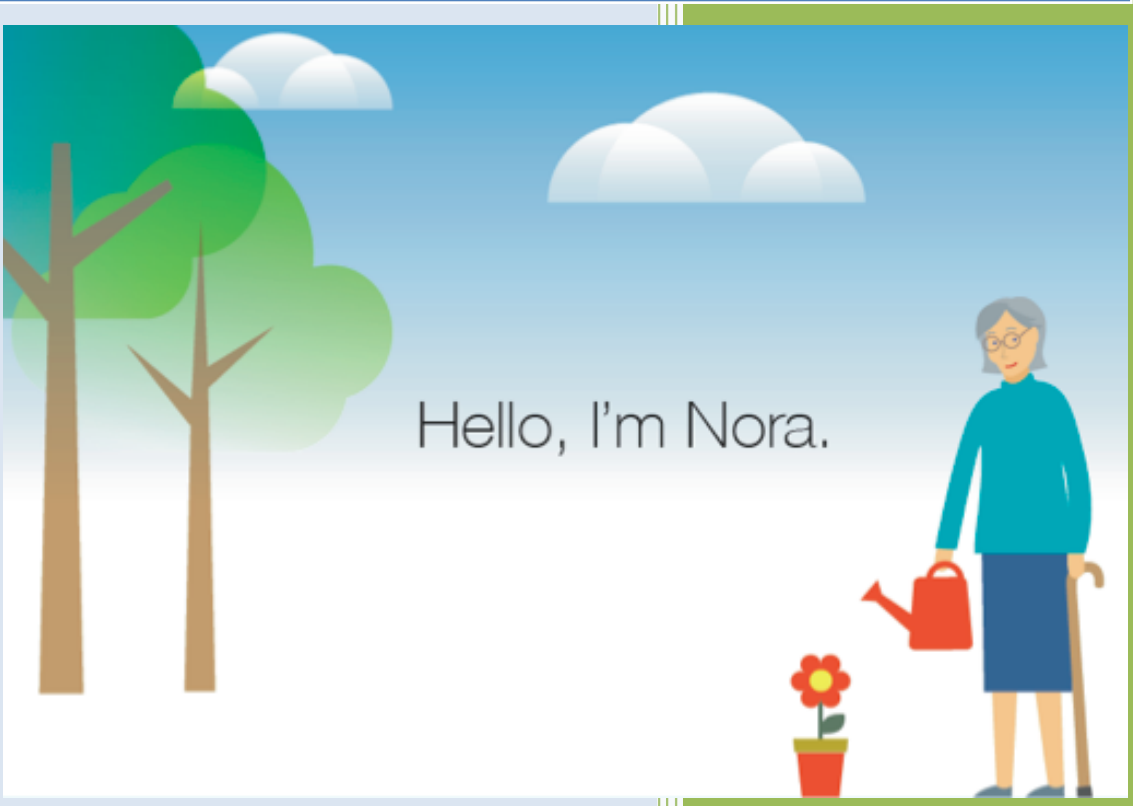
National Clinical & Integrated Care Programmes
Person-centred, co-ordinated care

OLDER PEOPLE

Integrated Care Programme for Older Persons

End of Year Report 2016



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Clinical Strategy and Programmes Division

Publication date: March 2017

Foreword

As co-chairs of the Integrated Care Programme for Older Persons, we are very pleased to bring you this report on the progress made in 2016 for the Integrated Care Programme for Older Persons (ICP OP). ICP OP set out to put in place the essential building blocks to facilitate a more integrated approach to delivering care for older people. This involved building relationships with local leaders and supporting them in establishing the early stages of the programme, such as establishing local governance structures that allows hospital and community services to work together and establishing community-based multi-disciplinary teams. The year has seen significant progress in terms of the development of a framework to support the implementation of services and teams working across traditional boundaries in 6 CHOs and acute hospitals. Taking an integrated approach has the potential to enable much more effective use of local resources in home care, rehabilitation and improving access to care when needed. Older person services nationally is involved in a wide range of initiatives to improve care in the community for older people through strategies such as the National Dementia Programme, reforms to home care and the implementation of the Single Assessment Tool. The enclosed report outlines where these services are being developed and the ongoing workplan for 2017 as we expand the programme's reach, going from 6 to 12 sites.

We would like to formally acknowledge the work and support achieved by the the ICP OP team under the leadership of PJ Hartnett and the National Steering and Working Groups for the Integrated Care Programme for Older Persons in the progress made to date. In particular, we would like to acknowledge the support of the National Clinical Programme for Older People under the leadership of Dr Diarmuid O Shea who have laid the groundwork for existing models of care in recent years and who are working in partnership with ICP OP through the National Working Group for Older People. Our thanks also to the clinicians, management teams of acute hospitals and CHOs and others who are showing great commitment through development of integrated services for older people in their local areas in becoming local sites of innovation or 'pioneer areas'. The learning from this process will, we hope, continue to inform how the programme and services will develop in the years ahead. We hope to bring you continued updates in the months ahead on the progress being made and value your feedback on the process as it is developing.

Ar scáth a chéile a mhaireann na daoine!

Dr Siobhan Kennelly,
National Clinical Advisor and Group Lead, Social Care Division
Clinical Lead, ICPOP

Michael Fitzgerald
Head of Operations and Service Improvement for Older People,
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Introduction

The Integrated Care Programme for Older People (ICPOP) and the National Clinical Programme for Older People (NCPOP) are leading out on the development of cohesive primary and secondary care services for older people especially those with more complex needs. The current focus is on the development of **12 pioneer sites nationally** (6 in 2016 and 6 in 2017), which builds on work and initiatives currently being developed locally in Ireland, and on the work to date on Acute and Mental Health pathways developed by the NCPOP. These sites are working to a 10-Step Framework that fundamentally adopts a population based approach with new ways of working, at the core of which is a case management approach to integrated care. The ICPOP proposes to implement, test and monitor integrated service developments for older people in pioneer sites and to evaluate this implementation so that lessons learned may be extended nationally.

