

# Integrated Care Programme for Older Persons



## ICPOP Service User Led Service Improvement Workshop CHO 5 Feedback Report



South Tipperary General Hospital, St. Luke's General Hospital,  
Waterford University Hospital and Wexford General Hospital.

# ICPOP Workshop on Service Improvement CHO5: South Tipperary General Hospital, St. Luke's General Hospital, Waterford University Hospital and Wexford General Hospital.



## WHO ATTENDED

There were over 100 participants in attendance at the workshop representing staff from CHO5, the four acute hospitals located within the boundary of the CHO, the four local authorities of Kilkenny, Waterford, Wexford and Tipperary, NGO's representing Older People, An Garda Síochána, sports partnerships and older people from the CHO5 catchment area.

## CONTEXT

Designing and delivering integrated care for older people across local communities and hospitals is a multifaceted collaborative process between providers, users and carers. It involves changing the way health and social care is planned and delivered whilst ultimately focusing on patient experience, outcomes and quality of care. A key driver of this change process is the inclusion of the patient voice as a partner for change and translating the information we receive through recorded patient experience of services into service improvement initiatives.

## PURPOSE OF THE DAY

On 29<sup>th</sup> November 2018 the Integrated Care Programme for Older People and the Age Friendly Cities and Counties Programme co-hosted a workshop on service improvement in Waterford. The scope of this workshop was CHO wide taking in the four acute hospitals co-located within the South East CHO5 catchment area. The process used was to harness data from patient surveys (e.g Your Voice Matters, National Patient Experience Survey) which provided information on patient experience and to use this data in order to focus improvement on what mattered to patients.

## METHODOLOGY

Participants received a presentation on patient experience received through each of the four patient feedback initiatives listed above, and were also presented with the descriptors of person-centred co-ordinated care as described by patients and patient representative bodies involved in the design of Your Voice Matters - The Patient Narrative Project. These descriptors were presented under the three themes of 1. Person-centred Care; 2. Co-ordination; and 3. Communication found on the next page.

This was followed by a presentation on the feedback from patients in the South East on their experience of using HSE services through the following four patient experience feedback processes; The National Patient Experience Survey, Your Voice Matters, Your Service Your Say, The Listening to Older Person's Workshop delivered by the HSE Quality Improvement Division.

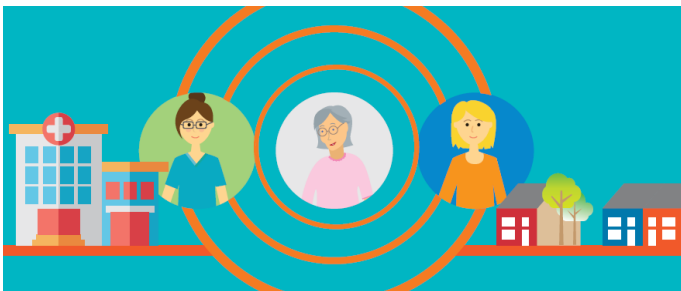


Below are three examples of descriptors of person-centred co-ordinated care from Your Voice Matters. These descriptors were agreed through a consultative process involving patients and patient representative organisations in the design of the Your Voice Matters survey.



### 1. Person-centred Care

Healthcare staff listen to me so that they understand my 'world' and what is important to me.



### 2. Co-ordination

My care includes issues that my health influences, like finances, housing, employment, ability to travel and access to transport.



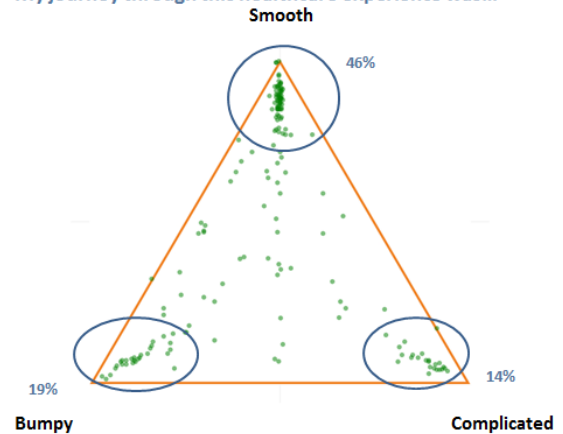
### 3. Communication

Staff communicate with me in a way that I understand.

