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Hello,
I'm Nora.

Making a start in Integrated Care for Older Persons

A practical guide to the local implementation of Integrated Care Programmes for Older Persons

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

OLDER PEOPLE

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

*"**I can plan** my care with people who **work together** to **understand me** and **my carer(s)**, allowing me control, and bringing together services to achieve the outcomes important to **me**."*

(National Collaboration for Integrated Care and Support, 2013)

Glossary of Terms

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

Foreword

Siobhan Kennelly *Clinical Lead ICPOP,* Michael Fitzgerald *Head of Operations and Service Improvement (Older People)* and Diarmuid O'Shea *Clinical Lead NCPOP*

Integrated Care is the way forward for promoting new ways of working together to improve the quality of care delivered by those of us who work in our health care system. This undoubtedly presents some unique challenges when applied to delivering this care across the continuum of care. What matters to an older person when they have contact with the health and social care system is that their care is better planned, better coordinated, better delivered and easier to access.

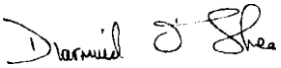
Building on the work started by the National Clinical Programme for Older People (NCPOP) in 2010, the Integrated Care Programme for Older Persons (ICPOP) is now working with National Divisions, Acute Hospitals and Community Healthcare Organisations at local and national levels to drive a co-ordinated, person focused approach to care using a 10 Step ICPOP framework.

This 'Making a start in Integrated Care for Older Persons Guide' represents an opportunity to give substance and more detail to the 10 Step Framework. It is informed both by evidence of 'what works' from both theory and the experience of implementation. As this document is a 'Getting Started' guide it is expected that learning from the local and national experience will inform subsequent editions.

We are indebted to colleagues across the health and social care system who continue to engage and work with ICPOP teams locally and nationally to improve services for older people. Much of their work is drawn upon in this document. We hope this guide supports and informs those who are 'Getting Started' on their own journey towards integrated care. We look forward to working with you in the years ahead to further improve the health and social care delivered to all of us as we age.

Siobhan Kennelly
Clinical Lead ICPOP

Michael Fitzgerald
Head of Operations and Service Improvement (Older People)



Diarmuid O'Shea
Clinical Lead NCPOP

Acknowledgements

The National Working Group wishes to acknowledge the support of the pioneer sites in providing material to illustrate key concepts. In addition, the membership of the National Working Group wants to express its appreciation for the support of the Clinical Strategy and Programme Division and the Social Care Division for its joint sponsorship of the Intergrated Care Programme Older Persons and National Clinical Programme Older People.

The NWG is also indebted to the support of the National Steering Group (ICPOP)* for its ongoing guidance, and the Programme for Health Service Improvement for it's support. Finally, the NWG Joint Chairs want to acknowledge the contributions of the NWG members;

ICPOP	NCPOP
Dr. Siobhan Kennelly Joint Chair	Dr. Diarmuid O'Shea Joint Chair
Mr. P.J. Harnett Joint Chair	Ms. Helen Whitty Joint Chair
Ms. Belinda Buckley	Mr. John Brennan
Ms. Dee Conroy	Ms. Carmel Hoey
Ms. Jennifer Hardiman	Ms. Deirdre Lang
Mr. Des Mulligan	

** See Appendix 2 for membership of the ICPOP Steering Group.*

Contents

Introduction

Why Implement Integrated Care for Older People?

Designing and delivering integrated care for older people across local communities and hospitals is a multifaceted collaborative process between providers, users and carers. It involves changing the way health and social care is planned and delivered whilst ultimately focusing on patient experience, outcomes and quality of care.

A compelling argument exists to change the health and social care delivery model in order to keep pace with changing population demographics and associated needs. Health and social care systems are recognising that sustainable strategies lie in a population-based health approach, including a focus on older persons as a key cohort (Gullery and Hamilton, 2015, Wodchis et al (2015). At the heart of this is the need for systems to move from acute, episodic care to longitudinal, coordinated and integrated care models, reflecting the growth in multi-morbidity and complexity of care needs.

'Building on the Work that has gone before'

There have been many excellent developments in the delivery of Health and Social Care services to Older People in Ireland. In fact Ireland is considered one of the best countries internationally in which to age (DOH 2013). Local health systems support many examples of good practice that enable older people to live healthily and well in their own community. This is reflected in the Government's Positive Ageing Strategy (DoH 2011).

The National Clinical Programme for Older People Specialist Geriatric Services Acute Model of Care (NCPOP 2012) has set out a number of key recommendations for the establishment of a Specialist Geriatric Service to achieve measurable improvements in outcomes for frail older people. The recommendations follow the end to end pathway/patient journey from their home, through primary care, acute care and discharge home. It also set out the design for Comprehensive Geriatric Assesment (CGA), subspecialty services, and the key roles that interdisciplinary education in areas including frailty will play in supporting the evolution of age attuned and age accommodating services that support ambulatory care.

The Integrated Care Programme for Older People (ICPOP) now seeks to build on this important work through active collaboration with clinicians and managers across the system. The 10 Step ICPOP Framework (ICPOP 2016) seeks to bring together the best attributes of local health systems and support clinicians and managers to build on the delivery of design models established in NCPOP (2012) using an integrated framework. In addition, a key building block will be to listen to the voices of older people within local areas to contribute to developing models of best practice that respond to those needs. It will also evaluate models as they emerge. There is much already being realised within the system to address key issues such as fragmentation and poor connectivity. We know from international evidence that integration takes time to evolve and results that support the approach take time. Whilst there is much to be positive about at this early juncture (ICPOP 2016) this guide is simply a starting point on a longer journey.

Implementing Integrated Care

In order to illustrate the integrated care journey, the ICPOP has developed 'Nora's Story' (http://www.hse.ie/eng/about/Who/clinical/Videos.html). This short animation sets out how integrated care can achieve a very different set of outcomes for the older person when care is planned, co-ordinated, and person centred. This is a very useful tool to use in delivering the message about the potential of integrated care to key stakeholders.

Implementing integrated care is a complex task that does not lend itself to a defined national 'model'. ICPOP has adopted a framework approach to build on established good practice within local health and social care services. This approach draws on evidence of systemic improvement in health (Harnett and Kennelly (in press), Greenhalgh et al 2009, Dixon-Woods et al 2012) whereby local innovation is supported by national enablers. In adopting this approach, the ICPOP seeks to recognise the lived reality of implementing change.

In that regard, an integration framework describes a fundamental ***principle of design*** rather than ***a system of delivery*** (Goodwin 2015). This approach is in keeping with the international experience of systemic change (Dixon-Woods et al, 2013, Greenhalgh et al 2012, Dixon-Woods et al (2011), West et al., 2014, Ovretveit 2011). This builds incrementally through small scale local successes which collectively deliver improved health and social care outcomes for older people within a local population.

Who is this guide for?

This guide provides information to support and guide clinicians and managers in establishing local, integrated health and social care services for older persons.

How should it be used?

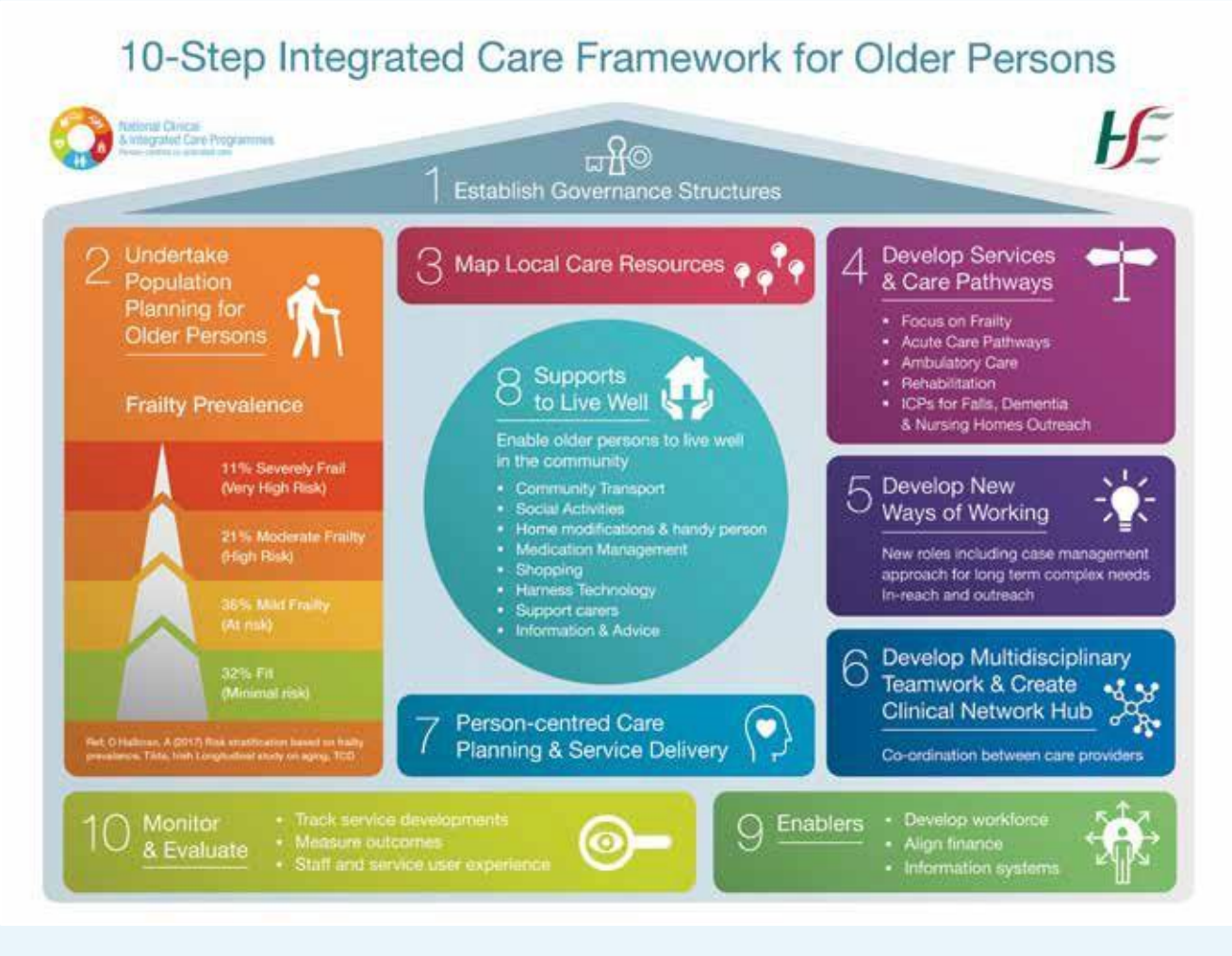
The guide describes a series of evidence based components of integrated care. Establishing governance is a key first step in developing bespoke pathways and enabling new ways of working such as a case management approach for older persons. It also sets out how some of the key enablers will be addressed nationally. There is an action(s) and deliverables associated with each of the components of the 10 Step Framework. In addition, relevant resources/links or contacts are provided where available.

