Sláintecare Integration Fund Learning Network Event

Innovations in shifting care to the community or providing hospital avoidance measures

@Sláintecare #Sláintecare
#RightCareRightPlaceRightTime

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Right Care.Right Place.Right Time.

Today is all about

- Networking among thematic lines in order to promote sharing experiences, learnings and problem solving

- Hearing from projects about:
  - Challenges, solutions and learnings around implementation, and
  - The value to your project of using networks

Kevin Meaney, Sláintecare - Integration Fund Evaluation

Monitoring and Reporting

- In line with previous advice provided by Pobal
- **Monthly Returns**
  - Progress update on agreed milestones, on outputs, on outcomes – narrative update, and Recruitment / Staffing update
- **Mid-term Return (End-June)**
- **Final Return (End-December)**

Evaluation Approach

- Evaluation will be based on the information provided in the Monthly Reports, Mid-term and Final Returns to Pobal (no additional reporting requirements).
- Final guidance on the evaluation to issue shortly, which will be carried out by the Department of Health.

Use of Detailed Progress Updates

- For each milestone/activity, grantees will be asked for specific output and outcome updates, and how the outputs are linked to the outcome.

- **Feedback on project relevance**
    - Details of how the project has met customer needs to date
    - Details of how the project helped to improve the current service delivery
    - Evidence of potential scalability and lessons learned

- **Economic Benefits**
    - Costs – Direct and Indirect
    - Benefits / Impacts in line with applications and Grant Agreements (further on next slide)

- **Project Implementation**
    - Programme and project management plans - project management and governance arrangements
    - Approach to management and delivery of results – delivery of project plan for delivery of agreed outputs and timeline of milestones achieved
    - Approach to risk management - approach to managing risks during and post implementation

Detailed Activities, Outputs and Outcomes for Evaluation

Activities; including	Outputs; including	Outcomes; including
Hiring of relevant professionals and team engagement	Meetings and consultation with target population, compared against target in Grant Agreement	Delivery of outcomes targets as detailed in the Grant Agreement
Delivery of actions as per the Grant Agreement	Detailed report of best practice for sharing purposes and lessons learned; quantitative and qualitative	**Can involve:**
Increasing engagements with target population	Referral of target population to most appropriate care setting	Reduced referrals, or more appropriate referrals to relevant health specialists
Delivery of the new service delivery model e.g. different referral patterns away from acute services	Financial and non-financial reports at April and end of process	Increased integration of care, e.g. home outreach/community referral rather than referral to acute location
Collection of the relevant financial and non-financial data to assess improvement, as agreed in Grant Agreement	New Service Delivery Model, how this is a new way to deliver care and is more appropriate	Emergency Department Attendances and Admission avoided/reduced
Monthly project management engagement with relevant organisation		Increased access to care, reduction in waiting times for patients
Sharing of best practice and lessons learned		Facilitating timely hospital discharge
		More cost effective means of delivering care
		Patient and Professional Satisfaction, through the use of surveys

Purpose of the Evaluation

- To identify the positive impacts of the Integration Fund on service/clinical outcomes and patient experience

- Can be used in order to make the case for additional funding. The evaluation approach is aligned with DPER guidelines on demonstrating impact.

- Will be used for the Communications Strategy to highlight the positive work of the Integration Fund projects.

Ciara Eustace, Sláintecare - Integration Fund Communications

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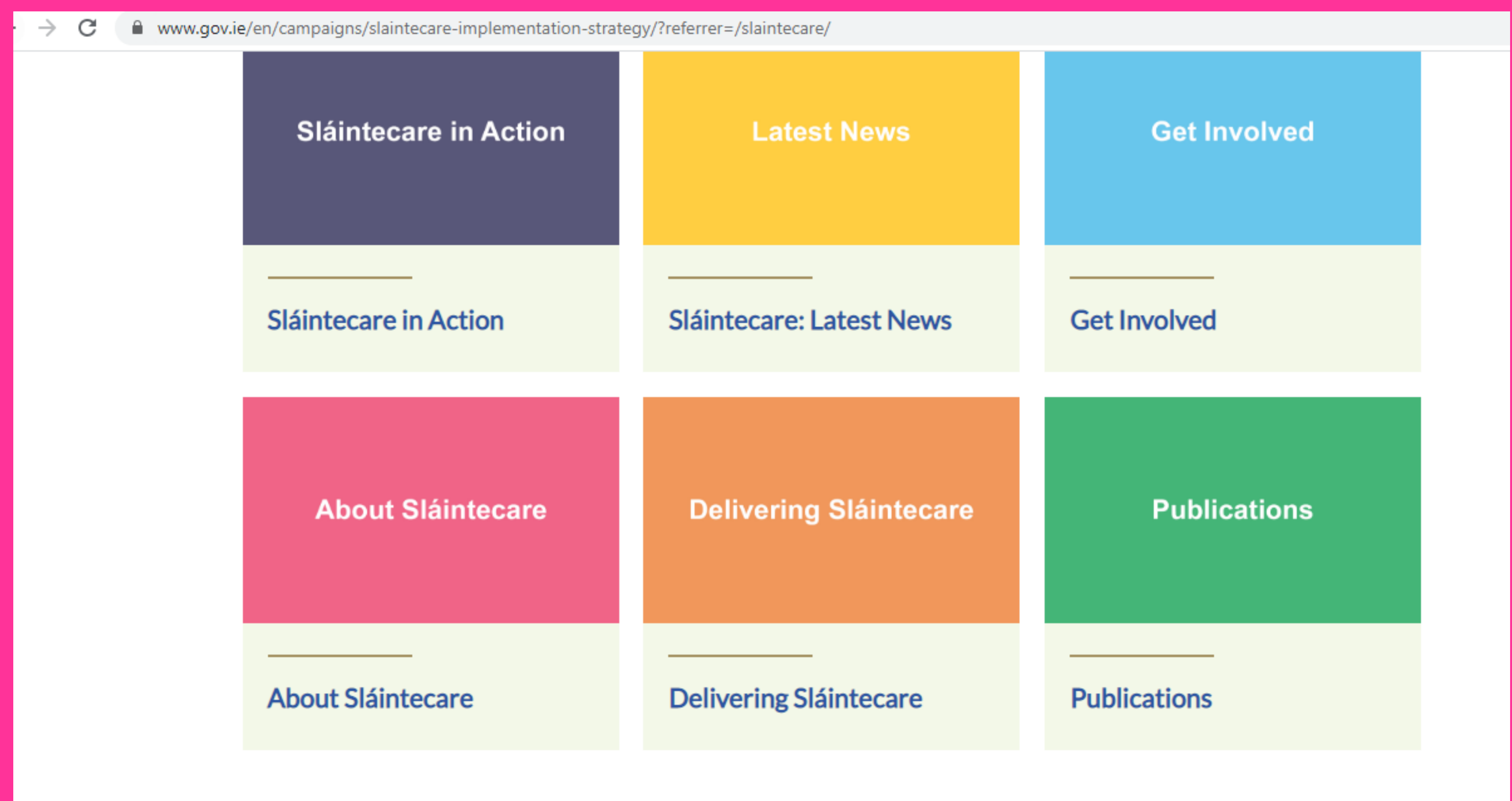
Sláintecare Integration Fund Communications

@Slaintecare

Sláintecare Integration Fund Communications



www.gov.ie/Slaintecare

Right Care Right Place Right Time for Student Sexual Health in Athlone Institute of Technology

Athlone Institute of Technology (AIT), with support from the Sláintecare Integration Fund, has launched a comprehensive student sexual health service to meet the needs of its growing student population – 61% of whom are aged 18-24 and are classified as 'high risk' for sexually transmitted infections (STI).

This innovative pilot project is being delivered directly to students on campus, reducing the substantial medical, non-medical and economic costs associated

Sláintecare Integration Fund Communications

Upcoming:

- Social Prescribing Day, 12th March
- Organ Donation Awareness Week, 28th March
- Arthritis Awareness Week, April
- World Asthma Day, May
- Skin Cancer Prevention Month, May
- World No Tobacco Day, May
- Bloom Festival (tbc), June
- Ploughing, September

Sláintecare Integration Fund Communications

Sláintecare.

Sláintecare Integration Fund Communications Questionnaire

Project ID: Project Title:
What issue / problem is this project addressing?
How is your Sláintecare project addressing this issue/problem?
Who will benefit from your project?

Sláintecare.

Sláintecare Integration Fund Communications Questionnaire

How many people will your project employ?
Where is your project target population?
Are all your staff in place and is your project up and running? (If not, please give estimated dates)

Sláintecare Integration Fund Communications

Are you ready to communicate about your project?

Do you have participants willing to tell their stories?

Improving Change Capacity, Health Services Change Guide - Anne Ryan and Caitríona Heslin, Organisation Development, Improving Change Capacity, HSE

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People's Needs Defining Change

HEALTH SERVICES CHANGE GUIDE

www.hse.ie/changeguide

Delivering Sláintecare & Service Priorities

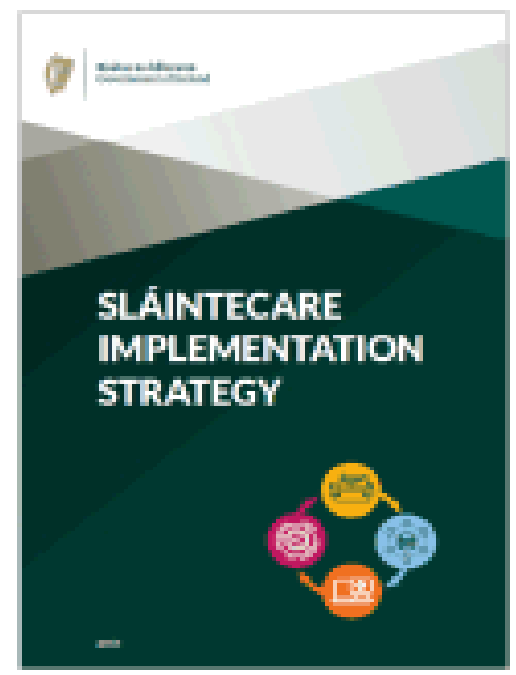

Figure 3: *Principles set out in the Sláintecare report*

Key Messages from the Literature on Change

- Understanding **complex systems** and **local context**
- Highlighted the **people and culture factors**
- Need to move to more **networked approaches**
- **Middle managers** and **clinicians - **'catalysts' for change
- Change shaped from the **'outside in'....**
- Blended approach between **change, quality improvement** and **project management**

Complex Systems need Simple Rules

- Agree shared purpose and direction

- Build relationships and networks

Use reliable methodologies

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Health Services
Change Framework
www.hse.ie/changeguide
Safer Better Healthcare, and Staff & Public Value
CHANGE OUTCOMES
FUTURE VISION
CURRENT SITUATION
DELIVER
DESIGN
DEFINE
CHANGE ACTIVITIES
People's Needs Defining Change
Service Users, Families, Citizens, Communities & Staff
Practice Collective Leadership
Understand Personal Experiences
Support Behaviour Change
Invest in People & Teams
Engage & Communicate
Model Shared Values
Use Evidence & Lever Technology
Be Accountable for Performance
Network & Partner
People & Culture Change Platform
CREATING READINESS
Human Resources
Leaders in People Services
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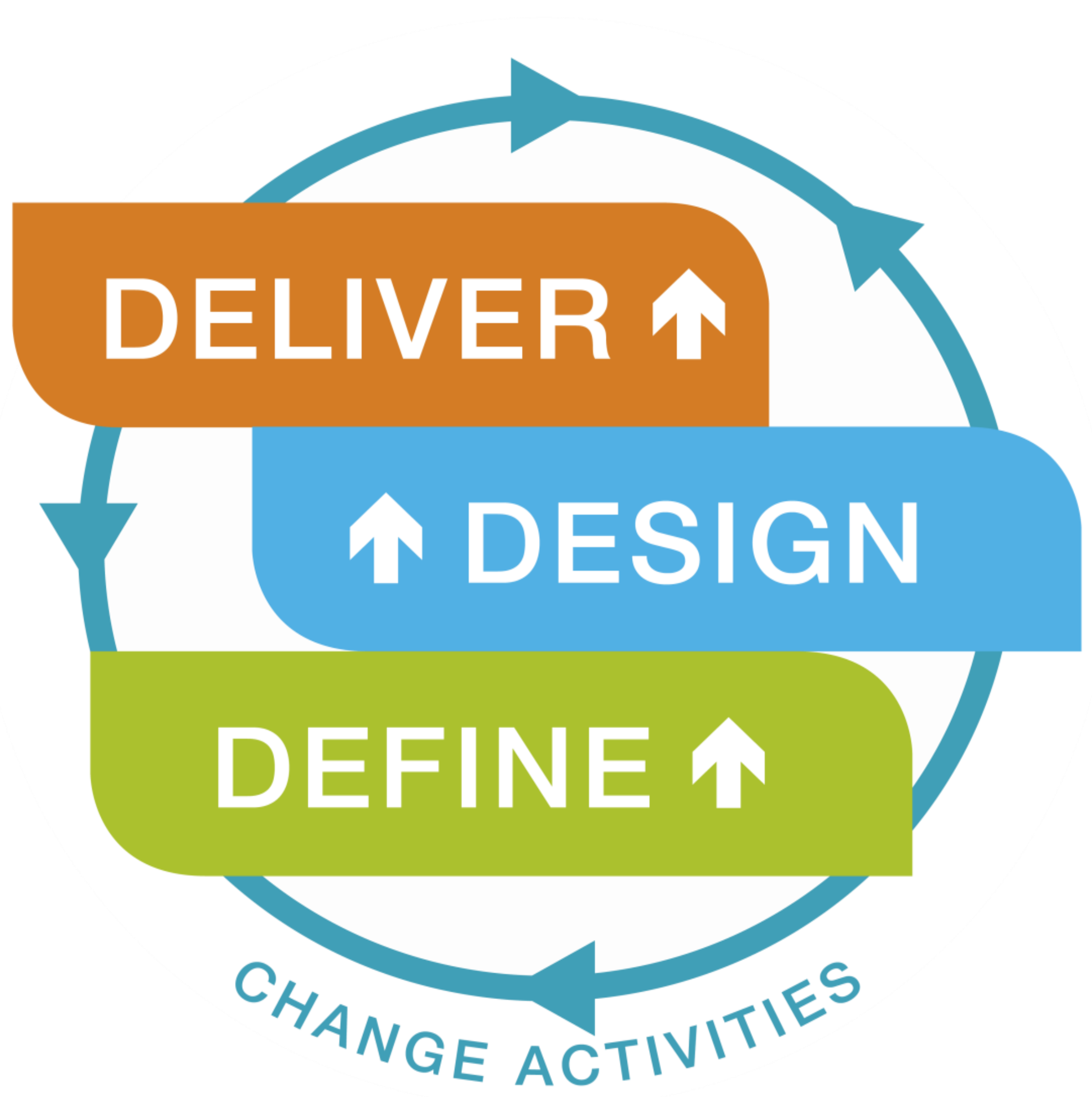
Change Activities



Complex Systems - use reliable methodologies

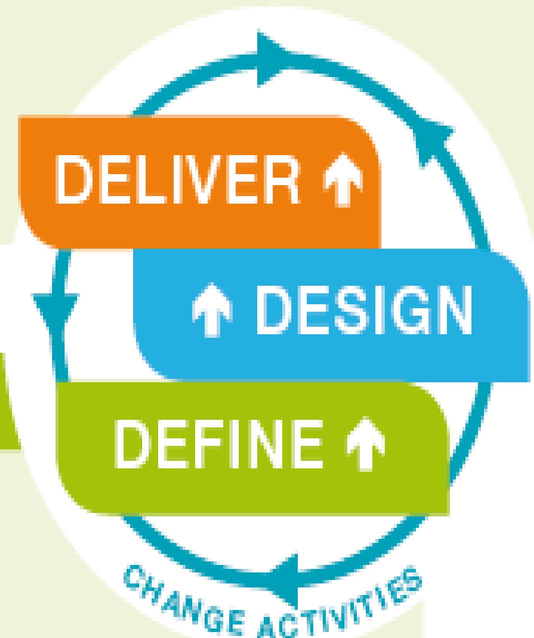
- **Change Activities aligned to Project Management**
- **Quality and service improvement methods**
- **Attend to the interaction between the parts ….focus on improving the system.**

Section 3: Define

3

Purpose of this stage

1. Initiate change by defining the shared purpose and need.
2. Understand the current context, levels of readiness and scale of the change.
3. Agree better outcomes and future vision.
4. Design measurement plan.
5. Develop the Business Case for Change.