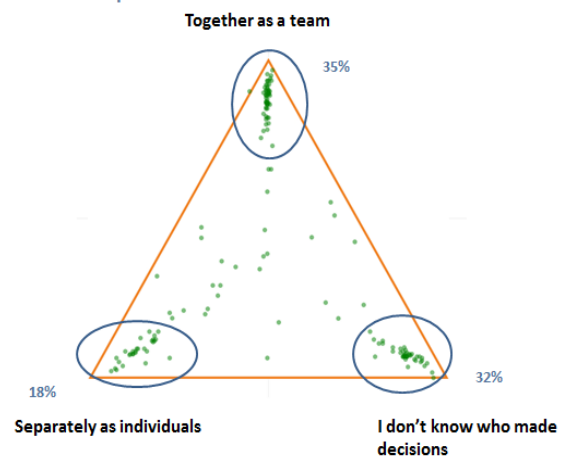
## CO-ORDINATED CARE

Figure 1. Summarised data from Your Voice Matters narratives received from patients in CHO5. Source Your Voice Matters Nov. 2018

My journey through this healthcare experience was...



In this experience the staff involved made decisions...



What does it mean?

- Nearly 1 in every 2 people are experiencing a smooth journey
- 1 in 4 people experience a disrupted journey
- Nearly 1 in every 2 people do not experience team decision making
- Nearly one third of people do not know who made decisions about their treatment and a quarter don't know what's happening after the experience was over
- For more than half of people follow-up is happening
- Not knowing what is happening is disempowering for people

Using the patient voice to inform service re-design and the development of integrated care

The HSE's Integrated Care Programme for Older Persons (ICPOP) ten-step framework makes reference to the need for bespoke care pathways as well as supports to live well.

Whilst important elements of the framework lie within the responsibility of statutory providers, we know that the social determinants of health have the biggest impact. In that regard it is important to recognise what older people value in maintaining their health and wellbeing. In addition, the kind of outcomes valued by service users and carers can differ from providers.

To include the patient voice in the improvement process participants were then split into groups and asked for their input on what good practice looked like to them under the three themes of Person-centred Care, Co-ordinated Care, and Communication, and to make suggestions on specific improvement projects that could be undertaken by the health services.

Example of data from the National Patient Experience Survey 2018 results:



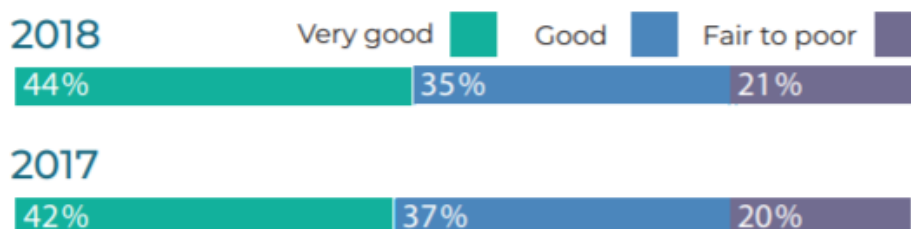
### NATIONAL PATIENT EXPERIENCE SURVEY 2018 - UNIVERSITY HOSPITAL WATERFORD



## University Hospital Waterford

### 2018 survey results

#### Overall experience



Values in figures do not always add up to 100% due to rounding.



response rate

## FINDINGS

A full record of the feedback received from the workshop participants is included on page 8 of this report. Some emergent themes from this feedback are as follows;

### 1. Patients as partners

Service Users want to be active participants in the management of their own health and wellbeing.

‘Speaking to the patient, not about the patient.’

‘Patients being given sufficient time to ask questions.’

‘Education about planning for the future.’

‘Information on how to stay well; eating, social interacting, exercising.’

### 2. The need for good communication and information, particularly when patients are transitioning from one care setting or professional to another, and from a care setting to home

‘Discharge pack with names and numbers of people to contact.’

‘Knowing who to contact if something goes wrong.’

‘Accurately transferring information about patients’ condition to other health care professionals.’

‘Clear information about who is dealing with my care.’

### 3. We need to better co-ordinate all of the services, statutory, voluntary, and community to deliver better outcomes for older people.

‘Links with local community services.’

‘Develop a comprehensive community network.’

‘Access to social outlets.’

‘Clear pathways and processes for service users and service providers.’