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 10 Essential Steps

Local resources, experience, people and geography differ from area to area and no one solution fits all. However, some key elements need to be in place to facilitate integration of care. This guide describes the 10 key essential steps that are needed to enable integrated care for older persons to be implemented, evaluated and sustained in all locations.



1 Establish Governance Structures

ACTION 1:

a. Set up a local integrated care governance group focused on the needs of older people within a given area.

b. Ensure membership reflects key stakeholders and ensures opportunities for meaningful engagement with older people using the services as part of the core function of this group.

Local Governance

Establishing a local governance structure across health and social care (including the third sector) with senior sponsorship is a fundamental starting point on the journey towards integrated care for older people (Jupp 2015, Collins 2016). It is often the case that examples of governance are already well established in many areas, for example integrated discharge planning structures, but a broader more inclusive membership will need to be considered. This builds on informal professional and managerial networks and fulfils a number of key functions (Nicholson et al., 2013).

The function of the local governance group will be to:

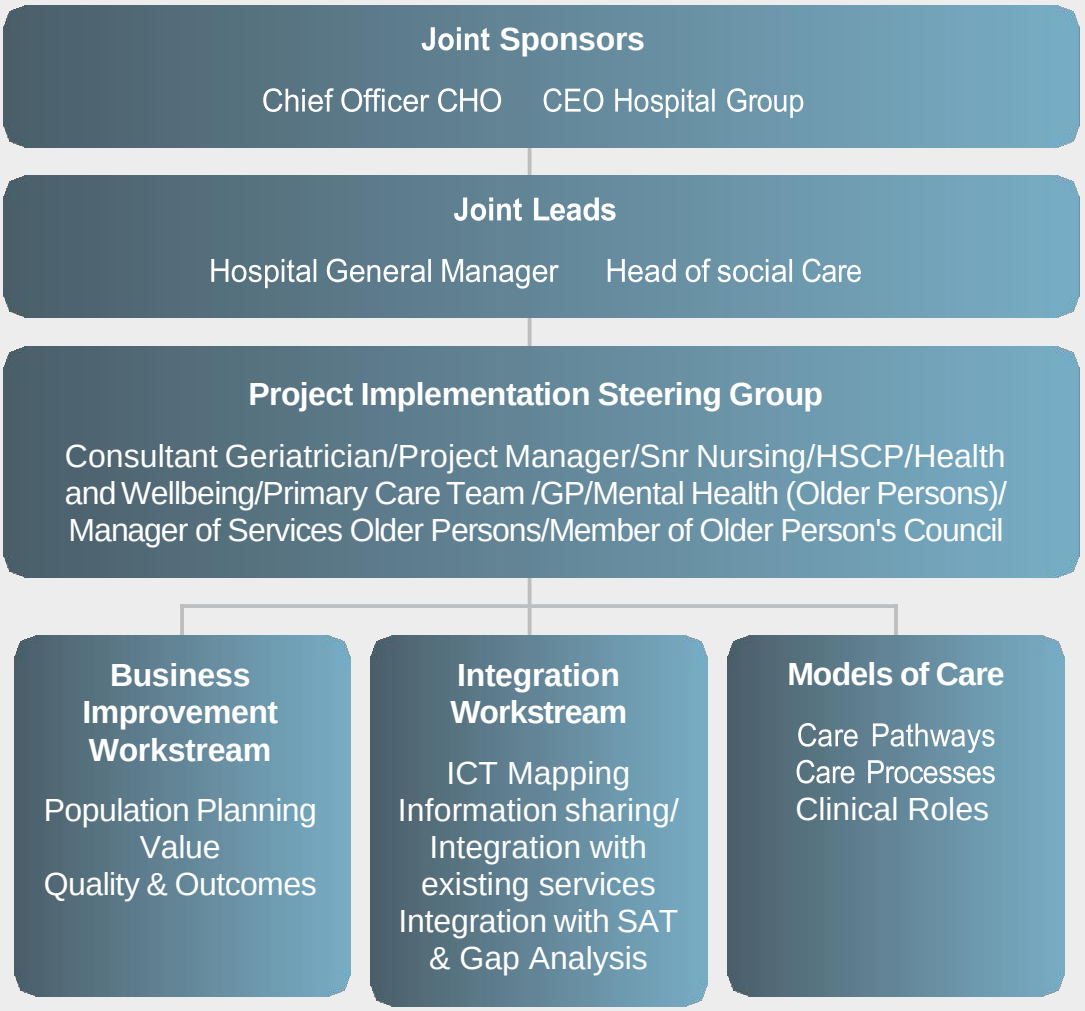
- Ensure a sustained focus on the development of services for a local identified population of older people
- Ensure appropriate clinical and operational leadership to develop and design services is supported and implemented
- Ensure the voice of older people is central to planning and design of these services
- Support the local and national evaluation of services in order to drive service improvement.

National Governance

A national governance structure (Appendix 1) has been developed to support local leadership in the implementation of integrated care and reflects a national mandate for this approach. The national governance structure assists through:

1. The Steering Group provides national sponsorship
2. The National Working Group enables the 10 Step framework
3. Ensures the experience of local implementation is reflected in national strategic developments.

Example of potential roles in local governance structures:



Deliverables from Step 1

- ✔ Local steering Group Terms of reference - See Appendix 1a
- ✔ Memoranda of understanding between service providers
- ✔ Steering group and implementation sub group (s) organogram (s) (with names and designation)
- ✔ Operational policy

2 Undertake Population Planning for Older Persons

ACTION 2:

a. *Identify Health and Social Care Network(s) in which there will be a focus on developing integrated care for older people. Ensure existing networks continue to be supported in service delivery / implementation.*

b. *Identify population trends for older people within those areas to inform service planning and development. Specific trends in older population subsets should be identified (e.g. >75's).*

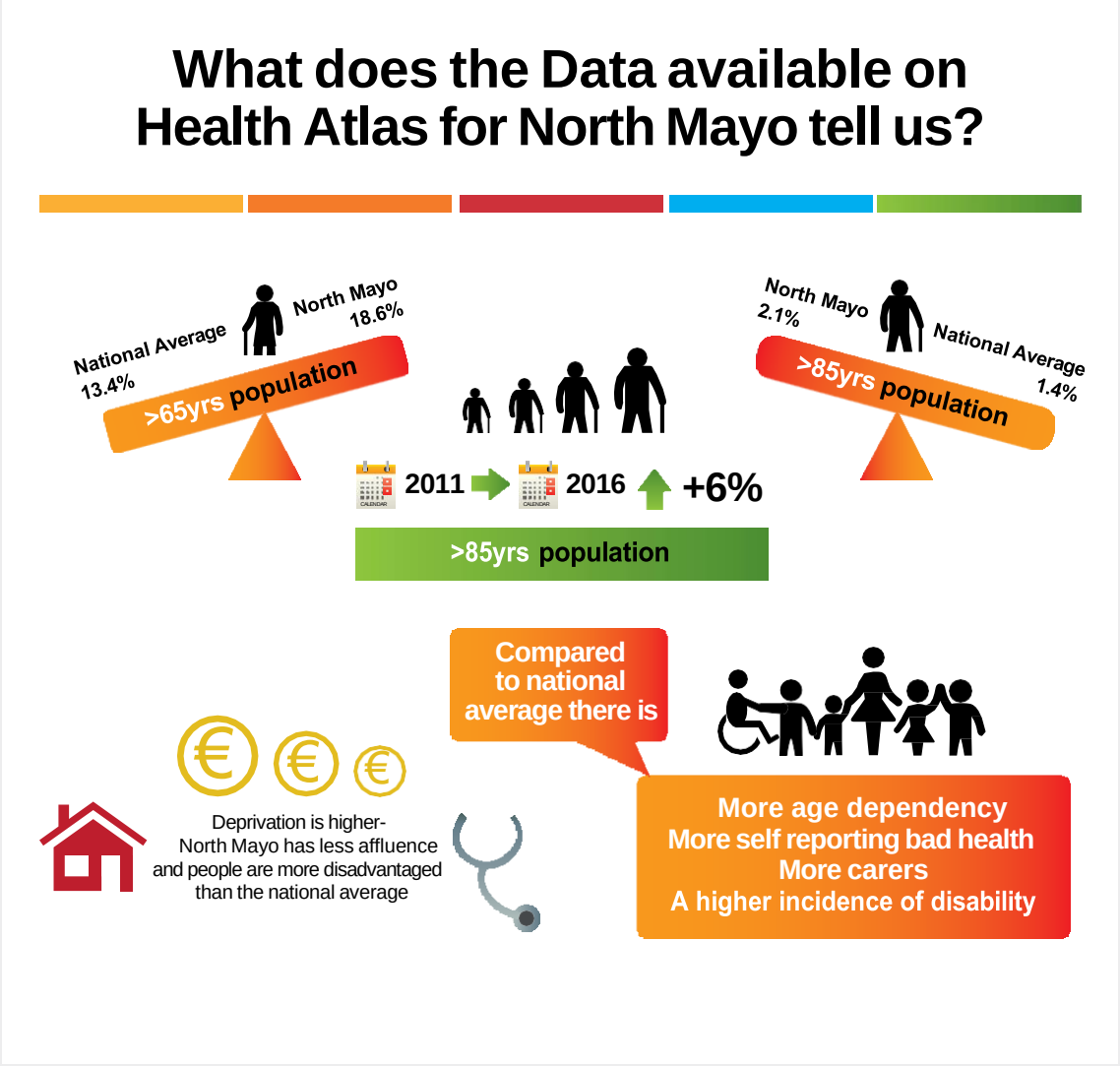
c. *Identify target populations who may have high complexity needs such as:*
   - *Older People with Frailty*
   - *Older People with high levels of acute hospital use*
   - *Older People with Falls*
   - *Older People with a history of cognitive vulnerability.*

Population planning describes the demographic and social characteristics of a target population. It is a key component in planning, developing and implementing integrated care for older persons (Kings Fund 2015). ICPOP recommends accessing locally available population health planning resources to enable projections of current and anticipated needs of older people. Information available on resources such as Health Atlas (https://www.healthatlasireland.ie) and TILDA (www.tilda.ie) includes:

- A breakdown of the population by age profile
- Information on the deprivation determinants for the local population
- Likely predictors of frailty within a given older persons population
- Self-reported Health Indicators for the local older persons population
- Health and social care resource profile.

