with community and hospital teams, managers, hospital ICT departments and the office of the chief information officer (OCIO) to identify and implement tools that would directly enable Integrated Care teams communicate and share information electronically across local care settings. Two workshops were facilitated with pioneer sites (CHO7/Tallaght and CHO 4/CUH/MUH) in May and June 2016 to establish their needs, priorities and their vision of how technology could be used to help integrate care. Outputs from these workshops are shown in figure 3:10.

On foot of the workshop outcomes, Microsoft Surface Pro Devices and Smart Phones were issued to all pioneer sites (see figure 3.11). This was to facilitate data collection (ICP OP process metrics), use of SAT, access to clinical information systems and sharing of care plans. The device roll out was completed in March 2018 (100 staff across 8 CHOs/HGs).

One of the core components of integrated care is adopting a case management approach (Stokes et al 2016). ICP OP developed links with the Health Innovation Hub (University College Cork) which facilitated access to health markets for technology start-ups. After a rigorous selection process (Mulcahy 2017), the Carefolk platform was selected for testing with CHO5/UHW and CHO4/CUH (www.carefolk.com). An evaluation of Carefolk platform is currently being undertaken by the health innovation hub, with a report due by the end of 2018.
Development of an Older Persons Dashboard

The absence of easily accessible older person data hampers efforts to improve patient pathways or redesign services. Whilst a significant amount of data was captured and routinely by services, there was no ‘go to’ place to access a bespoke suite of older person data. ICP OP consequently set about developing a ‘dashboard’ that would show a variety of data specific to older persons. The available HIPE data populates the acute hospital quadrant (see appendix for dashboard details) with the intention of capturing all data on the dashboard by the end of 2018.

Figure 3.12

Mapping of local resources

ICP OP helped to facilitate a resource mapping workshop with CHO1-Sligo. This allowed all local agencies to gain further insights into services available, develop a directory of service and mobilise community and hospital resources towards a common goal. CHO6-Vincents and CHO7-Tallaght have also mapped local resources and produced local guides.

Workforce development

ICP OP participated in workforce planning initiatives including the Department of Health Workforce Planning Framework (DoH 2017) and the Chief Nursing Office (Department of Health) on new and expanded nursing roles (DOH 2017), see ICP OP Workforce Planning Considerations document in Appendix 1. This resulted in an allocation of 61 (43 in 2017 and 18 in 2018) candidate Advanced Nurse Practitioners aligned to the ICP OP pioneer sites and supported pathway development (NWG 2017). A collaboration with Dublin City University explored the most appropriate models of case management with the outcome of this review due to be launched in Dec 2018. The NCP OP/Tilda Frailty Education Programme (NCP OP 2017) continues to be the most significant influence to age attune the workforce with in excess of 180 facilitators who in turn have trained 1200 staff to date. The programme is looking to expand to include HSCPs as well as nursing staff.

Utilisation of existing population planning resources

Health Atlas Ireland https://www.healthatlasireland.ie/ provides an analytical and display route to a range of datasets gathered by others including: demography (census etc.); hospital activity; prescribing; mortality; human resources; service location; along with a range of mapping functions. The data available on health atlas provides a useful resource for local sites in profiling populations and the wider social determinants of health. Health Atlas workshops were carried out with all sites to enable local managers with the tools to use Health Atlas for service planning purposes in local ICP OP governance groups.
Getting Started Document

ICP OP has contributed to or issued guidance documentation in order to age attune service transformation for older persons. This includes contributions to Slaintecare, the Blueprint for Urgent and Emergency Care, the Acute Floor (Frailty at the front door), HSE Workforce planning etc. ICP OP has also developed Patient Champion Guidance, Making a start in Integrated care Guidance, Case Management Guidance as well as this ‘lessons learned’ document.

Case Management Guidance

The adoption of a case management approach, reflected in the ICP OP 10 Step Framework, is a key tenet of integrated care. This approach, although commonplace in child protection and mental health, is not institutionally practiced within older person services. There was a need for greater clarification around a model that offered the best fit when working with a more complex older person cohort. ICP OP commissioned a review of case management models in use internationally, with a view to adopting the approach best suited to older persons. Dr. Louise Hopper (Dublin City University) led the review which highlights the models in use. The guidance draws on existing models that offer best outcomes, offers advice on the key components of a case management approach and makes recommendations on the model that has the best fit for older persons.

ICP OP Networking Days

ICP OP hosted six biannual networking days over the past 3 years. These were principally to facilitate networking between pioneer sites and allowed more established sites to share experience with new or prospective sites. Each networking day was thematically focused on the 10 Step ICP OP Framework with programme content specified by pioneer sites. Networking is recognised as a key part of any transformation effort (Greenhalgh et al 2004) in fulfilling the diffusion of innovation amongst high autonomy professionals. ICP OP networking days allowed a number of key co-production functions to be fulfilled including updates by ICP OP, recruitment for research and evaluation, peer to peer contact, user engagement and access to expert guidance.

ICP OP Website

www.icpop.org/

ICP OP has recently developed a website which acts as a central repository for ICP OPs tools and resources as well as a guide to the pioneer sites currently involved in the programme. It is intended to be a comprehensive resource for the network of health professionals and clinicians who are working collectively towards the integration of care for older persons in Ireland. The site is an easy to navigate information centre that includes useful videos, framework tools, publications , presentations and reference documents along with programme news and updates.
What difference has it made?
Introduction

International evidence suggests that it takes 3-5 years to implement integrated care (NHS 2017, Scirrocco 2017) and to yield the desired change. This reflects the fact that multiple enablers of care ICT, workforce changes, care pathway components and MDTs adopting a different approach takes time to become established. No one element on its’ own will provide a silver bullet. However, there are some early indications that changes within pioneer sites are delivering positive benefits. This is typically where local governance is functioning well and providing support to front line managers and clinical leaders.

In turn the work of these sites is generating a ripple effect locally and nationally. Fig 4.1 outlines this in action in Waterford Integrated Care Older Person (WICOP) project. The ripple effect of WICOP, outlined by Cooke (2018) illustrates how previously disconnected services that arose independently over the past number of years are yielding substantial benefits. This impact has resulted in ICP OP receiving expressions of interest from 8 additional areas within the past year to become ICP OP pioneer sites. This section offers an overview of ICP OP pioneer sites over the past 2 years.

Figure 4.1: Ripple effect of integrated care

<table>
<thead>
<tr>
<th>WICOP Impacts (since July 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients flow through 5 defined care pathways</td>
</tr>
<tr>
<td>Falls, Frailty, Memory, PD, General</td>
</tr>
<tr>
<td>&gt;2,500 MDT contacts recorded</td>
</tr>
<tr>
<td>Therapists empowered to deliver autonomous clinics</td>
</tr>
<tr>
<td>Experience of care</td>
</tr>
<tr>
<td>Intermediate Outcomes</td>
</tr>
<tr>
<td>All patients in receipt of CGA in ≤ 2 visits</td>
</tr>
<tr>
<td>Case management offered to most complex patients (Seen within 24 hours)</td>
</tr>
<tr>
<td>Direct admission to inpatient rehab (avoiding ED) for eligible crisis patients</td>
</tr>
<tr>
<td>Immediate escalation of HCPs for crisis patients</td>
</tr>
<tr>
<td>Expended admission from home to NH for appropriate crisis patients</td>
</tr>
<tr>
<td>Culture change</td>
</tr>
<tr>
<td>Reduced Length of Stay</td>
</tr>
<tr>
<td>1,082 bed days to saved with crisis intervention (Hub)</td>
</tr>
<tr>
<td>5-day reduction AvLOS for hip fractures</td>
</tr>
<tr>
<td>Medical DCs &gt;64 Oct ’17 – Apr ’18 reduced by 719 compared to previous year</td>
</tr>
<tr>
<td>All PCTs involved from outset</td>
</tr>
<tr>
<td>FBTs (medical) &gt;64 Oct ’17 – Apr ’18 reduced by 3,938 compared to previous year</td>
</tr>
<tr>
<td>Improved use of resource</td>
</tr>
<tr>
<td>Inpatient Management of frailty</td>
</tr>
<tr>
<td>Inpatient Management of frailty</td>
</tr>
<tr>
<td>Inpatient Management of frailty</td>
</tr>
<tr>
<td>WICOP road show has visited &gt;60 PHNs</td>
</tr>
<tr>
<td>End PJ Paralysis #UHWGetMoving</td>
</tr>
<tr>
<td>Pine Ward in new build allocated to frail elders</td>
</tr>
<tr>
<td>Previous “orphan” therapists now under WICOP umbrella</td>
</tr>
<tr>
<td>WICOP steering/governance committee meeting quarterly</td>
</tr>
<tr>
<td>Synergy between “old” and “new” integrated services</td>
</tr>
<tr>
<td>Many existing services have asked to join WICOP</td>
</tr>
<tr>
<td>Stroke SubComm completed RCPI QI Course streamlining acute management</td>
</tr>
<tr>
<td>SGW SubComm will direct development of Pine Ward to SGW</td>
</tr>
<tr>
<td>Experience of care</td>
</tr>
<tr>
<td>Improved use of resource</td>
</tr>
</tbody>
</table>

What difference has it made?

