Sláintecare Integration Fund Learning Network Event

Tuesday 10th December

@Sláintecare #Sláintecare #RightCareRightPlaceRightTime
# Sláintecare Integration Fund PMO Contacts

<table>
<thead>
<tr>
<th>Area</th>
<th>Community Healthcare Organisations</th>
<th>Role</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan</td>
<td>Portfolio Lead</td>
<td>Virginia Reid</td>
<td><a href="mailto:Virginia.reid@hse.ie">Virginia.reid@hse.ie</a></td>
</tr>
<tr>
<td>2</td>
<td>Galway, Roscommon, Mayo</td>
<td>Portfolio Lead</td>
<td>Iolo Eilian</td>
<td><a href="mailto:iolo.eilian@hse.ie">iolo.eilian@hse.ie</a></td>
</tr>
<tr>
<td>3</td>
<td>Clare, Limerick, North Tipperary</td>
<td>Portfolio Lead</td>
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<td><a href="mailto:aislingm.ryan@hse.ie">aislingm.ryan@hse.ie</a></td>
</tr>
<tr>
<td>4</td>
<td>Kerry, North Cork, North Lee, South Lee, West Cork</td>
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<td>Kathleen Canny</td>
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</tr>
<tr>
<td>5</td>
<td>South Tipperary, Carlow/Kilkenny, Waterford, Wexford</td>
<td>Portfolio Lead</td>
<td>Fiona MacNamara</td>
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</tr>
<tr>
<td>6</td>
<td>Wicklow, Dun Laoghaire, Dublin South East</td>
<td>Portfolio Lead</td>
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<td><a href="mailto:john.nwobo@hse.ie">john.nwobo@hse.ie</a></td>
</tr>
<tr>
<td>7</td>
<td>Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West</td>
<td>Portfolio Lead</td>
<td>Margaret McQuillan</td>
<td><a href="mailto:margaret.mcquillan@hse.ie">margaret.mcquillan@hse.ie</a></td>
</tr>
<tr>
<td>9</td>
<td>Dublin North, Dublin North Central, Dublin North West</td>
<td>Portfolio Lead</td>
<td>Nicola Byrne</td>
<td><a href="mailto:nicolam.byrne@hse.ie">nicolam.byrne@hse.ie</a></td>
</tr>
</tbody>
</table>
## Sláintecare Integration Fund PMO Contacts

<table>
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<th>Hospital Group</th>
<th>Role</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dublin Midlands</td>
<td>Portfolio Lead</td>
<td>Catriona McDonald</td>
<td><a href="mailto:catriona.mcdonald@hse.ie">catriona.mcdonald@hse.ie</a></td>
</tr>
<tr>
<td>Ireland East</td>
<td>Project Manager</td>
<td>Paul Marley</td>
<td><a href="mailto:paul.marley@hse.ie">paul.marley@hse.ie</a></td>
</tr>
<tr>
<td>Saolte</td>
<td>Portfolio Lead</td>
<td>Jo Shortt</td>
<td><a href="mailto:jo.short@hse.ie">jo.short@hse.ie</a></td>
</tr>
<tr>
<td>South/South West</td>
<td>Project Manager</td>
<td>Dervla Hogan</td>
<td><a href="mailto:dervla.hogan@hse.ie">dervla.hogan@hse.ie</a></td>
</tr>
<tr>
<td>UL Hospital Group</td>
<td>Portfolio Lead</td>
<td>Deirdre Mullins</td>
<td><a href="mailto:deirdre.mullins@hse.ie">deirdre.mullins@hse.ie</a></td>
</tr>
</tbody>
</table>
Registration

09.00-10.00
Laura Magahy
Executive Director, Sláintecare

Opening Address

Sláintecare.
Right Care. Right Place. Right Time.
Improving the service user experience is a fundamental Sláintecare goal and underpins all of our actions.
What is today all about?
Improving the patient experience