Define Activities

3.1 Identify Shared Purpose

- 3.1.1 Identify need
- 3.1.2 Examine drivers for change

3.2 Understand Current Services

- 3.2.1 Describe the current situation
- 3.2.2 Mobilise people and culture
- 3.2.3 Understand prevailing culture and values
- 3.2.4 Assess readiness and capacity for change
- 3.2.5 Assess and build energy for change
- 3.2.6 Identify levers for change

3.3 Agree Better Outcomes

- 3.3.1 Co-design the 'vision' for the future
- 3.3.2 Agree change outcomes and objectives

3.4 Measure for Success

- 3.4.1 Design measurement plan

3.5 Make Case for Change

- 3.5.1 Agree governance and mandate
- 3.5.2 Establish change management team
- 3.5.3 Identify resource requirements
- 3.5.4 Communicate the Business Case

Context for Change – Why What How Method

WHY

Environmental Shifts
(Driving change)

- Service user needs
- Population change
- Community experiences
- Economic factors
- Government policy, legislation and standards
- Technology/evidence
- Social movement
- Medical and drug advances

WHAT

Organisational Responses

- Models and pathways of care
- Strategy and policy
- Structures and processes
- Organisation purpose
- Levels of co-design with service users
- Work practices
- Service and quality improvement
- Focus on outcomes
- Technology and innovation
- Community involvement
- New power arrangements

HOW

Personal Implications

- Roles and responsibilities
- Team membership, structures and processes
- Work practices
- Skills and knowledge
- Values and behaviours
- Working arrangements
- Networks and connections
- Increased engagement
- Job satisfaction
- Direct reporting to 'working with'

Adapted from: *Fisher, K. et al (1995) [108]; McMurray, A. (2016a) [262]*

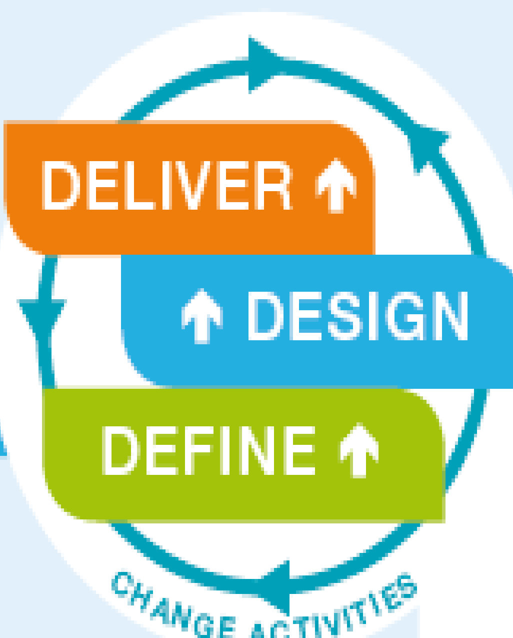
People's Needs Defining Change – Health Services Change Guide (2018: 54)
www.hse.ie/changeguide

Section 4: Design

4

Purpose of this stage

1. Progress co-design with key stakeholders.
2. Determine the detailed design of the Service Operational Model.
3. Test and refine the model for feasibility.
4. Agree Action Plan including required resources.
5. Communicate Action Plan.



Design Activities

4.1 Agree to Co-design

- 4.1.1 Agree service design principles
- 4.1.2 Address enablers of co-design

4.2 Design Service Operational Model

- 4.2.1 Confirm user need
- 4.2.2 Design service choices and options
- 4.2.3 Determine the detail of the Service Operational Model

4.3 Test and Refine

- 4.3.1 Test change in practice
- 4.3.2 Undertake gap analysis
- 4.3.3 Assess impact and interdependency

4.4 Agree Action Plan

- 4.4.1 Consolidate key change actions and measures
- 4.4.2 Identify risks and dependencies
- 4.4.3 Identify enabling and sustaining actions
- 4.4.4 Identify impact for resources
- 4.4.5 Clarify responsibility for action and timeframes

4.5 Communicate Action Plan

6.3 Essential Templates – Design

Template 6.3.1: Service Design – Option Generation and Appraisal

Template 6.3.2: Detailed Design of the Service Operational Model

Template 6.3.3: Service Design – Gap and Impact Analysis

Template 6.3.4: Action Plan

Section 4: Design 246

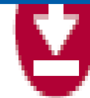
Enablers of Co-Design in Organisations and Services 249

Principles of Service Design Thinking 250

General Principles and Checklist for Decommissioning 251

Due Diligence 254

Template 6.3.1: Service Design – Option Generation and Appraisal (continued)



Ease of implementation (Guidance to assist you to rate ease of implementation)

	1	2	3	4
People impact	Will **fundamentally change** the roles and responsibilities of those involved in the provision of this particular service	Will have a **significant impact** on the roles and responsibilities of those involved in the provision of this particular service	Will have **some impact** on the roles and responsibilities of those involved in the provision of this particular service	Will have **no impact** on the roles and responsibilities of those involved in the provision of this particular service
Process and system impact	**Fundamental changes** to the way this particular service is managed	**Significant changes** to the way this particular service is managed	**Some changes** to the way this particular service is managed	**No change** to the way this particular service is managed
Budget impact	Implementation of the new operating model will **significantly increase the cost** to the health system of providing this service	Implementation of the new operating model will **increase the cost** to the health system of providing this service	Implementation of the new operating model will **have no impact on the cost** to the health system of providing this service	Implementation of the new operating model **will reduce the cost** to the health system of providing this service
Time to implement	Transition will **take greater than 3 years**	Transition will take between **2 years and 3 years**	Transition will take between **1 year and 2 years**	Transition will take **less than 1 year**
Cost to implement	Costs associated with implementation are estimated to be **high**	Costs associated with implementation are estimated to be **moderate**	Costs associated with implementation are estimated to be **low**	Costs associated with implementation are estimated to be **negligible**

Source: *HSE – Office of the Director General of the Health Service (2017) – Developed by PwC and HSE* [184]

Step 6: Evaluation Criteria – Overview

The preferred option emerges from plotting on the matrix below (Achievement of Objectives and Ease of Implementation) combined with alignment with design principles.

Alignment to design principles (see Step 3):

(Note the number score and associated explanation)

ACHIEVEMENT OF OBJECTIVES
(plotting the single score ticked – see Step 4)

4
3
2
1
0

Higher benefit,
more difficult to implement

Higher benefit,
easier to implement

Lower benefit,
more difficult to implement

Lower benefit,
easier to implement

0
1
2
3
4

EASE OF IMPLEMENTATION
(plotting the average score – see Step 5)

Section 5: Deliver

5

Purpose of this stage

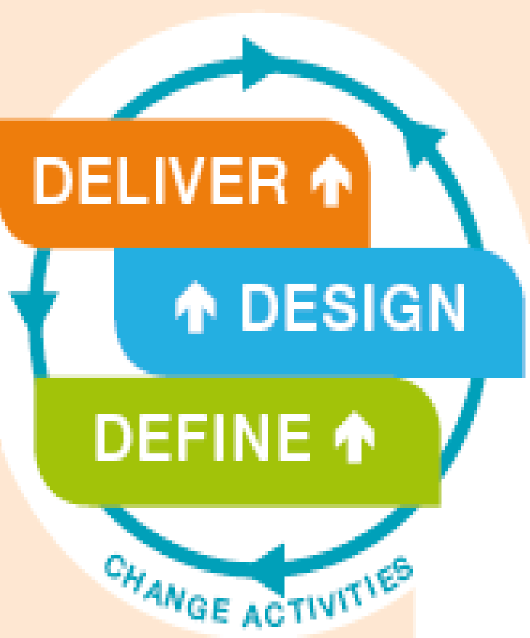
1 Implement actions and go live with the change.

2 Support all involved with implementation.

3 Measure progress in line with agreed outcomes.

4 Celebrate success.

5 Sustain improvements and share learning.



Delivery Activities

5.1 Implement Actions

- 5.1.1 Energise collective leadership and governance
- 5.1.2 Scale-up engagement and communication

5.2 Support Implementation

- 5.2.1 Intensify individual and team supports
- 5.2.2 Support inter-team/service and inter-agency working
- 5.2.3 Sustain engagement with service users, citizens and other key partners

5.3 Measure Progress

- 5.3.1 Adapt to emerging needs and take corrective action

5.4 Celebrate Success

- 5.4.1 Acknowledge increased change capacity
- 5.4.2 Mark key milestones

5.5 Sustain Improvement

- 5.5.1 Evaluate and share learning
- 5.5.2 Scale-up innovations

People and Culture
Readiness & Sustainability

People & Culture Change Platform

CREATING READINESS

Practice Collective Leadership
Engage & Communicate
People's Needs Defining Change
Service Users, Families, Citizens, Communities & Staff
Understand Personal Experiences
Model Shared Values
Support Behaviour Change
Use Evidence & Lever Technology
Be Accountable for Performance
Invest in People & Teams
Network & Partner
PEOPLE & CULTURE CHANGE PLATFORM

Template 6.2.8: People and Culture Change Platform – Readiness Factors

Purpose

This template assists in identifying readiness in relation to the People and Culture Change Platform outlined in the Change Framework. The findings will guide as to where focused attention is required to address cultural elements in an integrated manner.

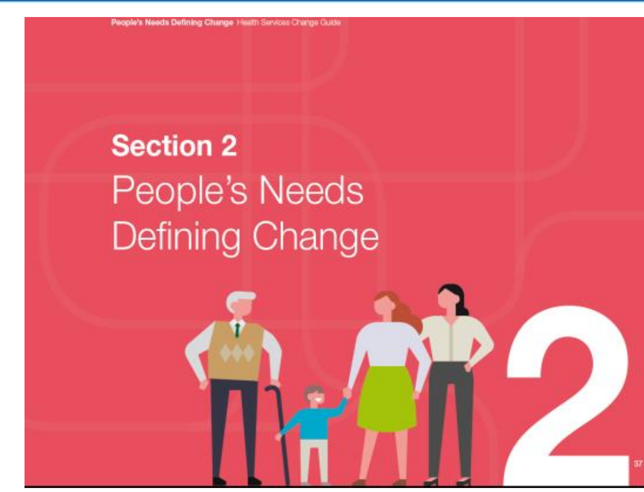
How to use it?

Carry out this exercise as a team-based activity. Use the key activities below to generate a rating for each of the people and cultural priorities outlined below. Identify actions to increase readiness based on the findings – actions can be prioritised as follows:

High: to maintain focus and do more of
Medium: to improve
Low: to target in a dedicated way

	Readiness How would you rate readiness?			
People and cultural factors - for more detailed explanation refer to 1.2.1 to 1.2.9	**High**	**Medium**	**Low**	**Action**
Practice collective leadership 1. Be self-aware 2. Role model the change 3. Communicate with integrity and purpose 4. Nurture collective leadership activity 5. Build relationships and create networks	*please number*	*please number*	*please number*	
Model shared values 1. Understand personal values 2. Connect on a noble goal – add public value 3. Translate values into action 4. Monitor performance in line with values	*please number*	*please number*	*please number*	

People's need – defining change



Review your engagement plan

- Who are the key people impacted by the change?
- How can you continue to engage with them to understand their needs?
- What will assist you to sustain communication & engagement during the change?

Human-Centred Design

What do people need?

What is technically and organisationally feasible?

What is financially viable?

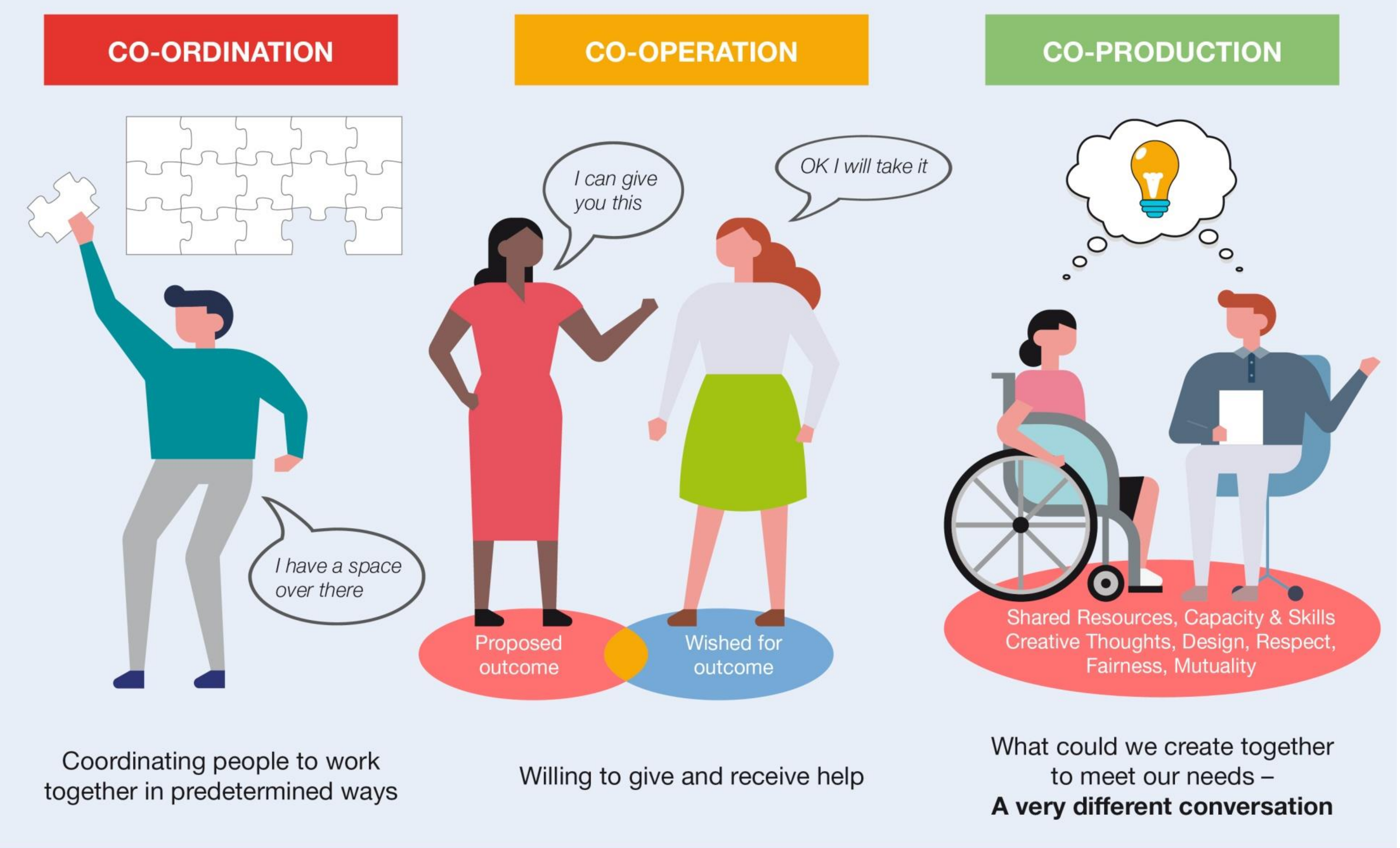
DEFINE

DESIGN

DISCOVER

DELIVER

People's Needs Defining Change – Health Services Change Guide (2018: 73)
www.hse.ie/changeguide


Journey to Co-production
CO-ORDINATION
CO-OPERATION
CO-PRODUCTION
I have a space over there
I can give you this
OK I will take it
Proposed outcome
Wished for outcome
Shared Resources, Capacity & Skills
Creative Thoughts, Design, Respect,
Fairness, Mutuality
Coordinating people to work together in predetermined ways
Willing to give and receive help
What could we create together to meet our needs –
A very different conversation
Adapted from: The Edge NHS (2016) [370]
People's Needs Defining Change – Health Services Change Guide (2018: 28)
www.hse.ie/changeguide

Understand Personal Experiences

"People support the change they help to create"

"People make change happen"

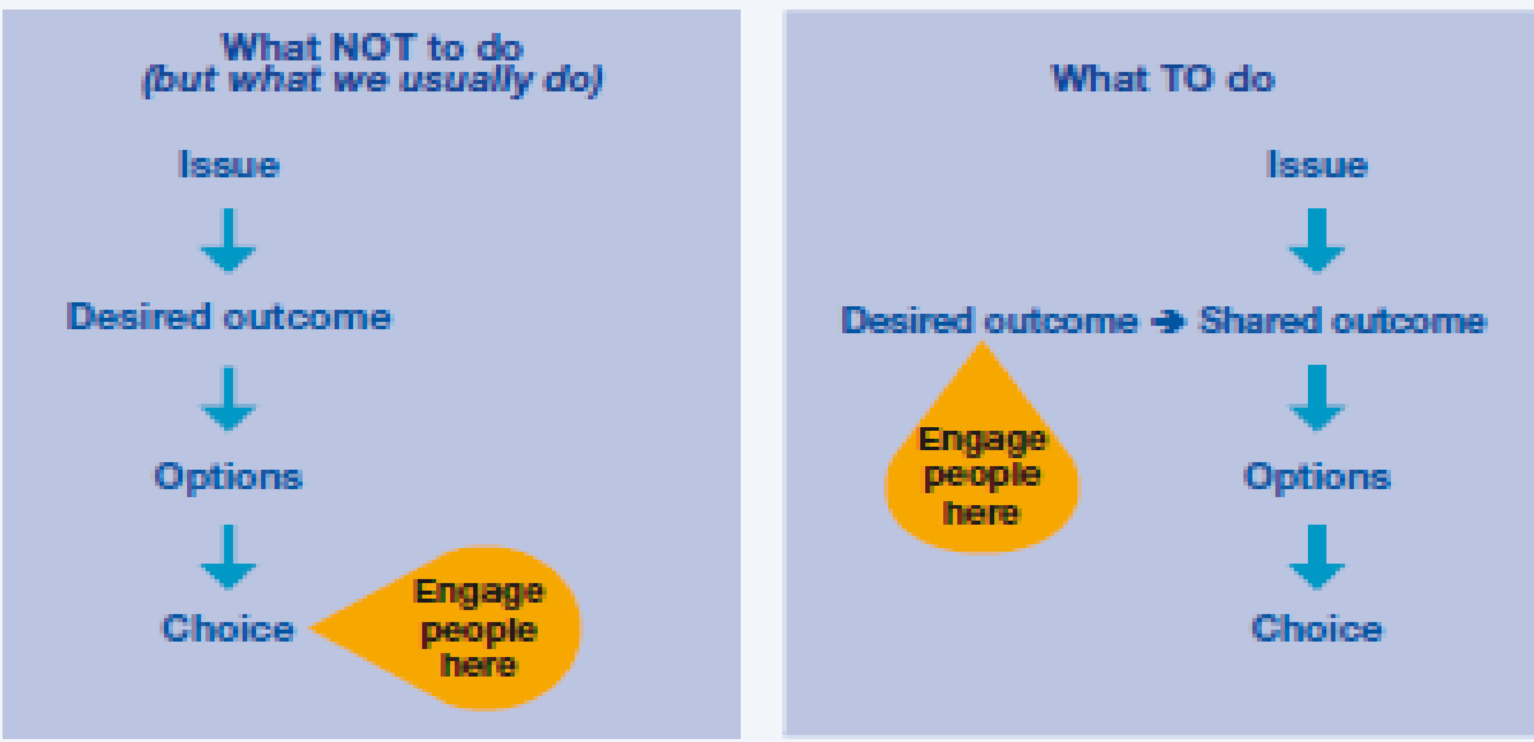
1. Facilitate transitions
2. Understand personal responses
3. Create the safety and space to support personal change
4. Understand and work with resistance and personal readiness

Figure 13: Working with Resistance to Change

Resistance behaviour is a good indicator of missing relevance. (Schirmer, H. 2015) [333]

Resistance to change should be seen as a dynamic energy that can bring about real and lasting change. It is a natural reaction and should be embraced as a normal part of change. Mark Jaben [24] assists us to understand resistance and challenges the concept of 'buy in' where we traditionally go to people with the solution and ask for their support for change. Looking for people to 'invest' in change is a more dynamic concept where we involve people in co-design in the first instance. Engagement begins at an earlier stage, focuses on the desired outcome, helps to increase readiness and reduces resistance.