All patients in receipt of CGA in ≤ 2 visits
New governance structures

A fundamental aspect of establishing good governance is the development of a steering group with senior leadership across stakeholder organisations that share a common strategic vision. Step 1 of the 10 Step Framework outlines the requirements to set up a local integrated care governance group focused on the needs of older people within a given area. The membership includes key stakeholders and ensures opportunities for meaningful engagement with older people using the services as part of the core function of this group. Four core deliverables were identified for the implementation of an effective governance structure. These are to have:

- Terms of reference for the steering group
- A memorandum of understanding between service providers across all stakeholder organisations.
- An organogram depicting the steering group and implementation sub group (s) with names and designations.
- An Operational Policy with clear a description of the modus operandi of the service

Governance in action: Waterford/CHO5 (WICOP)

The Waterford Integrated Care for Older People (WICOP) steering group is chaired by Professor Ríona Mulcahy, a Consultant Geriatrician other than the consultant clinical lead for the pilot site. This allows the clinical and management leads to take a step back from the governance and decision making process promoting openness and transparency across the stakeholder organisations. The role of the group is to ensure the project remains focused on providing patient-centred care for frail and complex older adult and remains aligned with the 10 Step framework. The steering group has a rich membership across acute and community care, primary care and third sector organisations with patient and carer representation.

Governance in action: Sligo/CHO1

The membership of the local ICP OP governance group includes senior management representation from Social Care, Health and Wellbeing, Public Health Nursing, and the Hospital General Manager. There is also senior clinician representation with three geriatricians attending who all take a lead role on individual care pathway workstreams. There are two service user representatives on the group, one from County Sligo and one from County Leitrim. The membership of the group also includes members with key responsibility for aligned programmes of work, e.g. CIT, Frailty Education, thus ensuring that there is oversight and a mechanism for setting clearly aligned priorities and objectives across these programmes in an integrated manner. This is represented in the organogram below:

These Government structures are now operating in 13 sites.
There is evidence that integrated and coordinated care leads to significantly better outcomes for frail older adults (Ellis et al, 2011, Silvester et al, 2016). Bespoke older person pathway improves outcomes for people identified with high-need. For example in long-term care settings where there are high numbers of people living with frailty and high complex needs, and integrated care pathways for people with dementia and people who fall or are at risk of falling). The focus has been on implementing new ways working to amplify existing resources and introduce new roles and functions that provide specialist secondary care for older people in the community. ICP OP has worked with Pioneer sites to map the journey of the older person through the “current state” service and through the “future state” informed by the complexities of the current state (see figure 4.4). The complete older person’s journey has been mapped from arrival in the emergency acute setting through the inpatient journey, community and social care setting, ambulatory care to living/ageing well at home. This process has empowered frontline staff, clinicians and managers to gain insights into the ‘as is’ and ‘to be’ pathway prompting interdisciplinary exchange of ideas and innovation.

**Figure 4.4: Mapping Workshop with CHO5 South Tipperary**

---

**Proposed Older Persons Pathway in CHO5-STGH – Phase 1**

<table>
<thead>
<tr>
<th>Primary / Community Care</th>
<th>Ambulatory Care</th>
<th>Acute Hospital Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has episode at Home</td>
<td>Outpatients Rapid Access Clinic (PRAC)</td>
<td>Patient admitted to ward</td>
</tr>
<tr>
<td>• Medically Unwell?</td>
<td>Day Care</td>
<td>Early Supported Discharge pathway (ESD) initiated</td>
</tr>
<tr>
<td>• Falls?</td>
<td>Outpatients Specialty Clinics</td>
<td></td>
</tr>
<tr>
<td>• Memory?</td>
<td>Integrated Care Team (MDT)</td>
<td>Frailty Pathway</td>
</tr>
<tr>
<td>OP/PHN/CNS</td>
<td>Geriatrician, Pharmacist, Physio, OT, Dietician, SLT, Admin</td>
<td>• Patient &gt;75</td>
</tr>
<tr>
<td>assessment</td>
<td>• Patient referrals triaged daily (Consult/Reg.)</td>
<td>• VIP Score &gt;2 &amp; Cat 2,3,4</td>
</tr>
<tr>
<td>Physio, OT, SLT, Dietician, Social Worker, Home help co-ordinators</td>
<td>• Weekly MDT meeting</td>
<td>• Dedicated frailty area</td>
</tr>
<tr>
<td>Appropriate for ICPOP?</td>
<td>• Caseload list &amp; notes prep (Admin)</td>
<td>• Speciality assessment (med/Surg/ED)</td>
</tr>
<tr>
<td></td>
<td>• Care Plan agreed</td>
<td>• ANP assessment</td>
</tr>
<tr>
<td></td>
<td>• Patients discharged from caseload to primary care</td>
<td>• Pt put on Frailty board if Appropriate for ICPOP?</td>
</tr>
<tr>
<td>Care at Home</td>
<td>OLHC Campus Cashel</td>
<td>Decision to Discharge</td>
</tr>
<tr>
<td>• Physio 2/week</td>
<td>Day Care</td>
<td>• Medical reconciliation by Pharmacist</td>
</tr>
<tr>
<td>• OT 2/week</td>
<td>Decision to Admit</td>
<td>• Assessment by appropriate ICPOP team member</td>
</tr>
<tr>
<td>• SLT 2/week</td>
<td></td>
<td>• Daily ICPOP MDT meeting</td>
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<tr>
<td></td>
<td></td>
<td>(Could assessment be done at home in some cases?)</td>
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</tbody>
</table>

Phase 2: Develop ESD Capacity, Enhance Community rehab enablement (CREC) in OLHC Cashel, introduce Case manager role, Expand Rapid Access Clinics.
Phase 3: Develop Specialist Geriatric Ward and Day Hospital.
Figure 4.5

The development of bespoke care pathways are a foundational component of ICP OP. The annual planning and funding cycle mitigates against strategic development. Where funding allowed, ICP OP supported incremental direct investment and support for resource allocation to pioneer sites. All areas opted to focus on an aspect of service redesign determined by local priorities, identified need, local resources and funding. Whilst individual sites opted to undertake service redesign in different parts of the pathway, all have had a positive impact within that discrete element of the patient’s journey. The development of a fully integrated service generally requires a more strategic use of existing and new resources. Table 4.5 is a representation of the current activity in each of the ICP OP pioneer sites in the individual care settings that together make up an end to end integrated care pathway for older persons. Whilst the targeted investment in integrated care teams has been the catalyst for the development of local bespoke care pathways, much of the activity has evolved as a result of an increased co-ordinated focus on older persons’ care, a focus on frailty, and the development of a frailty attuned workforce.