Integration Fund
477 applicants
122 successful projects

- Promote the engagement and empowerment of citizens in the care of their own health
- Scale and share examples of best practice and processes for chronic disease management and care of older people
- Encourage innovations in the shift of care to the community or provide hospital avoidance measures
Improving the patient experience

- Today’s purpose: We are here to listen, support and learn from one another

- Networking and sharing of information is vital to the successful delivery of the Sláintecare Integration Fund projects

- Harnessing the experience of existing networks, e.g. ICPOP and Chronic Disease Self Management

- With the Integration Fund projects we will be able to examine and test ways we can design and deliver services around the patient, putting them at the centre of the services they need.
The goal is to enable…

Right Care

Right Place

Right Time given by the Right Team
Through:

- Population based approach to planning services
- Clear pathways between GPs, community and social care services, and hospitals within geographical regions
- Empowerment of front-line staff, devolved responsibility and decision-making
- One budget per region
Progress To Date
Action Plan 2019

**Workstream 1**
Service Re-Design and Supporting Infrastructure

- 1.1 Data Research and Evaluation Programme
- 1.2 Population based Planning Programme
- 1.3 Service Re-design Framework Programme
- 1.4 Capital Planning Implementation Programme
- 1.5 E-Health Programme

**Workstream 2**
Safe Care, Co-ordinated Governance & Value for Money

- 2.1 Geoalign -ment and RICO’s Structure Programme
- 2.2 Corporate and Clinical Governance Programme
- 2.3 Public and Private Partners Programme
- 2.4 Eligibility / Entitlement Programme
- 2.5 Financing Reform Programme

**Workstream 3**
Teams of the Future

- 3.1 Workforce Planning Programme
- 3.2 Training Pipeline and new ways of Training Programme
- 3.3 Culture Change and new ways of Working Programme
- 3.4 Innovation / Capacity Building Programme
- 3.5 Future Intelligence / Influencers Programme

**Workstream 4**
Sharing Progress

- 4.1 Citizen & Staff Engagement & Empowerment Programme
- 4.2 Sláintecare Programme Implementation Office & Governance Programme
- 4.3 Evaluation Framework & Reporting Progress Programme
- 4.4 Integration Fund & Sláintecare Budget Management Programme
- 4.5 Communications & Recognising Success Programme

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Sláintecare.

Right Care. Right Place. Right Time.
Sláintecare Q3 Deliverables

- 114 deliverables to September 2019

- 93% on track with 7% having minor challenges
  (to be delivered before year-end)
Budget 2020
## Budget 2020 and Sláintecare, including..

<table>
<thead>
<tr>
<th>Amount 2020</th>
<th>Funding Areas</th>
</tr>
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<tbody>
<tr>
<td>€10 million Enhanced Community Fund (€60 million in 2021)</td>
<td>Up to 1,000 therapists, nurses and other frontline staff to care for people in the community, including advisers for people with Dementia. This will allow us to treat people in the community, closer to their own homes, reducing community waiting lists.</td>
</tr>
</tbody>
</table>
| €20 million Integration Fund      | Scaling successful projects for:  
- Engagement and Empowerment of People in the Care of their own health  
- Moving care from the hospital to the community  
- Care of Chronic Diseases and Older Persons |
| €12 million Care Redesign Fund    | Care redesign - providing care at the least form of complexity, in accordance with the clinical care programmes, to people in the right location. |
Implementation Analysis
Foundational Decisions

- Six new Regional Health Areas
- New HSE Board & CEO in place
- GP Contract
- Enhanced Nurse Contract agreed
- National Clinical Programmes Review and Recommendations
- Dialogue Forum with Voluntary organisations
- Community Health Care Networks
- De Buitléir Report published
### Sláintecare Reform Initiatives:

#### Capacity Plan/ Waiting List Implementation Framework

**As per the Health Service Capacity Review to 2031**

**Projected 2031 demand**
- +7,150 acute beds
- +2,930 primary workers
- +11,900 residential beds
- +11,130 Home care pm
- +7.2m home help hrs