Example of Data generated by Health Atlas

Dr. Howard Johnson (Clinical Lead, Health Intelligence, Knowledge Management, Health & Wellbeing Directorate, HSE) is working with the national ICPOP team to introduce key people in each of the local sites to population planning using Health Atlas. This data can be used as one of the tools to inform the planning of services and resources around specific needs of older populations in local areas.



Other useful resources for population planning

healthintelligenceireland@hse.ie

- **County and city population profiles** can be accessed on the Central Statistics Office website http://census.cso.ie/areaprofiles/ These provide a description of the population, with comparisons to the country as a whole with regard to age, marital status, household composition, language, employment, social class, education, disability, carers, and general health.
  http://www.hse.ie/eng/services/publications/planningforhealth.pdf
  Planning for Health - Trends and priorities to inform health service planning. HSE 2017.

- **Population profiles for use in health service planning** are available through the public health section of the HSE website:
  http://www.hse.ie/eng/services/list/5/publichealth/publichealthdepts/pub/profiles.html
  In addition to demographicand socioeconomic information, they set county and city data in a national context for levels of deprivation, trends in age-standardised hospital discharge rates and mortality rates for heart disease and stroke, cancer, respiratory system, and injury and poisoning.

http://dementia.ie/images/uploads/site-images/Dementia_Prevalence_2011_2046.pdf Information on current and projected prevalence rates for dementia in Ireland. This report gives information by County and by age group.

Deliverable from Step 2:

✔ Older Persons Population plan

3 Map Local Care Resources

ACTION 3:

Identify, map and develop a directory of all healthcare resources, agencies and groups in the area, that are central to the development of sustainable integrated care for older persons.

The function of mapping resources in a local area is to:

1. Ensure all services for older persons are identified within a given area and collated into a local service directory
2. Ensure appropriate targeting of future service provision builds on the population planning approach
3. Provide opportunities for signposting to ensure effective utilisation of services.

In order to ensure the development of a local resource map for older persons the local Governance group should ensure:

- Consultation with the third sector, local authority, age friendly alliance, older persons council
- Regular updating and management of the directory developed.

Mapping of local resources, together with the population profile created through Step 2 will inform the next stage in the process, Developing Services ans Care Pathways.

Example:

https://www.ijic.org/articles/10.5334/ijic.2417/ Developing a tool for mapping mental health care provision in Europe: the REMAST research protocol and its contribution to better integrated care.

Examples of the categories and types of services relevant in a local scenario are as follows:

- Acute hospitals
- Day hospitals/community hospitals
- Rehabilitation
- Long Term Care Facilities
- Ambulatory Care,
- Primary Care Teams
- Day Care Centres
- Home Care
- Pharmacies

- Community intervention teams (CIT)
- OPAT Programme
- Palliative Care services
- Integrated care teams for older persons

- Active retirement
- Older Persons Councils
- Age and opportunity
- Local Community Development Committees
- Muintir na tire

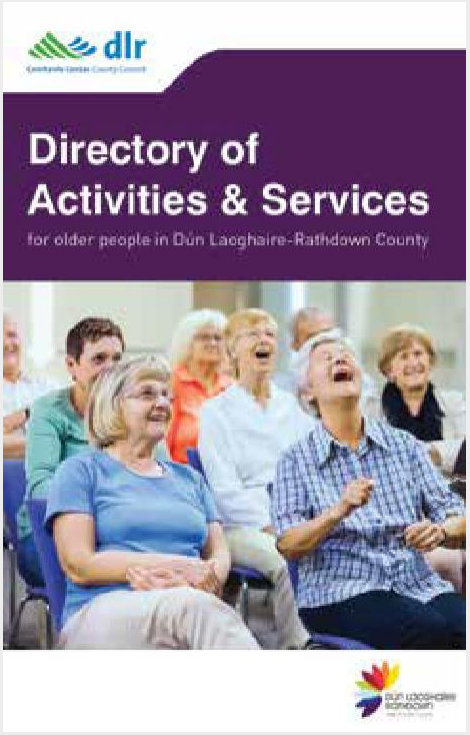
- Family resource centres
- Senior Citizens' Clubs
- Day Centres
- GAA Social Initiatives
- Community groups

- OPRaH (Age Friendly Ireland 2015)
- The Nestling Project (Netwellcasala 2015) in Co. Louth

Example - Dún Laoghaire-Rathdown Directory of Services

The example below is a directory that originated from the Dún Laoghaire- Rathdown County Development Strategy 2002-2012, and the second implementation Plan 2006-2008. The Older Person Service Providers Forum, a sub structure of the Healthy County Forum, identified the need for a Directory of Activities & Services for Older People in the Dún Laoghaire-Rathdown County. The HSE was the original lead agency in the compilation of the Directory in collaboration with personnel from Dún Laoghaire-Rathdown County Council, Dublin Dún Laoghaire Education Training Board, Dún Laoghaire-Rathdown Network of Older People, Dún Laoghaire-Rathdown Chamber and An Garda Síochána. The information contained in this updated version of the directory is the original data but has been updated to reflect the changes of contact details and personnel.

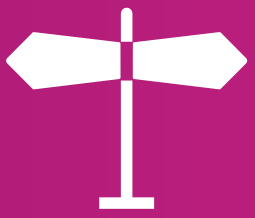
The directory is available in print and online at
http://dlrppn.ie/directory-of-activities-and-services-for-older-people-in-dun-laoghaire-rathdown/



Deliverable from Step 3

✔ Local Directory of Services

4 Develop Services and Care Pathways



ACTION 4: Develop Services and Care Pathways

"Comprehensive Geriatric Assessment (CGA) is the organised approach to assesment designed to determine an older persons medical conditions, mental health, functional capacity and social circumstances. Its purpose is to coordinate and develop an integrated plan for treatment and rehabilitation, support and long term follow up." NCPOP, 2016

- *Conduct care pathway mapping exercise which ensures potential for access to CGA is maximised*
- *Prioritise key pathways and services to be developed for older persons in areas including frailty, falls and dementia.*

Focus on frailty

Frailty is "A medical syndrome with muliple causes and contributors; characterised by diminished strength, endurance and reduced physiolgical function that increases an individual's vulnerability for developing increased dependency and / or death." (Morley et al, 2013)

Frailty in older people is one of the key challenges in addresing the health and social care issues that arise in an ageing population as comorbidities increase, vulnerability to the side effects of medications become more problematic and physiological changes such as reduced muscle strength predispose to adverse events such as falls (Clegg, 2013). Frail older people have been shown to be vulnerable to adverse health outcomes such as falls, hospitalisations, disability and mortality (O Caoimh, 2014) and frailty status at time of acute hospital admission predicts adverse outcomes including new discharge to nursing home, development of pressure ulcers and mortality (Hubbard, 2017).

Data from The Irish Longitiudinal Study on Ageing (TILDA) suggests that up to 25% of older people in Ireland are living with frailty while a further 45% are at risk of being pre-frail when a frailty index measure is applied (Roe L et al, 2016).

A range of validated instruments to measure frailty are available with varying degrees of sensitivity and specificity. (Rockwood Frailty Score, PRISMA 7, Edmonton Frailty Assessment). The National Clinical Programme for Older People (NCPOP) has outlined an approach to the identification and management of frailty using Comprehensive Geriatric Assessment (CGA). (NCPOP, 2016)

In terms of integrating care for older people across the continuum the concept of frailty and its management assumes particular importance for two reasons:

1. In identifying populations with high levels of frailty, services can be appropriately directed and targeted (Oliver 2016)
2. An emerging evidence base suggests that proactive intervention with community dwelling older people and those presenting to acute hospital at risk of frailty may reduce its prevalence and improve outcomes (Puts et al., 2017, Cameron et al., 2013)

Case finding approach / Risk Stratification for frailty

Case finding for frailty presumes that earlier detection and management of health and social care problems for older people will promote better outcomes and reduce long-term morbidity. There is a need to develop systems that identify and manage frailty in older people presenting to acute and community services at an earlier stage in their presentation (O Caoimh, 2014; NCPOP, 2017)

The use of Comprehensive Geriatric Assessment (CGA) clearly demonstrates improved outcomes for older people with frailty (NCPOP, 2012; NCPOP, 2016). The Single Assessment Tool (SAT) represents a key opportunity in implementing CGA across acute and community healthcare and supporting a cordinated response to same. SAT is discussed in further detail in Section 9.