### Overview of pathway development

<table>
<thead>
<tr>
<th>Living at home with supports</th>
<th>Primary Care</th>
<th>Ambulatory Care</th>
<th>ED frailty at the front door</th>
<th>Inpatient</th>
<th>Rehabilitation</th>
<th>Domiciliary follow up by MDT</th>
<th>Residential Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHO1 Sligo</td>
<td>![In place]</td>
<td>![In place]</td>
<td>![In place]</td>
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<td>![In place]</td>
<td>![In place]</td>
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<tr>
<td></td>
<td>MDT Based in St Johns Hospital</td>
<td></td>
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<tr>
<td>CHO2 Mayo</td>
<td>![In place]</td>
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<td><img src="https://via.placeholder.com/15" alt="" /></td>
<td>![In place]</td>
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<tr>
<td></td>
<td>MDT to be based in PCC</td>
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<tr>
<td>CHO3 Limerick</td>
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<tr>
<td></td>
<td>MDT to be based in St Josephs Ennis</td>
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<tr>
<td>CHO4 Cork</td>
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<tr>
<td></td>
<td>MDT based in Community Hospital</td>
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<td>CHO5 Waterford</td>
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<tr>
<td></td>
<td>MDT based in Day Hospital</td>
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<td>CHO5 Kilkenny</td>
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<tr>
<td></td>
<td>Case Managers recently recruited</td>
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<tr>
<td>CHO5 South Tipperary</td>
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<td></td>
<td>MDT to be based in Cashel community hospital</td>
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<tr>
<td>CHO6 St. Vincents</td>
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<td></td>
<td>MDT based in Clonskeagh</td>
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<td>CHO7 Tallaght</td>
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<tr>
<td></td>
<td>MDT based in PCC</td>
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<tr>
<td>CHO8 Louth</td>
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<tr>
<td></td>
<td>MDT based in Cottage Hospital</td>
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<tr>
<td>CHO9 Beaumont</td>
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<tr>
<td></td>
<td>MDT based in Day Hospital</td>
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<tr>
<td>CHO9 Connolly</td>
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<tr>
<td></td>
<td>MDT based in Day Hospital</td>
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<tr>
<td>CHO9 Mater</td>
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</tbody>
</table>

| ![In place] | ![Underway] | ![Plans in place] |
Inpatient Pathway

The inpatient pathway outlined in the NCPOP Model of acute hospital care (NCPOP 2012) focusses on Specialist Wards for Older People with Frailty (SGW) staffed by multidisciplinary teams and gerontologically trained nursing and medical staff that support the delivery of Comprehensive Geriatric Assessment (CGA) and early Supported Discharge for admitted patients.

Key Pathway Elements

• Specialist geriatric ward model commenced in 2016.
• Outcomes focused on reduced average length of stay and improving patient experience.
• Community based integrated case management model commenced 2017.

Benefits

• Results indicate Reduction in AVLOS of 2.6 days achieved (April 2016 vs April 2017)
• 87% of patients had care plans developed in the first 6 months of 2018
Early supported discharge and Rehabilitation Pathway

Rehabilitation can be provided in an inpatient, outpatient or home setting depending on the complexity of health and social care needs of the person. This pathway component focusses on access to inpatient and outpatient rehabilitation with supported assessment, therapies and clinical support.

Key Pathway elements

- Community based case management model supporting early involvement of the MDT for rehabilitation and discharge planning enabling early supported discharge from the acute hospital ward to home,
- Time limited case management for 14 days with a multidisciplinary co-located team in an ICP OP hub site.
- Aligned with existing services for older persons e.g. Falls, dementia, rehabilitation.
- Early Supported Discharge
- Early review in Day hospital post discharge
- Support via Case manager post discharge.
- Linkage with Community Intervention Team (CIT)

Benefits

- Preliminary results indicate a reduction in Length of Stay (LoS) and readmission rates for patients on the integrated care team’s case load –
  - Only 7% of patients seen by ICP OP needed to be referred on to an acute hospital for further care*
  - Only 8 (3%) patients discharged from ICP OP were referred back to the team within 30 days*

*Data period Jul17-Jun18
St Luke’s Hospital Geriatric Emergency Medicine Service (GEMS) is focusing on a model for the early identification of frailty to promote a more coordinated care approach, the earlier identification of patient complexity and better decision planning. Senior clinical decision makers aligned with gerontologically trained nursing and therapy support staff in ED / AMAU are important elements of this service.

**Key Pathway Elements**

- Routine screening for frailty in the AMAU/ED. Early interdisciplinary assessment using a Variable indicative of Placement (VIP) screen for all presentations >75yrs in order to activate a CGA.
- Dedicated CNS, Physiotherapist and Occupational Therapist based in the Acute floor, with access to Pharmacy and led by a Consultant Geriatrician.

**Benefits**

- Results indicate that in 2017 4,170 >75yrs presentations (98%) were screened on presentation with 65% receiving CGA, 59% were moderate or severely frail.
- AVLoS was reduced by 1.6 days for >80 yr.
- There were 1362 CGA’s carried out over a 12 month period*

*Data period Jul17-Jun18

As GEMS is the “Acute Floor Assessment” all referrals generated by the GEMS team will be documented in the patient’s clinical record and on the blue CGA form. If their condition changes at a later date a referral to the appropriate services is completed at ward level by the nursing staff/team with the primary care of the patient.
Ambulatory Care Pathway and Hub

The Waterford Integrated Care Older Person Hub functions as the coordination, information and training hub for older persons services.

Key Pathway elements

- Facilitates integration between hospital and community services and acts as a resource for all involved in delivering older person’s services.
- Based in the day hospitals with access to outpatient diagnostics /therapy staff enabling ‘rapid access’ CGA and ongoing therapy to support Early Supported Discharge
- Rapid Access clinics to support ongoing care in the community
- Provides expedited assessment for frail older persons presenting to ED, GP or AMU seeking to maximise the number of people who can access care in the least restrictive setting

Benefits

- >2,500 MDT contacts recorded since ICP OP commenced
- 1,082 bed days saved with crisis intervention (Hub)
- Medical Discharges >64 between Oct ‘17 – Apr ‘18 reduced by 719 compared to previous year
- 97% of patients had a CGA completed*

*Data period Jul17-Jun18
Ambulatory Care Pathway and Hub

Ambulatory Care Hub in place in Clonskeagh. Community based integrated care team focussing on supported discharge and hospital avoidance, and a focus on short-term, community based rehabilitation (usually up to 6 weeks duration)

Key Pathway elements

- Re-enablement of older people following acute illness or injury.
- To facilitate early discharge from hospital when appropriate.
- To avoid hospital admissions and emergency department attendance where possible.
- To have a focus on continuity of care (with existing community services and activities).
- To transition older people to longer term services and activities which promote health and well-being.

Benefits

- 81% of patients seen by the ICP OP team were discharged back to their own homes*
- 42% of patients were seen within 48hours of being referred to the ICP OP team*
- 93% of the patients seen on the caseload were seen at home

*Data period Jul17-Jun18
Primary Care integrated Pathway

The Tallaght Integrated Care team acts as a liaison between the hospital and primary care teams and other network services to enable a smooth transition of care across the services for the service user. The team facilitates rapid access to a complete geriatric assessment of the older person with complex needs both at home and in a clinic setting to ensure timely access to services and supports to address assessed needs. Where Long Term Care is required cases are expedited from the community with the assistance of the primary care team.

Key Pathway elements

Avoidance of unnecessary duplication of services and service user narrative.

Agreed referral protocols so that older persons experience a smooth transition without boundaries between and within services.

Avoid hospital admissions and emergency department attendance where possible.

Focus on population health initiatives e.g. MedEx.

To have a population of older persons who will be empowered with better information about their care and be better able to navigate and access the health and social care system.

Benefits

- 325 referrals into ICP OP team*
- Only 3 patients referred back into the team within 30 days*
- 783 direct contacts with patients by the team*
- 77% patients discharged from ICP OP back to their own home

*Data period Jan-Sep18
“This approach means we have a shared goal in wanting to help the older person, especially those with complex needs. We don’t want to see them going in and out of hospital all the time or being sent to long term care if they don’t need to be there.

Everybody’s being really enthusiastic, the hospital staff and the community staff have been great in changing the way we work.

Traditionally it might have been a bit difficult to develop a new way of working but we find it’s working really well for us.”

Clare O Leary, Senior Physiotherapist, CHO 7/Tallaght University Hospital
Primary Care Integrated Pathway

The Community Virtual Ward supports older people to remain at home for longer and is designed to ease the burden on overstretched hospital services and reduce the number of unplanned hospital admissions. The Virtual Ward provides an infrastructure to facilitate service provision providing support for people in the community with increasing complex medical and social needs.

Key Pathway elements

There are 3 virtual wards within the clinical case management service in Dublin North, colour coded as Red, Amber and Green.

Each ward will have a set criterion for admission and number of visits/contact required, and this will assist in prioritising services.

The virtual wards also provide an alert for the acute hospital, for patients at risk of a hospital admission highlighting potential problems and history of events.