**Capacity Targets:**
- 2,590 Acute beds
  - 2,100 inpatient beds
  - 400 day beds
  - 180 Adult CCU beds
- 3,840 Primary Workers
  - 1,980 GPs
  - 1,180 PHNs
  - 510 AHPs
- 13,000 Residential beds
- 19,460 Home Care packages
- 12.5m Home help hours

**Impact of Reform**
- +2,590 acute beds
- +3,840 primary workers
- +13,000 residential beds
- +19,460 home care pm
- +12.5m home help hrs

#### Healthy Living
- ~990 acute beds
- 530 primary workers

**Associated activity to include:**
- Implementation of Healthy Ireland Framework
- Making Every Contact Count
- HSE National Priority Programmes including: Health Childhood; Healthy Eating & Active Living; Reducing Alcohol Consumption; Smoking cessation; Obesity management; Cardiac/pulmonary rehab;
- Positive Ageing
- National Screening Service
- National Immunisation Programme
- Public Health Protection
- Promoting patient self-care and improving healthy behaviours

#### Enhanced Community Care
- +1,900 acute beds
- +1,230 primary workers
- +600 residential beds
- +7,200 home care pm
- +4.8m home help hrs

**Associated activity to include:**
- Development of and investment in comprehensive and integrated community based services (National/Regional/CHNs)
- Redesign and implementation of integrated care for older people and chronic disease management across primary care, acute hospitals and services for older persons via CHNs /Regional Areas /Integrated Care Programmes
- Increased eHealth infrastructure
- Enhancing social care provision to provide timely step down and home care support
- Development of community-based diagnostic facilities
- National adoption of ambulatory emergency care model
- Social Inclusion Measures
- Hospital Avoidance Measures

#### Hospital Productivity Improvements
- - 1,670 acute beds
- +210 primary workers
- +500 residential beds
- +1,130 home care pm
- +0.5m home help hrs

**Associated activity to include:**
- National adoption of ambulatory care models
- Improved ward management – including ‘Home by 11’ and “Discharge to assess”
- Shift of procedures to lower acuity settings – including day case and outpatients
- Improved management of outpatients, reducing ratio of follow-up appointments.
- Reconfiguration of service into networks (major trauma centres, stroke, complex surgery)
- Establishment of elective specialist centres
- Better use of Model 2 hospitals for high-volume low complexity cases

Enhanced Community Care
- +1,900 acute beds
- +1,230 primary workers
- +600 residential beds
- +7,200 home care pm
- +4.8m home help hrs

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### Impact of Reform
- +2,590 acute beds
- +3,840 primary workers
- +13,000 residential beds
- +19,460 home care pm
- +12.5m home help hrs
What’s happening next…
• Planning and co-design for the regional areas
• Ongoing programme of citizen and staff engagement and empowerment
• Decision on de Buitléir Report
• Decision on elective hospitals location
• Co-design of pathways to keep people well and independent
• Next engagement session: end of Q1 2020
Sláintecare, working together, across the system
Thank you!

helloslaintecare@health.gov.ie

#Sláintecare #RightCareRightPlaceRightTime
Paul Skinnader, Executive Director, Pobal

Pobal Support and Engagement in 2020
Pobal

Pobal Support and Engagement in 2020

Paul Skinnader, Executive Director, Pobal

Sláintecare Integration Fund
Learning and Networking Event
December 10th 2019
Pobal in Brief

- Works with 4 Government Departments, plus the SEUPB
- Supports for 25 programmes (2018)
  Excludes sub-programmes or one off projects
- Circa €700m Funding Distributed in 2018
Today Pobal is engaged to deliver, support and manage funding programmes on behalf of the Irish Government and EU bodies. It is a vehicle for delivering programmes and informing policy.

At the heart of Pobal’s ethos is a focus on supporting communities and local agencies towards achieving social inclusion, reconciliation and equality through integrated social and economic development within communities.

Pobal has been at the forefront of delivering valuable services to some of the most marginalised communities in Ireland for the past 27 years on behalf of government.