Mark Jaben on the science behind resistance to change



We don't need buyers (who "buy-in" to change)   We need investors

Adapted from: *Bevan, H. (2017e: 17)* [24]

People's Needs Defining Change – Health Services Change Guide

Managing Personal Transitions

Managing Personal Transitions – making the most of change

1. ENDING, LETTING GO

Help people deal with their loss by...

- Identify who is losing what
- Acknowledge the reality of people's losses
- Accept signs of loss and grieving
- Give people information regularly
- Define what's changed and what stays the same
- Treat the past with respect
- Mark endings
- Focus on the continuity of what really matters

2. NEUTRAL ZONE

Critical personal adjustment and re-patterning happens here...

- Key signs to look for:
  - Low motivation and anxiety
  - Self-interest and resentment
  - Polarised thinking
- This is also a creative time
- Provide support for innovation and discovery
  - Embrace losses, setbacks and failures as starting points to new ways of working
  - Give people time and resist the push for early closure
- Set short-term goals
- Strengthen connections between groups
- Communication is key... personal stories are particularly useful

3. THE NEW BEGINNING

Time for new identities, new energy and a new sense of purpose

- Timing of 'roll out' is key
- Focus on shared purpose
- Create the picture to bring it to life
- Make sure Action Plan is clear
- Agree ways people can continue to contribute and participate
- Reinforce the new beginning:
  - Be consistent
  - Ensure quick wins
  - Make new identity visible
  - Celebrate the new beginning

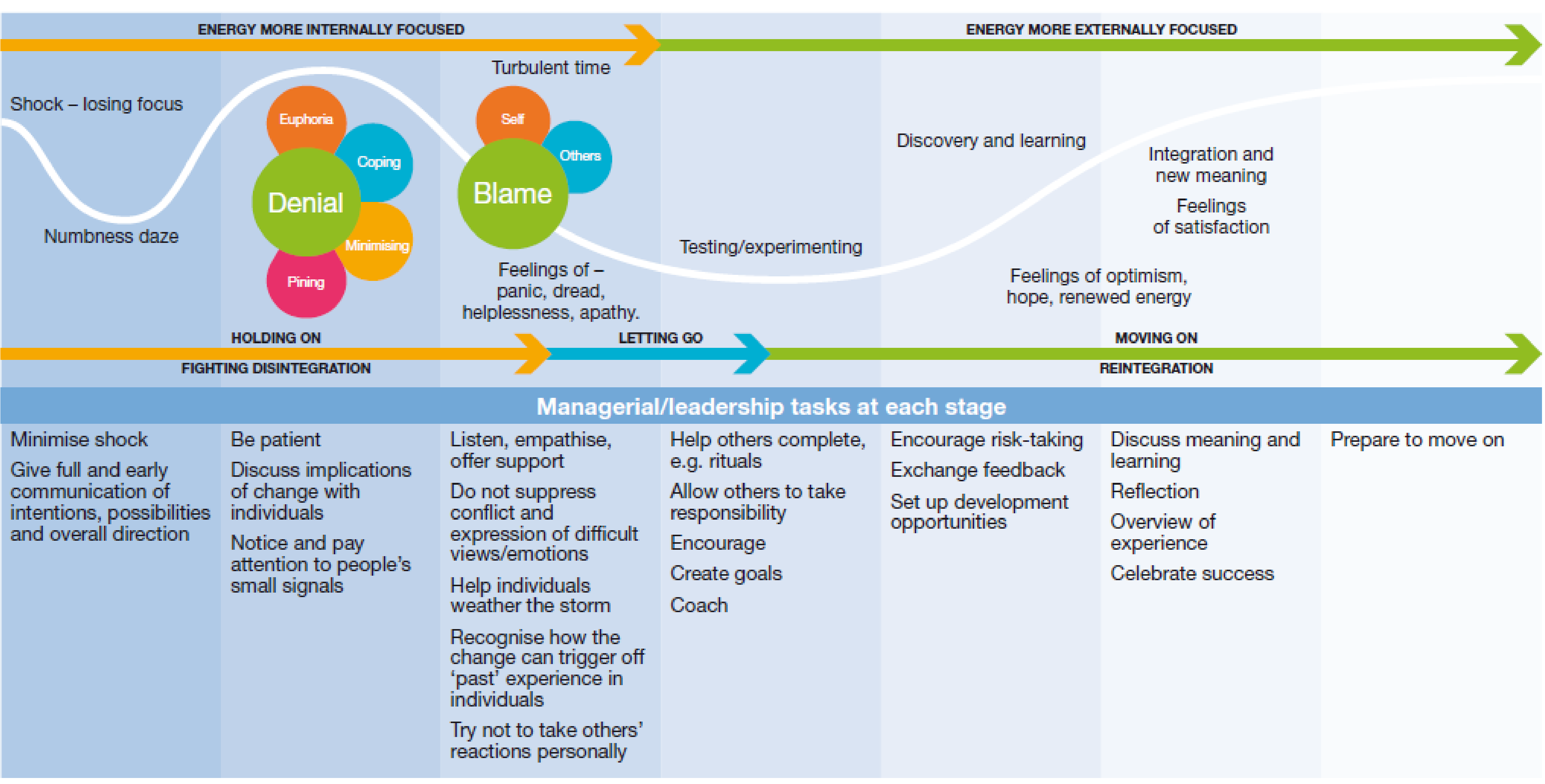
Adapted from: *Bridges, W. et al (2017) and Weld, S. (2017)*

People's Needs Defining Change – Health Services Change Guide (2018: 20)
www.hse.ie/changeguide

Personal Experiences

Kübler-Ross Change Curve

The Kübler-Ross Change Curve is helpful in understanding reactions and feelings in relation to change. It assists people in plotting their individual reactions and to engage in discussion to assist them to address their concerns and maximise their contribution.



Adapted from: *Kübler-Ross, E. (1997); McMurray, A. (2016b)*

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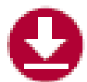
Template 6.2.6: Personal Readiness for Change



Purpose

This template assists you to understand levels of personal readiness for change and to assist conversations with individuals and teams to address readiness factors.

How to use it?

Individuals can complete this readiness table. A composite score for the team can also be compiled. Rate 1-5, where 1 = Low and 5 = High. High scores indicate positive levels of readiness.

Identify actions: Based on the outcome of the above, what key actions are needed to increase personal readiness for change? How can concerns highlighted be addressed? What actions require personal follow-up? What actions require attention at team or service level?

People in the service:	LOW 1	2	3	4	HIGH 5
Understand the external forces that are driving the change and the perceived value of the change					
Have been afforded an opportunity to have their say and get involved, have identified what is important to them					
Are willing to let go of the status quo and open to a new future					
Have resolved emotional issues from past changes and recovered from any personal toll these changes created					
Have confidence that decisions regarding the change will be made fairly and justly					
Feel they have a degree of influence over making this change					
Are confident they will get support, access to necessary organisational resources and be equipped with new skills					
Have confidence in the leader's credibility and capacity to manage the change in a collective manner					
Feel they have the ability to make the change a success and fulfil its requirements					
Express a level of urgency about the change, and their ability to respond effectively					
Believe they will be empowered as a result of the change					
Are comfortable with uncertainty and can live with some ambiguity as things unfold					

Adapted from: *Ackerman Anderson, L. and Anderson, D. (2010: 81)* [3]
People's Needs Defining Change – Health Services Change Guide

Template 6.4.2: Personal Checklist for Change

Purpose

This checklist identifies some of the factors that are important at an individual level in relation to a person's commitment to engage in a change process.

How to use it?

Staff may wish to complete this checklist and use the findings as a basis for discussion and action planning at team level.

These are the factors that I need to believe in to support the change	Yes / No
I am clear about the reasons for change.	
I agree change is necessary.	
I am clear on the outcomes of the change for service users.	
I have access to regular information.	
I have access to information relevant to my role and the role of my team.	
I have worked out the personal impact of the change.	
My concerns have been listened to.	
My concerns have been responded to.	
I have had an opportunity to influence decisions.	
I have had an opportunity to be involved.	
I believe the change is well planned.	
I am clear on the change implementation Action Plan.	
Milestones are being acknowledged and celebrated.	
We are meeting change objectives.	
I am feeling positive about the future.	

Adapted from: *The Workplace Change Project (2016)* [381]
People's Needs Defining Change – Health Services Change Guide

Template 6.4.3: Working with Emotional Reactions to Change

Purpose

This template outlines possible emotional reactions to change that may be evident at individual and team levels. It assists reflection and conversations that can prompt action.

How to use it?

Consider the questions below and use them to prompt conversations within the team – agree actions that will address issues that arise.

No.	Key considerations	Actions
1.	Do the change leaders need support to understand people's emotional reactions during change? Do people feel supported by the organisation leadership? Is a support plan in place?	
2.	Are there legacy issues from past change efforts that need to be considered? Has the pace of recent changes had a significant personal impact?	
3.	Do people fully understand the need for the change – what is driving it?	
4.	Consider the potential 'negative' impacts on people in the current change plan? How can these be worked through and minimised?	

Further Information

Visit us online
www.hse.ie/changeguide

Change Guide
is interactive!

Go to **page 7** and click on any element of the **Change Framework** OR navigate from the **Contents** section (pages i-v).

Access all of the Essential Templates and Additional Resources.

People's Needs Defining Change – Health Services Change Guide

Welcome to the Change Hub

With the Health Services Change Framework as its foundation, the Change Hub supports all staff to gain the knowledge, skills and confidence to approach change in a way that improves the prospect of a good outcome for all involved.

Here you will find practical tools, resources, and the experience of colleagues, to increase your understanding of the importance of the people and culture change platform, and how to work with that platform to define, design and deliver safer, better healthcare and staff and public value.

Click on elements of the interactive Change Framework Image below to find out more.

Contacts

Change Guide: www.hse.ie/changeguide

Change Hub visit: www.hseland.ie

Email: changeguide@hse.ie

Twitter handle: @HSEchange_guide

#PeopleAndCulture #ChangeGuide #ChangeClinic

The International Foundation for Integrated Care (IFIC), Prof Áine Carroll

Sláintecare.
Right Care.Right Place.Right Time.

IFIC Ireland

SláinteCare Integration Fund Learning Network

March 2nd, 3rd and 4th 2020

Prof Áine Carroll – aine.carroll@ucd.ie

The International Foundation for Integrated Care (IFIC) is a not-for-profit organisation that inspires, influences and facilitates the adoption of Integrated Care in policy and practice around the world.

The Foundation's vision is that people, families and communities benefit from person-centred Integrated Care and support to maximise their health, wellbeing and independence.

IFIC Ireland Governance and Structure

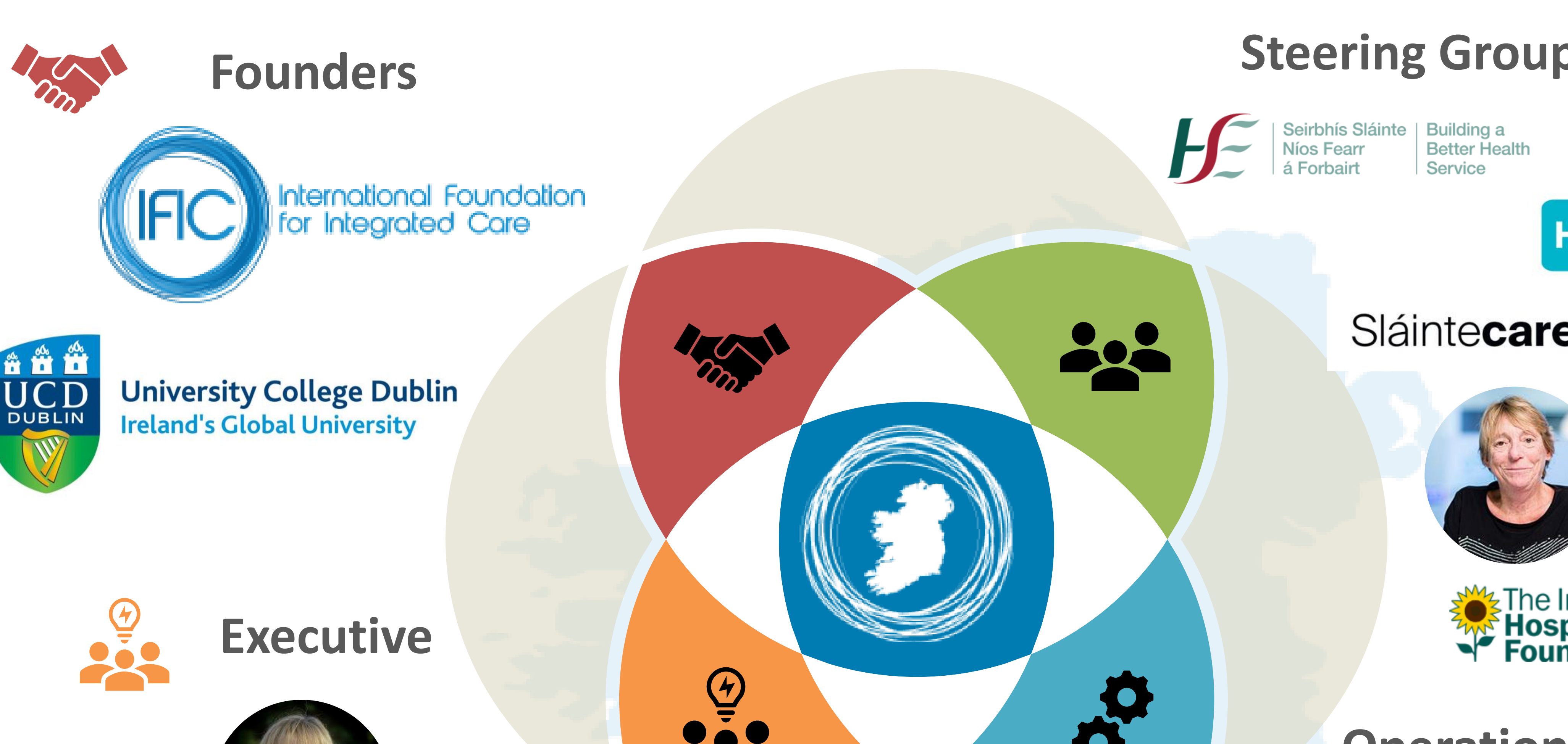
Advancing the science, knowledge and adoption of integrated care in policy and practice in Ireland

Founders

International Foundation for Integrated Care

University College Dublin
Ireland's Global University

Executive

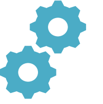


Steering Group

Health and Social Care

Striving for the best care at end of life for all

Operations



2019

ACCELERATED LEARNING PROGRAM

- 5 days, 8 attendees, 10 faculty members, 1 site visit
- 100% would Recommend to Management and Peers
- 75% rated as Excellent or Very Good

WEBINAR SERIES

- 6 Sessions
- 211 Attendees
- 7 International Speakers
- 6 Irish Speakers

COMMUNICATIONS

- 3 Newsletters
- 25%+ growth in subscribers
- Twitter + Facebook engagement growth

WORKSHOP

- November 29th Belfast
- 70+ Attendees
- 12 Speakers from across the island of Ireland – sessions on Social Prescribing, Integrated Care in NI, Digital Enablers

HUB COLLABORATION

IFIC Scotland, IFIC Australia and IFIC Canada

ValueCare

- Integrated care for the elderly supported by ICT
- Launched December 2019
- Cork/Kerry pilot area

SAMPLE KEYNOTES

- ESRI September 24th
- HMI October 2nd
- SláinteCare Integration Fund Learning Network Launch December 2nd
- And more

OPERATIONS

- Grant applications
- Relationship management
- Knowledge translation
- Event logistics and more

University College Dublin
Ireland's Global University

Plans for 2020

Knowledge Mobilisation

- Webinar Series, 6 Sessions: *"Making Integrated Care Happen"*, February to July 2020
- Workshop Series, 3 Sessions
- National Forum, May 6th 2020 UCD

- Recruitment of research assistant
- Launch of pilot in Cork/Kerry

IFIC Collaborations

- International hubs
- ICIC20
- Irish SIG leadership

Knowledge Tree

- Digital gateway to explicit knowledge relevant to integrated care across a range of key dimensions.