The number of interventions and services provided within the virtual wards will depend on level of patient need, as well as risk of admission to hospital as perceived by the primary care teams in conjunction with specialist geriatric services.

Figure 4.12: Deployment Chart: CVW/ Primary Care/ BH Referral Pathway to Dublin North Integrated Care Team for Older Persons

Process is Service User Lead, underpinned by Effective Communication Systems & Integration across Teams, Services & Agencies
The pathways in action described in this document demonstrate that ICP OP sites are implementing elements of an overall end to end care pathway for older persons in their local area. Table 4.13 shows a complete journey for older people incorporating existing care pathways.

**Figure 4.13**

The pathways in action described in this document demonstrate that ICP OP sites are implementing elements of an overall end to end care pathway for older persons in their local area. Table 4.13 shows a complete journey for older people incorporating existing care pathways.
“We have adopted a new way of working once we’ve joined this team. We are now a multi-disciplinary team where all the professional roles are blurred and have all learned new skills and we cross cover each other as a result. When we visit we see the patient in a holistic way from their mental health, to their physical health, to nursing issues and we are all prepared to go the extra mile. I think this is the success.”

Catherine O’ Mahony, Clinical Nurse Specialist, CHO4/ Cork University Hospital
Multidisciplinary teams and clinical networking HUB

Multidisciplinary team (MDT) working is a key requirement of the ICP OP framework. Working in multidisciplinary teams has become the norm in healthcare as it has proven to be more effective (MHC 2010). There are obvious advantages to staff and service users in terms of efficiency, expertise, support, job satisfaction, innovation and quality of outcomes Onyett with SCMH (2001). 13 Multi-Disciplinary Teams (MDTs) were established with ICP OP funding. Multidisciplinary, Community based teams that target the most complex and at risk population of older persons. This team acts as a catalyst for integration locally. The need to support MDTs to function well is therefore critical to the design and testing of ICP OP in order to deliver bespoke care pathways. Whilst we know that multidisciplinary teams are significant and central to the implementation of integrated care, how the team functions operationally is a key component to how effective that team is.

Multidisciplinary teams in action: Cork/CHO4

The Cork integrated care team is led by Catherine O’Mahony the case manager and team leader. Whilst team members are operationally responsible to Catherine on a day to day basis they remain professionally accountable to their discipline’s Head of Service. To ensure clarity regarding each team member’s accountability, Catherine has developed a matrix:

<table>
<thead>
<tr>
<th>Work Task</th>
<th>Accountable person / Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational policy implementation and adherence monitoring</td>
<td>Team Lead</td>
</tr>
<tr>
<td>Daily Workload Allocation and staff management</td>
<td>1</td>
</tr>
<tr>
<td>Disciplinary and grievance procedures</td>
<td>2</td>
</tr>
<tr>
<td>Discipline specific In-service training / meetings</td>
<td>3</td>
</tr>
<tr>
<td>Professional / Clinical supervision</td>
<td>3</td>
</tr>
<tr>
<td>Professional training / CPD</td>
<td>3</td>
</tr>
<tr>
<td>Recruitment</td>
<td>1</td>
</tr>
<tr>
<td>Mandatory training</td>
<td>1</td>
</tr>
<tr>
<td>ICT team meetings /training</td>
<td>1</td>
</tr>
<tr>
<td>Quality adherence and improvement plans</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Audit</td>
<td>1</td>
</tr>
<tr>
<td>Activity reporting</td>
<td>1</td>
</tr>
</tbody>
</table>

Key: 1 = Lead responsibility, 2 = Co Lead, 3 = In discussion with

The team meet on a daily basis as part of a “virtual” ward round. Utilising the electronic virtual ward developed on the iPMS system and a white board the team:

» Discuss the previous day’s activity
» Review patient goals
» Review new patients
» Plan the daily workload – timing, joint visits, route planning

The team also have a full MDT meeting to discuss all patients on the caseload with the lead consultant geriatrician on a weekly basis. The consultant reviews all clients regardless of their source of referral (MUH or CUH). This MDT also acts as a great education tool for the whole team.

The Cork team feel they have “blurred the lines” and developed new skill sets that allow them to work cross discipline and learn from each other professionally.
“Part of the success of this project is that Social workers, OTs and Physios are coming together nationally to try to overcome the challenges and standardise the approach to care”

Patrice Reilly (Social Work Team Leader, CHO 9)
To ensure optimum functioning of the team and effective patient outcomes, the roles of the multidisciplinary team members in care planning and delivery must be clearly negotiated and defined. At the core of this is an Operational Policy, which reflects the shared understanding of the core mission of the team and ‘how things work’. This includes the target client group, clarity of purpose, capable practice approach (who is best placed to do what), evidence informed approach (knowing what works). Each ICP OP Pioneer Site is required to develop an operational policy and submit this as part of their Structural Metrics submissions.

The MDT function is to coordinate older persons health and social care needs involving all of the agencies involved through a clinical network hub. Waterford Integrated Care Older Person Hub (fig 4.14) functions as the coordination, information and training hub for older person’s services. This facilitates integration between hospital and community services and acts as a resource for all involved in delivering older person’s services. It provides expedited assessment for frail older persons presenting to ED, GP or AMU seeking to maximise the number of people who can access care in the least restrictive setting. Incremental investment in CHO5/Waterford University Hospital has leveraged existing resources more effectively.

Figure 4.14: Waterford Integrated Care Older Person Hub

What difference has it made?
Case Management Approach
Case Management is a complex intervention that involves organising and coordinating care for the individual. It forms a key cornerstone of a new way of working that enables and supports the delivery of secondary care in the community appropriate to the needs of older adults with complex needs and long term conditions such as frailty. The flexibility and adaptability of case management models is a key strength as approaches can be tailored to suit a diverse range of settings and locations. Emerging evidence suggests that case management approaches have a key role to play in achieving improvements in clinical care and in system- and patient-oriented outcomes. The potential benefits of this approach seem to be most significant for individuals ‘at risk’ of hospitalisation and for those living with multiple health problems.

Community Virtual Ward Model
Older Persons Care North Dublin Primary Care
In North Dublin primary care a Community Virtual Ward (CVW) model was developed to emulate aspects of hospital care in the home. The model is overseen by a Clinical Case Manager and supported through an integrated approach to care including primary care services such as the GP, public health nurse (PHN), physiotherapist, occupational therapist and social worker as well as, specialist gerontology services based in the acute hospital and Day hospital. The level of service interventions and monitoring are guided by levels of virtual wards (VW) with the greatest activity within the high risk (red) level VW. In the red level VW, patients are reviewed at a minimum of once weekly for up to 30 days, with a number of individuals requiring visits every day or every second day throughout an acute episode of care. Following a period of stability patients are transferred to lower level VWs (amber moderate, green low risk) with interventional strategies provided to maintain levels of function and health status in preparation for discharge to community care. This includes a follow up by a PHN within four to six weeks post discharge from the CVW. Since 2015 there has been a 43% reduction in unplanned hospital admissions and a 57% reduction in ED presentations. The number of falls have been reduced by 28% following a programme of case management with tailored interventions through a CVW approach to care. Interventional strategies with defined periods of monitoring (up to 90 days) have improved healthcare outcomes such as nutritional status and function. Following a period of admission to the CVW approximately 50% of patients classified as high risk with severe levels of frailty have been supported at home and thus, delayed or avoided the need for long term care.

The model of care has developed into a conceptual model of risk with early identification of characteristics of risk suggestive of adverse outcomes such as hospitalisations or institutionalisation. Research investigating risk stratification and management has shown key stages in the CVW case management process that determine outcomes through health states predicting the likelihood of remaining at home versus institutionalisation. Hospital metrics of risk have been tested as part of a CVW case management approach and show promise in predicting outcomes in a high risk group to assist in reducing unnecessary hospital admissions. Hence, the CVW has evolved from a model of service provision to include a conceptual model of risk through a case management approach to care, with service delivery that is in or near the home.