Over 500 staff based across Ireland in 12 locations
Design of funding programmes
Appraisal of applications
Beneficiaries supports and services,
Contract Management
Payments
Monitoring and Research
Compliance and Audit
Government partners

Includes:
- Youth Services Grant Scheme
- Better Start
- Learner Fund
- Early Years Capital
- Early Childhood Care & Education (ECCE)
- Community Childcare Subvention
- Access Inclusion Model
- Area-Based Childcare
- National Childcare Scheme (NCS)

- Rural Social Scheme (RSS)
- TUS
- Gateway
- Ability

- Social Inclusion & Community Activation Programme (SICAP)
- Scheme to Support National Organisations (SSNO)
- Seniors Alert Scheme
- LEADER
- Dormant Accounts Fund
- Community Services Programme (CSP)

- Healthy Ireland Fund
- Sláinte Care Integration Fund
- Community Mental Health Fund

- PEACE IV

Special EU Programmes Body
Foras Úm Chláir Speisialta An AE
Board Oireacht Ocht UE Projects

Sláintecare.

government supporting communities
Strategic linkages
Supporting and Strengthening Governance and Quality Service Delivery

- Over 1,200 Grant Agreements issued (2018)
- 3,747 Childcare Compliance Visits completed
- 329 ECCE services benefitted from on-site mentoring - Better Start.
- Over 150 Audit/Verification Visits completed
- Revised ‘Managing Better’ Series (Dec 2018)
- ‘Helping Hands’ (Apr/May 2019)
- Charity Trustees Week (Nov 2019)
- 53 Grant Agreements under Healthy Ireland R3
Pobal and Sláintecare Integration Fund

- Pre-Contracting process
- Issuing Grant Agreements
- Financial Payments
- Monitoring and Reporting
- Audit and Verification
Support and Engagement in 2020

• Each Grantee will have an allocated staff member (Development Co-ordinator)

• Sláintecare Operational Manual Version 1

• 4 support events in January in Sligo, Waterford and Dublin (x2)

• Project leads and staff who will be completing financial and progress reporting should attend
Grant Agreements

• All Grant Agreements have been issued.

• Please sign and return as soon as possible

• Please review and action any specific pre-payment and/or post-payment contract conditions

• Projects with a condition relating to revising project outcomes need to begin review now.
Further Information

- Pobal website: [www.pobal.ie](http://www.pobal.ie)
- Twitter account @pobal
- LinkedIn
Presentations by Integration Fund Projects
Lyndsey Anderson

Sustain and Expand TRY
Targeted Responses at Youth (TRY)
Right Care, Right Place, Right Time

LYNDSEY ANDERSON AND KARL DUCQUE

10TH DECEMBER 2019
Context

- St Teresa’s Gardens
- The target groups
- Care and Control Approach
- From the pilot to today
Target Group Profile

- Very Challenging/Extremely marginalised
- Characteristics of the target group
  - Mostly chaotic drug users/ alleged criminal activity
  - Alienated from/ hostile towards mainstream society
  - Often very unwell
Intervention & Outcomes

- **Intervention:** An intensive consistent, relentless & sustained approach for connection
- **Approach saves people ending up in critical care**
- **Outcomes**
  - Individual
  - Family
  - Community
Current Stage

- Consolidate
- Establish TRY as an independent entity with accompanying governance compliance
- Extension sites
- Continued work with funders for sustainability
Some Challenges

- Progress is not all in one direction – the Bridge
- Different groups – different approaches
- Partnership approach to funding
- Evaluation – not overburdening front line
- Staff are the greatest asset but turnover is likely to be high.
Thank You
Anita Murray

Integrated Foot Protection Service for Residents of Community Healthcare East
Right Care, Right Place, Right Time
Integrated Foot Protection Service
Sláintecare Learning Network Event, 10th December 2019

Anita Murray - Senior Podiatrist Diabetes, St. Columcille’s Hospital
Anita.Murray2@hse.ie  @AnitaMurrayPod

Alison Wellwood – Senior Physiotherapist, Community Health East (CHO 6)
Alison.Wellwood@hse.ie  @WellwoodAlison
How Diabetes impacts the feet