National Working Group for Older People

2016 marked the programme initiation and the coming together of the ICPOP and the NCPOP to form the **National Working group for Older People.** This report summarises the key aspects of the programme which were delivered in 2016 and on the planned deliverables for 2017.

Aims and Objectives of the Programme

The **aim** of the integrated Care Programme for Older Persons is to develop and implement integrated services and pathways for older people with complex health and social care needs, shifting the delivery of care away from acute hospitals towards community based, planned and coordinated care.

The **objective** of the programme is to improve the quality of life for older people by providing access to integrated care and support that is planned around their needs and choices, supporting them to live well in their own homes and communities.

Context

In Ireland, there is a change in the profile of the population demographics for a variety of social and economic reasons. The demographic challenge facing the Irish health and social care system includes:-

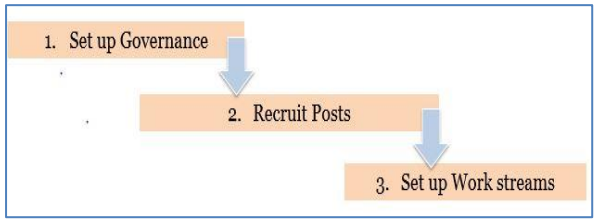
1. People aged 65 and over comprise 12.7% of the population and use 53% of inpatient beds.
2. People aged 85 and over represent 1.4% of population and use 13.5% of inpatient beds.
3. There will be 107,600 (17.3% increase) additional people aged 65 years and over by 2021
4. There will be 15,200 additional people aged 85 years and over by 2021”
5. 4.1% of the population provide unpaid care with the profile of carers aging (39% increase in over 75yrs).
6. Patients over 75yrs spend 3 three times longer in ED than those aged 65 or less. Up to 40% of those waiting >24 hrs are >75.
7. 50% of Acute Hospital delayed discharges require NHSS or a Home Care Package
8. For Patients over 85 years, approximately 600 acute hospital presentations can be anticipated per 1,000.

Programme Overview

The high level overview of the ICPOP programme is as shown below

Phase	Start	End	2015				2016				2017				2018			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Initiation and Planning	Jul 2015	Mar 2015																
2.Pre- Mobilisation	Jan 2016	Dec 2016																
3. Implementation	Sep 2016	Dec 2017																
4. Evaluation and Roll Out	Mar 2017	Dec 2018																

Key deliverables for 2016

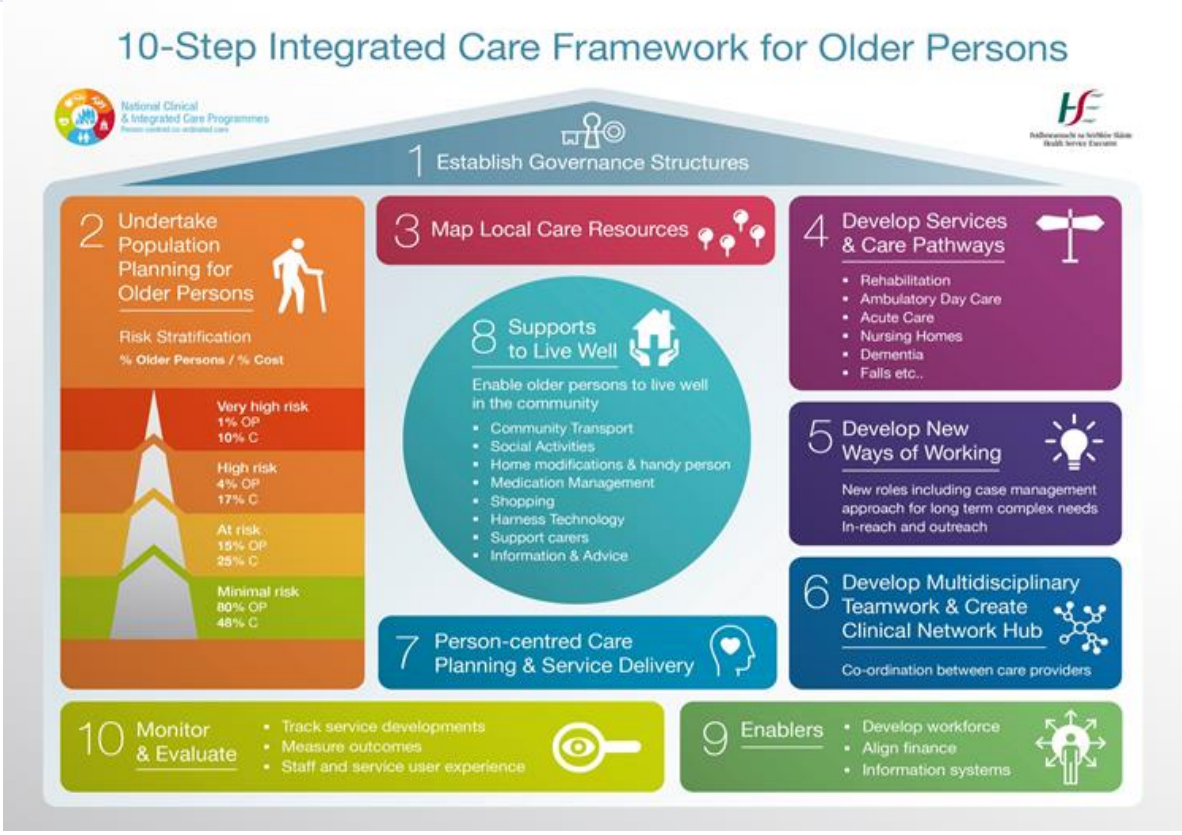


The ICPOP identified three key deliverables for 2016. The focus was on establishment of National and local **governance** structures, **recruitment** of 35 WTE posts nationally at 6 Pioneer sites and setting up of **workstreams** at sites locally.