The NCPOP recommends that a specific focus on the use of CGA to identify frailty should be deployed in the following populations:

1. Older people who fall
2. Older people who have developed mobility problems
3. Older people who are on multiple medications and are perceived as vulnerable to their side effects
4. Older people who have a history of confusion or have a known diagnosis of dementia
5. Older people with multiple complex co-morbidities

(NCPOP, 2016)

“Identification of frailty in older people should primarily be on the basis of conditions associated with frailty. Those at risk of frailty or with complex co-morbidities or dementia should be considered for CGA and the findings should be documented in their permanent health record” (NCPOP, 2016)

Designing Services to meet the needs of older people with frailty or at risk of frailty

Evidence suggests that bespoke pathways work well in improving outcomes for older people. Examples of bespoke pathways include:

1. Ambulatory Care Hubs. (E.g. day hospitals with access to outpatient diagnostics /therapy staff enabling ‘rapid access’ CGA and ongoing therapy to support Early Supported Discharge) (NCPOP 2012)

2. Acute Frailty pathways that enable a 'front door' response. (E.g. ED / AMAUs using CGA to assess needs of older people in a timely manner with appropriate senior clinical decision makers and a multidisciplinary team). (NCPOP 2017)

3. Specialist Wards for Older People with Frailty (SGW) staffed by multidisciplinary teams and gerontologically trained nursing and medical staff. (NCPOP 2012)

4. Access to inpatient and outpatient rehabilitation with supported assessment, therapies and clinical support. (NCPOP 2012)

5. Integrated Care Teams for Older People with Complex Needs in the Community to include a focus on:
   - Specialist pathway development in areas of identified high-need. (E.g. Long-term care settings where there are high numbers of people living with frailty and high complex needs).
   - Specific links between primary and secondary care services (e.g. GPs, Community Nursing, Geriatricians, Mental Health Services and HSCPs) that promote rapid identification and management of frailty, risk of frailty and early access to rehabilitation and care.
   - Development of integrated care pathways for people with dementia and people who fall or are at risk of falling.

1. Ambulatory Care Hubs

The breadth of assessment, rehabilitation and services provided in a Day Hospital (DH) will vary dependent on the setting. The key components of a DH are as follows:

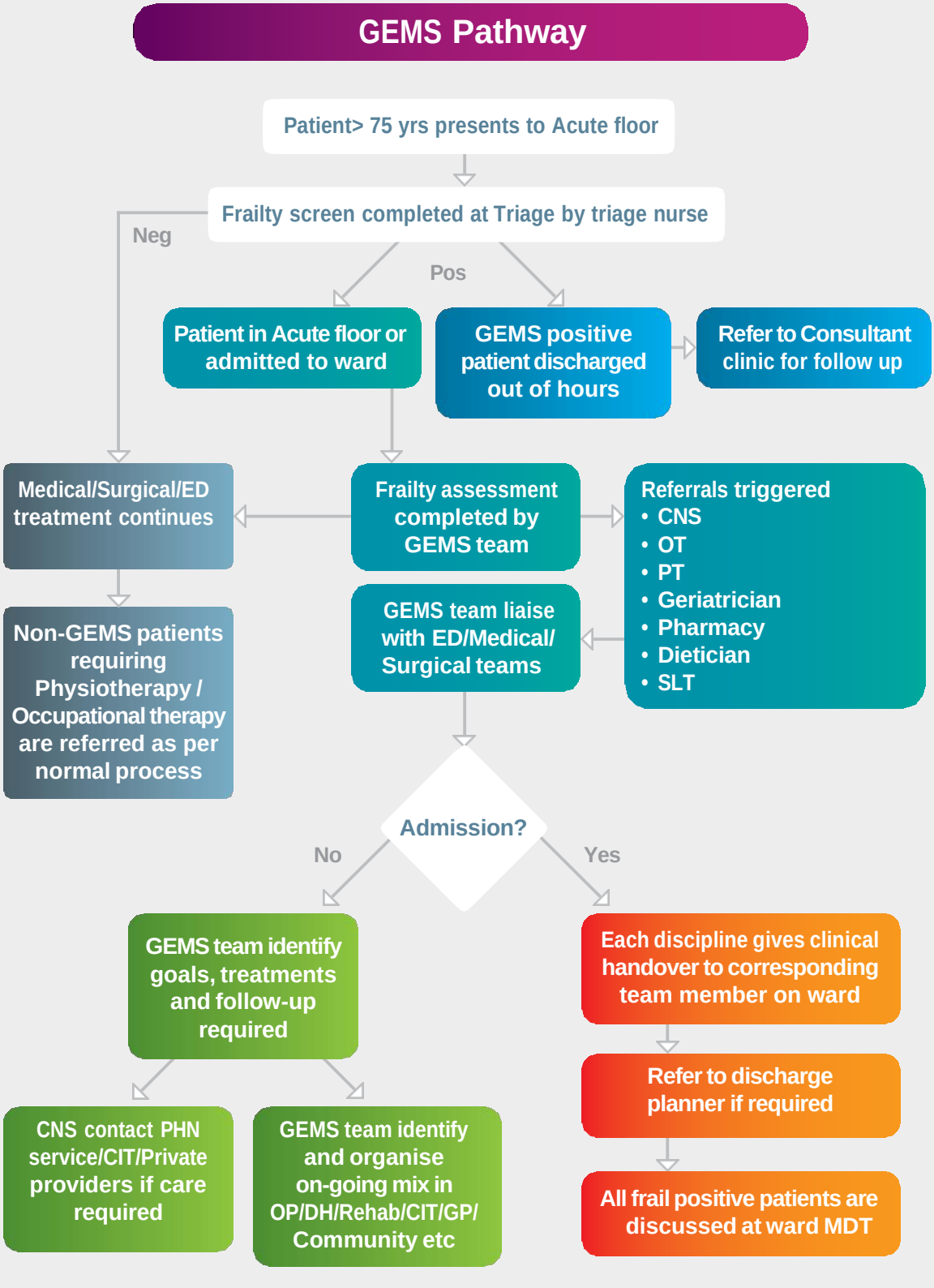
- The DH is a hub for ambulatory specialist services for older people, supporting integration between hospital, home based services and primary care
- It is staffed by a core multidisciplinary team (MDT) addressing services such as, falls , memory clinic, movement disorders , frailty
- Out-patient healthcare services include multidisciplinary assessment, treatment and rehabilitation, with attendance for assessment or for day care (full or part-day) by community- based older people
- Rapid access clinics provide CGA to support ongoing care in the community
- The DH functions as a hub for information, education and training for patients, carers and professionals. (NCPOP 2012).

2. Front door response to frailty

Prolonged inpatient stays in acute hospital cause deleterious effects for many older people. There is considerable evidence that the early identification of frailty leads to a more coordinated care approach, earlier identification of patient complexity and better decision planning. Senior clinical decision makers aligned with gerontologically trained nursing and therapy support in ED / AMAU are important elements of such services. (NCPOP 2017)

Examples

St Luke's Kilkenny (Geriatric Emergency Medicine Service)



3. Acute Hospital Inpatient care for Older people

The NCPOP Model of acute hospital care (NCPOP 2012) outlines the key aspects of acute hospital care delivery that support Comprehensive Geriatric Assessment in that care setting. A systematic review has shown that deployment and early access to CGA within the acute hospital setting reduces mortality, inpatient stay and rates of institutionalisation in hospitalised older people (Ellis et al, 2011). Additionally, national experience of the implementation of the Specialist Geriatric Ward model in acute care has demonstrated key improvements in outcomes such as lengths of stay for older people and improved outcomes. Specifically the Model of Care recommends the designation of Specialist Geriatric wards supported by access to medical, nursing and HSCPs with training and expertise in older person's care as a fundamental component on the delivery of CGA.

4. Rehabilitation Services

Rehabilitation is a progressive, dynamic, goal-oriented and often time-limited process which enables an individual with impairment to identify and reach his / her optimum mental, physical, cognitive and social functional level. It can be provided in an inpatient, outpatient or home setting depending on the complexity of health and social care needs of the person. Two or more of the following risk factors may indicate a need for early involvement of MDT for rehabilitation and discharge planning or unmet medical needs:

- Difficulty with mobility
- A history of recurrent or multiple falls
- One or more unplanned admissions in the previous three months
- A history of cognitive impairment
- A stroke in the past three months
- Difficulty in performing one or more basic ADL in the three days prior to admission
- Poor nutritional status
- Continence issues.

(NCPOP 2012)

5. Integrated Care Teams for Older People with Complex Needs in the Community

Recent initiatives have focussed on the development of services that can enable the delivery of integrated care across a number of settings and specifically focus primary care and secondary care expertise for older person's care as required in the community setting. Some patients require a case management approach (see Step 5 – new ways of working) that can ensure that the older person receives a coherent and consistent service as they navigate multiple services. They are especially appropriate for people where significant difficulties may be encountered in accessing regular follow-up either through primary or secondary care settings and where a different approach is required. They are also particularly appropriate to populations of frail 'house-bound' older people where multiple significant medical, psychological and social issues are at play.