Leadership Development

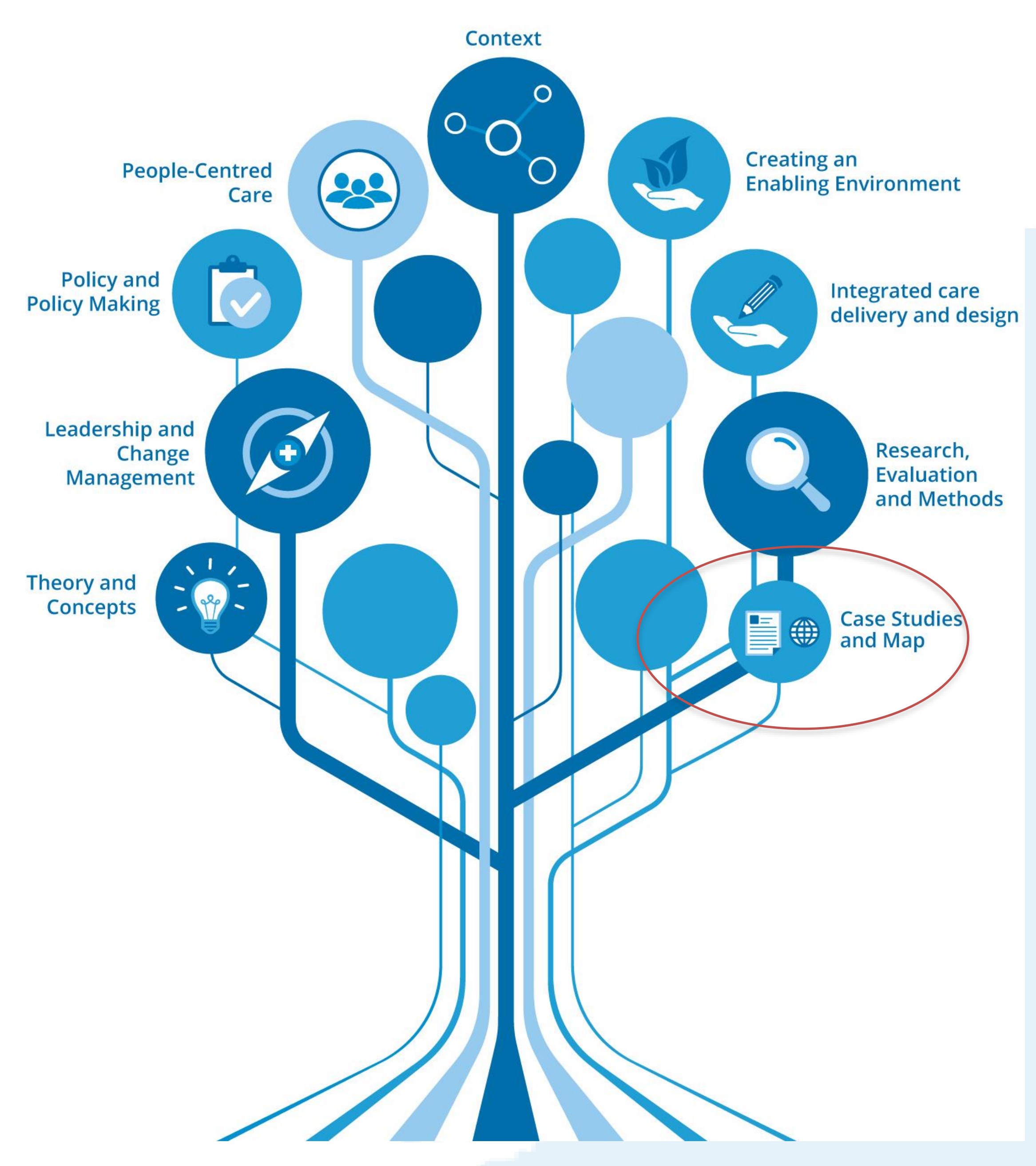
- Accelerated Learning Program, Autumn 2020
- National Case Study Submission Portal

Operations and Communications

- 4 newsletters
- Irish subscibers and Irish members of the IFIC network
- Grant applications
- Relationship management
- Supporter and Knowledge Partner growth

University College Dublin
Ireland's Global University

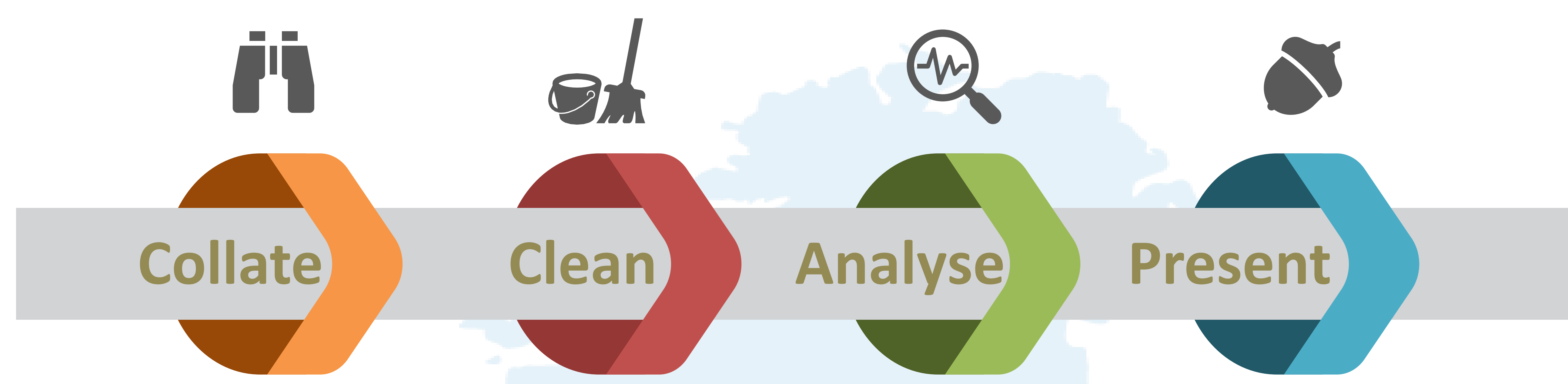
IFIC Ireland Knowledge Tree



- A gateway to academic databases, institutional repositories, IFIC International and public web resources
- Central Reference Repository for integrated care digital resources and artefacts relevant to an Irish context
  - Best Practices
  - Case Studies
  - Publications
  - Learning Modules
  - Research
- Digital Artefacts
  - Blogs
  - Webinars
  - Conference Talks
  - Podcasts
  - Journal Articles
  - and more

IFIC Ireland Knowledge Tree

A living digital resource that is continually updated, maintained, useful and used



Identify and Gather

- Appropriate sources
- Artefacts
- Links

- Remove duplication
- Incomplete artefacts
- Outdated sources

- Cross-reference
- Assign Topics
- Researcher associate review

- Digital accessibility
- Sign-posting for relevance
- Knowledge translation

integratedcarefoundation.org/ireland

@IFICinfo #IFICIreland

IFICIreland@integratedcarefoundation.org

Sláintecare Integration Fund Learning Network Event

Innovations in shifting care to the community or providing hospital avoidance measures

Monday 2nd March 2020

@Sláintecare #Sláintecare
#RightCareRightPlaceRightTime

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Presentation and Q&A by Integration Fund project on project progress, challenges, solutions and learnings:

Pain Management Education Project - Siobhan McEniff – Clinical Project Manager, Sligo University Hospital

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Chronic Pain Management Project SUH/CHO1 ID 463

Sláintecare Integration Fund Networking Event

2.3.2020

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Project Definition

Pain Management Education Programmes (PMEP)– moving management of chronic pain from the acute hospital to community /home

Sligo University Hospital SUH/CHO 1

*Malin Head is 184.5 km to Sligo (2 hours 36 minutes)

* Claremorris 80 km (1 hour 10 minutes) to Sligo Referrals Longford, Cavan, Roscommon

Background and Context

- 506 pts. on waiting list (206 routine, 300 urgent)
- 1 OPD clinic per week – urgent > 12 months
- 4 OPD clinic per week- routines > 12 to 15 months
- Routine procedure waiting list 24 months (2 theatre slots)
- Routine planned procedure list 4 years

Pilot PMEP Programmes

* 2019, 3 pilot programmes
* Outcomes:
  * 89% of pts. noted functional improvement
  * 23% decrease in depression
  * 42% decrease in anxiety
  * 34% decrease in psychological distress

Purpose and Project Deliverables

* 1. Develop an outreach pain specialist team (4.5WTE) , with design of integrated clinical pathways
* 2.Roll out of PMEP programmes across community catchment areas
* 3.Development of a pre-clinic 2 hr education workshop in chronic pain for patients awaiting a pain service
* 4.Provision of individual counselling/physiotherapy sessions
* 5.Review and evaluation against agreed metrics

Alignment with Sláintecare Goals/Strategic Actions

Sláintecare Goal	Strategic Actions
Governance	1 and 2
High Quality, Accessible and Safe Service	3, 4, 5, and 6
financially sustainable service	7 and 8
Enable system to deliver its goals	9 and 10

Challenges and Learning

* National approval between Sláintecare and the HSE for a HR Recruitment process for backfill for posts
* Challenges around numbers of recruitment campaigns and timelines/ impacting on deliverables to 31.12.20.
* Accommodation
* Project management support and expertise
* Lack of psychology service in SUH
* Hidden costs- travel
* App-tracking ‘catch my pain’/support
* GP/patient reps

Next Steps

* New staff start date
* Research and develop pain education workshop - visit UK site
* Identify additional community sites for the programme matched to geo-demographics of patients on waiting list
* Deliver 9 PMEP programmes
* Network with other Sláintecare projects in the areas of self-management, exercise and social prescribing (Project ID's 284, 8, 31,135, 137,219, 413, 418,38, 78,98, 162,185, 252, 370, 31)

The Team

Presentation by Integration Fund project on using networks to deliver Integration Fund Project

Beaumont Hospital/National Ambulance Service Alternative Care Pathways Project, Pauline Ackermann, Head of Clinical Services, Beaumont Hospital

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Beaumont Hospital and National Ambulance Service: *Pathfinder Service*

Pauline Ackermann
Head of Clinical Services (Beaumont Hospital)
Co- Chair of Pathfinder Steering Group

This project has received funding from the Government of Ireland's Sláintecare Integration Fund 2019 under Grant Agreement Number 392

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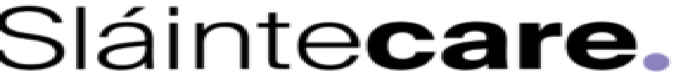
Using Networks to deliver our Sláintecare Integration Fund Project

- What Pathfinder sets out to do
- How networking made it possible for Pathfinder to grow from an idea to a reality
- Building and growing networks: Personal reflections



What Pathfinder sets out to do

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OSPIDÉIL RCSI

Do we need to change how we work?

Beaumont 2018
- 9861 patients aged over 75 presented to ED: Approx. 50% were admitted (ALOS 17.26 days)

↑ 22% presentations
- A recent review highlighted a 22% increase in presentations (n=3035) of ≥65 years to Beaumont Hospitals ED between 2015 and 2018. Common trend amongst many EDs nationally and will continue to increase.

Risk to Older Persons
- Older persons are at risk of adverse events when presenting to ED

North Dublin 2026
- By 2026 there will be a 44% increase in the >65 years population of North Dublin. We are already seeing this trend in our ED.

Patients and ACP's
- Literature review highlights that 78% would consider Alternative Care Pathways (ACPs)
- Examples of ACPs in UK that are very successful
- **New care pathways for older people are needed.**

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Current practice for 999 calls

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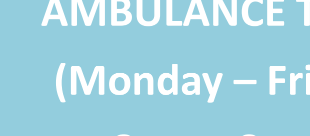
SERVICE MODEL

1 RRV + 28% non-conveyance rate



- 3x Advanced Paramedics &
- 1x WTE Clinical Specialist Occupational Therapist/
- 1x WTE Clinical Specialist Physiotherapist

AMBULANCE TEAM

(Monday – Friday; 8am – 8pm)

13 patients per week

1-4 calls per day

FOLLOW-UP TEAM

(Monday – Friday; 8am – 4pm)

7 patients p/w

12 Special Assist calls p/w

3-5 patients per day

- 1x WTE Senior Occupational Therapist/
- 1x WTE Senior Physiotherapist

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Beaumont Hospital

Referral Process

Beaumont Catchment Area – Most calls go to DFB Control - Pathfinder filter

Call passed to National Emergency Operations Centre (NEOC)

Passed to Pathfinder Ambulance Team in Rapid Response Vehicle

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Rialtas na hÉireann
Government of Ireland

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OSPIDÉIL RCSI

Call Codes – Focused for Tests

EMS Response

Clinical Status	Code	Description	Essential Response	Response to scene	Vehicle type	Additional Response
1 Life threatening	Echo	Life threatening – Cardiac or respiratory arrest	Ambulance with minimum Paramedic	Lights and siren	Ambulance	a) Advanced Paramedic. b) Responders (CFR if no hazards, trauma or DNAR) c) Minimum 3 to 4 practitioners or responders on scene
	Delta	Life threatening other than cardiac or respiratory arrest	Ambulance with minimum Paramedic	Lights and siren	Ambulance	a) Advanced Paramedic for specified DCR codes. b) Responders (minimum EFR) if able to get to scene prior to ambulance.
2 Serious not life threatening	Charlie	Serious not life threatening – immediate	Ambulance with minimum Paramedic	Lights and siren	Ambulance	Advanced Paramedic for specified DCR codes
	Bravo	Serious not life threatening – urgent	Ambulance with minimum Paramedic	Lights and siren	Ambulance	
3 Non serious or life threatening	Alpha	Non serious or non life threatening	Ambulance with minimum EMT	Lights and/or siren discretion	Ambulance or Intermediate Care Vehicle	
	Omega	Minor illness or injury	Ambulance with minimum EMT	Lights and/or siren discretion	Ambulance or Intermediate Care Vehicle	

Ambulance Team Assessment

Advanced Paramedic

- Primary Survey
- Medical History (AMPLE)
- Vital signs incl. blood glucose reading
- 12 lead ECG if required
- Head to toe assessment in cases of a fall
- Medication changes
- Documentation

Beaumont OT/PT

- Baseline functioning report
- Upper and lower limb power and range of motion assessment
- Transfers and functional mobility assessment
- Home environment assessment
- Frailty screening
- Cognitive & delirium screening
- Activities of daily living assessment
- Falls risk assessment
- Screening need for referral to HSCP colleagues/ services

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Emergency Call to Pathfinder Service

5 Alpha

17 Alpha

26 Alpha

30 Alpha

Treat and Discharge

1. Compensatory strategies
2. Education
3. Equipment provision
4. Adaptation of home

Treat and Refer

1. Primary Care Teams – OT, PT, GP, PHN
2. Community Integration Team (CIT)
3. Integrated Care Team (ICT)
4. Day Hospital MDT – SLT, MSW, Dietician, Pharmacy, Nursing, Geriatricians
6. Voluntary Sector – ALONE, NCBI, Siel Bleu, Alzheimers society, etc.