Role of the Pioneer Sites

Funding was allocated to 6 Integrated care teams in2016 in CHO1, CHO4, CHO6, CHO7,CHO8 and CHO9. Sites were selected based on an assessment of 'readiness' criteria where aspects of Integrated care were already being developed locally.

A further 6 teams have been funded for 2017 (locations are currently being finalised).



Framework for Integrated Care

A key component of the Programme was the development of a 10-Step Framework which sets out the desired direction of travel for the integration of health and social care for older people nationally. The emphasis is on a population health approach that requires a joint approach to planning from CHOs and Acute Hospitals reflected in a governance structure through local implementation teams.

The development of the framework is informed by international evidence and best practice as to the approaches and structures that best support an integrated approach to older persons care (references below).

This incremental framework approach has at its core, a focus on evaluation of structure (governance and teams in place), process (measuring care processes, transitions between care) and outcomes (patient centred outcome measures and value based care) and is underpinned by ICT, Financial and Workforce enablers.

References:

Goodwin, N. (2013). Understanding integrated care: a complex process, a fundamental principle. International Journal of Integrated Care(13), 1.

Nolte Nolte,E. McKee M. (2008). Making it Happen in: Nolte E, McKee M, editors. Caring for People with Chronic Conditions: A Health System Perspective, Maidenhead: Open University Press.

RAND Europe (2010). Evaluation of Integrated Care Pilots. Available at: www.rand.org/randeurope/research/health/projects.html

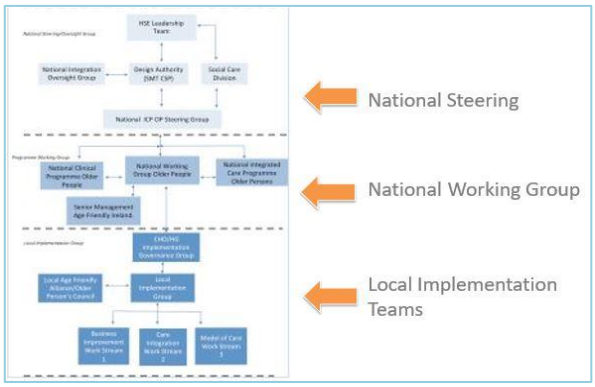
Wodchis, W.P., Dixon, A., Anderson, G.M., Goodwin, N., 2015. Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. Int. J. Integr. Care 15.

Key progress 2016

Key Progress 2016 - 10-Step Framework

Step 1 :- Governance

A **National Governance Structure** has been established with quarterly Steering Group meetings (chaired by Michael Fitzgerald, Head of Operations & Service Improvement for Older People) and Dr. Siobhan Kennelly (National Clinical Lead, Social Care and Integrated Care for Older Persons). Monthly Working Group meetings also take place (chaired by Dr. Diarmuid O'Shea, National Clinical Lead for Older Persons Programme and Dr. Siobhan Kennelly(see Appendix 1 - Governance chart).



Local Governance Steering groups and Implementation Teams have been established at the 6 pioneer sites (2016).

Step 2 :- Population Planning

Population health planning describes the demographic and social characteristics of the population to be served and is the first component in planning, developing and implementing the Integrated Care Programme for Older People. Population Health planning for older people starts with the geographic area and stratification of the population within this area. Older people with high complex needs and frailty are identified to enable planning of services and resource requirements around these needs.

The use of **Health Atlas** as a tool for population planning was presented and discussed with sites a **Networking Forum for all sites in December, 2016.** Follow-up workshops for individual sites are planned for early 2017 to focus on local population planning to describe the current and projected number and location of the population in the defined geographic area within the pioneer site.

Step 3 :- Resource Mapping

Mapping of local resources was carried out in 2016 to identify Clinical healthcare services, statutory and voluntary healthcare resources agencies and groups with the intention of producing a local service directory for Older Persons services in each pioneer area. Progress (2016) was as follows :-

- ✓ CHO 1 – Mapping exercise complete across Acute and CHO
- ✓ CHO 4 – Mapping exercise commenced
- ✓ CHO 7 – Mapping exercise commenced
- ✓ CHO 8 – Proposal for detailed mapping exercise drafted

Step 4 :- Develop Services and Care Pathways

The ICPOP aim is for pioneer sites to develop bespoke care pathways in line with the NCPOP Model of Care, for the specific needs of older people, particularly those who are frail or at risk of frailty. Care

Pathway mapping and implementation of Clinical pathways had commenced in some sites in advance of the ICPOP. Progress in Pioneer Sites (2016) was as follows :-

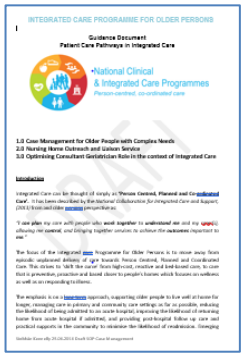
- ✓ **CHO 1**:- Sligo University Hospital introduced a Specialist Geriatric Ward with a specialist 'on-take' older persons care pathway in May 2016 using a frailty pathway within the acute hospital. Indications are that changes in practice are increasing discharge rate, thus creating capacity when required.

- ✓ **CHO 4** :- CHO4 implemented an integrated falls service in 2016 to provide rapid access to multi factorial fall risk assessment for people over 65 at risk of falling . This pathway links ED, Specialist Falls Service and Community Fall Risk and provides coverage for a population of approximately 170,000 in Cork City and environs.

- ✓ **CHO 7** : -Pathway mapping commenced

Step 5 :- Develop New ways of Working

In 2016, **35 WTE posts** were funded in **6 teams within 6 CHOs**. By year end, **21 posts** had been recruited, with the remainder of posts scheduled to be in place by March 2017. Details of posts recruited are given under the section on Key Progress per CHO in Appendix 2.