The Stairway to Amputation, 2010
Development of the Integrated Diabetic Foot Protection Service

Seamless Care (Patient flow)
Governance structure
Service Promotion
Improved experience and referral

Integrated Referral and Service Model

Case Finding & Register

Service Development (Active Foot management)

Service Development (Active Foot Prevention)

Research best practice/Audit
Working Group
Provide Governance
Objectives with common interests
Optimise skills and expertise
Sponsorship from Senior Management
Problem solving and decision making
Measurable outcomes

Patient Involvement
Streamline MDT appointments
To improved Patient Journey and experience
Measurable outcomes

Service Action Plan with key objectives (linked to HSE Values & goals)
• Regular 1:1s
• Weekly protected time
Diabetic Foot Screen: Moderate, High OR Active Foot disease

REFER TO INTEGRATED DIABETIC AT RISK FOOT PROTECTION SERVICE FOR TRIAGING

PODIATRIST LED INITIAL REVIEW

ACTIVE FOOT DISEASE MDT MANAGEMENT
- Manage within Podiatrist Led clinics
  - Non Healing
    - REVIEW WITH MDT IN SCH OR SVUH
  - Healed
    - ULCER PREVENTION INTERVENTION PATHWAYS

PODIATRY LED OFFLOADING PATHWAY
- Sufficient Offloading
  - CONTINUE TO REVIEW WITHIN SERVICE
- Insufficient Offloading
  - REVIEW IN INTEGRATED CLINIC OR REFER FOR SURGICAL OPINION

INTEGRATED OFFLOADING PATHWAY
Development of the Integrated Diabetic Foot Protection Service

Seamless Care (Patient flow)
Governance structure
Service Promotion
Improved experience and referral

Integrated Referral and Service Model

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Patient Involvement
Streamline MDT appointments
To improved Patient Journey and experience
Measurable outcomes
<table>
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<tr>
<th>MEASURE</th>
<th>BEFORE</th>
<th>AFTER</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait Time for service</td>
<td>52 weeks</td>
<td>6 weeks</td>
<td>46 weeks improvement in wait time</td>
</tr>
<tr>
<td>Patient Journey Steps</td>
<td>6 steps</td>
<td>3 steps</td>
<td>Patient journey reduced by 3 steps</td>
</tr>
<tr>
<td>Average Foot Function Index</td>
<td>60%</td>
<td>13.6%</td>
<td>46.4% improvement in pain and disability</td>
</tr>
<tr>
<td>Direct Cost Saving</td>
<td>€18,214</td>
<td>€5175</td>
<td>€13,038 saving in cost of orthotics, 72%</td>
</tr>
</tbody>
</table>
I tended not to walk at all before my orthotics, now I am quite comfortable doing 6km, I find great support in them and am absolutely thrilled!

I can do more walking now so my blood sugars are coming down and its helping my weight...

I’m walking up and down the Pier again, I haven’t been walking for months..I can get down to the church now..I don’t know myself!
WHERE ARE WE NOW?

• Care Pathway
  – In line with the national model, Patient centred, focused on prevention, interprofessional, all At Risk Foot cases, care closer to home, Integrated with secondary care

• Specialist At Risk Foot National CPD Day
  – Education
  – Building a network nationally and internationally

• Slaintecare project
  – Joining both our projects across the sectors into one streamlined service
  – opportunity to demonstrate scalability and what an effective service might look like going forward into the future
Reflecting in Action

• Now into next phase of project with what challenges have you had?
  – Time
  – Working outside our comfort zone, managing up
  – Bringing the right levels of posts into deliver the project
• Were they anticipated?
• How did we address that?
• Ongoing ulcer for two years
• 3 infections
• Weekly dressing with PHNs
• Upon Offloading healed within two weeks
• 3 months post healing patient walking 7km x 4 times weekly
• Reports feeling less anxious and happier within himself now as he had a constant fear he would lose his leg
Thank you

Anita Murray - Senior Podiatrist Diabetes, St. Columcille’s Hospital
Anita.Murray2@hse.ie @AnitaMurrayPod
Alison Wellwood - Senior Physiotherapist, Community Health East (CHO6)
Alison.Wellwood@hse.ie @WellwoodAlison
Group Discussion on how the Integration Fund projects are delivering the Right Care in the Right Place at the Right Time
Question 1 - How is your project delivering the right care in the right place at the right time?
Sláintecare Integration Fund Communications

Why?
Who?
What?
How?
Sláintecare Integration Fund Communications

Why?