Convey to ED

1. Transfer of patient to Beaumont Hospital's Emergency Department (ED)
2. Handover to the FIT Team
3. May be appropriate for same day ED discharge

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Follow-Up Team activities

For example:

1. Referral to BH OPD services: appointment scheduled with the clinic for the next day (NAS arranged transport)
2. Liaison with BH Consultants to expedite reviews
3. Liaison with GP
4. Provision of equipment
5. Education re medication compliance
6. Liaison with community and voluntary agencies

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Case Studies- 1

Background

- 87 year old lady and son called 999 feeling flat for 3 days and generally unwell: 26A05
- Previous medical history: IDDM, polymyalgia, high blood pressure
- Baseline function: ass of 1 for PADL, mobile short distance with w/s and independent with transfers

Assessment

- Paramedic: Pre-Hospital Early Warning Score= 3 (respiration rate 20, blood sugar 19.5), medication list and recent changes, 12 lead ECG.
- OT: transfers, functional mobility, home environment, cognitive screen

Outcome: Treat and refer

1. Referred to Diabetic Day Clinic: appointment scheduled with the clinic for the next day (NAS arranged transport)
2. Liaison with psychiatry of old age (low mood and clarity regarding antipsychotic prescription)
3. Liaison with GP
4. Provided a raised toilet seat and rails

Case Studies- 2

Background

- Special assist call post fall. 3 emergency calls in previous 2 weeks. Crisis point- imminent A&E presentation likely. Referred to Pathfinder from DFB crew : 17A04
- Previous medical history: RA, previous Stroke
- Baseline function: independent with transfers and mobility with stick. No HCP.

Assessment

- Paramedic: Pre-Hospital Early Warning Score= 0. Likely RA flare-up. Poor compliance with analgesia.
- PT/OT: transfers, functional mobility, home environment, social issues.

Outcome: Treat and refer

1. 3 visits by Pathfinder team
2. Education re medication compliance.
3. Equipment provided: hospital bed and mattress, raised toilet seat, pressure cushion, bed leaver.
4. Liaison with Beaumont Rheumatologist- appointment brought forward.
5. Liaison with ALONE re housing issue.

2016 | 2017 | 2018 | 2019 | 2020

Uncovering a new idea

Exploring what is possible

Designing a new way of doing things

Testing and learning

Scaling for impact

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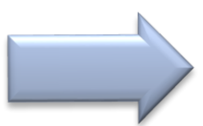
Everything Begins as an Idea

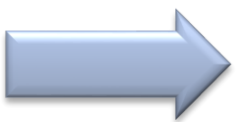
UK conferences, Social media, MSc Research

2016-2017



Approach to the Acute Hospital Division (Colm Henry)

April 2017



Referred to Martin Dunne (NAS Director) April 2017

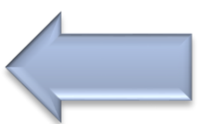
"Ride Along"

October 2017

Cathal O'Donnell

(Medical Director NAS)

May 2018



Beaumont and NAS meetings summer 2018

NAS and Beaumont agree to test using existing resources

October 2018

Stakeholder engagement starts

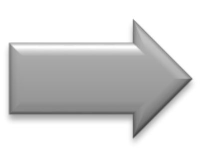
October 2018 onwards

SOP, Risk and Legal, structure of working, referral pathways agreed

Feb-April 2019

Everything Begins as an Idea

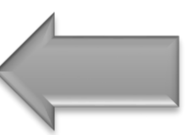
Agree start date for
Phase 1 Pilot
Reconfigure in-patient resources
March 2019



Test 1 commences
Alternative Care Pathways
May 2019

Sláintecare integration fund application
May 2019

Learning from test 1 and agree to test again in October
June-July 2019



Phase 2 agreed
Reconfigure in-patient resources
August 2019

Sláintecare application approved
September 2019

Test 2
Completed October 2019

Pathfinder service commencing March 2020

Sláintecare Integration Fund Award

- Staffing
- Electronic Patient Care Record
- Vehicle purchase and fit-out

Pathfinder Project Management Documentation

Pathfinder HR Documentation

Pathfinder Finance Documentation

Sláintecare Learning Network

Pathfinder Steering Group

Pathfinder Grant Agreement

Pathfinder HSE PMO Case Management Support

Pathfinder Pobal Case Management Support

Pobal Support Documents

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How networking made it possible for Pathfinder to grow from an idea to a reality

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OSPIDÉIL RCSI

HSCPs
Uncovering a new idea
CCO Office
NAS Director
Exploring what is possible
David Willis
Martin O'Reilly
ED FITT
Alison Enright
Tom Horwell
William Merriman
Cathal O'Donnell
Lawrence Kenna
Emergency Medicine
Frank Rice
Colm Hugh
Paul Dunne
Paul Maloney
BH Physio
Paul Bernard
Paramedics
Pauline Ackermann
Louise Lawlor
Patients & Families
Voluntary Agencies
BH CEO
Ciara O'Reilly
ED Nursing
Community Services
Ivan Clancy
Testing and Learning
Emergency Medicine
Designing a new way of doing things
St Joseph's services
Prof Jan Sorenson
Geriatricians
Scaling for Impact
Risk & Legal
Human Resources
Sláintecare Programme Implementation Office
HSE Strategic Transformation Office
Pobal
Sláintecare Central Admin team

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Beaumont Hospital

Networks for…

- Making the case: Alternative Care Pathways can work in North Dublin
- Learning how the NAS works
- Developing the Alternative Care Pathway
- Training and Education
- Case finding
- Standard Operating Procedure & Algorithms
- Project Governance
- Service Delivery

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Building and growing networks: Personal reflections

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OSPIDÉIL RCSI

- The network will start with you, so care about your idea
- Be willing to let others share and be part of your big idea
- Communicate, communicate, communicate
- Get to know your local networks
- Grow your network by developing insight into their system

- Be prepared to prove your case in real life
- Connect with managers and leaders at critical points to ensure you remain authorised as you work through design, testing and implementation
- You may need to grow and maintain multiple networks over the lifetime of your project
- Who will join your network next?

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Networking to

Learn

Create

Solve Problems

Share Resources

Influence

Transform

Steering Group members

Richard Quinlan, Chief Ambulance Officer, North Leinster (Co-Chair)

Lawrence Kenna, Advanced Paramedic

Prof Cathal O'Donnell, Medical Director

David Willis, Clinical Information Manager

Pauline Ackermann, Head of Clinical Services (Co-Chair)

Paul Maloney, Occupational Therapy Manager

Catriona Ni Chearbhaill, Physiotherapy Manager

Ivan Clancy, Deputy Physiotherapy Manager

Pathfinder Staff

Paul Bernard, Clinical Specialist Occupational Therapist

Grace Corcoran, Clinical Specialist Physiotherapist

Laura Hogan, Advanced Paramedic

Rebecca Hollywood, Advanced Paramedic

Willie Howard, Advanced Paramedic

Claire O'Brien, Senior Occupational Therapist

Peter Ward, Senior Physiotherapist

Sláintecare Integration Fund Learning Network Event

Best practice and processes for chronic disease management and care of older people

Tuesday 3rd March 2020

@Sláintecare #Sláintecare

#RightCareRightPlaceRightTime

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Presentation and Q&A by Integration Fund project on project progress, challenges, solutions and learnings:

SMILE supporting multimorbidity self-care, Margaret Curran, Caredoc

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SMILE
Project 137

Sláintecare Integration Fund Learning Network event

Project progress, challenges, solutions and learnings

Margaret Curran

Margaret.curran@caredoc.ie

3rd March 2020

SMILE

Supporting Multi-morbidity self-care through Integration, Learning and eHealth

- A new innovative way for citizens to proactively self-manage their care

Objectives

- Early identification of deterioration in participants health
- Empower citizens to engage with their own health within the community setting
- Reduction in unscheduled hospital attendances

Supported by Dundalk Institute of Technology (NetwellCASALA) and Trinity College Dublin

Criteria for Enrolment

The cohort of patients are:

- Total population over 18
- Two or more conditions
  - Coronary Obstructive Pulmonary Disorder (COPD)/Chronic Bronchitis/Emphysema/Asthma
  - Congestive Heart Failure (CHF)
  - Heart Disease, Coronary Artery Disease or Cardiovascular Disease Hypertension (Blood Pressure), Atherosclerosis (Cholesterol), Angina, Arrhythmia
  - Diabetes

Project implementation

- Information meetings with relevant stakeholders
  - Colleague Mary speaking in the afternoon!
- Enrolment of participants
- ICT configuration and implementation
- Secondment of staff
- Call assessment centre configuration
- Contact with participants (Questionnaires and devices)

- Appropriate data protection policies and consent forms

Progress

- Purchased Health Monitoring devices
  - Pulse Oximeters
  - BP Cuffs
  - Smart Watches
  - Samsung Galaxy Tabs
- Identifying the patients
- Configuration of software
  - ProACT – CABIE SIMS – Developed by DKiT and TCD

Progress

- Scheduling of patients to receive devices (holidays, hospital etc)
- Enrolment forms, consent forms
- Questionnaires (EQ-5D-DL health questionnaire, comorbidity index, technology usage questionnaire)
- Educate and training on devices for patients
- Support calls to participant by Nursing Team
  - 118 have completed the initial questionnaire

Participants to date	
Technology deployed and receiving calls from nurse	79
Support calls (no technology and receiving calls from nurse)	39
Awaiting scheduling (not availble yet)	10
Not interested in participating	16
Uncontactable	12
Total	**156**

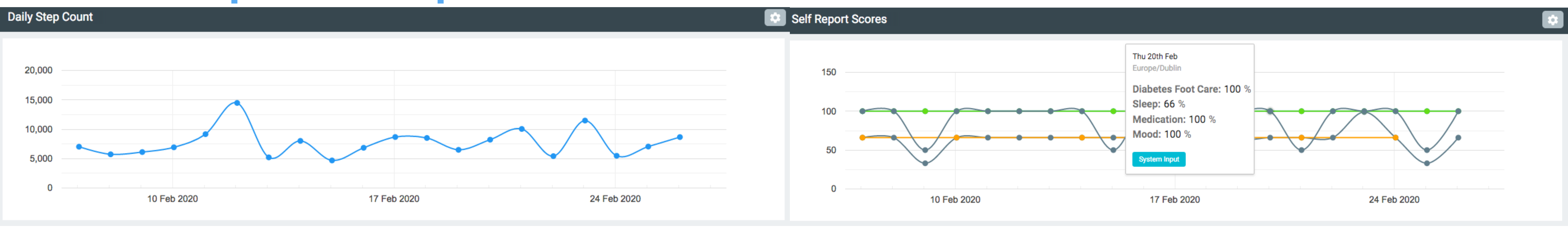
Challenges and solutions

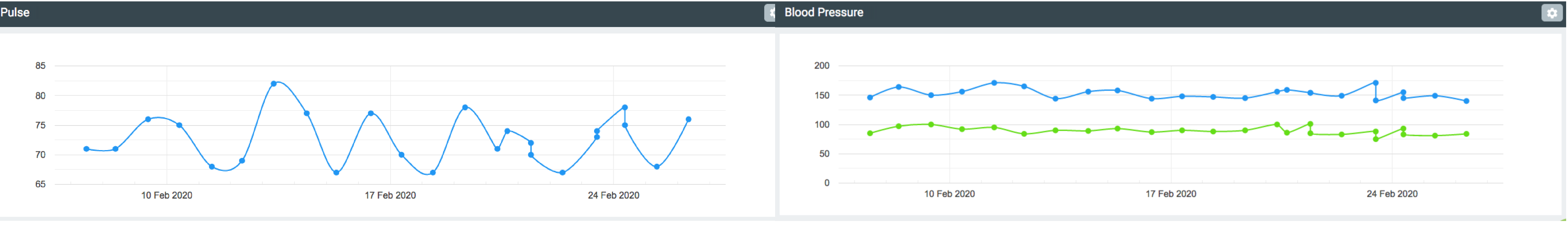
- Arranging time to meet GPs, practice nurses, consultants etc
- Technical challenges
- Training of participants
- Project evolved
  - People motivated and encouraged to participate
  - Addressing the challenge of being part of the programme – but not suitable technology wise
  - Cohort group
    - People who had no internet – keeping them involved
    - Provided with support call – no technology

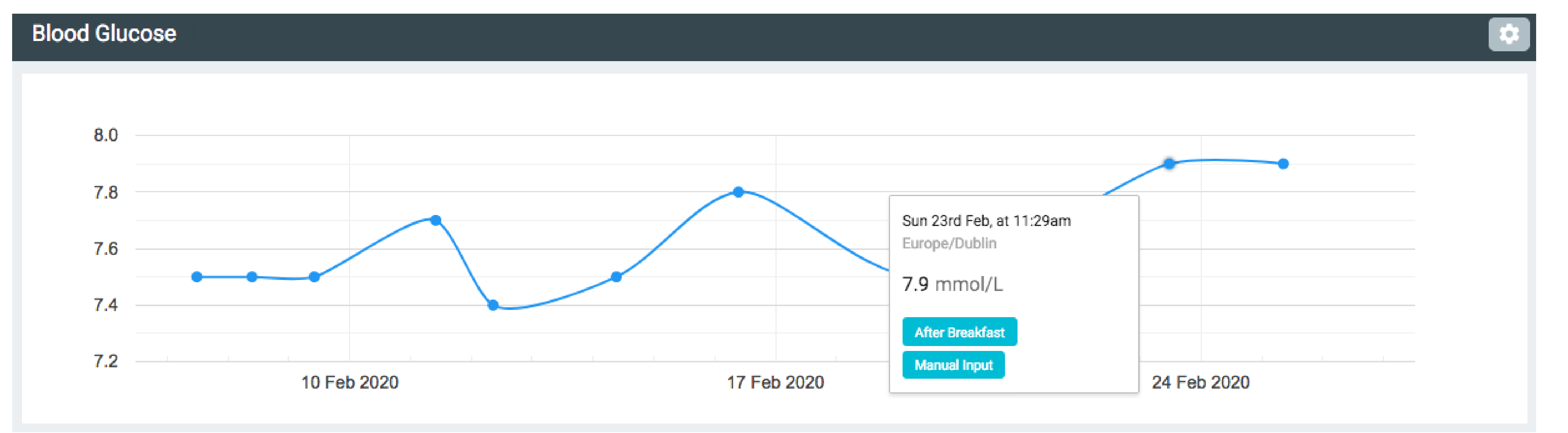
Learnings

- Be flexible
- Communicate
- Adapt and evolve the project to suit the participants needs
  - Holidays
  - Hospital appointments
  - Calling after work
  - Rescheduling when necessary
- Iterative in what you do
  - Flexibility to change as required
- Technology – adapt and change

Sample outputs from the software







Thank you

Questions & Answers

Presentation and Q&A by Integration Fund project on project progress, challenges, solutions and learnings:

Chronic Disease Management Programme- Catriona Renwick, Living Well Coordinator, South East Community Healthcare

Sláintecare.
Right Care.Right Place.Right Time.

Your toolkit for better health

Catriona Renwick

Living Well Coordinator

South East Community Healthcare (SECH)

Project ID: 78
Delivery of the Stanford Chronic Disease Self- management Programme (CDSMP) across the South East
Project Sponsor: Derval Howley Head of Health and Wellbeing
Project Manager: Kate O Connor, Self Management Support Coordinator for Chronic Conditions
Project Administration: Ciara Cross Lunney

Living Well

A programme for adults with long-term health conditions

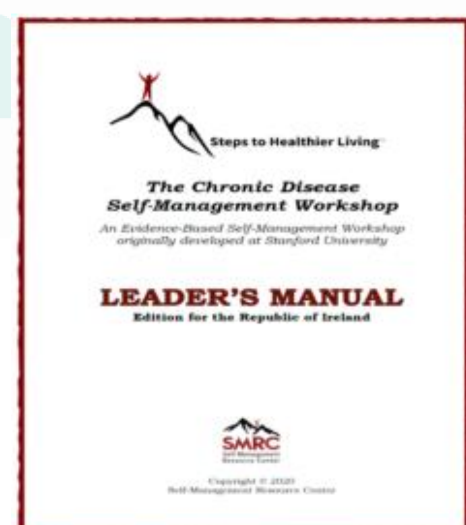
Six week group programme

Supports people living with one or more long term health conditions to develop self management skills.

Progress

National (6 Slaintecare Projects)

- ✓ Standardisation of logo and name
- ✓ Standardised promotional materials
- ✓ National Communications
- ✓ Research Partnership with Trinity College Dublin
- ✓ Leaders manual Edition for the Republic of Ireland approved by Self Management Resource Centre



Progress in South East

- ✓ SECH Living well Regional Steering Group established
- ✓ Partnership with Arteritis Ireland to deliver first 5 programmes
- ✓ Living Well coordinator and admin commenced
- ✓ Briefings with existing tutors completed
- ✓ 69 people commenced first 5 programmes
- ✓ 28 people completed 4 day Living Well leadership training using Irish manual
- ✓ Your Voice Matters patient narrative being piloted in first 5 programmes

SECH Living Well Steering Group

Challenges

- **National**

× Lack of National Oversight Group and Lack of National Project Lead as were envisioned by the Self management support Framework
× 6 different projects, budgets, staff.
× Delays (promotional materials research project)

- **South East**

× Short timeframe
× Recruitment and backfill delays
× Accommodation
× Evaluation length
× No shows for transport
× Using UK text books (some guidelines different)
× Literacy issues with attendees

Solutions

- **National**

✓ Self-Management Support Interim National Advisory Group (INAG) providing oversight

✓ 6 CHO's project managers con call weekly

✓ Addition to UK manual on Irish Guidelines

South East

✓We started before we were ready.