INTEGRATED CARE PROGRAMME FOR OLDER PERSONS

Guidance Document
Patient Care Pathways in Integrated Care

National Clinical & Integrated Care Programmes
Person-centred, co-ordinated care

1.0 Case Management for Older People with Complex Needs
2.0 Nursing Home Outreach and Liaison Service
3.0 Optimising Consultant Geriatrician Role in the context of Integrated Care

Introduction

The aim is to develop new roles that will interact with existing hospital and community based multidisciplinary teams, adopting a case management approach for a targeted population of frail older people. The proposed solution involves incrementally building integrated care teams that will provide the catalyst for local integration

A **Guidance Document** outlining the essential elements of **Case Management for Older People with Complex Needs** was prepared by ICPOP in July 2016 and issued to pioneer sites.

Step 6 :- Develop MDT & create Clinical Network Hub

The setting up of Clinical Network Hubs has commenced in **CHO 6, CHO 7 and CHO 8** to date. The purpose of the clinical network hubs is to have a centralised location and process for Multi-disciplinary teams to discuss the needs of older people with frailty and complex care needs ensuring daily liaison between teams.

Step 7 :- Person Centred Care Planning and Service Delivery

Develop an approach to care planning that is person centred, longer term and coordinated and includes user and carer input. Introduce ways of thinking and doing things that sees older people using our services as equal partners in planning, developing and monitoring care to make sure it meets their needs..

Step 8 :- Supports to Live Well

The Integrated Care programme for older people is currently encouraging pioneer sites to have patient and carer representatives at the core of integration locally with **key older people or their advocates on the steering group for each area**. The plan is for local service leaders to work with voluntary agencies in developing a range of community supports that enable older persons to live well in their communities. This plan will be developed further in 2017.

Step 9 :- Enablers – Develop ICT

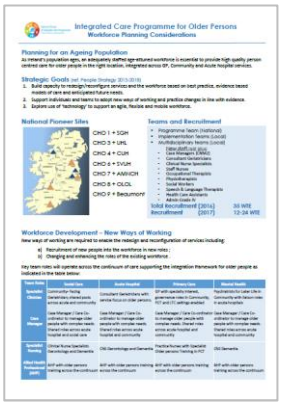
Throughout 2016, the ICPOP engaged with the Office of the Chief Information Officer (OCIO) in the HSE to scope out how information communication technology (ICT) can be used to enable information sharing between MDTs in primary and secondary care services. A timeline of engagements and activities that took place in 2016 is given in the table below.

	2016												2017		
	Q1			Q2			Q3			Q4			Q1		
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
Engagement with OCIO- Shared record			Q1/Q2												
Tallaght ICT Workshop					9 June										
Cork ICT Workshop						23 June									
Pioneer Sites Networking Day						29 June									
Process Mapping - Information Flow							7 July								
Priorities Definition								Jul/Aug							
Shared Record Market Capability Analysis (OCIO)									26, 27 Sept						
Feedback from attendees(OCIO)										Oct/Nov					
SAT Functionality assessment(OCIO)											Nov				
Hardware - Statement of need												Dec			
Pioneer Sites Networking Day												1 Dec			
Development of NQAIS Dashboard for OP											Nov, Dec, Jan				

Two ICT Scoping workshops took place in Tallaght and Cork in May/June 2016 to identify ICT priorities at sites. Priorities were identified as :-

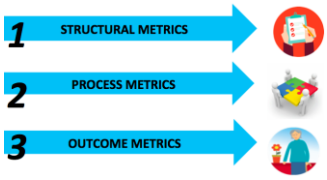
1. Hardware Equipping for Pioneer Sites
2. Use of SAT as platform for Care Coordination/Care Planning
3. Information Sharing for MDTs across care settings (cloud based)
4. Secure email
5. MDT Hub ICT Equipping (inclwifi)
6. Community Access to Healthlink
7. Community Access to iPims – iPimsalerts

Step 9 :- Enablers – Develop Workforce


Integrated Care Programme for Older Persons
Workforce Planning Considerations

The ICPOP documented their approach to Workforce planning in September 2016 in a paper (Appendix 3) outlining the key requirements for workforce development as Ireland's population ages. The requirement is to ensure an adequately staffed age-attuned workforce, integrated across GP, Community and Acute hospital services. The paper outlines **new ways of working** across the continuum of care supporting the integration framework for older people, **new roles** across care settings, the need for a **competency framework**, education and **specialist training programmes** where working with older persons is a core part of education. The NCPOP have also recently published a strategic workforce planning document informing specific medical workforce planning requirements to meet the needs of older persons services in the coming years

Step 10:- Monitor and Evaluate



In 2016, the National Working group for Older People defined the approach to measurement and evaluation in terms of three sets of metrics;

Structural Metrics, **Process** Metrics and **Outcome** Metrics.

- ✓ **Structural Metrics -Track the development of services**
  Using HIQA themes and standards for this type of service, priority standards and measures have been identified for each of the National framework 10 Steps, along with the associated structural or systems indicator (see Appendix 4).

- ✓ **Process Metrics - Measure activity and outcomes**
  Process Indicators based on the tracking of activity levels to identify how the service is functioning, are currently being finalised and broadly encompass; referrals, caseload, discharges, liaison and onward referrals. These monthly measures have been co-produced with existing pioneer site team members in particular roles with a case management function.

- ✓ **Outcome Metrics - Measure Care Outcomes, PROMs, Staff and Service User experience**
  The National Working Group for Older People is currently developing dashboards and IT solutions that will demonstrate data trends and hospital utilisation for those patients aged 75 and over which can be compared to pioneer and non-pioneer sites and at a national level. **Patient-reported outcomes measures (PROMs)** attempt to capture whether the services provided improved patients' health and sense of well-being and are a critical component of assessing whether clinicians are improving the health of patients. These metrics will be developed further in 2017.