### 4. We need to impart positive messaging and place a greater emphasis on staying well

‘Greater emphasis on prevention.’

‘Using the media positively to get information out about services in the community.’

‘Proactive instead of reactive care.’

‘Social prescribing.’



### NEXT STEPS

The feedback from the workshop will be considered by the governance groups of the Integrated Care Programme for Older Persons in each of the four sites in the South East. This will then be used to inform the selection of two Service Improvement Projects in each area. Locally identified Patient Champions will be invited to participate in this process.

The ICPOP team would like to thank all attendees for their participation and input on the day. A special thanks to the staff of the HSE in the South East who were involved in the organisation of this event, and to the Age Friendly Programme Managers in the Waterford, Wexford, Kilkenny and Tipperary local Authorities for their assistance and participation.

### TAKING A CO-PRODUCTION APPROACH

*“Co-production is not just a word, it’s not just a concept, it is a meeting of minds coming together to find a shared solution. In practice, it involves people who use services being consulted, included and working together from the start to the end of any project that affects them.”*

To facilitate the inclusion of the voice of the older person in the re-design of services and inservice improvement projects, ICPOP are recruiting Older Person’s Patient Champions. Participants at the workshop were given a copy of the ICPOP Patient Champion leaflet and details of how to make contact with the programme.

We want to partner with you. If you are interested in getting involved as a Patient Champion please contact Des Mulligan at [des.mulligan@hse.ie](mailto:des.mulligan@hse.ie) or on 086 604 4038.



The leaflet features the HSE logo at the top left with the text 'Building a Better Health Service' and 'Seirbhís Sláinte Níos Fearr á Forbairt' in Irish. A circular illustration shows a woman named Nora watering a flower, with the text 'Hello, I'm Nora.' next to her. The main title 'Integrated Care Programme for Older Persons' is in large white text on an orange background, followed by 'PATIENT CHAMPION PROGRAMME' in white text on a dark orange background. Below the text is a photograph of a group of older people sitting in a room, looking towards the left. At the bottom, there are three logos: 'National Clinical & Integrated Care Programmes' (person-centred, co-ordinated care), 'Age Friendly Ireland', and 'OLDER PEOPLE'.



## EXAMPLES OF PATIENT NARRATIVES FROM YOUR VOICE MATTERS.

*"I attended (hospital) with an older person, they were very upset and confused in the waiting area the staff were very kind to them and kept updated on progress."*

*"I have recently been diagnosed with COPD. I have just completed pulmonary rehabilitation programme and found it very helpful with my condition."*

*"We are very happy with primary care in Cashel. Home helps, mental health, public health nurses, xray department and all others."*