✓Partnerships

✓Wide representation on steering group

✓Assistance provided for evaluation

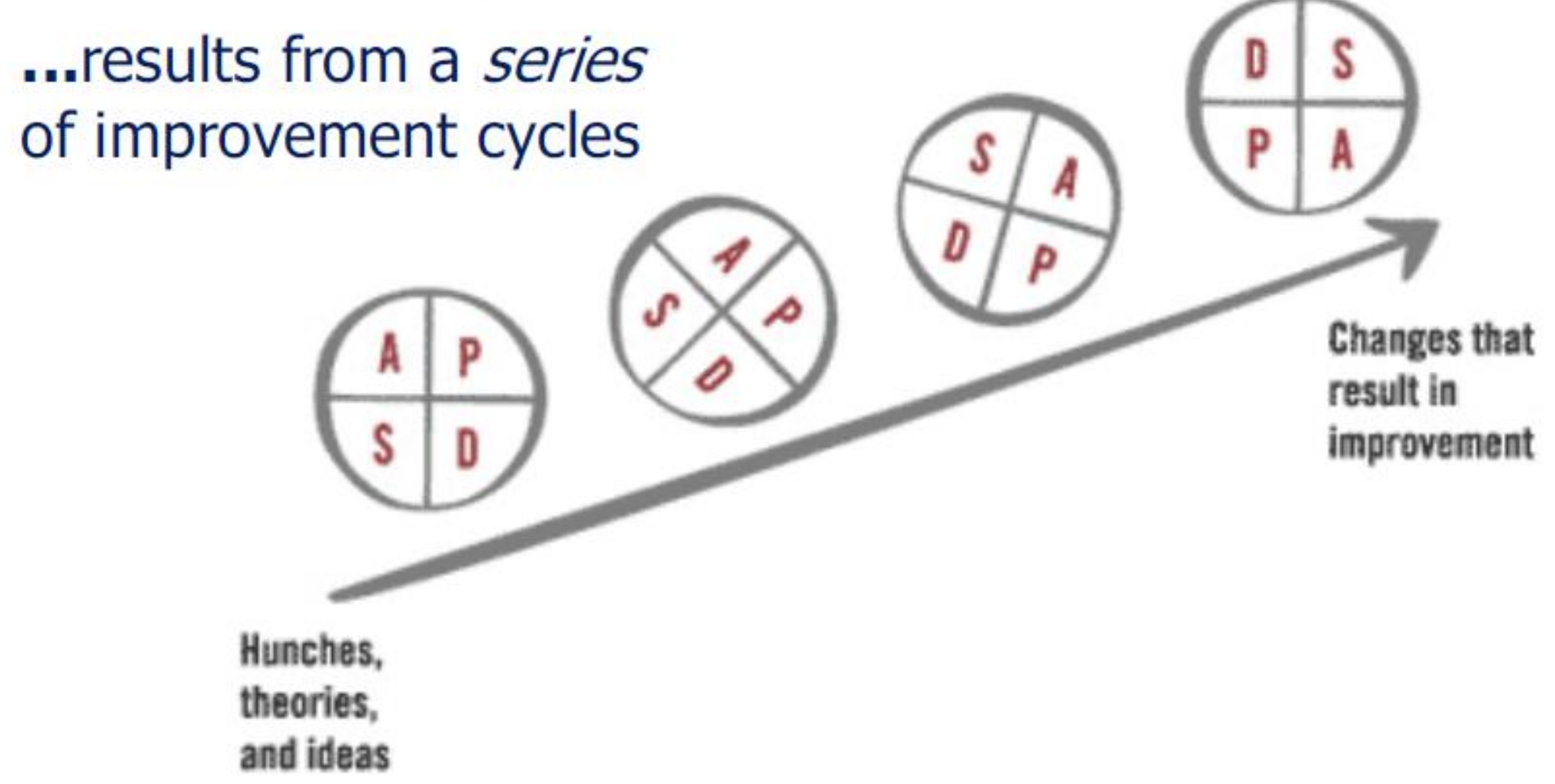
✓Flexible with working space

Lessons Learnt

- ✓ Partnerships essential
- ✓ Equality in terms of partnership with peer involvement.
- ✓ Different voices on steering group avoided group think
- ✓ Keep an eye on milestones
- ✓ Risk assessment on venues
- ✓ Allow extra time on timetable for evaluation
- ✓ Be able to quickly respond to feedback

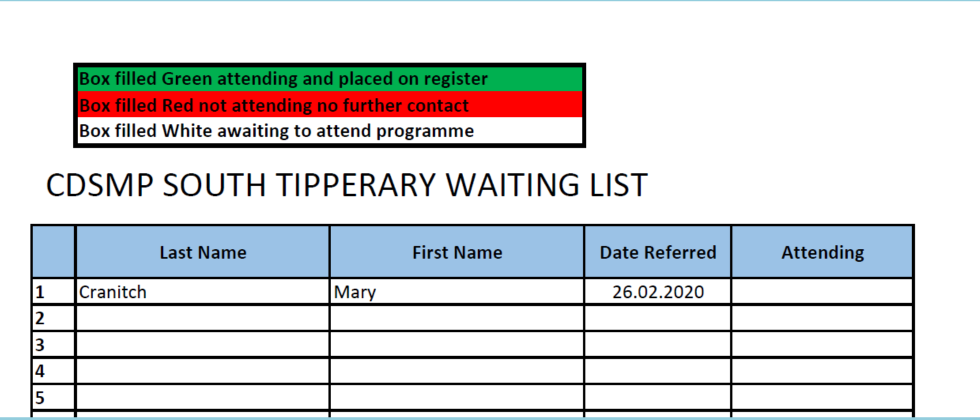
Continuous improvement…

…results from a *series* of improvement cycles



Next Steps

- Tutor briefing of new tutors
- Updating existing tutors on Irish manuals
- Upgrade resource table
- Roll out of the remaining 25 programmes
    - -10 programmes for Q2
    - -5 Programmes for Q3
    - -10 Programmes for Q4



Box filled Green attending and placed on register
Box filled Red not attending no further contact
Box filled White awaiting to attend programme

CDSMP SOUTH TIPPERARY WAITING LIST

	Last Name	First Name	Date Referred	Attending
1	Cranitch	Mary	26.02.2020	
2				
3				
4				
5				

- 3 Work placement programmes
- Evaluate use of Your Voice Matters
- Master training and accessor training for coordinator

Health Innovation Hub "Spark Ignite"

Jane O'Flynn

Sláintecare.
Right Care.Right Place.Right Time.

connecting innovation with healthcare

HIHI Vision

Establish Ireland as a **leading location** for start-ups and expanding healthcare companies

Drive collaboration between the health service and enterprises

Support our **Healthcare Innovators**, stimulating ideas, assessing and supporting on the development pathway.

GALWAY
NUIG
DUBLIN
TCD
CORK
Health Innovation Hub Ireland HQ
UCC
CIT

Health Innovation Hub Ireland is

a partnership of Irish clinical and academic centres

supported by Department of Health, Department of Business, Enterprise and Innovation, Health Service Executive and Enterprise Ireland

partnered with SFI, IDA, HRB, eHealth Ireland

HIHI supports
1 Innovation from Companies
2 Innovation from Healthcare Staff
3 Cultural Change and Education

500+ companies / healthcare professionals

100+ projects

100+ attendees at HIHI workshops / diploma

Annual Call for Projects

Open Door

Companies

Healthcare Staff

ARMED

Arthritis Rehabilitation through the Management of Exercise and Diet

Sláintecare.

Knee arthritis affects 400,000 people in Ireland with only 2,206 converting to total knee replacement annually.

ARMED is exercise and weight management programme delivered by a multi-disciplinary team lead by Clinical Specialist Physiotherapist Dr. Brenda Monaghan in Our Lady’s Hospital, Navan.

HIHI is supporting this project.

Out-patient Appointment Booking
system piloted in CUMH

62% of patients opting to choose their appointment online

45% of appointments booked outside working hours (Monday – Friday 9am-5pm)

3.3% DNA rate vs previous 23%

DNA rate reduced by **1% = €5,000,000**
€5M can be saved annually in clinical and administration costs per 1% reduction in DNA Rates across the HSE

Oral Care for Older People

Educational Programme

Poor oral hygiene has significant impact on a person's health and wellbeing. 40% of those over 75 years of age have no natural teeth and only 7% of over 65s have healthy gums.

HIHI validated and tested the programme with nurses, care assistants and nursing students.

Bord Altranais accredited Continuous Education Units.

www.hih.ie

CLOSING DATE

13th March

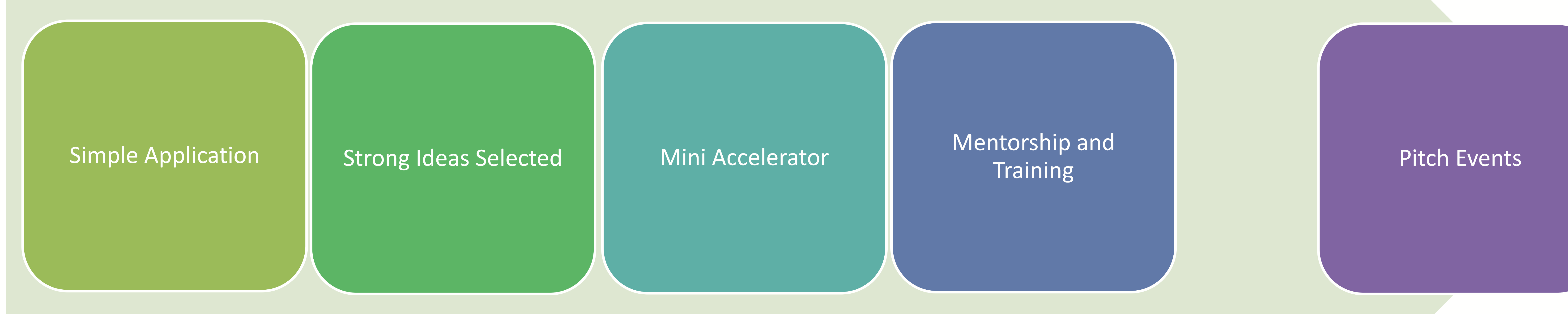
big idea?

Spark Ignite Competition 2020

Launching 3rd February

Open to all HSE staff

HIHI Spark Ignite 2020 - Process



Do you have a 'big idea' that can make a real and positive impact on the patient experience in the healthcare system? Then we want to hear from you.

Applications now open to all HSE staff.
Closing date: 13th March 2020

www.hih.ie
info@hih.ie
#HIHISparkIgnite

Who can apply?

All HSE and Voluntary Hospital Staff

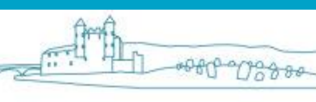
How do I apply?

Via an online portal at **www.hih.ie**

What do the winners get?

- Funding to develop their idea
- Ongoing mentorship

Winner Individual Prize	€3000
Winner Team Prize	€3000
Three Runner Up Prizes	€1000



connecting innovation with healthcare

www.hih.ie

jane.oflynn@cit.ie

Presentation by Integration Fund project on using network to deliver Integration Fund Project

SMILE supporting multimorbidity self-care - Margaret Curran and Mary Burke, Carlow Emergency Doctors-On-Call

Sláintecare.
Right Care.Right Place.Right Time.

SMILE
Project 137

Sláintecare Integration Fund Learning Network event

Using your networks

Mary Burke – mary.burke@caredoc.ie

3rd March 2020

SMILE

Supporting Multi-morbidity self-care through Integration, Learning and eHealth

- A new innovative way for citizens to proactively self-manage their care

Objectives

- Early identification of deterioration in participants health
- Empower citizens to engage with their own health within the community setting
- Reduction in unscheduled hospital attendances

Supported by Dundalk Institute of Technology (NetwellCASALA) and Trinity College Dublin

Building on our networks

- Caredoc Co-operative 450 GP Members
- OOH's - South East, North West, South Wicklow
- Provide triage services – North Dublin , North East
- Community Intervention Teams – Carlow, Kilkenny, Tipperary, Waterford, Wicklow
- Integration - HSE Primary Care, Public Health, Acute Hospitals, NAS, Mental Health, Tusla
- Information meetings with relevant stakeholders

Stakeholders

GP’s

- Building on existing relationships
- Scheduling Information Meetings with GP’s & Practice Nurses
- Involved in Chronic disease clinics

Hospital Consultants & Nurse Specialists

- Using opportunities to speak to clinicians at clinical and governance meetings
- OPD Clinics
- Grand Round Meetings

Finding solutions

Meeting stakeholders at convenient times & locations

- Hospital meetings at lunch times
- Evening meetings for working group
- Evening meetings, early morning for GPs

Allowing people to express their concerns

- Listening and taking on board concerns
- Understanding their point of view
- Resolving and adapting

Bringing people on board

- Convincing colleagues of the win-win situation for patients and stakeholders
- Persistence and clear communication
- Recognising competing agendas and priorities of other groups
- Making judgements on the pace of change
- Allowing everyone's' view to be heard

Communication is key

- Explain what SMILE is
- How it is delivered
- By whom it would be delivered
- How the service is different
- Governance
- Impact on stakeholders
    - Will this increase my workload?

Early Testimonials

- P30: has reduced her cigarettes with a view to giving them up completely. She has also increased her exercise. Very happy to be part SMILE and very grateful to have interaction with nursing team.
- P57: Delighted to have people looking after her. Has a difficult home life. Has 2 grandchildren living with her one of whom has mental health issues. Her husband has had a recent dx of prostate CA. SMILE has made her realise the importance of looking after herself.
- P83: Delighted to have been selected to partake in SMILE project. Has sent a thank you letter to his GP.
- P01: Fantastic project to be involved in. Anxious that it would not be stopped after 6 months.
- P54: Delighted to be part of SMILE as he had been non-compliant with his medication and diet. Smile helping him understand his condition and has increased his motivation to improve his health.

Thank you

Questions & Answers

Presentation by Integration Fund project on using network to deliver Integration Fund Project

National Quality Improvement Team – Mary Browne, School of QI, HSE

Sláintecare.
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Health Service Executive Ireland

National Quality Improvement Team

School of QI
Dr Mary Browne

Our mission

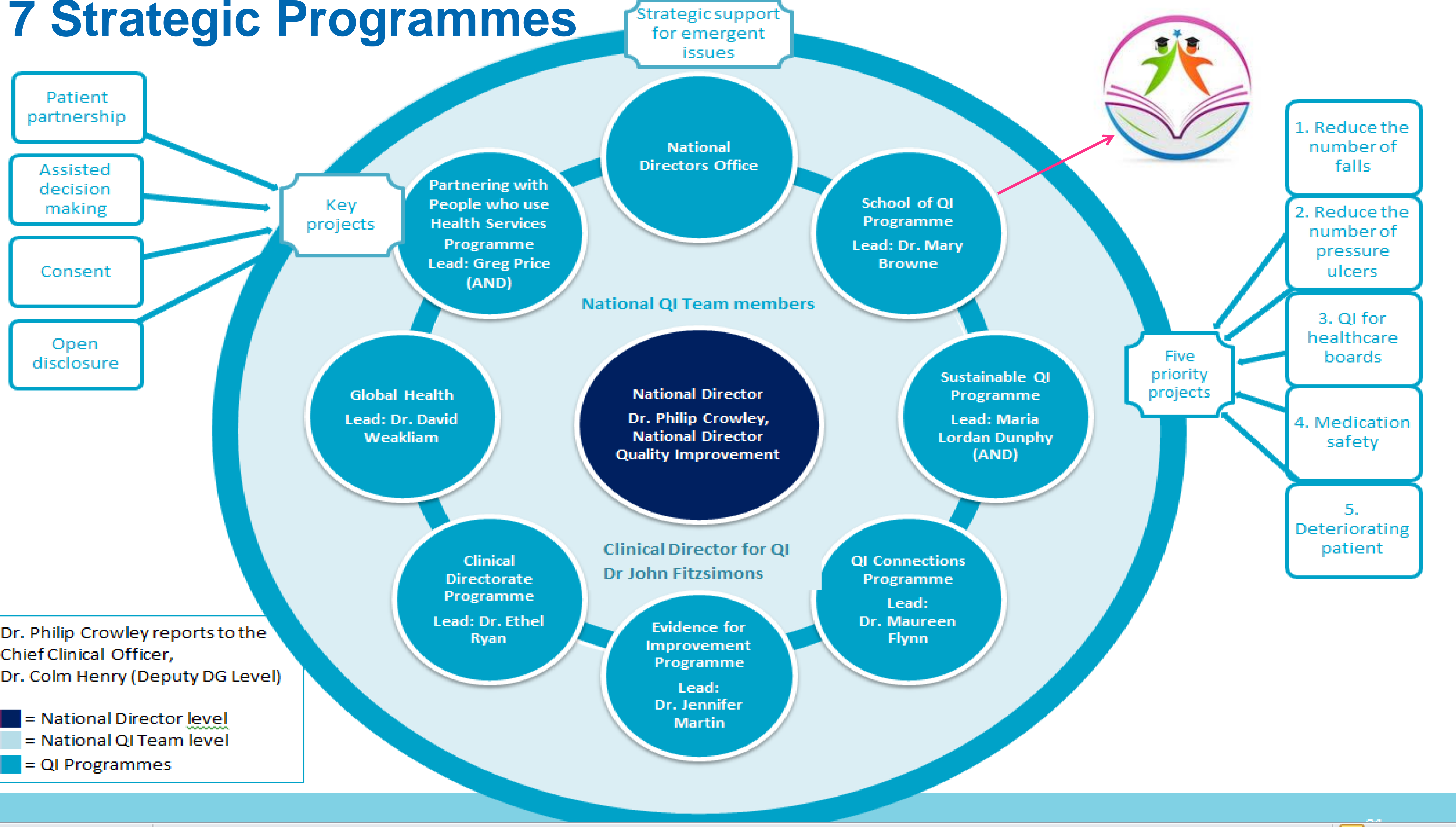
"We work in partnership with staff and people who use our health and social care services to lead innovation and sustainable QI to achieve measurably better and safer care"

PARTNER
Work with and connect people across the system (service users, clinicians, managers, national bodies) to inform and align development

ENABLE
Build capability for leadership and quality improvement through learning and development opportunities

CHAMPION
Continually share information, evidence and learning to support people working in practice and policy to improve care

DEMONSTRATE
Use evidence to identify the need for, and demonstrate the impact of quality improvement


7 Strategic Programmes
Strategic support for emergent issues
Patient partnership
Assisted decision making
Consent
Open disclosure
Key projects
National Directors Office
Partnering with People who use Health Services Programme
Lead: Greg Price (AND)
School of QI Programme
Lead: Dr. Mary Browne
National QI Team members
Global Health
Lead: Dr. David Weakliam
National Director
Dr. Philip Crowley, National Director Quality Improvement
Sustainable QI Programme
Lead: Maria Lordan Dunphy (AND)
Clinical Director for QI
Dr John Fitzsimons
Clinical Directorate Programme
Lead: Dr. Ethel Ryan
Evidence for Improvement Programme
Lead: Dr. Jennifer Martin
QI Connections Programme
Lead: Dr. Maureen Flynn
Five priority projects
1. Reduce the number of falls
2. Reduce the number of pressure ulcers
3. QI for healthcare boards
4. Medication safety
5. Deteriorating patient
Dr. Philip Crowley reports to the Chief Clinical Officer,
Dr. Colm Henry (Deputy DG Level)
= National Director level
= National QI Team level
= QI Programmes

Our Journey in building QI knowledge and skills

Our Journey so far..