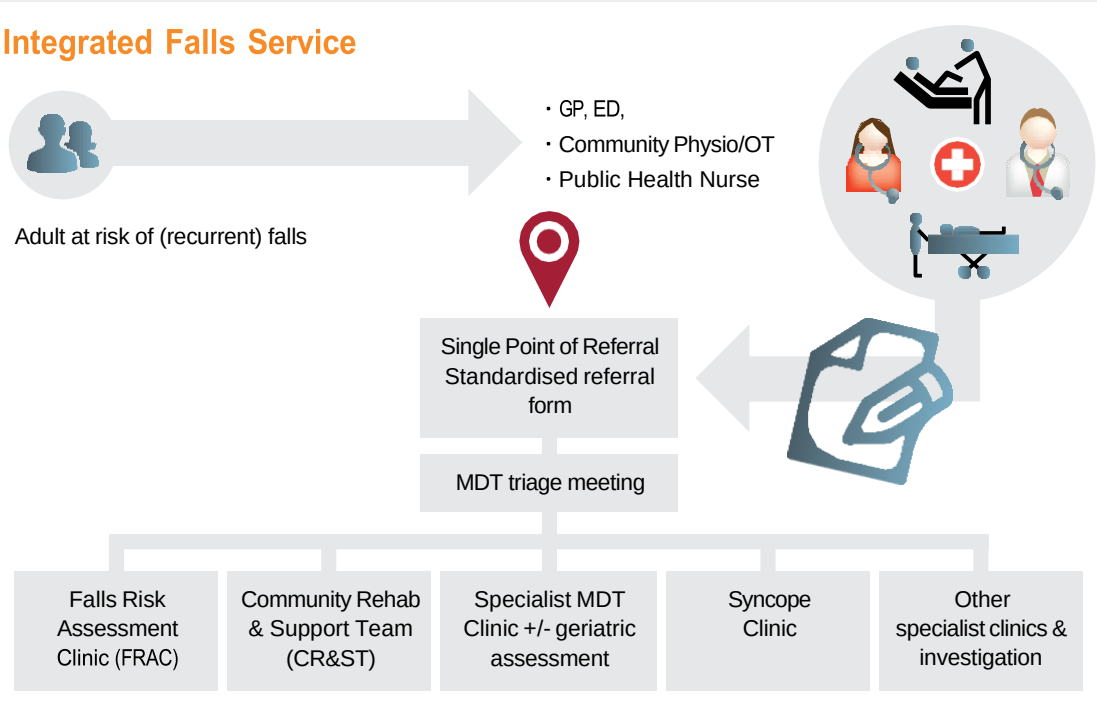
The following examples illustrate the care pathways that have been developed across acute hospital and community settings:

Example 1 - Connolly Hospital / Mater/ Dublin NW Nursing Home Outreach Model

This model commenced as a pilot project in 2007 and has developed and embedded within the local area. An audit identified high levels of presentations from nursing homes in the local area with significant re-attendance rates to ED. A similar model in Dublin NW / Mater Hospital has been developed since 2009. A consultant geriatrician and clinical nurse specialist team provide outreach support to 26 nursing homes (1800 beds) through GP referral and follow up of identified residents following hospital transfer and discharge. The teams have ready access to diagnostics, records and results as required while operating and outreaching across the CHO in both public and private nursing home settings. Despite a 30% increase in the total number of nursing home beds in the population in North Dublin both teams have demonstrated reductions in admissions to acute hospital from same. A comprehensive database of all nursing home contacts, directors, GPs is readily accessible to the team which ensures a rapid response to referrals and also assists with information flow particularly of patients with complex needs who are newly transferred. A number of significant successful initiatives have been developed that support advanced care planning, community intervention team / OPAT support of NH residents, education (www.inecma.org) and quality improvement in delirium care and better prescribing practice.

Example 2 - Cork Integrated Falls Service

The aim of the **Cork Integrated Falls service** is to ensure that people at risk of falling have access to timely assessment by health professionals with the **knowledge and skills** to do a **comprehensive standardised** falls risk assessment in the **appropriate setting** whether community or specialist falls services.



The falls service provides...

Imporoved integration between ED & Urgent care services, community services GPs and Specialist Falls Service	✓ Single point of access ✓ Falls Service Office ✓ Coordinator based in ATC ✓ Standard referral form
6 new community-based fall risk assessment clinics (FRAC)	✓ 4 in Cork city, 2 outlying clinics (North and South of the city).
Reengineered Specialist Falls Service	✓ Single referral pathway to specialist assessment in the ATC ✓ Incorporating existing service strands and a new rapid access specialist clinic
Monitoring and evaluation of implementation	✓ Activity metrics: case identification, waiting times for assessment, assessment outcomes / onward referral
Standardisation falls management in continuing care	✓ Standardised plans & documentation for falls management ✓ Implementation lead & site champions ✓ Routine audit & feedback

Deliverable from Step 4

- ✓ Demonstrable use of CGA in care settings (including SAT)
- ✓ Care Pathway Mapping process underway
- ✓ Changes in care pathways evaluated and demonstrating improved outcomes for older service users

5 Develop New Ways of Working

ACTION 5:

a. Develop a case management approach to manage the care needs of older people with the highest level of complexity.

Background :

There is a good evidence on 'what works' in integrating care for older people (Boult et al 2011, Keong et al 2013, Trivedi et al 2013, Mitchell et al 2015, Nolte 2012, Oliver et al 2014).

This describes key interventions, which include:

1. **A Case management approach** provides a named point of care and co-ordination of care
2. **Working across care settings** adopting an interagency approach (common assessment and shared care plan focused on a high priority population).

A case management approach has been used in care settings with populations who have significant vulnerabilities and where care is fragmented. A case management approach works well for populations at risk such as older people with complex needs. It provides:

1. A named point of access in the health and social care system for older people with complex needs
2. A point of coordination across care settings and between health and social care professionals
3. Clinical expertise in the assessment and care needs of older persons with highly complex needs.

Case Management is a "proactive approach focussed on high-risk patients with a combination of medical, nursing, pharmaceutical care and social care needs" (LTCC, 2012)

The key functions of such an approach are to enable:

- Roles to become key points of access in the system when complex care issues / frailty emerge
- Older people and families navigate the care system across acute and community systems
- Co-ordinated care where multiple services are involved and have sufficient autonomy to guide how those services can be optimally delivered
- Development of care plans based on good quality comprehensive assessment which will anticipate and inform ongoing and likely future care needs over the short-medium term.

Emerging experience of case management suggests tangible improvements in quality and continuity of care and improved satisfaction for patients and staff. It is recognised that impact on emergency hospital admissions and bed days are highly dependent on case managers having timely access to alternatives to admission including rehabilitation, community intervention teams, day hospital for older person and other ambulatory care services. A primary aspect of the Integrated Care model is that the Case Manager operates at the patient interface whether in the community, acute hospital, community nursing unit or day hospital for older persons.

Case Management roles should function therefore as key roles within an integrated care team for older people. In supporting the role to function as designed the following components are key:

- Have access to a Consultant Geriatrician and H&SCP team and day hospital to facilitate rapid access assessment of older people with complex needs
- Works in close partnership with Consultant Geriatrician on clinical matters and functions as part of a core integrated care team
- Have access to acute inpatient care records
- Have access to patient records in the community
- Be able to access respite and rehabilitation beds in the community in conjunction with an agreed plan of care with the Geriatrician
- They should be able to access a direct route to acute hospital care for the patient when this is needed
- Be able to access services that support the older person in their home on an emergency basis including Community Intervention Teams, Public Health Nursing Teams/ Community RGN and home care services
- Have a designated and managed caseload reflective of the acuity and complexity of a designated group of frail older people within a given community health network.

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:

Team Roles	Social Care	Acute Hospital	Primary Care	Mental Health
	Community Hospital with mix of Rehabilitation, and long-term care beds with MDT support	Specialist Geriatric Ward aligned with Acute Model of Care for Older Person (NCPOP, 2012)	Community Intervention Teams optimised to support the care of older persons at home	Mental Health services that meet needs of the person with complex mental health issues and dementia
Dedicated Care settings with Older persons Focus	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 older people living with dementia
	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., Out of Hours, GP care, ambulance & paramedic services	Nursing Home Outreach Support

Example of case management in action

The Clinical Case Manager role is a senior nurse working across primary and secondary care supported by the wider multidisciplinary team including specialists in gerontology and GPs. The aim of the role is to provide a model of case management through appropriate risk stratification and co-ordination of services in order to provide timely service interventions tailored to individual needs and appropriate follow up with defined periods of monitoring. This includes facilitation of access to the day hospital if there is evidence of clinical or functional deterioration and/or organisation of a planned admission to hospital to reduce the need for long term care and support the older person at home for as long as possible. This approach to care assists in improving the quality of life and care for patients and their families within the community adopting an integrated approach to care and has been the recipient of a HSE Excellence award.

http://www.hse.ie/eng/about/our-health-service/excellence-awards/2016-awards/community-virtual-ward/

Examples:

Case Manager roles and Community Virtual Ward Model supporting older people in the community who have complex medical and social needs, Dublin North City and County clare.lewis@hse.ie

Community Reablement in Dublin North City, an innovative approach to maintaining the independence of older people at risk of functional decline austin.warters@hse.ie

Dementia Elevator: An innovative approach to community development in dementia education. Dementia Elevator aims to prepare communities and health systems to respond to people with dementia. www.dementiaelevator.ie

Falls Prevention Awareness Programme in Community Hospitals- Older People's Service Donegal Raise awareness of falls prevention amongst staff, residents/patients, families and friends melissa.currid@hse.ie

Frail Elderly Assessment Team (FEAT) in Emergency Department, Galway University Hospital, provide an alternative model of care to frail older people attending the ED orla.sheil3@hse.ie

Frail Intervention Therapy Team (FITT) Beaumont Hospital, early assessment in the ED ciaraoreilly@beaumont.ie / paulmaloney@beaumont.ie

Nurse Led Memory Assessment Clinic (MAC) Age Related Health, Tallaght Hospital deborah.fitzhenry@amnch.ie / cathy.mchale@amnch.ie

Deliverable from Step 5

✔ MDT Staffing List reflecting case management and assertive outreach/in-reach function

6 Develop MDT Teamwork and Create Clinical Network Hub

ACTION 6:

a. ***Develop*** *a multidisciplinary teams approach to co-ordinate older persons health and social care needs.*

b. *Establish a* ***clinical network hub*** *to manage current and emerging needs of older people with frailty and complex care needs.*

Multidisciplinary Teamwork

Working in multidisciplinary teams has become the norm in healthcare as it has proven to be more effective (MHC 2010). There are obvious advantages to staff and service users in terms of efficiency, expertise, support, job satisfaction, innovation and quality of outcomes Onyett with SCMH (2001). To ensure optimum functioning of the team and effective patientoutcomes, the roles of the multidisciplinary team members in care planning and delivery must be clearly negotiated and defined.

This requires:

- respect and trust between team members
- the best use of the skill mix within the team
- agreed clinical and managerial governance structures
- agreed systems and protocols for communication and interaction between team members.