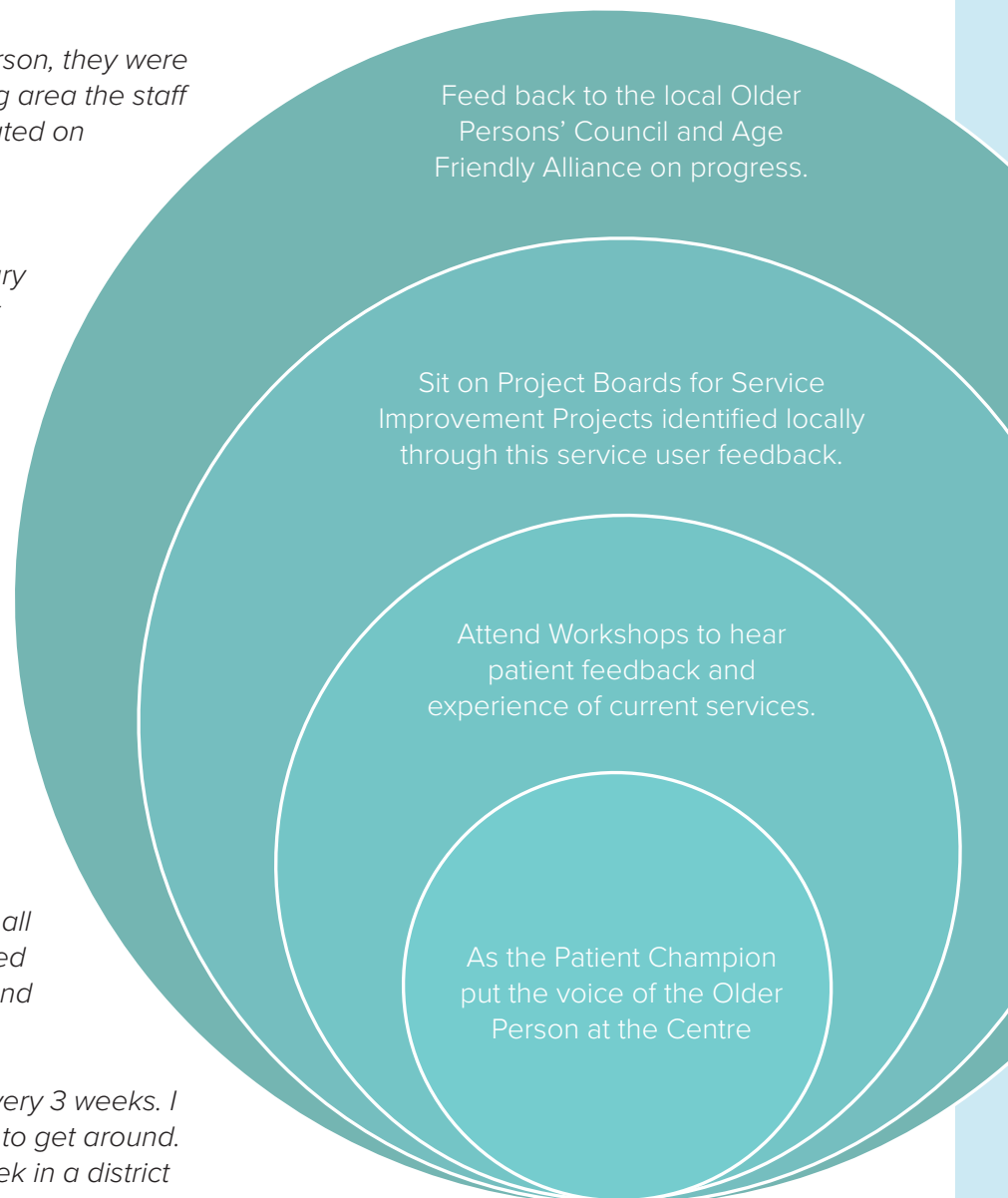
*"Service user admitted to hospital very poorly treated. Staff at hospital had no patience for the service user, they had no time to interact."*

*"Attended GP with a health scare, she assured me and arranged for a specialist appointment. Specialist followed up very quickly and put my mind at ease. Had tests done quickly, all were explained and outcomes provided promptly. Very good communication and done in a timely fashion."*

*"The public health nurse calls once every 3 weeks. I am living on my own and use a frame to get around. The nurse suggested respite for a week in a district hospital. I am going back home in a weeks time. I am very anxious to get home. I was reluctant to go to the district hospital as I was happy at home. I feel that there wouldn't be a need to go for respite if I had more home help. I had two girls home help coming for 2 years bit they got moved and I no longer see them. They replaced them with one girl less qualified for home help."*

*"I have been receiving treatment in the pain clinic. I find the waiting times on arrival can be quite a while. I also find some of the treatments a little intense as I feel sore afterwards. I have been prescribed numerous painkillers and would prefer to have alternative treatments explored."*

## THE ROLE OF THE PATIENT CHAMPION



*"I attend my GP every 3 months for diabetes tests. I have asked my GP could they change some of my medication as I think some of them are making me sick and dizzy, and thought they might be the cause of my tinnitus and hearing impairments. But they don't think they are, so I would like my GP and consultant to please listen to their patients more. They will tell you that they are the doctor and me the patient. So when a family member comes with me, they listen to them much better, and a lot of what GPs tell you its very hard for me to understand on my own."*