Networking Events and Conferences 2016

The ICPOP participated as speakers in a number of National conferences in 2016 listed in Appendix 5. Pioneer Sites Network meetings were also held for all Pioneer Sites in June and December 2016.

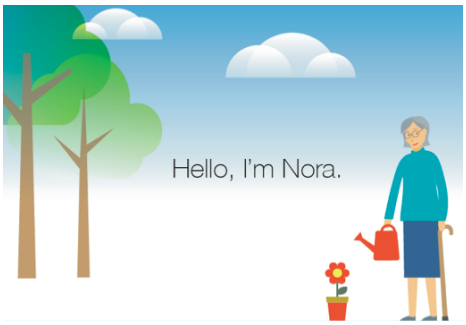
Key Priorities 2017

Key Priorities 2017

The Integrated Care Programme for Older Persons and the National Clinical Programme for Older People are working closely together on priorities for 2017. The National Working group (ICPOP/NCPOP) has brought the objectives of the two programmes together and identified key areas of focus for 2017 in the table below:

Key Priorities 2017 - National Working Group Older People		2017
		Q1 J F M | Q2 A M J | Q3 J A S | Q4 O N D
Existing sites	Continued Implementation of 10 Step Framework at existing Pioneer sites	January - December
New sites	Bring 6 new sites on board using 10 Step Framework	April - December
Population planning	Utilise SAT data for planning from min 1 site	April - September
	Facilitate Population Planning workshops utilising Health atlas in 6 sites	April - October
Mapping pathways	Map pathways with 3 sites and disseminate	August - December
	Work with Dementia Programme on alignment with Dementia Pathways	March - November
	Revise and update the Specialist Geriatric Services Model of Care (2012)	April - December (to end of Q4 2018)
	Publish Specialist Geriatric Services Mental Health Service Provision Model of Care	January - June
	Development of Delirium Management on the Acute Ward ED/AMAU pathway	January - September
	Development of the Syncope/Transient Loss of Consciousness ED/AMAU	January - June
	Develop National Transfer Letter: Communication between acute and residential services	January - December (to end of Q4 2018)
Workforce	Embed a case management approach in 6 sites	January - December
	Input to national workforce for a (DOH and HSE)	Jun
	Publish a Strategic Vision and Educational Framework for Nursing Staff working with Older People	January - December
Education	Test Interdisciplinary training in one ICT OP team	June - July
	Promote availability of Dementia training on Pioneer sites	Aug - Oct
	Deliver a Frailty Education Programme in association with TILDA (sponsored by ONMSD) and in collaboration with AMP and EMP, to train nursing staff as national trainers across CHO, Primary Care and Hospital Groups	January - December
ICT	Operationalise ICT hardware in 3 sites	January - July
	Implement SAT as platform for care coordination in 1 Site (minimum)	April - December
	ICT Equipping for 3 No. Virtual Hubs	April - December
Measurement	Establish a suite of Older Person Metrics (Dashboard, NQAIS, Programme metrics)	July- December
	Evaluate case management approach in 6 sites	Aug--December
	Test and gather Case Management Process Metrics	July- December
	Survey Acute Hospitals to estimate delivery of model of care and associated standards	
	Evaluate "What Matters to You" (WMTY): a quality improvement initiative to enhance compassionate person-centered care in one ward in two acute hospitals in Ireland	January - December
Documentation	Launch Implementation Guidance; 'Making a Start on Integrated Care, Older Persons'	May

Communications 2017



The ICPOP, in conjunction with the Social Care Division of the HSE, developed a 7 minute video clip illustrating how older persons care is currently managed and how this might look in the future when care is Integrated across primary care, hospital and community, from a patient perspective (Nora).

Click https://www.youtube.com/watch?v=UIvnJJWyUuQ

to see the video.

A detailed communications plan will be developed in 2017 for all stakeholders along with a proposed ICPOP Microsite.

Your involvement matters! Contact the team...

We'd be delighted to discuss any aspect of the programme.