(Ref http://www.health.nsw.gov.au/healthone/Pages/multidisciplinary-team-care.aspx)

In addition, in order to operationalise team function, there is a need to develop a shared understanding of the core mission of the team and how this is achieved. This shared understanding becomes critically important in integrated care for older persons, where MDT roles and functions span service delivery across hospital and community, especially where different lines of accountability cross. At the core of this is an Operational Policy, which in essence reflects the shared understanding of 'how things work'. This includes the target client group, clarity of purpose, capable practice approach (who is best placed to do what), evidence informed approach (knowing what works). As a consequence of moving from institutional to community based team working Mental Health services have had significant experience of this. A comprehensive interactive resource on Multidisciplinary Teamwork is included in the references which provide some practical guidance in addressing this.

Clinical Network Hub for Older Persons Services: Includes a typical exchange of agencies involved and others who may participate as required. Whilst variation on this may evolve, the basic principle is to create a virtual or actual space in which the needs of older persons in the network is focussed on in an immediate and frequent manner. This can range from urgent access for health and social care needs to advice and information which allows services to be planned and delivered in a co-ordinated manner, using the full range of community and statutory services.

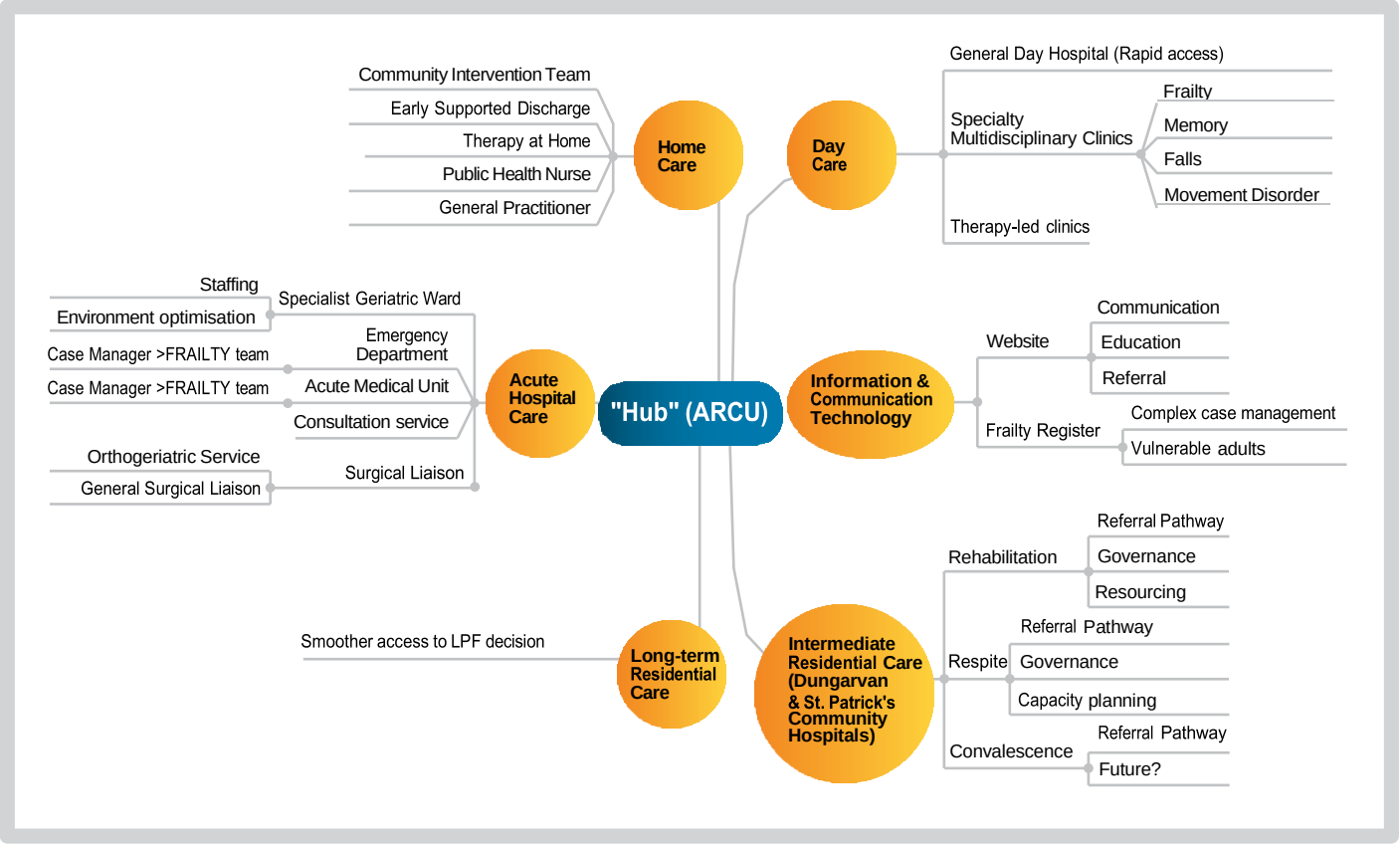
Frequency; Daily discussion; teleconference or meeting as agreed locally

Focus; Clinical management of care needs and development of inter-agency care plan

Chair: Consultant Geriatrician (or nominee)

Examples - MDT HUB

Waterford Integrated Care Older Person Hub functions as the coordination, information and training hub for older person's services. This facilitates integration between hospital and community services and acts as a resource for all involved in delivering older person's services. It provides expedited assessment for frail older persons presenting to ED, GP or AMU seeking to maximise the number of people who can access care in the least restrictive setting.



Deliverable from Step 6

✔ Operational Hub in situ

7 Person Centred Care Planning and Service Delivery

ACTION 7:

a. *Develop an approach to care planning that is person centred, longer term and coordinated to include user and carer input.*

b. *Engage with older people as equal partners in planning, developing and monitoring care to meet their needs.*

c. *Engage with local older people through structures such as the Older Person's Council facilitating a co-production approach to service improvement/service design.*

What is person centred care?

Person centred care is defined as care that is respectful and responsive to individuals needs and values, and partners with them in designing and delivering that care. (HIQA 2012)

Person centred practice

Person centred practice principles		Key elements
1	Acknowledging patients as Partners in their own care	• Patient and family engagement • Treating patients as individuals • Respect for patient autonomy • Respect of patient privacy - value placed on patient/ healthcare professional relationship rather than encounter (Kitson et al 2014) • Comprehensive Geriatric Assessment (NCPOP 2016) • "What Matters to You" (2016) • 'Hello, my name is'. Ref. http://www.hse.ie/eng/about/Who/QID/Person-Family-Engagement/hellomynameis/Checklist-to-assist-HSE-sites-implementin-hello-my-name-is-.pdf • Caring Behaviours Assurance System - Ireland (CBAS-I) (ONMSD 2016)

Person centred practice principles		Key elements
2	Creating environments where managers and clinicians can engage with patients and deliver care that is focused on their individual needs and goals.	• Empowering patients to take an active role in their care plan / decision making /Advanced Care Directives/ End of life care • Goal setting • Multidisciplinary approach to management • Patients and families as advisors • Patient rights and responsibilities • "Patients' experiences should be the fundamental source of the definition of quality." (Donald M. Berwick)
3	Supporting patients, families and communities to participate in service design and delivery of care.	• Information / education for patients and families • Be supported to stay well • Language and different cultures • Supports required and available to patients and his/her family • Triage/referral so patient is seen by the most appropriate healthcare professional
4	Providing care that is coordinated.	• Documentation • Communication between clinicians and patients/families • Making sense of services required • Connecting care-key healthcare professional co-ordinating single access point – Case Manager Role • Discharge planning and post discharge follow up – Discharge Planning E-Learning Programme HSE Land
5	The Care Environment.	• Organisational leadership, mission statement and commitment to quality • Context in which care is delivered and including appropriate skill mix; • Systems that facilitate shared decision-making; effective staff relationships; supportive organisational systems, the sharing of power, and the potential for innovation and risk-taking (McCormack McCance 2006) • Attitudes and organisation culture • Attributes of staff • The physical environment

Adapted from: Framework for Quality Improvement in our Health Services (2016)

Taking a co-production approach to the development of person centred care planning and service delivery.

Healthcare outcomes are not created by healthcare professionals working alone. They are co- created by patients and communities. 'Person centred community focused approaches lead to better outcomes (https://www.nationalvoices.org.uk/).

Service User Experience and Feedback

Patient feedback is a powerful tool in a systematic approach to improving health services for patients. The following are examples of HSE initiatives to measure patient experience, interpret patient feedback, and develop service improvement initiatives.

Your Service Your Say http://www.hse.ie/eng/services/yourhealthservice/feedback/Complaints/Policy/complaintspolicy.pdf

Patient Narrative Project http://www.hse.ie/eng/about/who/cspd/patient-narrative/

National Patient Experience Survey https://www.patientexperience.ie/

Listening to Older People Workshops http://www.hse.ie/eng/about/Who/QID/Person-Family-Engagement/ResourcesQID/Listening_to_Older_People_Report_2015.pdf