Source: Your Voice Matters, November 2018

Group	Theme	What does good look like?	What could we do to improve?
Group 1	Person-centred Care	<ul style="list-style-type: none"> <li>Listening to the patient</li> <li>Clear information about who is dealing with my care</li> </ul>	<ul style="list-style-type: none"> <li>Links with local community services</li> <li>Discharge pack with contact names and numbers when leaving hospital</li> </ul>
Group 2	Communication	<ul style="list-style-type: none"> <li>GEMs Service</li> <li>Co-ordinated care and communication across disciplines</li> <li>Case Manager</li> <li>Primary care teams</li> </ul>	<ul style="list-style-type: none"> <li>Integrated Care teams</li> <li>Step-up beds</li> <li>GEMs services in hospitals</li> </ul>
Group 3	Co-ordination	<ul style="list-style-type: none"> <li>Social Prescribing</li> <li>Co-ordinated care and communication</li> <li>Clarity of information</li> <li>Listening to older people and their needs</li> <li>Proactive instead of reactive care</li> <li>Comprehensive joining of the dots</li> </ul>	<ul style="list-style-type: none"> <li>Ensure the right people are making the decisions, broader range of opinions needed</li> <li>Less nursing homes, more developments to facilitate independent living</li> <li>Local oversight group to connect services and develop better community links</li> </ul>
Group 4	Person-centred Care	<ul style="list-style-type: none"> <li>Clear explanation / information about care plan</li> <li>Speaking to the patient, not about the patient</li> <li>Patients given sufficient time to ask questions</li> <li>Autonomy - patient having ownership over care</li> <li>Privacy and dignity</li> <li>Dietary requirements considered</li> </ul>	<ul style="list-style-type: none"> <li>A case manager</li> <li>Discharge pack with numbers and names of people to contact</li> <li>Media coverage of services available to people in the community</li> <li>Transport to appointments</li> <li>Social Prescribing</li> <li>Education around planning for future</li> </ul>
Group 5	Communication	<ul style="list-style-type: none"> <li>Communication between healthcare professionals</li> <li>Information explained properly</li> <li>Knowing who to contact if something goes wrong</li> <li>Patient given enough time with staff</li> <li>Good GP relationship</li> </ul>	<ul style="list-style-type: none"> <li>Accurately transferring information about patients condition to other health care professionals</li> <li>Using the media positively to get messages out about services in the community</li> <li>Information and education on how to stay well; eating, social interaction, exercising</li> <li>Involvement of statutory bodies</li> </ul>
Group 6	Co-ordination	<ul style="list-style-type: none"> <li>Knowing who to contact at a local level</li> <li>Access to social outlets</li> <li>Good contact with PHN</li> <li>Transport to day centre</li> </ul>	<ul style="list-style-type: none"> <li>Greater emphasis on prevention</li> <li>Develop a comprehensive community network</li> </ul>

Group 7	Communication	<ul style="list-style-type: none"> <li>• Interdisciplinary communication</li> <li>• Clarity of information / process for patient</li> <li>• Case Management</li> <li>• Listening to the patient</li> <li>• Clear, concise and appropriate terminology</li> <li>• Clear pathways and processes for service users and service providers</li> </ul>	<ul style="list-style-type: none"> <li>• Transport for patients</li> <li>• Patient feedback</li> <li>• Information more readily available</li> </ul>
Group 8	Co-ordination	<ul style="list-style-type: none"> <li>• Good Case manager</li> <li>• Roles clearly defined</li> <li>• Social Interaction</li> <li>• Technology / electronic records</li> <li>• Day centres</li> <li>• Integrated Care</li> </ul>	<ul style="list-style-type: none"> <li>• Case Manager</li> <li>• Speed networking days</li> <li>• Known contact person</li> </ul>
Group 9	Co-ordination	<ul style="list-style-type: none"> <li>• Everyone knows their role</li> <li>• Case Manager</li> <li>• No delays waiting for services</li> <li>• Co-ordination between services</li> </ul>	<ul style="list-style-type: none"> <li>• Directory of Services</li> <li>• Co-ordination with statutory, voluntary and community services</li> </ul>



*"I attended acute hospital in April for vomiting and diarrhea. I was admitted to A&E. I was left waiting quite a long time before anyone came to examine me or speak to me. I felt that I was a burden to the hospital when I was admitted to the ward. I felt that the hospital had no time to attend to me that it was all my carers that did all the work with me, eg. personal care, feeding, changing. I felt afraid, anxious, nervous as I did not know what was happening. Only for my carers advocating on my behalf I don't think anything would have been done. As I felt they were not bothering to listen to me as I had a disability and I did not matter."*



*"1. Respite offered 1 hour away and would have no visitors for the week despite neighbours getting place within 15 minutes. 2. Offering respite & suggesting carer they take out for 3 hospital appointments during respite. 3. Phone today & respite tomorrow is it don't suit ask again."*

Source: Your Voice Matters, November 2018







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