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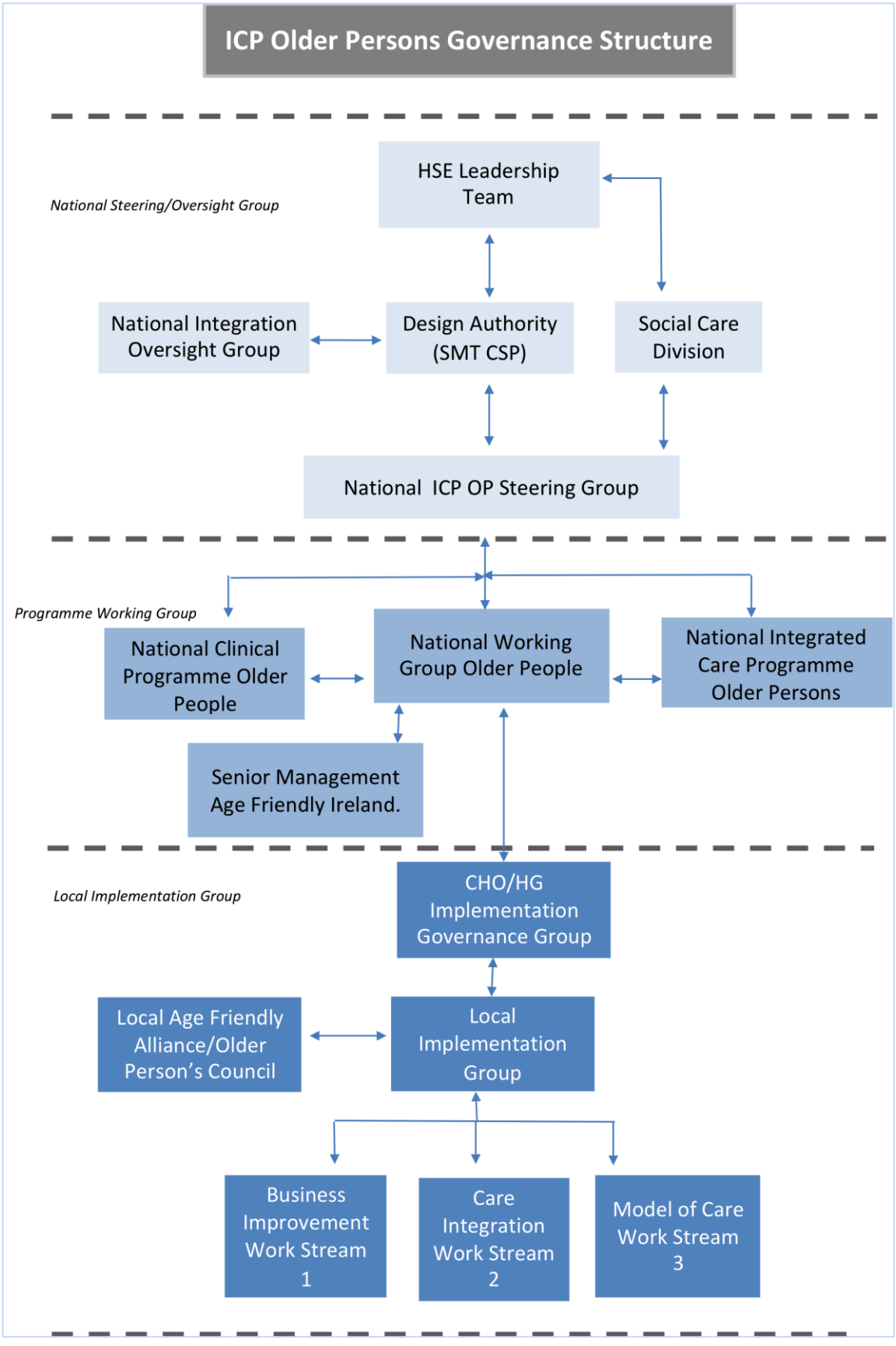
Appendices

Appendix 1–Governance Structure



Appendix 2 - Key Progress in Pioneer Sites 2016

CHO 1

Governance

- ✓ Team Lead Nominated
- ✓ Implementation Team in place
- ✓ Steering Group meeting monthly since September 2016

Recruitment -

- ✓ 6 posts recruited
- ✓ Speech & Language Therapist
- ✓ Senior Social Worker,
- ✓ Health Care Assistant,
- ✓ Clinical Nurse Specialist, CNM2,
- ✓ Staff nurse,
- ✓ Staff nurse

Workstreams

- ✓ Acute Frailty pathway in place.
- ✓ Mapping exercise complete across Acute and CHO complete as per ICP OP framework.
- ✓ MOU in place - Agreement of integrated posts/ working practices between Acute and CHO
- ✓ Community Based Geriatrician & MDT under CAWT at advanced stage of progression
- ✓ Sligo/Leitrim Older Person Change Plan drafted from ICP OP/ CHO 1 workshop- Jan 2017

CHO 4

Governance

- ✓ Team Lead Nominated
- ✓ Implementation Team in Place
- ✓ Steering group meeting monthly since October 2016
- ✓ Work-streams membership and TOR completed

Recruitment (full MDT Team recruited - Feb 2017)

- ✓ 5/6 Posts recruited
- ✓ Clinical Nurse Specialist (pending)
- ✓ CNM2, Case Manager (pending)
- ✓ Senior Physiotherapist, (offered)
- ✓ Senior Admin Grade IV (offered)
- ✓ Senior OT (offered)

Workstreams

- ✓ Progressing through sub work-streams, e.g. medical governance, community
- ✓ Care pathways workshop (ICP OP/CHO4/CUH/MUH on 31.1.17)

CHO 6

Governance

- ✓ Team lead appointed
- ✓ Governance structure formed out of the existing Frail Older Persons Implementation Group (CHO6, SVUH, SMH,SCH & Community) -June 2016

Recruitment

-

- ✓ 3/6 Posts offered from panel
- ✓ MDT Team recruited –
- ✓ Consultant Appointment anticipated June 2017.

Workstreams

- ✓ Project Plan agreed jointly CHO/SVUH
- ✓ Formal induction programme for Community/Hospital planned for late January/early Feb 2017.
- ✓ Location secured for Team within CHO 6

CHO 7

Governance

- ✓ Team Lead Nominated
- ✓ Implementation Team in Place
- ✓ Steering group meeting monthly since October 2016

Recruitment

- ✓ 6/6 posts recruited
- ✓ Consultant geriatrician in place
- ✓ Senior Occupational Therapist in place
- ✓ senior physiotherapist in place
- ✓ team leader social worker offered
- ✓ cnm2 starting
- ✓ grade iv offered

Workstreams

- ✓ Pathway mapping commenced
- ✓ Location for team secured

CHO 8

Governance

- ✓ Team Lead Nominated
- ✓ Implementation Team in Place
- ✓ Steering group meeting monthly since October 2016

Recruitment (complete Feb 2017)

- ✓ 4/6 posts recruited
- ✓ Case Managers x 2
- ✓ Senior OT,
- ✓ Senior Physio
- ✓ Senior SALT (EOI)
- ✓ Admin Support

Workstreams.