What difference has it made?
Case Management in Action

CHO 9/ Connolly Hospital – Case management
Key Pathway elements – Home Visits

CHO 9 Connolly

The Clinical Case Manager role involves a senior clinical role ("typically a nurse") working across primary and secondary care supported by the wider multidisciplinary team including specialists in gerontology and GPs. The aim of the role is to provide timely service interventions tailored to individual needs and appropriate follow up with defined periods of monitoring. This includes facilitation of access to the day hospital if there is evidence of deterioration and/or organisation of a planned admission to hospital to reduce the need for long term care and support the older person at home for as long as possible. Community management (home/day hospital) are a central element of the Case Manager role conducted in approximately 71% of patients referred. The ability to arrange care assessment to take place from the patients’ home means the intervention will be better suited to the specific needs of patients based on services and resources available.

Figure 4.15

"If the Case Manager was not visiting patients at home and directly organising supports such as medications, CIT and home care packages these patients would be attending our Emergency Department."

(HSE Patient Flow Co-ordinator, Connolly Hospital)
Supports to live well

Enabling older adults to live well within their own communities is a complex undertaking. This cannot be achieved by health and social care services alone. Ireland has a very rich tapestry of community and voluntary organisations. These provide services that address older peoples’ needs in many diverse areas. This includes tackling loneliness and isolation, maintaining independence or by promoting positive health through recreational and physical activity. Opportunities for economic and civic engagement that can influence transportation and housing are embraced. Integrated care teams older person, seek to tap into this rich tapestry through adopting a care co-ordination and signposting approach.

The Older Persons Integrated Care Team in Co Louth work in a very integrated manner with the wide and varied support groups and organisations that are available throughout the county, which are additional to HSE supports.

There are a vast array of voluntary and community based organisations in addition to a well established and supportive Age Friendly Alliance who have a user representative on the local Steering Group. Working with organisations such as Drogheda and District Support 4 Older People (DDS4OP), Cuidigh Linn, The Alzhiemer’s Society, ALONE, Louth Family Carers, Flexibus and IWA enables the team to manage patient care in a truly integrated and holistic way. Working with such organisations not only complements the work of the wider OPIC Team but it also very much supports the Case Management model within Integrated Care and most importantly enables the individual to continue to remain living well at home following their discharge from the OPIC Team.

The Older Persons Integrated Care Team in Co Louth work in a very integrated manner with the wide and varied support groups and organisations that are available throughout the county, which are additional to HSE supports.

An additional resource in Co Louth is Netwell Casala which is based in DKIT and is a research and community project that aims to translate ideas into practical solutions with an overall aim of improving the lives of older people. Some of their projects include Cultaca (Community navigator), the Great Northern Haven (housing project of purpose built smart homes), monthly Memory Café, proACT (integrated technology systems) and the provision of Home Respite hours all of which the OPIC Team are linked in with in order to support individuals to remain living at home, safe and well for longer.

A more recent addition to resources and supports in Co Louth are the appointments of both a Community Navigator and an Implementation Lead through the mPower project. The mPower project is a 5 year CAWT funded programme with an aim to support over 65s living with long term conditions, enable people to live safe and well in their own homes and to support self-management of their care in the community.

What difference has it made?
Person centred service design

The Integrated Care Programme for Older Persons has taken a co-production approach to service design and service improvement strategically engaging older people in a meaningful way so that the voice of the older person is at the centre of all we do. This is demonstrated through the participation of older people and organisations representing older people in governance structures at both a national and local level, and the recruitment of Older Persons’ Patient Champions to work with local steering groups on improvement projects designed to address issues raised through feedback from patients on their experience of health and social care services.

Co-production in Action

The ICP OP have developed a Service Improvement process for pioneer sites that uses patient experience feedback to drive the improvement agenda locally. A number of sites held workshops with key stakeholders, including older people, in 2018. One of these sites was CHO9/Beaumont Hospital.

Patient experience feedback received through HSE initiatives such as the National Patient Experience survey was considered by service users, healthcare professionals, and staff from NGO’s and local authorities, and suggestions for improvement projects were recorded on the day. This feedback was considered by a sub-group of the local ICP OP governance group, including a Patient Champion, and improvement initiatives were selected for action.

An example of one of these initiatives is a project to improve the co-ordination of services locally and build an assets based approach to health and social care with Primary Care Teams. This project is being co-led by a member of the Integrated Care Team, and a volunteer Patient Champion. The project will have three stages as follows;

• A networking event for health and social care professionals, local authority staff, and community and voluntary groups with the aim of building key relationships to enable a more co-ordinated response to the needs of patients held in September 2018. Over 120 individuals registered for the event.

  ‘The Speed Networking Event provided a great opportunity to meet with service providers and people who are dedicated to improving the support services for older people in the community. It gave me a great opportunity to connect with other people within the health care network and within community engagement. The event this morning made me reflect that it would be great to develop our partnership together with a variety of care providers as a Community of Practice (COP). This event makes you realise that there is the potential to develop the health and well-being of older people in a holistic way set within an integrated care context within the community.’ Dr Trudy Corrigan, School of Policy and Practice, Dublin City University.

• A follow-up event open to service users to build awareness of local services and how to access them.

• Engagement with Primary Care Teams locally to inform them about the community assets available locally that can play a role in maintaining the older person living well at home in their own community. A local Directory of Services for Older People is being developed as a tool for the teams.

This is just one example of an initiative where the Patient Voice is being used to drive the improvement agenda within the ICP OP, and where patients are involved in co-designing and co-delivering a local solution. As the number of sites involved in this work grows the intention is to develop a Co-production Network across the programme where professionals and patients involved in this work can share ideas and learn from one another.
What have we learned?
Implementation insights

ICP OP has had the opportunity to work with pioneer sites in designing and testing a new model of integrated care for older persons with complex, longitudinal needs over the past 2 years. Whilst each pioneer site implemented a component of an integrated care pathway some common lessons have emerged irrespective of location.

1. Governance is fundamental
   • A national governance structure, namely the National Working Group, Older Persons, has proven to be an important focal point for national service redesign. This provided a forum for the inclusion of older persons through Age Friendly Ireland and allowed consultation on strategic initiative such as the development of candidate Advanced Nurse Practitioners.
   • A functional local governance structure that supports local clinical and managerial entrepreneurs to implement service redesign is fundamental to the process of change. Without local executive support and sponsorship (i.e. from the Clinical Director and Senior Acute Hospital and Community Managers) there is a high likelihood that any progress will be limited, commitment will fade and any investment will not yield a dividend.

2. Relationships have to be cultivated
   • It takes time to build trust and agree a common vision based on mutually agreed goals.
   • Mobilising a common vision requires all parties to set aside professional and organisational interest and build social capital that can be harnessed in order to make progress in the interests of staff and patients.

3. Developing a shared local roadmap is a critical step
   • The ICP OP 10 Step Integrated Care Framework is viewed as having a very high degree of utility by local managers and clinicians as it gives change agents autonomy whilst setting out the national ‘direction of travel’. This approach accommodates local variation to a national ‘model of care’.
   • Every local health and social care ecosystem is unique and consequently centrally designed solutions do not translate into a local context. Implementation of integrated care for older persons has to be flexible enough to accommodate this local context, opportunity and history.
   • Mapping the local older person pathway across primary/community, ambulatory emergency and inpatient pathways is a key task for local leaders. This captures the common vision in a coherent service map that can be developed incrementally and harnesses the good things already happening.
   • The development of a Community Hub as a focal point of mapping service delivery allows services to be delivered and developed more effectively.
   • New MDTs need clarity in terms of their role and how they fit into an overall pathway.

4. New resource can be used to mobilise existing resources more coherently
   • In taking an assets based approach there is an opportunity to revisit what’s already in place and ensure these assets can be best utilised in managing the needs of an older person with frailty as a long term condition.
   • Integrated care needs dedicated, local programmatic support to succeed. The daily grind of helping to develop a new way of working cannot be left as an ‘add on’ to the day job. The more successful sites have either a dedicated person or protected time devoted to supporting the change.
   • When people are given ownership and opportunity there is a recognition of and an appetite for change. Existing local resources can be amplified and used more effectively with
a small amount of national support. Momentum builds locally and from the ground up more effectively than from the top down.

• Service users and carers are a substantial asset and should be included in the redesign process from the start.

5. Enablers

• Key national enablers (ICT, HR, Population planning and Finance) are not currently designed to support integrated care but are critical to its success.

• Implementing integrated care is context dependant and that is highly dependent on local operational and clinical leadership. It takes time to embed and is heavily influenced by local factors

• Implementation in complex systems won’t happen by simply developing models, guidance or frameworks. A dedicated team such as ICP OP has fulfilled a key role in facilitating national strategy in combination with local project implementers.