Levels of Learning

Level 3 – Influencing & Advising on QI
For those who advise, coach, facilitate and support QI

Level 2 – Delivering QI
For Teams

Level 1 – Understanding QI
For Everyone

Programmes of learning

© Can Stock Photo - csp26449127

Level 1
Building the Foundations for Quality Improvement

Digital Introduction to QI hosted on HSELand, and NQI Team Website

Delivered as a Face-Face 1 Day Workshop or online modules for **everyone**

Level 2
Quality Improvement in Practice

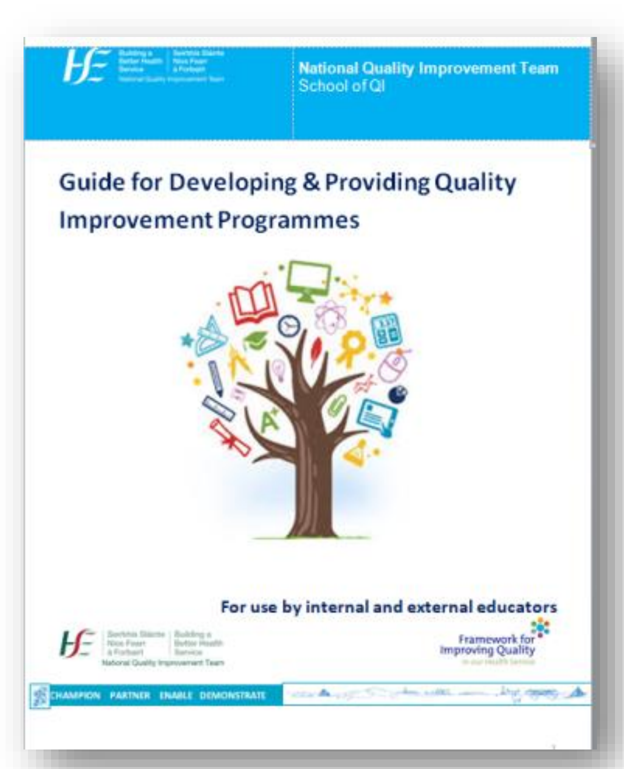
Delivered via a series of Face to Face Workshops and project clinics over a 6 month period for **teams**

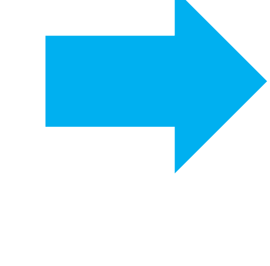
Level 3
Diploma i Leadership & Quality in Healthcare

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Co-delivered by HSE & RCPI over a 9 month period for those who influence, facilitate, coach and advise on QI - **team** based

Build local capability





Local Project Clinic Support

Guide for developing and providing QI programmes

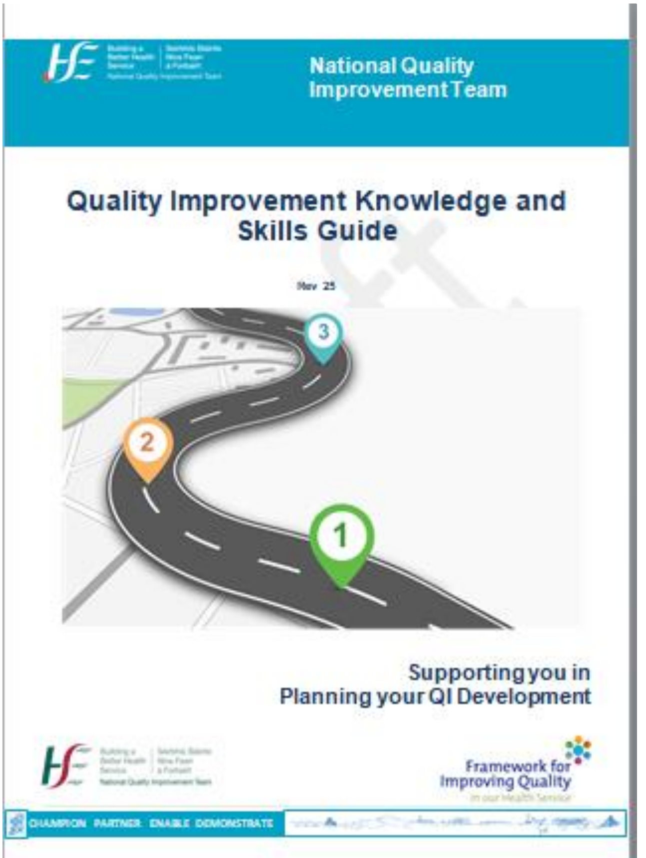
Train-the-Trainer
Facilitation Skills
Coaching Skills for QI

Master class series/QI Collaboratives

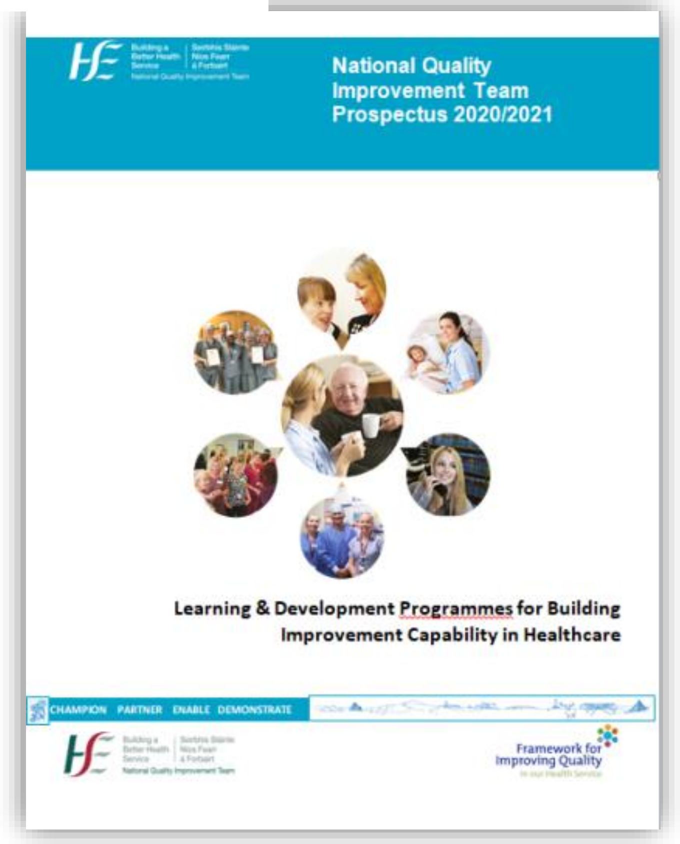
Resources

COMING SOON

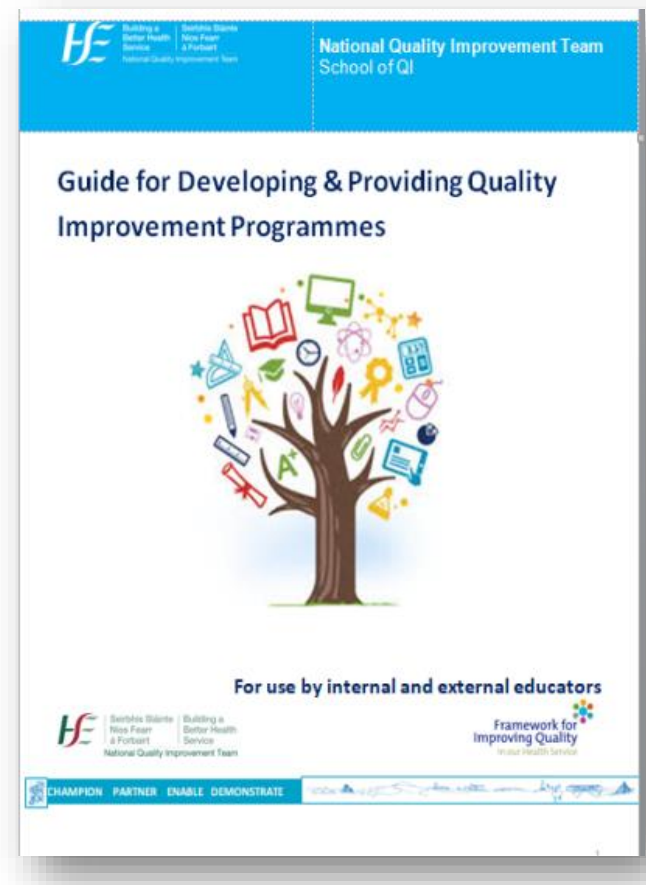
COMING SOON



Quality Improvement Knowledge & Skills Guide
Self-Assessment Tool



NQI Team
Prospectus of Learning Programmes



Guide for developing and providing QI programmes

Qualityimprovement.ie

Revamped website & online resource repository

Twitter: @NationalQI

Web: www.qualityimprovement.ie

Email: Mary.browne7@hse.ie

veronica.hanlon@hse.ie

Lisa.toland@hse.ie

Phone:

Sláintecare Integration Fund Learning Network Event

Promote the engagement and empowerment of citizens in the care of their own health

Wednesday 4th March 2020

@Sláintecare #Sláintecare
#RightCareRightPlaceRightTime

Sláintecare.
Right Care.Right Place.Right Time.

Presentation and Q&A by Integration Fund project on project progress, challenges, solutions and learnings:

Student sexual health service - Laura Tully, Athlone Institute of Technology

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Student Sexual Health Service

Laura Tully R.G.N.
Institute Nurse & Health Centre Coordinator
Project Lead

Sláintecare.

An Roinn Sláinte
Department of Health

Student
Sexual Health Service

- Equitable & Accessible
- High Quality
- Comprehensive
- Shift Care
- Detect & Treat STI's earlier
- Prevent & reduce the burdens associated with STI's
- Health promotion, education & awareness

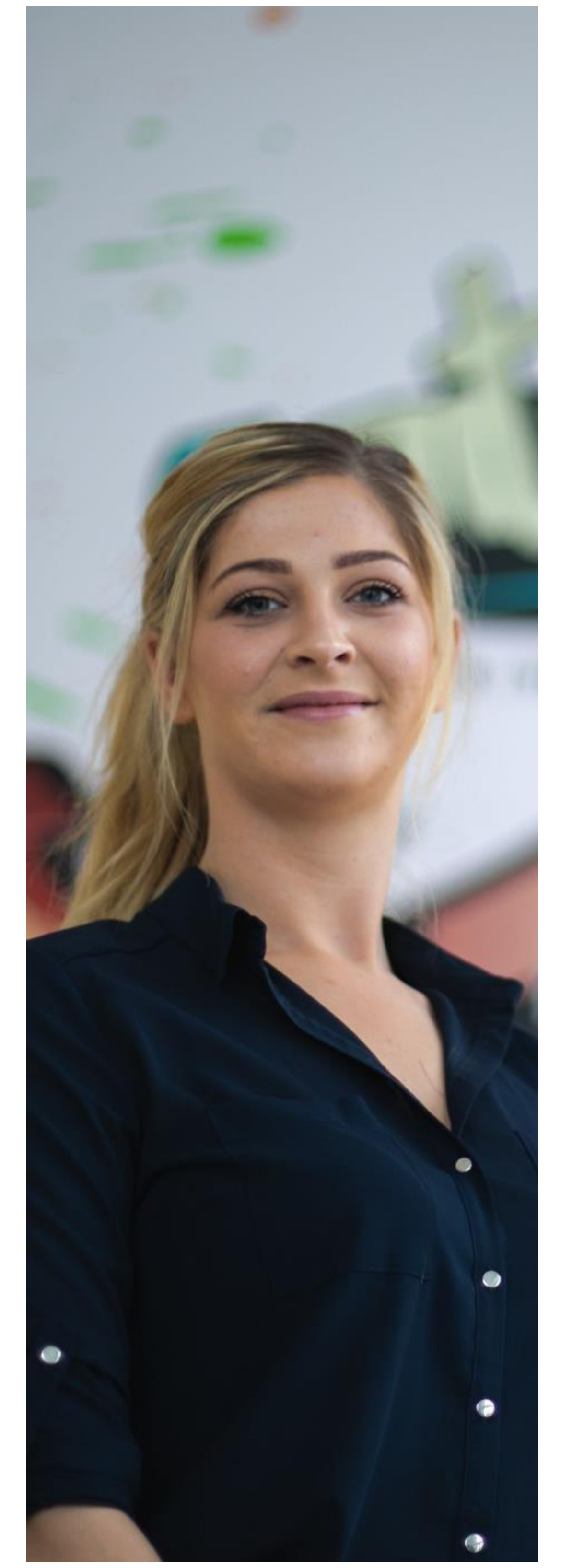
Project Progress

- 154 Consultations
- 59% never had sexual health screen
- 37% Symptomatic
- 5% MSM attendance
- Partner Notification 11%
- Contraception 34%
- Public Health 16
- Health Promotion
- Communications

"Do not judge me by my success, judge me by how many times I fell down and got back up again"

Challenges, Solutions & Learning

- World of Academia
- Space
- Threat to Project
- Continuity of Care



Patient Satisfaction

"convenient location & times"

"really useful on campus"

"lovely lady, made me feel very comfortable"

"very confidential"

"late evening appointment really suited me"

"would not have gone elsewhere, glad it is here on campus"

THE TIMES THE SUNDAY TIMES
GOOD UNIVERSITY GUIDE 2020
INSTITUTE OF TECHNOLOGY OF THE YEAR
AIT
Connect & Discover
Right Care
Right Place
Right Time

Presentation and Q&A by Integration Fund project on project progress, challenges, solutions and learnings:

HAIL Community living mental health recovery coordinator -Tom Gifford, Housing Authority For Integrated Living

Sláintecare.
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Housing Association for Integrated Living (HAIL)