- ✓ Standard Operating Procedures
- ✓ Data collection processes developed
- ✓ Proposal for Mapping exercise
- ✓ Wider community scope- Social Care Programme (The Nestling Project)
- ✓ Potential to tap into CAWT and REDZ funding for Social Brokerage, single point of access and telecare/telemedicine,

CHO 9

Governance

- ✓ Team Lead Nominated
- ✓ Implementation Team agreed in principle
- ✓ Steering group established

Recruitment (complete March 2017)

- ✓ Consultant Geriatrician
- ✓ Clinical Nurse Manager (Case Manager)
- ✓ Senior Social Worker
- ✓ Senior Occupational Therapist
- ✓ Senior Physiotherapist
- ✓ Grade IV

Workstreams

- ✓ Operational Policy being developed

Appendix 3 – Workforce Planning

Planning for an Ageing Population

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

Strategic Goals (ref. People Strategy 2015-2018)

1. Build capacity to redesign/reconfigure services and the workforce based on best practice, evidence based models of care and anticipated future needs.
2. Support individuals and teams to adopt new ways of working and practice changes in line with evidence.
3. Explore use of 'technology' to support an agile, flexible and mobile workforce.

National Pioneer Sites

CHO 1 + SGH

CHO 3 + UHL

CHO 4 + CUH

CHO 6 + SVUH

CHO 7 + AMNCH

CHO 8 + OLOL

CHO 9 + Beaumont

Teams and Recruitment

- Programme Team (National)
- Implementation Teams (Local)
- Multidisciplinary teams (Local)

New staff (NSP 2016)

- Case Managers (CNM2)
- Consultant Geriatricians
- Clinical Nurse Specialists
- Staff Nurses
- Occupational Therapists
- Physiotherapists
- Social Workers
- Speech & Language Therapists
- Health Care Assistants
- Admin Grade IV

Total Recruitment (2016) 35 WTE

Recruitment (2017) 12-24 WTE

Workforce Development – New Ways of Working

New ways of working are required to enable the redesign and reconfiguration of services including:

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

Key team roles will operate across the continuum of care supporting the integration framework for older people as indicated in the table below:

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

New Roles across Care Settings

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

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

Competency Framework

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

Workforce Considerations

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

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

Key operational challenges

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

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

References

1. *Workforce Planning document for Physicians in Geriatric Medicine (NCPOP December 2013),*
2. *Strategy for Gerontological Nursing in Ireland (NCPOP, June 2015).*
3. *Strengthening a Competent Health Workforce for the Provision of Coordinated/Integrated Health Services (WHO 2015)*
4. *New Ways of Working for Everyone (DoH, UK,2007)*
5. *The Ten Essential Shared Capabilities, (DoH, UK,2004)*
6. *The Capable Practitioner (Sainsbury Centre, UK,2001)*

Appendix 4 – Structural Indicators

Integrated Care Framework (Phase 1), Older Persons	Theme and Standards for Quality and Safety (HIQA)	Structural or Systems Indicator	Key Deliverable(S)
1. Establish Governance Structures	**Theme 5:** Leadership, Governance and Management		
Set up a local Integrated Care governance structure with Senior Clinician and Management sponsorship. This may include and expand on existing structures that are functioning well across community and hospital.	**Standard 5.1** Providers of Services for Older People have clear accountability arrangements to achieve the delivery of safe, high-quality care **Standard 5.2** Providers of Services for Older People have formalised governance arrangements for assuring the delivery of safe, high-quality care **Standard 5.3** Providers of Services for Older People have effective management arrangements to support and promote the delivery of safe, high-quality care	Accountability arrangements in place Governance structures in place Management structures in place	**(5.1)**Steering Group Terms of reference Memorandum of understanding between service providers. **(5.2)** Steering group and implementation sub group (s) organogram (s) (with names and designation) **(5.3)** Operational policy
2. Undertake Population Planning for Older Persons	**Theme 8** Use of Information		
Identify the Community Health Networks (CHNs) in pioneer catchment; describe baseline population for these networks, estimate local older person population demand and implications for planning. Identify relevant area of operation for development of services for older people.	**Standard 8.1** Providers of Services for Older People use information as a resource in planning, delivering, managing and improving the safety and delivery of care	Information on local population used in the development of plans for services for older people	**(8.1)**Population plan report and map of community health networks.
3. Map Local Care Resources	**Theme 8** Use of information		
Carry out baseline resource mapping in relevant CHN/Acute Hospital area to describe existing social, community, hospital and voluntary services. Mapping to comprise an inventory and/or surveys of :- Community and social services :- Facilities, capacity, staff, estimated activity; community, short and LTC Ambulatory services :- Diagnostic, assessment, care planning, rehabilitation accessible from	**Standard 8.1** Providers of Services for Older People use information as a resource in planning, delivering, managing and improving the safety and delivery of care	Information on community, social, ambulatory, acute and voluntary services is used in the development of plans for services for older people	**(8.1)** Local Directory of Service

community or hospital *Acute services :- Facilities, capacity, staff, pathways, procedures* *Voluntary agencies, community resources, age friendly initiatives in the area etc. .*			
4. Plan and Develop Services and Care Pathways	**Theme 1:** Person-centred Care and Support **Theme 2:** Effective Care and Support **Theme 3:** Safe Care and Support **Theme 5:** Leadership, Governance and Management		
Develop age attuned services and pathways for older persons spanning both community and acute hospital in line with the NCPOP Model of Care. This will involve a number of measures being initiated or sustained in accordance with the NCPOP, including Geriatrician-led MDT working across an integrated care pathway, comprehensive geriatric assessment, an ambulatory care pathway with day hospital access, specialist geriatric wards and acute frailty units, early supported discharge, falls/dementia/polypharmacy pathways.	**Standard 1.1** The planning, design and delivery of services are informed by older people's identified needs and preferences. **Standard 5.4** Providers of Services for Older People set clear objectives and develop a clear plan for delivering safe, high-quality services **Standard 2.1:** Services for Older People are provided through a model of care designed to deliver safe, high-quality care Standard 3.1 Providers of Services for Older People effectively identify, manage, respond to and report on patient safety incidents.	Plan agreed for integrated services for older people within and between care settings Staff and facilities in place to deliver services in accordance with model of care Systems in place to record, manage, respond to and report on patient safety incidents	**(1.1)** User survey **(5.4, 2.1)** Care Pathway Mapping process underway (graphic) **(3.1)** Quality and risk issues addressed through local QI processes
5. Develop New Ways of Working	**Theme 2:** Effective Care and Support		
Develop roles to support older person as they navigate the system. Assign some staff to work across primary care, social care, mental health, acute hospitals, carers, families and community agencies; include emerging roles (case managers) as well as new and enhanced roles for Geriatricians, Health and Social Care Professionals, peer support roles, etc.	**Standard 2.2** Older people receive integrated care facilitated by staff, including case managers, whose roles include supporting patients to transfer safely and efficiently within and between services	WTEs Clinical Case manager for older persons WTEs Consultant Geriatrician for ambulatory care services for older people is required to work with the Case Manager and for Nursing Home Liaison WTEs Clinical Nurse Specialist	**(2.2)** MDT Staffing List reflecting case management and assertive outreach/in-reach function