6. Research

ICP OP and the School of Health Policy and Management, Trinity College Dublin undertook collaborative research into how insights from implementing ICP OP might inform Slaintecare, especially as a gateway towards universal healthcare implementation. This consisted of a mixed methods approach using a survey and case studies from three ICP OP Pioneer sites. The methodology centred on survey of 220 practitioners implementing integrated care (36% return rate) and 3 case studies using participant observation, documentary review, co-produced by engagement, workshopping and feedback loops. The results of the survey on the 10 step framework suggested a high degree of validity and utility by practitioners and managers (see appendix 2) as a tool to implement integrated care. The survey and case study research evidences challenges around provider skills and competencies, managing patient access and pathways, and the creation of organisational systems to underpin new service delivery designs. It concluded that learning how pioneer initiatives and discrete programmes can grow locally, scale more broadly and buy-in is critical to meet the challenges of UHC policy implementation and integrated care.

The following are a synopsis of the key insights into the hidden dynamics associated with implementing integrated care for older persons

1. Methodology Matters (complexity trumps control)
   It is fundamental that there is recognition that implementing change of a systemic nature is taking place in a complex adaptive system. The approach has to be iterative and organic. It also has accommodate high autonomy professionals where social influence is not amenable to programmatic management.

2. All Integration is local
   Local history, resources, ownership and culture are the key ingredients for integrated care. The ability to lead this collaboration locally has a profound impact on the potential to redesign services.

3. Improvement is iterative, dynamic and organic
   The iterative nature of improvement in complex adaptive systems respond to the dynamics and influence that can changes and give rise to new opportunities. It takes time to build trust and confidence in mutually agreed goals. Incremental, small steps (the ‘grind’) constitute the substantive change effort rather than dramatic, short term change.

4. Local governance is key
   A functioning, local governance structure, underpinned by senior executive clinical and managerial sponsorship, is an essential prerequisite for effective integration of care. This provides strategic and operational coherence and allows opportunities for redesign to be leveraged.

5. Population is fundamental (not organisation)
   A focus on prioritising population need, specifically those that will benefit from integrated care, has to supersede institutional concerns in order to health and social care to be delivered across boundaries. ‘Fixing the system’ is secondary to person centred care population and place base care.

6. Trust people who know their business
   The most useful function a national programme can perform is to facilitate clinical and managerial entrepreneurs to fulfill their local vision. Meaningful strategic change is driven locally with national supports not vice versa.

7. Respect trumps resource
   Whilst necessary, resource is not sufficient for change to happen. Paying attention to and respecting the importance of peoples work leverages latent capacity to make the transformation of older persons care happen.
Opportunities for scaling up

Introduction

The publication of Slaintecare (DoH 2018) as the framework for health system transformation in Ireland is critically important. This provides a policy bridge with the potential to support the ICP OP 10 Step Framework in moving from the ‘design and test’ phase to scaling up. The Slaintecare Implementation Plan on integrating care reflects many of the issues addressed by ICP OP (Governance, ICT, Workforce, Research) and specifically references the intention to accelerate the integrated care programme for older persons (action 4.5, p.74). The following insights are offered as part of this acceleration.

1. The interface between local redesign and national policy is critical to support sustainable change. This needs to be reflected in support for governance structures that are mandated to deliver new care models.

2. Dovetailing future ICP OP developments with Community Health Networks allows a focus at a population level on older person’s services.

3. Fundamental national policy targets (KPIs) need to be made explicit and outcome measures agreed. The absence of meaningful national metrics makes measurement and evaluation impossible.

4. The emerging HSE commissioning process needs to support an incremental, strategic redesign of services (through local governance) that empowers and incentives local leaders to develop services that are sensitive to local context.

5. Despite some positive local examples of collaboration between primary and secondary care, there is a need to mobilise strategic linkages more substantively (nationally and regionally) through new commissioning structures.

6. Structure (governance) to bring coherence of efforts and maximize resource and benefits in order to integrate related initiatives needs to be strengthened (Home care, Falls, Dementia, Old Age Psychiatry, SAT, CIT, voluntary sector).

7. Integrated care needs to be built incrementally and undertaken at community network level with relevant partners (primary and acute partners, third sector agencies, local authorities business and academia).

8. Strategic funding is required. This includes repurposing existing funding or combining this with new ‘seed’ funding.

9. Dedicated expertise is required to support the change nationally and regionally. Change doesn’t happen spontaneously and capacity to support change is necessary as this is a dynamic social process, not a technical fix.

10. Alignment of existing and new resources is a key task whereby strategic change is proposed.¹

11. Development of a sustainable means of gathering and using data is needed to support change. Existing data systems provide a basis for building on this.

¹ In order to achieve this, Integrated Joint Boards (IJB) have been established to manage the €8b of the €13b Scottish health and social care budget.
“One of the things that’s really important from a universal care point of view is to try and get a holistic, whole systems approach in order to deliver integrated care.

ICP OP generates really positive feedback loops from the practical experience of health and social care givers on the ground to our most senior health policy formulators/makers”.

Dr Sarah Barry, Assistant Professor, Public Health & Primary Care, Trinity College Dublin
Proposed Approach to scaling up?

Four key strategic questions need to be addressed before embarking on scaling up. This is necessary in order to align strategic effort and determine value. The first of these concerns fundamental agreement on the goals of scaling up. The proposed approach suggests a balance of institutional and citizen goals.

The second strategic consideration is which ‘route’. The timing of the Community Healthcare Network (CHN) development provides an opportunity to develop primary and secondary networks at 50,000 scale. This facilitates a realistic service delivery model.

A third strategic consideration is concerned with ‘how’ (methodology used) to scale. A collaboration between the ‘Pathways to Universal Healthcare Project (TCD) and ICP OP (Harnett and Kennelly 2018 and Barry and Ni Fhaolain 2018) indicates that an implementation model that sets a strategic direction but allows local flexibility on implementation has demonstrated considerable consensus on ‘what works’. This approach allows local leaders to earn autonomy incrementally and in turn rewards strategic service redesign with further resources.

This operates on the basis that local resources (people and care processes) can be more effectively leveraged with a relatively small investment and is a departure from a traditional ‘additionality’ mindset where change can only happen with significant investment. This puts the process in the hands of local clinical and managerial leaders rather than corporate ownership and includes service users in the redesign process.

A final strategic consideration is ‘what’ to scale. To date, the evidence supports some fundamentals of redesign as set out earlier (ref pathways). The indications to date support a combination of design features that includes community ambulatory pathways, partnering more effectively with voluntary community providers, users and carers and orienting the incentives towards a Home first model.

(Ref; www.socialinnovationchange.org)
Recommendations for scaling up

1. Fundamental national policy targets need to be made explicit and outcome measures agreed.
2. The emerging HSE commissioning process needs to support an incremental, strategic redesign of services that empowers and incentives local leaders to develop services that are sensitive to local context.
3. Interface between local redesign and national policy is critical to support sustainable change.
4. Integrated care needs to be built incrementally and undertaken at community network level with relevant partners (primary and acute partners, third sector agencies, business and academia). This takes time to yield results.
5. Strategic funding is required. This includes repurposing existing funding or combining this with new ‘seed’ funding.
6. Dedicated expertise is required to support the change nationally and regionally. Change doesn’t happen by spontaneously and capacity to support change is necessary as this is a dynamic social process, not a technical fix.
7. Alignment of existing and new resources (e.g. CIT) is a key task whereby strategic change is proposed.
8. Develop sustainable means of gathering and using data is needed to support change. Existing data systems provide a basis for building on this.

Recommendations on enabling functions

1. Use funding as an active instrument of change. This includes existing and new funding.
2. Enhance population planning expertise and capacity locally.
3. Mandate integrated care at a policy level.
4. Focus on measures of outcome that matter to the population the value proposition.
5. In order to deliver change at scale ICT and communication needs to have capacity to deliver functional support.
6. Changes are required to recruitment process which are unwieldy and protracted leading to long delays.

Mobilising Enablers

Key Lessons in Integrating care for Older Persons

The following reflects the lived experience of ICP OP and feedback from sites.