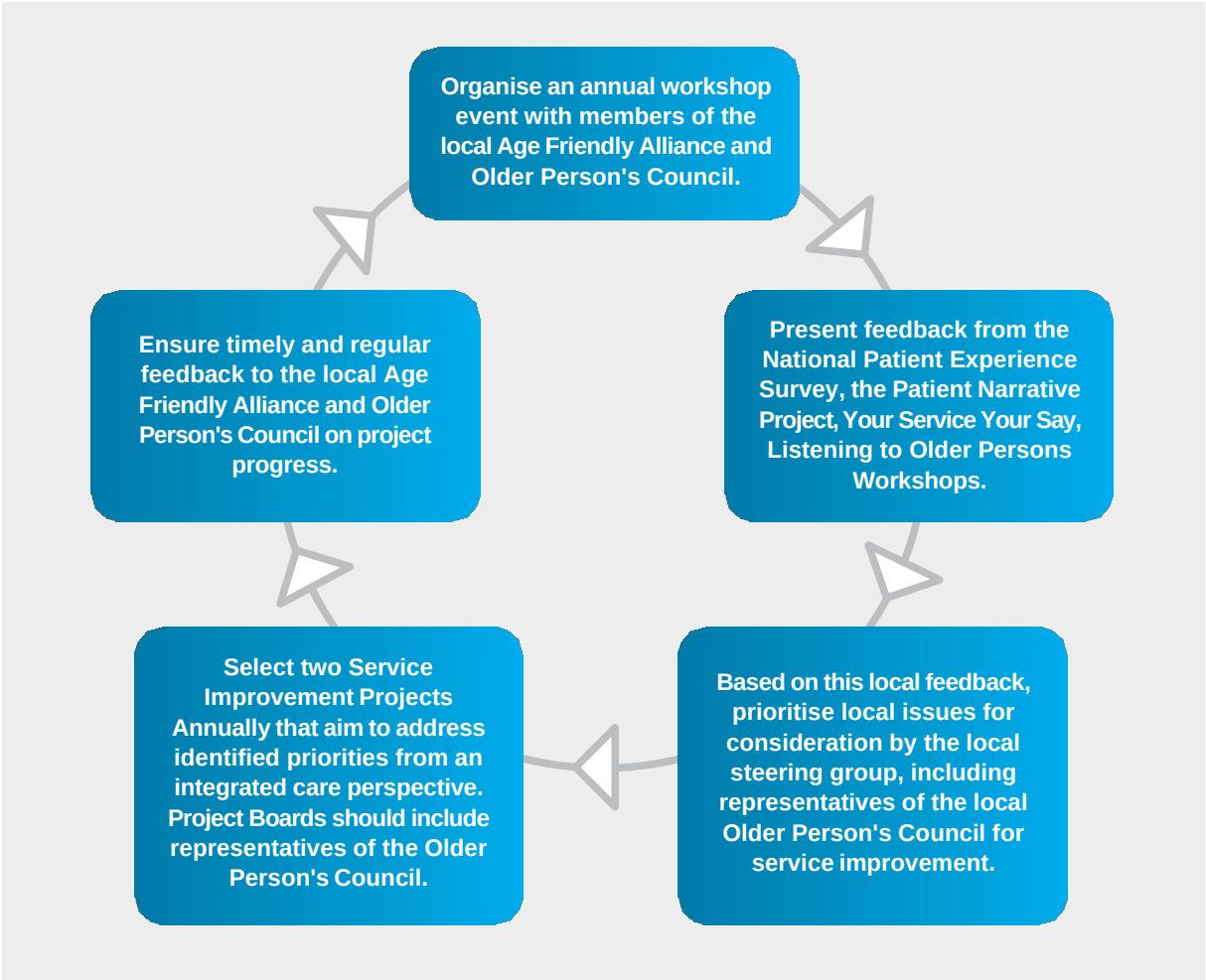
The National Working Group for Older Person's (NWGOP) has entered into a Memorandum of Understanding with Age Friendly Ireland in order to establish structures and mechanisms to enable local ICPOP Steering Groups take a co-production approach to service improvement that involves the voice of the Older Person at the heart of that process.

The NWGOP, Age Friendly Ireland (AFI) and the Chair of the Older Person's Councils will collaborate in supporting the co-production of integrated care for older persons. This will:

- Identify international best practice in the co-production of older person services
- Support the development of older person's patient champions
- Support the flow of information between the NWGOP and local pioneer sites
- Explore avenues to support policy and planning ideas and progress them through appropriate channels.

In order to make Co-production a reality locally the following is proposed:

- Local Steering Groups are asked to engage with the local Age Friendly Alliance and Older Person's Council with a view to identifying local people willing to become Older Persons' Patient Champions
- HSE representative on the Age Friendly Alliance is also a member of the ICPOP Steering Group
- ICPOP locally to take a collaborative approach to service improvement and develop the role of the Patient Champions in the following process.



Example - AgeWell Limerick

AgeWell partners with community-based organisations to recruit and train able healthy older people (age 50+) as peer companions, called “AgeWells.” AgeWells come from the same communities as their clients and are matched to clients based on several factors including: demographics, geography, gender, language, personality, and interests. AgeWells visit with their client’s weekly and follow up with regular phone calls. AgeWells use smart phones to capture data relating to health and wellbeing using a 20/20 screening tool (20 questions/20 observations). The app is synchronised with an online management platform; responses trigger algorithms that generate action items and referrals for evaluation, care and other services. The survey is dynamic and personalised, adding/eliminating questions based on diagnosis and responses. Designed by New York-based academic gerontologists to identify evolving environmental, social and health risks and problems, it can be tailored for particular settings or needs. It provides precise health data and comprehensive information, facilitating early identification of risks, problems; eg. during a home visit, AgeWells may schedule an appointment with an identified service, e.g. for a delivery from Meals on Wheels. With its focus on social engagement, health promotion and data analytics, the AgeWell model could significantly extend the reach, range, innovation and impact of support and advocacy services for our older people.

https://www.agewellglobal.com/pilots

Deliverables from Step 7

- ✔ User questionnaire/survey and survey outcome report annually
- ✔ Name of user/carer on steering group
- ✔ Two quality initiatives using co-production per annum

8 Supports to Live Well

ACTION 8:

a. Local service leaders to work with voluntary agencies in developing a range of community supports that enable older persons to live well in their community.

Background

As the number of older people in society increases the construct of ageing is being revisited. Getting older is seen as a time of opportunity with society and communities benefitting from the skills, generosity, and experience of older people (ISAX 2016). The factors that influence successful ageing are multidimensional. The way older people perceive themselves and how they are viewed by others can have a measurable effect on health and wellbeing.

The recent Healthy and Positive Ageing Initiative (HAPAI) report, Positive Ageing (2016), National Indicators Report (DOH 2016) presents findings on what matters for older people. Some of the findings include:

- 80% of people aged 50+ report their health as good or very good
- 80% of people aged 50+ report high life satisfaction
- 85% of people aged 50+ engage in at least one social leisure activity on a weekly basis
- 93% of people aged 50+ have at least one supportive relative or friend
- 66% of people aged 50+ reported high neighbourhood social capital.

However, some areas of concern include:

- Almost half (48%) of people aged 50+ have a slow walking speed indicating they may be frail
- Just over 1 in 4 (27%) of people aged 65+ have fallen in the previous two years
- More than one in three (36%) of people aged 50+ show evidence of mild cognitive impairment
- 6 out of 10 people (61%) aged 50+ have a chronic disease
- 28% of people aged 50+ are taking 5 or more medications
- One third of people (33%) have difficulty accessing social facilities.

Enabling people stay well and healthy

Healthy Ireland (2013), seeks to improve the health and wellbeing of our population.

The inclusion of the Local Health and Wellbeing lead on local Steering groups is important in order to facilitate older people to live well in their own communities for as long as possible.

The Making Every Contact Count programme supports the implementation of Healthy Ireland through health professionals using their routine consultations to:

- Empower and support people to make healthier choices to achieve positive health outcomes to support chronic disease prevention and management
- Enable health professionals to recognise their role and opportunities they have through their daily interactions with patients to support them to make and sustain health behaviour changes
- To do this, the health service needs to build a culture and operating environment that supports continuous health improvement through the contacts that it has with individuals.

See http://www.hse.ie/eng/about/Who/healthwellbeing/Making-Every-Contact-Count/About/

Self management support

Self management support is the provision of education and supportive interventions to increase the persons's knowledge, skills and confidence in managing their condition. The patient-health professional relationship changes from the traditional approach to a partnership where the patient is an active participant in their care.

See http://www.hse.ie/eng/health/hl/selfmanagement/

Age Friendly Ireland

The Irish Age Friendly Cities and Counties Programme, is Ireland's adaptation of the World Health Organisation's Age Friendly Cities and Communities model. Under the leadership of the local authority Chief Executives, in collaboration with Older Peoples' Councils the following structures are in place:

- **Age Friendly Alliance:** a high level cross-sector group, often chaired by the local authority Chief Executive
- **Age Friendly City and County Strategies:** address the priority issues identified by older people in the local area
- **Older People's Council:** Representative groups of older people, established by local authorities in response to the National Positive Ageing Strategy (2013), through which older people can raise issues of importance.

The Age Friendly City and County Programmes is an important resource in the development of a holistic Integrated Care Model for Older People at a local level. They can provide a key point of contact in developing specific elements of the model of care such as:

- Service User Engagement on local steering groups through contact with the Older Person's Councils
- The development of case studies to demonstrate good practice, and local challenges, through the recording of service user stories
- Mapping the 'as is' scenario at a local level of supports that enable older people to live well.
- The establishment of a local forum for the commencement of a health and wellbeing focus on service design and service delivery
- Service user involvement in Quality Improvement Initiatives identified through the work of the local Steering Group, and initiatives such as Your Service Your Say, Listening to Older People Workshops, the National Patient Experience Survey, and the Patient Narrative Project. (Please see section 7 for detail on these initiatives).