• Tell your stories
• Share your success
• Share examples of best practice
• Connect with each other
• Connect with us
• Learning and dissemination
Sláintecare Integration Fund Communications

Who? You!!

[Images of people playing games and a group of men standing together]
Sláintecare Integration Fund Communications

What?

Integration Fund Communications Strategy
Integration Fund Communications Campaign
Videography
Digital Media
Sláintecare Integration Fund Communications

How?

- Website
- Facebook
- Instagram
- Twitter
- Media
- Newsletters
- Internal Comms
- Conferences / Events
Your ideas / suggestions?
Kate O’Connor, Self-Management Support Coordinator for Chronic Disease

Self-Management Support Coordinators for Chronic Disease Network

Sláinte care.
Right Care. Right Place. Right Time.
Self-management Support for Chronic Conditions Network

Kate O Connor
Self-management Support Coordinator for Chronic Conditions
(Asthma, COPD, Diabetes, Cardiovascular Disease and Stroke)
South East Community Healthcare
“A snowflake is one of the most fragile creations, but look what they can do when they stick together”
Agenda

• What is Self-management Support?
• What is the Self-management Support Coordinators for Chronic Conditions network?
• How can our network help you?
• Steps to setting up our network?
• How is our network helping us to deliver on Slaintecare projects?
Care Plans and Action Planning

Cardiac and Pulmonary Rehab

Self-management Support

Managing Medications

Peer Support Groups

Waterford Social Prescribing Service

Diabetes Education

QUIT

STRESSCONTROL

SPORT IRELAND
Self Management Support timeline

2016
Donegal Project

Nov 2017
Framework

Dec 2017
Coordinators appointed

Sept 19
8 Sláintecare projects
Who are the Self Management Support Coordinators network?

We are:
• A team of 9 coordinators
• One coordinator in each CHO area
• We are based in the community and report to Head of Health and Wellbeing.
• We link with all services including those based in hospitals, voluntaries and community.
• Each coordinator has a Health and Social Care background.
Self-management Support mandate
COPD, Asthma, Diabetes and Cardiovascular Disease
How we can help you?
Directories of Services and Programmes for Adults with Asthma, COPD, Diabetes, Heart Conditions and Stroke, Downloadable from:
www.hse.ie/selfmanagementsupport

“How we can help you?
Connecting People to Services and Services to each other”
Steps to setting up our network

✓ Identify the benefit of working together
✓ Come together as a network
✓ Agree ways of working
✓ Rotation of roles
✓ Agree protected schedule of skype and face to face meetings
✓ Communication processes
  ✓ Skype
  ✓ Shared drive
✓ Establishment of governance
✓ Identify and address priorities
✓ Develop working groups
Geographical challenges
From Letterkenny to Kilkenny
Benefits of working as a network

✓ Sharing of knowledge, expertise and data
✓ Avoiding duplication of effort
✓ More powerful advocacy for projects
✓ Enhanced profile for projects
✓ Networking opportunities outside our own geographical area
✓ Learning from others successes and failures
  ✓ Plan Do Check Act
✓ Supporting each other with local priorities
✓ Celebrating successes
How we are working together to deliver our Slaintecare project?