Policy

Heretofore there was no policy mandate underpinning integrated care. Slaintecare (Gov. of Ireland 2017) when mobilised has the potential to provide a policy context for implementing integrated care.

User involvement

Service users value inclusion and are a resource, not just a consumer of service. Users and carers are willing partners and have concrete and practical contributions to make.

ICT

Local (smaller scale) solutions need to be leveraged as part of shift left stay left. Agreed mechanism to provide scale up/adaptation of IT solutions is required. Strategic vision needs to be balanced with functional support.

Measurement

Current community data collection, analysis and utilisation requires significant development and are not adding value or sustainable in its current form.

Workforce

Clinicians and managers understand and welcome new roles working across boundaries. Teams require operational and clinical leadership to function well. Working with older persons is increasingly an attractive career option.

Communication

Changes at scale require a broader, more substantive communication support that uses various media.

Funding

Yearly estimates cycle at odds with and undermine strategic change. Development funding is seen as marginal and therefore not core business. No incentive/mecanism are in place to use existing funding differently. The financing model needs to proactively support changes to the service model.

Population planning

Focusing on population needs as a strategic priority is critical for care pathways to function effectively. Any scale up of integrated care will require the mobilisation of national and local population health specialists.
Proposed next steps

The Slaintecare (GoI 2018) goal is deliver real and sustained improvements in the provision of healthcare for all citizens. The Slaintecare Implementation Plan (GoI 2018) aims to become a ‘living implementation process’. Within this implementation plan, the intention to accelerate the ICP OP (Action 4.5.1, p.41) is warmly welcomed. ICP OP is already addressing other Slaintecare Actions, for example bespoke pathways for populations (Action 4.1) and new community based roles (Action 4.2) and will benefit from GP contractual changes proposed (Action 4.4).

ICP OPs’ core function is service redesign and to that end it has worked with academia, business, statutory and non-statutory agencies in order to address this goal. In engaging with service users and agencies involved with older persons it has become clear that service redesign on its own will not fully achieve integrated care. This will only be realised by an inclusive, assets based, holistic approach, that addresses housing, employment, transport, physical activity and social inclusion within communities, http://agefriendlyireland.ie/cities-and-counties-programme). This requires an ecosystem approach whereby ICP OP contributes to the overall goal of improving aging well in place as part of a broader coalition of effort.

Figure 5.6

Recommended actions

It is in this context that the following ICP OP ‘next steps’ are recommended for endorsement by senior executive leaders and a refreshed mandate agreed on key enablers if the acceleration of integrated care for older persons is to be addressed;

1. Leadership and Governance

The learning to date has indicated that areas with functional governance and committed leadership has made more progress. This not only allows operational implementation but addresses the fundamental of a population based (rather than institutional) approach to integrated care. ICP OP has worked with existing sites in promoting patient champions. It is recommended that the all areas undertaking integrated care have a structure across hospital and community that includes service users as well as a coalition of agencies involved with older persons.

2. Information Communication Technology

The intention to shift left, stay left is congruent with the ICP OP mission. However, integrated ICT systems are at best fragmented or non-existent in many community services. This means data collection, repeat investigations and inefficient working is wasteful for users and providers. However, Ireland has a thriving technology sector as evidenced by the Health Innovation Hub. It is recommended that ICP OP has dedicated ICT support that targets functional implementation of new technology or harnesses existing ICT systems. This includes implementing a case management system at that can interface with existing systems and provide a community ICT infrastructure.
3. Workforce

New roles and functions have been successfully implemented within ICP OP such as Community Geriatricians, Health and Social Care Professionals and Case Managers. In addition, it has been possible to integrate new candidate Advanced Nurse Practitioner roles into integrated services. However, timely recruitment is hugely problematic with a time lag (9-12 months) that slows down implementation. It is recommended that the HSE HR considers a nominated link person at a national level to fast track a process to support a shift towards integrated, community roles.

4. Finance

Current funding arrangements do not incentivise innovation or integration. ICP OP has learned that the use of a small amount of funding can yield a significant amount of return on investment by giving local clinical and managerial leaders the autonomy to strategically invest where needed. In three pioneer sites, a total of €1.060m invested yielded a return of €7.747 in terms of notional savings. ICP OP recommends that formal mechanisms are considered to incentive the use of existing funding differently. In addition, a 3 year planning cycle should facilitate the use of new development funding to be used strategically. A concurrent economic evaluation of investment is recommended in each new funding commitment.

5. Scale up

To date most ICP OP sites have delivered one or more stages of an integrated care pathways. Whilst they are necessary building blocks and deliver better results (FiTT, Early Supported Discharge), as indicated (p.22), the full value of investment in integrated care requires end to end pathways to be in place. ICP OP recommends that a more in-depth mobilisation takes place in a single ecosystem (e.g. a CHO) in order to fully deliver end to end pathways and to mobilise the key enablers (workforce, ICT, Finance). This will allow meaningful transformation to take place at scale regionally with lessons learned at this stage informing further investment. This will require ICP OP to be resourced to deliver this and to take the opportunity to mobilise resources in tandem with local change management/programmatic resources.
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## Appendix 1 – Glossery of terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADL's</td>
<td>Activities of Daily Living</td>
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<tr>
<td>AFI</td>
<td>Age Friendly Ireland</td>
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<tr>
<td>AMAU</td>
<td>Acute Medical Assessment Unit</td>
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<tr>
<td>CHO</td>
<td>Community Healthcare Organisation</td>
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<tr>
<td>CIT</td>
<td>Community Intervention Team</td>
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<tr>
<td>CGA</td>
<td>Comprehensive Geriatric Assessment</td>
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<tr>
<td>DH</td>
<td>Day Hospital</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<td>GEMS</td>
<td>Geriatric Emergency Medicine Service</td>
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<td>GDH</td>
<td>Geriatric Day Hospital</td>
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<td>HIQA</td>
<td>Health Information and Quality Authority</td>
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<td>HSCP's</td>
<td>Health and Social Care Professionals</td>
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<td>ICP OP</td>
<td>Integrated Care Programme for Older Person’s</td>
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<td>ICT</td>
<td>Information and Communications Technology</td>
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<tr>
<td>ISAX</td>
<td>Ireland Smart Ageing Exchange</td>
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<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
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<tr>
<td>NWGOP</td>
<td>National Working Group for Older Person’s</td>
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<tr>
<td>NCPOP</td>
<td>National Clinical Programme for Older People</td>
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<tr>
<td>PROMS</td>
<td>Patient Reported Outcome Measures</td>
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<td>PREMS</td>
<td>Patient Reported Experience Measures</td>
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<tr>
<td>SGW</td>
<td>Specialist Geriatric Ward</td>
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<tr>
<td>SAT</td>
<td>Single Assessment Tool</td>
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<tr>
<td>CNSp</td>
<td>Clinical Nurse Specialist</td>
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<td>OT</td>
<td>Occupational Therapist</td>
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<td>PT</td>
<td>Physiotherapist</td>
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<td>SLT</td>
<td>Speech and Language Therapist</td>
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<td>PHN</td>
<td>Public Health Nurse</td>
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Appendix 2 – Workforce Planning

Integrated Care Programme for Older Persons
Workforce Planning Considerations

Planning for an Ageing Population
As Ireland’s population ages, an adequately staffed age-attuned workforce is essential to provide high quality person centred care for older people in the right location, integrated across GP, Community and Acute hospital services.

Strategic Goals [ref. People Strategy 2015-2018]
1. Build capacity to redesign/reconfigure services and the workforce based on best practice, evidence based models of care and anticipated future needs.
2. Support individuals and teams to adopt new ways of working and practice changes in line with evidence.
3. Explore use of ‘technology’ to support an agile, flexible and mobile workforce.