		Care of the Older Adult for ambulatory care services and Nursing Home outreach WTEs Administrative support	
6. Develop Multi-disciplinary Teamwork and Create Clinical Network Hub	**Theme 2:** Effective Care and Support		
Develop a multi-disciplinary team approach and create a clinical network hub to discuss care plans for of older people with frailty and complex care needs. Ensure daily liaison between community and hospital teams via the clinical network hub to manage the current and emerging needs of identified at risk older persons.	**Standard 2.3** Older people receive integrated care which is coordinated effectively within and between services.	Systems and procedures in place to deliver integrated care for older people	**(2.3)** Operational Hub in situ
7. Person Centred Planning and Delivery of Care	**Theme 1:** Person-centred Care and Support **Theme 2:** Effective Care and Support		
Develop an approach to care planning and delivery that is person centred, longer term and co-ordinated across hospital, community and social care settings, and includes user and carer input.	**Standard 1.2** Older People are empowered to make informed decisions about their care **Standard 1.3** Informed consent to care is obtained in accordance with laws, regulations and best available evidence **Standard 2.4** Care is planned and provided to meet the older person's assessed needs, while taking account of the needs of other people using the service	Referrals, assessments and onward referrals monitored by case managers, ambulatory and acute care	**(1.2)** User questionnaire/survey And survey outcome report annually **(1.3)** Name of user/carer on steering group **(2.4)**Two quality initiatives using co-production per annum
8. Supports to Live Well	**Theme 4:** Better Health and Wellbeing		
Local service leaders to work with voluntary agencies, community resources, age friendly initiatives in developing a range of community supports that enable older persons and their carers Enablers to live well in their community.	**Standard 4.1** The health and wellbeing of older people are promoted, protected and improved **Standard 4.2** The health and wellbeing of older people's carers are promoted, protected and improved	Coordinated programme in place to support health promotion for older people Carer needs assessment is incorporated into comprehensive	**4.1** Shared CHO H&W Lead plan in place

		geriatric assessment	
9. Enablers	**Theme 6:** Workforce **Theme 7:** Use of Resources **Theme 8:** Use of Information		
Develop a local Integrated Care Change Plan that includes a process to address Workforce, Finance, and Information System, development to enhance care integration for older persons.	**Standard 6.1** Providers of Services for Older People ensure their workforce has the competencies to provide safe, high-quality care **Standard 7.1** Providers of Services for Older People plan and manage the use of available resources to deliver safe, high-quality care efficiently and sustainably **Standard 8.2** Providers of Services for Older People have effective arrangements in place for information governance	Plan for ongoing staff development in place, based on assessment of training needs	**(6.1, 7.1)** Staff development and training Plan **(8.2)** IT hardware distributed and IT training delivered **(8.2)** Healthmail in place and being used by the team **(8.2)** SAT being used for care coordination
10. Monitor and Evaluate	**Theme 2:** Effective Care and Support		
Monitor the implementation of the integrated care programme Evaluate across key domains, Quality, Access, Outcomes, Value (cost). *Capture Service user and Staff experience:-* *Patients and carer Qualitative Surveys* *To capture views of patients and carers on quality and safety of care, identify positive experiences and suggested solutions for improvements* *Management and staff Qualitative Surveys* *To capture views of staff (acute, GPs and primary care, social care) on quality and safety of care, identify what is working well and suggested solutions for improvements* *Economic Evaluation*	**Standard 2.5** The effectiveness of care for older people is systematically monitored, evaluated and continuously improved	Information governance included as part of overall governance and planning for integrated care Performance indicators regularly reviewed by management and multidisciplinary teams in each care setting	**(2.5)** Structural measures quarterly report **(2.5)** Process measures monthly report **(2.5)** PROMS & PREMS twice yearly report **(2.5)** Older Person Dashboard on steering group agenda **(2.5)** NQAIS (OP) available to clinicians

Appendix 5 - Conferences & Events

Leadership & Innovations in Older Peoples Services Summit — **Tue, 12th April 2016**
ONMSD, The Conference Centre , Dublin Castle

'Transforming Care of Older People in Ireland' — **Tue, 24th May 2016**
Integrated Care Programme & National Clinical Programme for Older People
Royal College of Physicians of Ireland

Pioneer Sites Networking Day — **Thu, 29th June 2016**
Integrated Care Programme & National Clinical Programme for Older People
Aisling Hotel

IGS Conference — **Fri, 30 September 2016**
The Malton Hotel , Killarney

"The Journey To Person-centred, Integrated Care – New Ways Of Working" — **Tue, 18th October 2016**
HSE Clinical Strategy and Programmes Division,
Royal Hospital, Kilmainham

St Lukes Conference — **Sat, 22nd October 2016**
Royal College of Physicians of Ireland

Pioneer Sites Networking Day — **Fri, 1st December 2016**
Integrated Care Programme & National Clinical Programme for Older People
Farmleigh House