✓ Governance
✓ Weekly skype calls
✓ National GANNT chart
✓ Subgroups to progress pieces of work
  ✓ Evaluation
  ✓ Universal programme name and messaging
✓ Communication Resources
“It is amazing what you can achieve when you do not care who gets the credit”
Lunch
12.30-1.30
Overview

1. The challenge of implementing integrated care

2. The nature of the work

3. Some insights from implementation
**Fig 3: Underlying concepts, theories on the nature of spread (Greenhalgh et al., 2004)**

<table>
<thead>
<tr>
<th>Let it happen</th>
<th>Help it happen</th>
<th>Make it happen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Features</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unpredictable, un-programmed, uncertain, emergent, adaptive, self-organising</td>
<td>Negotiated, influenced, enabled</td>
<td>Scientific, orderly, planned, regulated, programmed, system ‘properly managed’</td>
</tr>
<tr>
<td><strong>Underpinning theory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complexity theory</td>
<td>Knowledge creation cycle</td>
<td>Social network theory</td>
</tr>
<tr>
<td><strong>Assumed mechanisms for the spread of innovation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural emergent</td>
<td>Social, organisational and technical</td>
<td>Managerial</td>
</tr>
</tbody>
</table>
Change methodology is critical

- The attributes that lead to systemic improvement in healthcare are different.

- Complex systems self organise, therefore imposing a ‘solution’ doesn’t work.

- **Co-design** and creating the **conditions for change** are required, (not just programmatic management).

Integrated care is “an ‘art form’ founded on a colourful pallet of values and perceptions arising from several political, organisational, professional and clinical fields”.

Valentijn (2016)
Implementing change in complex systems

10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures

2. Undertake Population Planning for Older Persons

3. Map Local Care Resources

4. Develop Services & Care Pathways
   - Focus on Frailty
   - Acute Care Pathways
   - Ambulatory Care
   - Rehabilitation
   - ICPs for Falls, Dementia & Nursing Homes Outreach

5. Develop New Ways of Working
   - New roles including case management approach for long term complex needs
   - In-reach and outreach

6. Develop Multidisciplinary Teamwork & Create Clinical Network Hub
   - Co-ordination between care providers

7. Person-centred Care Planning & Service Delivery

8. Supports to Live Well
   - Enable older persons to live well in the community
     - Community Transport
     - Social Activities
     - Home modifications & handy person
     - Medication Management
     - Shopping
     - Harness Technology
     - Support Carers
     - Information & Advice

9. Enablers
   - Develop workforce
   - Align finance
   - Information systems

10. Monitor & Evaluate
    - Track service developments
    - Measure outcomes
    - Staff and service user experience

Frailty Prevalence
- 11% Severely Frail (Very High Risk)
- 21% Moderate Frailty (High Risk)
- 36% Mild Frailty (At risk)
- 32% Fit (Minimal risk)

Integrated Care
Older People, ICPOP/NCPOP
Pioneer Sites Networking Forum

Integrated Care Programme for Older Persons Networking Day
Farmleigh House, Dublin
Thursday the 7th of December 2017
Older Persons Service Model

Shift Left of Resources & Activity
Least Intensive Setting / Care / Interventions

Living well with supports

Community Health Network (CHN)

Primary Care Team
- Psychiatry of Later Life
- Occupational Therapist
- Speech & Language Therapist
- Deities
- Podiatry/Chirokody
- Social Worker
- Community Intervention Team
- Older Persons Residential Services

Ambulatory Care Hub

Case Management • Multidisciplinary Team • Specialist Care Pathways

Hospital Care
- Acute Floor Frailty at Front Door Response
- Inpatient Acute Frailty Unit
- Early Supported Discharge
- Rehabi/Rehabilitation
- Community Response Beds

Citizen
- Neighbours, family, friends, community
- Housing
- Home Supports
- Financial Security
- Health & Purpose
- Eating & Nutrition
- Education
- Transport
- Community Supports
- Citizen Management
- Telco

HAPPY AT HOME
GENERAL PRACTICE AND ENHANCED PRIMARY CARE
RAPID RESPONSE SPECIALIST CARE IN THE COMMUNITY
Governance

Programme Sponsorship and Governance Group
Chief Officer CHO/Chief Executive (Hospital Group) co-chair, Heads of Service CHO, Clinical Lead for Integrated Care, Managerial Lead for Integrated Care.