National Pioneer Sites

<table>
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<tr>
<th>Team Roles</th>
<th>Social Care</th>
<th>Acute Hospital</th>
<th>Primary Care</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community-Facing Geriatrician; shared posts across acute and community</td>
<td>Consultant Geriatricians with service focus on older persons</td>
<td>GP with specialty interest, governance roles in Community, PCT and LTC settings enabled</td>
<td>Psychiatrists for Later Life in Community with liaison roles in acute hospitals</td>
</tr>
<tr>
<td>Specialist Clinician</td>
<td>Case Manager / Care Co-ordinator to manage older people with complex needs. Shared roles across acute hospital and social care</td>
<td>Case Manager / Care Co-ordinator to manage older people with complex needs. Shared roles across acute hospital and community</td>
<td>Case Manager / Care Co-ordinator to manage older people with complex needs. Shared roles across acute hospital and community</td>
<td>Case Manager / Care Co-ordinator to manage older people with complex needs. Shared roles across acute hospital and community</td>
</tr>
<tr>
<td>Case Manager</td>
<td>Clinical Nurse Specialists Gerontology and Dementia</td>
<td>CNS Gerontology and Dementia</td>
<td>Practice Nurses with Specialist Older persons Training in PCT</td>
<td>CNS Dementia</td>
</tr>
<tr>
<td>Specialist Nursing</td>
<td>AHP with older persons training across the continuum</td>
<td>AHP with older persons training across the continuum</td>
<td>AHP with older persons training across the continuum</td>
<td>AHP with older persons training across the continuum</td>
</tr>
<tr>
<td>Allied Health Professional (AHP)</td>
<td>AHP with older persons training across the continuum</td>
<td>AHP with older persons training across the continuum</td>
<td>AHP with older persons training across the continuum</td>
<td>AHP with older persons training across the continuum</td>
</tr>
</tbody>
</table>

Total Recruitment (2016) 35 WTE
Recruitment (2017) 12-24 WTE

Workforce Development – New Ways of Working
New ways of working are required to enable the redesign and reconfiguration of services including:

a) Recruitment of new people into the workforce in new roles;
b) Changing and enhancing the roles of the existing workforce.

Key team roles will operate across the continuum of care supporting the integration framework for older people as indicated in the table above.
New Roles across Care Settings

New ways of working will need to be flexible and responsive operating across different care settings as indicated in the table below:

<table>
<thead>
<tr>
<th>Dedicated Care settings with Older persons Focus</th>
<th>Social Care</th>
<th>Acute Hospital</th>
<th>Primary Care</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Hospital with mix of Rehabilitation, Short stay and long-term care beds with MDT support</td>
<td>Community Intervention Teams optimised to support the care of older persons at home throughout the continuum</td>
<td>Specialist Geriatric Ward aligned with Acute Model of Care for Older Person</td>
<td>Mental Health services that meet needs of the person with complex mental health issues and dementia</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Care Hub with MDT support and Rapid access support pathways</td>
<td>Frailty Units in AMAU with dedicated Geriatrician and supports at hospital ‘front-door’</td>
<td>Reablement teams that support rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Home Outreach Support</td>
<td>Ambulatory Care Hub with MDT support and rapid Access pathways</td>
<td>Out of Hours supports enhanced to support care at home (Inc., OOH GP care, ambulance &amp; paramedic services)</td>
<td>Nursing Home Outreach Support</td>
<td></td>
</tr>
</tbody>
</table>

Competency Framework

In a context where the majority of hospital discharges, social care provision and primary care capacity are consumed by older persons, workforce planning and development needs to recognised that they now constitute ‘the bread and butter’ of the health and social care system. The shift from acute episodic care to longitudinal planning and coordination requires an age attuning the workforce. A Capable Practitioner type framework founded on ten essential shared capabilities (or similar e.g. palliative care framework) would allow the development of a skill set across a range of care setting for practitioners, irrespective if their core client group. This sets out the level of competency expected of them and how the organisation will help them achieve this. Individual capabilities and competencies need to be developed and supported to ensure an effective, balanced team approach with skill blending, balanced case-loads and individual responsibilities.

Workforce Considerations

1. Competency framework (who needs to know what?)
2. What do they need to be able to do (care process?)
3. Education and training (how do educate, upskill?)
4. Functional/operational design (how do they go about their work?)
5. Governance (what works best in terms of accountability and support?)

Key workforce planning for the ICPOP considerations should focus on the recruitment of doctors, nurses, social care and allied health professionals who have undertaken specialist training programmes where working with older people is a core part of education and training. Against this backdrop, the National Clinical Programme for Older People has produced a Workforce Planning document for Physicians in Geriatric Medicine (December 2013), and a Draft proposal for the development of a Strategy for Gerontological Nursing in Ireland (June 2015).

Key operational challenges

Some fundamental workforce challenges for developing an age attuned workforce are listed. This will not only include recruitment of Key Roles required, but ensuring that the structures that are embedding (CHO, AHG) do not mitigate against an integrated approach to caring for older persons across primary care, acute hospitals, social care, and mental health boundaries.

- MDT working
- Working across service boundaries
- Having dual (or more) reporting relationships
- Decision making (e.g., positive risk taking)
- Working in ‘non institutional’ setting
- Recruitment into dedicated OP roles
- Readiness of system (locally and nationally)

References

1. Workforce Planning document for Physicians in Geriatric Medicine (NCPop December 2013),
4. New Ways of Working for Everyone (DoH, UK,2007)
5. The Ten Essential Shared Capabilities, (DoH, UK,2004)
6. The Capable Practitioner (Sainsbury Centre, UK,2001)
### Appendix 3 – Key deliverables of 10 Step framework

<table>
<thead>
<tr>
<th>Governance</th>
<th>Population Planning</th>
<th>Mapping local resources</th>
<th>Develop pathways</th>
<th>New ways of working</th>
<th>MDT and hub development</th>
<th>Person centred care</th>
<th>Supports to live well</th>
<th>Enablers</th>
<th>Measurement &amp; evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Steering Group Terms of reference</strong></td>
<td>Population plan report and map of community health networks.</td>
<td>Local Directory of Service</td>
<td>User Survey</td>
<td>National Frailty Education Programme (NFEP) initiated</td>
<td>Operational hub insitu</td>
<td>User questionnaire/ survey and survey outcome report annually</td>
<td>Shared CHO H&amp;W Lead plan in place</td>
<td>Staff development and training Plan</td>
<td>Structural measures quarterly report</td>
</tr>
<tr>
<td><strong>Memorandum of understanding between service providers.</strong></td>
<td>Care Pathway Mapping process underway (graphic)</td>
<td>NFEP governance structure in place</td>
<td>Name of user/ carer on steering group</td>
<td>IT hardware distributed and IT training delivered</td>
<td>Process measures monthly report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Steering group and implementation sub group (s) organogram (s) (with names and designation)</strong></td>
<td>Quality and risk issues addressed through local QI processes</td>
<td>Attendance at NFEP is multidisciplinary</td>
<td>Two quality initiatives using co-production per annum</td>
<td>Healthmail in place and being used by the team</td>
<td>PROMS &amp; PREMS twice yearly report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Operational Policy in place</strong></td>
<td>MDT Staffing List reflecting case management and assertive outreach/in-reach function</td>
<td>SAT being used for care coordination</td>
<td>Older Person Dashboard on steering group agenda</td>
<td>NQAIS (OP) available to clinicians</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 – Utility of 10 Step framework

<table>
<thead>
<tr>
<th>Category</th>
<th>Agree &lt;4</th>
<th>Agree ≥4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>Technology</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Collaboration</td>
<td>0%</td>
<td>96%</td>
</tr>
<tr>
<td>User Input</td>
<td>0%</td>
<td>94%</td>
</tr>
<tr>
<td>MDT Working</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Case management</td>
<td>0%</td>
<td>94%</td>
</tr>
<tr>
<td>Care Pathways</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>Mapping Existing Resources</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Population Approach</td>
<td>22%</td>
<td>78%</td>
</tr>
<tr>
<td>Governance</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td>Overall 10-Step Score</td>
<td>8%</td>
<td>92%</td>
</tr>
</tbody>
</table>

0% 20% 40% 60% 80% 100%
“I can honestly say that for the 1st time in 5 years in dealing with the HSE/HSE funded services, The Tallaght integrated care team has been the only service to engage with us in a proactive way, they actively listen to our parents and to us and have given us wonderful advice on how to best care for them, they have contacted us to check in as to how things are, rather than us having to repeatedly phone them. It is obvious that different members of the team talk to each other thus reducing the care burden on us. Individually the staff are empathetic and very helpful.

I believe that with the support of programs like the Tallaght integrated care team older people like my parents would be able to stay at home longer if they wish to do so, instead of having to go into nursing homes prematurely.”

*Angela Moore, Family Carer*
National Clinical & Integrated Care Programmes
Person-centred, co-ordinated care