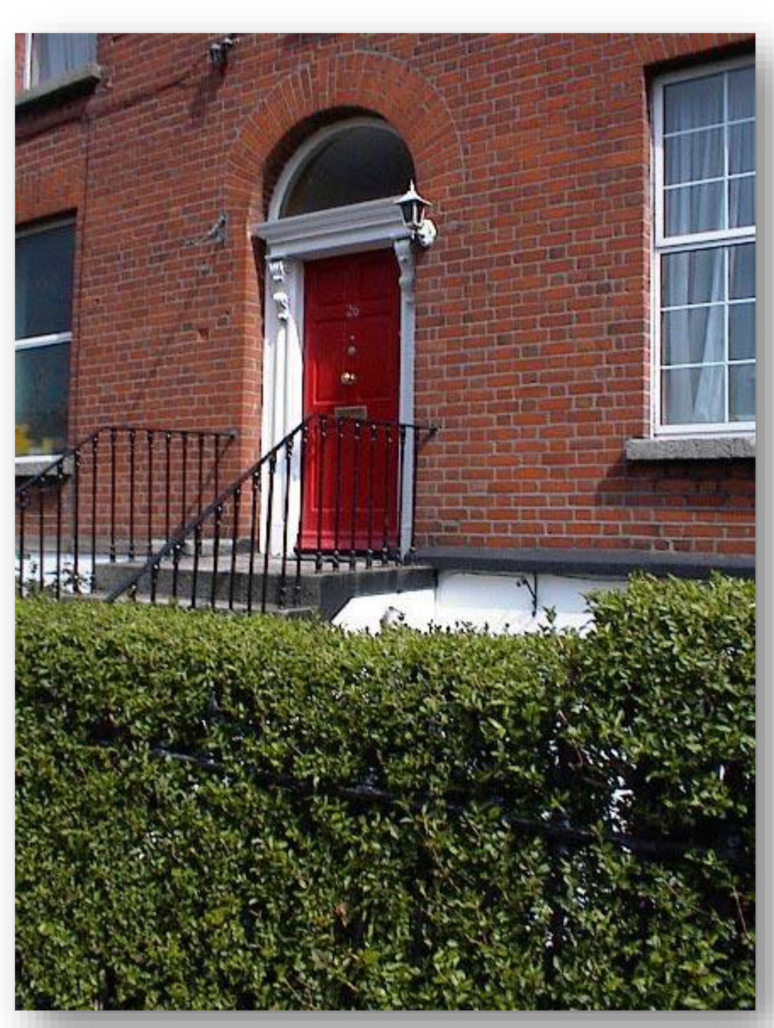
Wednesday, 4th March 2020

Tom Gifford & Steven O Riordan

About HAIL

- HAIL (Housing Association for Integrated Living) was founded in 1985 as a not-for-profit, Approved Housing Body

- Our mission is to provide housing and individually tailored services to support people, primarily those with mental health difficulties, to integrate and live independent lives in the community



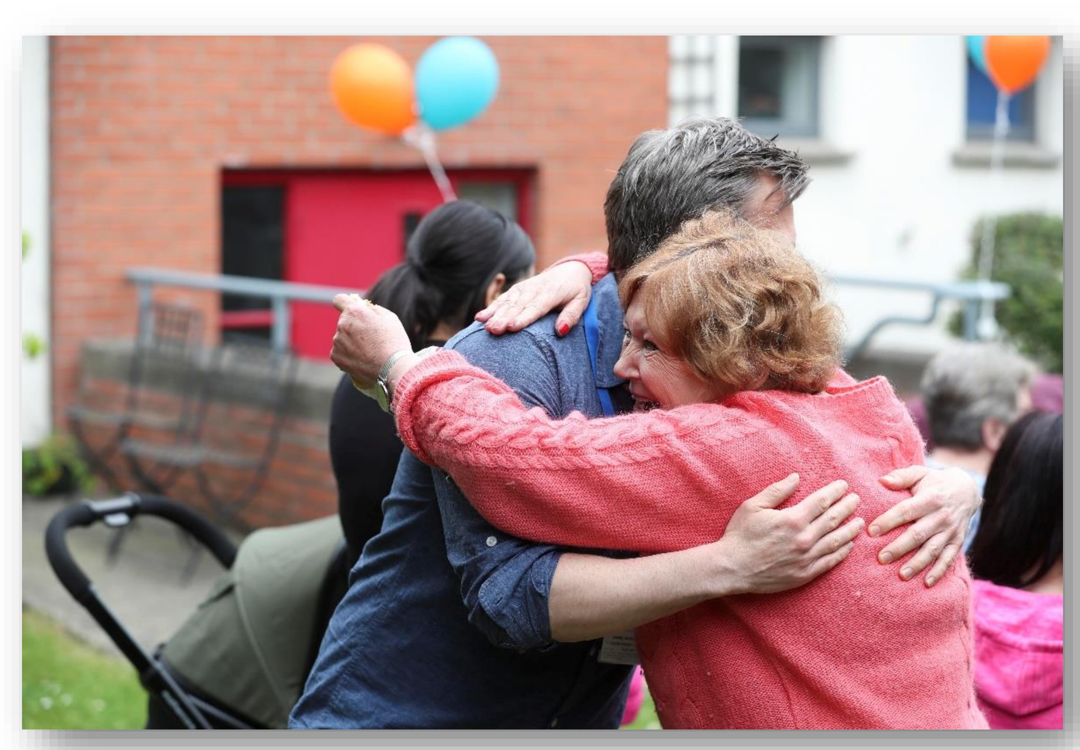
Peer Support - Progress

- Recruitment of a Peer Support Coordinator in February 2020

- Development of Policies and Core Competencies for Peer Support Work in HAIL

- Development of service brochure

- Networking with key mental health organizations in the community to promote volunteer recruitment and training



Peer Support - Challenges

- Embedding a peer support model in HAIL
- Development of S.M.A.R.T. action plan
- Piloting evening and weekend work
- Overcoming risk-related barriers
- Sustainability and future funding
- Measuring interventions and outcomes

Peer Support - Solutions

- Inclusion of all staff in change management process
- Positive risk management strategies for service delivery
- Secure, long-term financial support to meet the projects core costs
- Good evidence based practice in terms of incremental development, governance and ethos of peer-led projects
- Expansion of peer service to include wider mental health community

Peer Support - Learning

- Multifaceted and inter-dependent nature of project requires disciplined goal setting
- The fine-line between consolidation and expansion
- Recognition of the value that co-production and peer support can offer
- Inherently challenging organisational and systemic cultures of traditional mental health support

Presentation by Integration Fund project on using network to deliver Integration Fund Project

Inclusion Health Primary Care: Demonstration of an Integrated Care approach into a scalable model (Homeless Health Link),

Maxine Radcliffe, HSE

Sláintecare.
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Sláintecare Project 322 Inclusion Health Primary Care

Maxine.radcliffe@hse.ie
Jess Sears Depaul CNM
Tadg Lehane GP Thomas Court Medical Centre

Health Priorities and Homelessness

- Patients priorities often radically different than from a clinician's perspective
- Focus on their priority and then work towards clinical goals

Often high levels of risk

For example

- Impulsive self harm and substance use
- self neglect of significant physical health problem
- Unmet mental health needs
- Harm from others
- Mobility issues and high falls risk

Lived Experience

“The friend had been here and there, and had been played about from hand to hand, and had come back as she went. At first it was too early for the boy to be received into the proper refuge, and at last it was too late. One official sent her to another, and the other sent her back again to the first, and so backward and forward, until it appeared to me as if both must have been appointed for their skill in evading their duties instead of performing them”

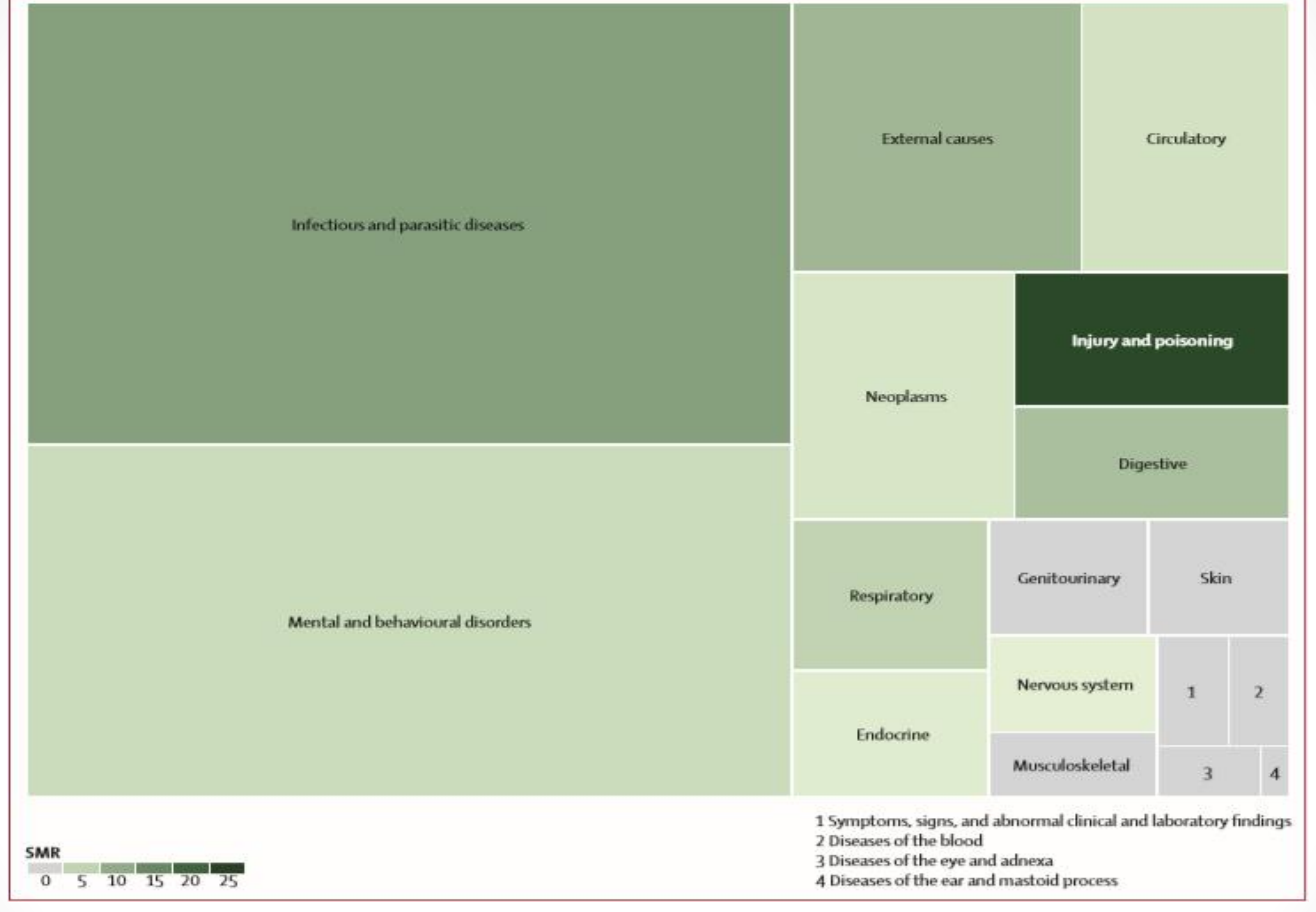
Charles Dickens; Bleak House

Burden of Disease

- Almost always multi-morbid – Hewett et al (2016) ‘tri-morbidity’: physical health, mental health and addiction.
- Aldridge et al 2018 systematic review: Homeless populations experience extreme health inequities across a wide range of health conditions, with the **relative effect of exclusion being greater in women than men**
- **Aging population:** considered to be of “older age” at 50 years old compared to general population (Hahn, 2016). Present with early onset of geriatric conditions in their 50’s compared the general population 15-20 years older (70’s -80’s) (Brown, 2012)
- High rates of cognitive impairment, functional impairment, urinary incontinence, multimorbidity (85% > 1 chronic condition) (Brown, 2012)

Epidemiology of Homelessness

- Very location specific: extremely different issues between London, Dublin and San Francisco for example
- Aging population: 30% over 50 years old, 65+ years to triple by 2030
- Lack of data from Primary care in Ireland
- Secondary care Ireland : SJH (Ni Cheallaigh, 2017) higher rates of attendance to ED (Emergency Departments) (0.16 vs. 3.0/year) and longer bed days (0.3 vs 4.4 days/year) homeless population compared to the housed population. 40% of homeless individuals left before being seen and 15% of this cohort left hospital during admission before completing treatment, with attendance to follow up appointments at about 10-15%.
- Depaul service Pilot: 30 residents accounted for 2% of all ED visits/bed days in 2016 in a catchment of 240, 0000 people



Aldridge et al Treemap; Data grouped according to the ICD 10 and summary estimates of

Homelessness: Mortality in Ireland

Table 7: Standardised Mortality Ratios 2011–2015

	Males			Females		
Year	Observed*	Expected±	SMR	Observed	Expected	SMR
2011	13	4.9	2.7	4	0.65	6.2
2012	26	5.8	4.5	8	0.8	10.0
2013	26	6.1	4.3	9	1.0	9.0
2014	37	6.4	5.8	12	1.3	9.2
2015	54	5.4	10.0	12	1.3	9.2

* Number of observed deaths in the homeless population

± Number of expected deaths (calculate expected number of deaths among homeless as: mortality rate in general pop multiplied by the number of homeless people per age group)

Ivers and Barry 2018 Mortality amongst the Homeless Population in Dublin

Julian Tudor Hart

1971 The Inverse Care Law:

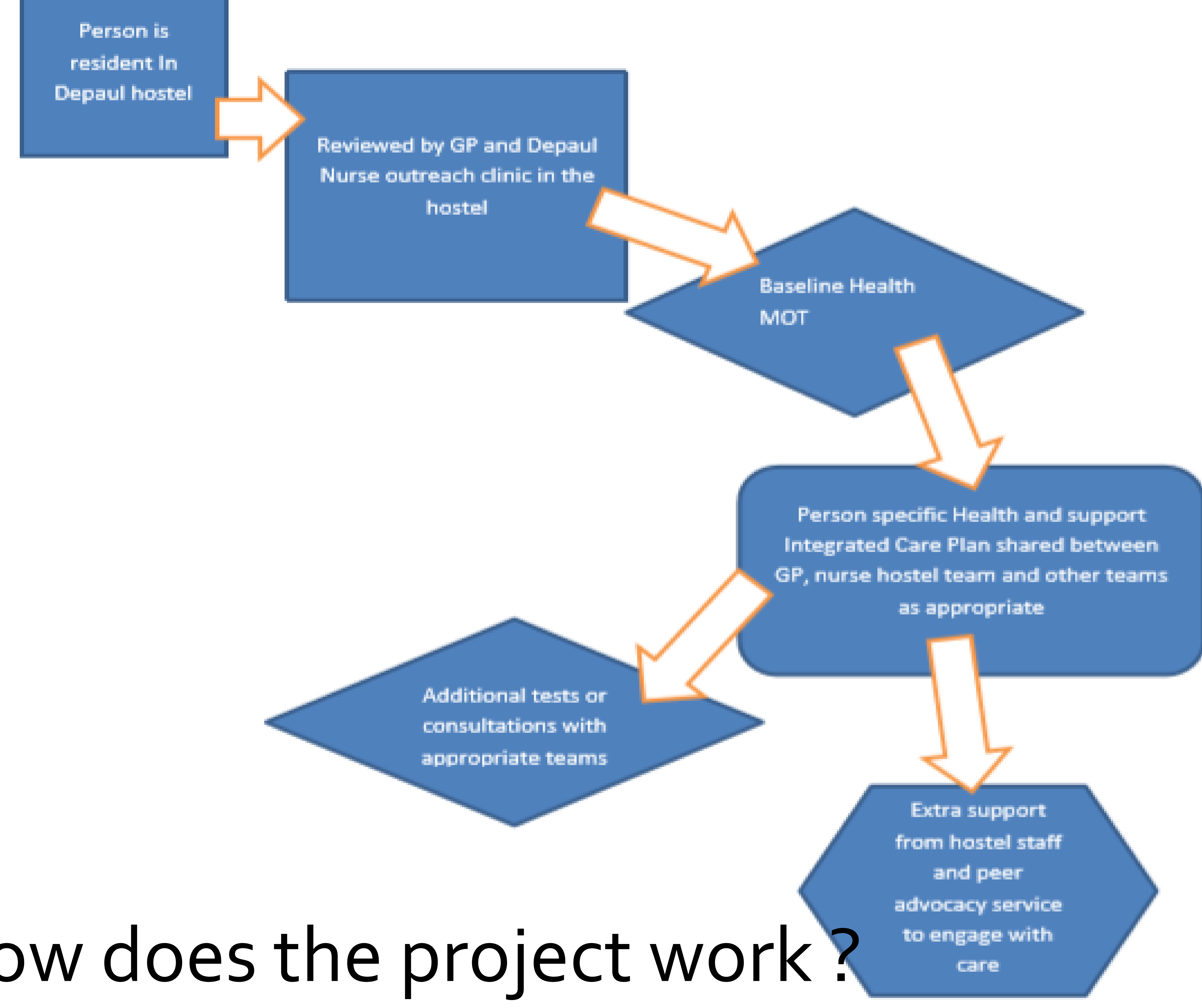
“The availability of good medical care tends to vary inversely with the need for it in the population served.

Project Partners

Thomas Court Medical Centre

Client

Wha



How does the project work ?

What will our project do?

Outcomes All patients across the three Depaul hostels with the enhanced service to be offered baseline physical health MOT's with at least 50% completion of this during the project period

- All patients with a **recorded chronic non communicable disease** to complete appropriate cycles of care

For example Patients with alcohol dependence to have liver enzymes (GGT and ALT) measured and nutritional assessment with vitamin supplementation prescribed as appropriate.

Intended Output Reduced acute care utilisation and reduction of inpatient bed days amongst cohort

Partnership working: value of networks

Multiple networks intersect that enable us to deliver this

Working in inclusion health requires ‘boundary spanning’ and

Network of Homeless healthcare allies - Whatsapp Homeless clinical groups

Inclusion health MDT

Inclusion Health Forum

Network of Inclusion Health Nurses

Homeless network – DRHE

Slaintecare network

Thank you!

www.gov.ie/slaintecare

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