Local Implementation Group

Individual working groups
In-patient pathways
Ambulatory Care HUB/CHN
Supports to live well
Research/Innovation
The following are a synopsis of the key insights into the hidden dynamics associated with implementing integrated care for older persons.

1. **METHODOLOGY MATTERS (COMPLEXITY TRUMPS CONTROL)**

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

2. **ALL INTEGRATION IS LOCAL**

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

3. **IMPROVEMENT IS ITERATIVE, DYNAMIC AND ORGANIC**

   It takes time to build trust and confidence. The dynamics are ever changing opportunities arise and influences change. Incremental steps (the grind) constitute the substantive effort rather than the grand (programmatic control).

4. **LOCAL GOVERNANCE IS KEY**

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

5. **POPULATION IS FUNDAMENTAL (NOT ORGANISATION)**

   A focus on prioritising population need, specifically those that will benefit from integrated care, has to supersede institutional concerns in order to health and social care to be delivered across boundaries. 'Fixing the system' is secondary to person centred care population and place base care.

6. **TRUST THE PEOPLE WHO KNOW THEIR BUSINESS**

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

7. **RESPECTS TRUMPS RESOURCE**

   Whilst necessary, resource is not sufficient for change to happen. Paying attention to and respecting the importance of people work leverages latent capacity to make the transformation of older person care happen.
Integration Fund projects networking and workshop on the Sláintecare Integration Fund Learning Network
Question 2:
In terms of the progress of your project, what’s working well / (what will work well)? (5 minutes – please list on post-its and stick on board)
Question 3:
In terms of the progress of your project, what are / could be the challenges? (5 minutes – please list on post-its and stick on board)
Question 4: How can the Sláintecare Integration Fund Learning Network support you to successfully deliver your project?
Muriel Farrell, Sláintecare Integration Fund
Sláintecare Integration Fund Learning Network - Next Steps
Change Guide delivering improvement

Figure 3: Principles set out in the Sláintecare report
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 1-5).

Access all of the Essential Templates and Additional Resources.

People's Needs Defining Change – Health Services Change Guide
Áine Carroll, International Foundation for Integrated Care (IFIC)
Sláintecare Learning Network Launch

10th December 2019
#IFICIreland
IFIC is a non-profit members’ network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice.

The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World.
## Meet the Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dr. Sloan Harper</strong></td>
<td>Chair IFIC Ireland, Director Integrated Care HSCBNI</td>
</tr>
<tr>
<td><strong>Prof. Áine Carroll</strong></td>
<td>Co-director IFIC Ireland, Professor of Healthcare Integration and Improvement, UCD</td>
</tr>
<tr>
<td><strong>Fiona Lyne</strong></td>
<td>Co-director IFIC Ireland, Director Communications IFIC International</td>
</tr>
<tr>
<td><strong>Karen O’Connell</strong></td>
<td>Coordinator IFIC Ireland</td>
</tr>
<tr>
<td><strong>Darren Curran</strong></td>
<td>Interim Marketing Officer IFIC Ireland, Communications and Marketing IFIC International</td>
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</tbody>
</table>

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Aims & Objectives of IFIC Ireland

➢ Advance the science, knowledge and adoption of integrated care in policy and practice in Ireland and internationally
➢ Enable the exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services
➢ Develop the capacity and capability of managers and clinicians to deliver integrated care, including raising awareness of the benefits of integrated care with front line teams, but also senior management and governing boards
➢ Facilitate international, regional and local collaborations with established centres including IFIC Scotland and Australia
➢ Identify international best practice and transferable lessons for the Irish context
➢ Celebrate what is working in Ireland and how that can be transferred to the international community.
➢ Work with business partners to improve technology and other innovations that will support the advancement of integrated care and better outcomes for patients and communities
IFIC Ireland Knowledge Tree

- A gateway to academic databases, institutional repositories, IFIC International and public web resources
- Central Reference Repository for all 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

A movement for change
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Closing Remarks
Project one-to-one Contracting discussions with Pobal