Examples - Nestling Project

Based in the north east, the nestling project is a collaborative initiative between Dundalk Town Council, the HSE in the Dublin North East area, and the Netwell Centre in DkIT, aimed at transforming communities, environments and technologies to support older people to age-in-place. The project is built around a 16 unit demonstration housing scheme for older people in Barrack Street, Dundalk, supported by a range of integrated frail elderly services organised within the context of the HSE's primary care team strategy. Designed with sustainability in mind, the homes are equipped with a range of assistive and monitoring technologies that can support greater independence and can keep the occupant better connected to family, friends and service providers, if they wish it. https://www.netwellcasala.org/great-northern-haven/

Other examples include;

Age friendly communities http://agefriendlyireland.ie/age-friendly-practice-skerries/

Age friendly resources; http://agefriendlyireland.ie/playing-your-part/

Age Friendly Cities and Counties Contacts Map

http://agefriendlyireland.ie/participating-cities-and- counties/

A good example of co-production in operation is the development of the Vantastic Health Route transport initiative for Older People in Fingal County Council. Older people identified the limited availability of state funded non-emergency medical transport as a barrier to attendance at hospital and other health related appointments. The combined efforts of the membership of the Age Friendly Alliance led to a door-to-door service for older people being developed. Today over 600 people are using the service. https://www.changemakers.com/discussions/entries/health-route

HSE and Genio Community Supports Model for People with Dementia https://www.genio.ie/system/files/publications/DEMENTIA_SERVICE_DESIGN_SUMMARY.pdf

An evaluation of personalised supports, conducted by Prof Suzanne Cahill and colleagues describes the interventions in more detail and also the outcomes obtained. These reports can be found at https://www.genio.ie/system/files/publications/Evaluation_Dementia_Support_Worker_Initiative.pdf and at https://www.genio.ie/our-impact/research-evidence/flexible-respite-options-dementia

http://www.genio.ie/system/files/publications/GENIO_DEMENTIA_AT_GUIDE_WEB.pdf.
An evaluation of the application of telecare and assistive technology in four sites in Ireland is at http://www.genio.ie/system/files/publications/GENIO_DEMENTIA_AT_EVALUATION.pdf and the learning is summarised for others to use in the main report and also a one-page https://www.genio.ie/system/files/publications/GENIO_DEMENTIA_AT_EVALUATION_SUMMARY.pdf

https://www.genio.ie/our-impact/research-evidence/dementia-risk
This paper includes the outputs from a workshop of five HSE & Genio projects and thus combines learning from Irish services with a consideration of the wider context around risk. The paper also describes the Personal Risk Profile – a practical framework to guide decision making and balance risk of harm with quality of life gain.

Deliverable from Step 8

✔ Co-produced Health & Wellbeing plan in place

9 Enablers

ACTION 9:

a. *Exploit existing and new technologies in hospitals and community services to enable clinical information sharing across settings, coordination of care and support of older persons to live well at home.*

b. *Work with local Information and Communication Technology (ICT) departments to identify tools that can be implemented*
   - *Single Assessment Tool (SAT)*
   - *Healthlink (e-referrals e-discharge etc.)*
   - *Link to Hospital Patient Administrative Systems (PAS)*
   - *Local innovations in Telehealth and assistive technologies*

c. *Have a local workforce plan that reflects the needs of older persons.*

Clinical Information Sharing

Integration of care is only possible through communication and sharing of patient information. This needs to be made available to many different professionals in different locations working within integrated care teams and can be assisted greatly by Information and Communication Technology (ICT) systems that enable:

- Better information sharing
- Better care coordination across settings
- Supported self-management at home.

There are a number of existing and new ICT systems currently in use in Ireland which can be exploited where available.

ICT Enablers

In advance of the long term roll out of a full electronic health record system (EHR) by e-health Ireland, the ICPOP will assist with the enablement of care coordination across settings through:

1. Supply of Tablet computers and Smartphones to staff directly involved in the coordination of older persons care, to enable better communication and electronic sharing of information across settings, including the enablement of Cloud based Information Sharing

2. Supply of the Single Assessment Tool (SAT) for assessments, care coordination and planning of care for older people
3. Working with the Health Innovation Hub and Office of the Chief Information Officer (OoCIO) to test innovations in technology, telehealth and assistive technologies at selected sites
4. Promoting use of Healthlink at local sites for secure transmission of clinical patient information, eReferrals, Discharge summaries etc.
5. Promoting remote access to hospital patient administration systems (PAS) at local sites where possible.

Single Assessment Tool (SAT)

The Single Assessment Tool (SAT) is a comprehensive electronic standardised assessment used to assess the health and social care needs of older people. The implementation of the SAT will allow for the development of Comprehensive Geriatric Assessment (CGA) at a systematic level (NCPOP 2016). SAT ensures that all relevant health and wellbeing information about an older person can be gathered from one assessment process, rather than through a battery of individual tests. SAT is currently being implemented nationally on a phased basis throughout 2017/2018, in the first instance to ensure that every person being assessed for the Nursing home support services (NHSS), and all older people applying for the Home Care Package scheme (HCPS), participate in a standard and thorough assessment, regardless of where they live or who is doing the assessment. It is envisaged that SAT will also be used by Integrated care teams for care co-ordination and development of individualised care plans that consider all of the person's needs.

Healthlink: Hospital / Community

Healthlink is a national service, currently used by 83 sites (July 2016), that provides a web-based messaging and e-referral service. This allows the secure transmission of clinical patient information between Hospitals, GPs, nursing homes, dental services, step up/ step down facilities and other health care agencies. It is envisaged that healthcare professionals working in integrated care will log onto remotely via **HealthlinkOnline** to view patient messages such as laboratory results, referrals, discharge summaries.

Hospital Systems - Patient Administration System (PAS)

A Patient Administration System (PAS) supports the day-to-day running of a hospital and stores patient demographic data, admissions, discharges, transfers, record keeping and billing information. All acute hospitals in Ireland have a PAS system, with over 50% using the product iPMS. iPMS is also used in community hospitals, community nursing units, mental health services, community ophthalmology, Genito Urinary Medicine clinics, community speech and language therapy clinics, fertility clinics, day hospitals and other community services such as podiatry. Integrated care teams should work with the local hospital ICT departments to enable remote access to hospital patient administration systems (PAS) where possible.

Primary Care Systems

Over 90% of the 1,300 general practices in Ireland are computerised, using General Practitioner Practice Management Systems (PMS). Integrated care teams can communicate securely with GPs and Pharmacies using **Healthmail**, a secure clinical email service that allows staff with HSE or Voluntary hospital email addresses to communicate securely with non HSE health care providers.

Telehealth

Technology enabled care (TEC) can help support people to live independently at home, and increase their ability to self-manage their own health and well being. Telehealth is simply the use of digital information and communication technologies, such as computers, sensors, wearable devices and mobile devices, for supported self management of health and well-being, while the patient is at one location and the health care provider is at a different location.

The Health Innovation Hub Ireland (HIH) supports TEC and Telehealth innovations in Ireland by facilitating and managing the trialing and evaluation of these products in clinical settings (primary care, hospitals, pharmacies and community health centres). The ICPOP is working closely with the health innovation hub and the HSE office of the chief information officer (OoCIO) to test innovations in technology, telehealth and assistive technologies at selected sites.

eHealth Ireland's Quality Innovation Corridor

The Quality Innovation Corridor is designed to open up innovation pathways through which clinicians can access seed funding for digital innovation. (www.ehealthireland.ie)

Telehealth - Examples

Louth - REmote **M**onitoring for **T**echnology **E**nhanced **C**are **(REMTEC)**
Louth Age-Friendly Alliance, in conjunction with CHO8, Dundalk Institute of Technology (NetwellCASALA), Louth County Council, Louth Economic forum and ALONE have embarked on a project to meet three objectives in the region namely:

1. The establishment of an e-Service to support the integration and effectiveness of health and social care services for frail older persons and chronic illness in the region
2. Empowering individuals to use REMTEC to help support greater self-management of chronic illness, improve clinical outcomes and to enhance their quality of life (QoL) and Subjective Well-Being (SWB)
3. Strengthening the capacity of economic partners and the business/enterprise sector to participate in the e-Services marketplace in the region.

ALONE – Technology Platform

ALONE has created a technology platform which adopts an innovative and proactive community based approach that could revolutionise independent living.

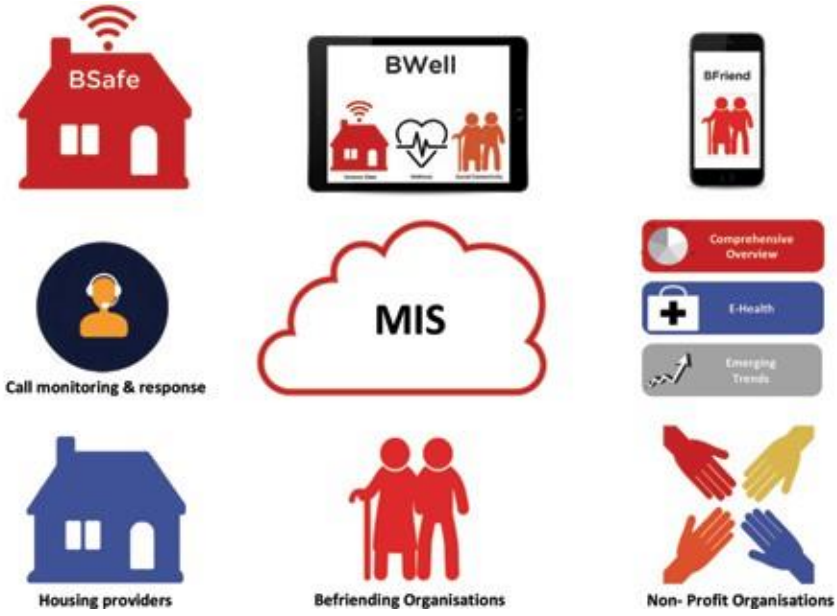
ALONE has adapted and customised their Management information System (MIS) to assist in the recording, management, analysing and reporting on their work with the older people they support. The ALONE MIS is a cloud based system assisting the delivery of a quality assured and effective service. It providers a 360º view of an older person, helping to prevent risks and to make more informed decisions. Our MIS is available to non-profit organisations, we are currently supporting 10 non-profit organisations on this part of our platform. We aim to offer this to another 15 organisations by the end of 2018.

With funding from Social Innovation Fund Ireland, a grant supported by Google.org and the Irish Government, we have developed an innovative technology platform with our MIS at the centre.

We have added three new components to our platform, which will be available for use by by individuals and their families, community groups, befriending organisations and housing providers.

These components are:

- **BSafe:** an individualised package of assistive technology and sensor devices in the person's home which focus on emergency response and proactive interventions.
- **BWell:** a smart device with a mobile application for the older person; focusing on the areas of social interaction, mental and emotional health and physical health. BWell information can be shared with family members and health professionals with the person's permission.
- **BFriend:** a mobile application for volunteers and staff members, allowing them to easily feedback concerns or good news about the person they visit.



Workforce 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. The goals outlined in the HSE People Strategy (2015-2018) are to:

a) Build capacity to redesign/reconfigure services and the workforce based on best practice, evidence based models of care and anticipated future needs

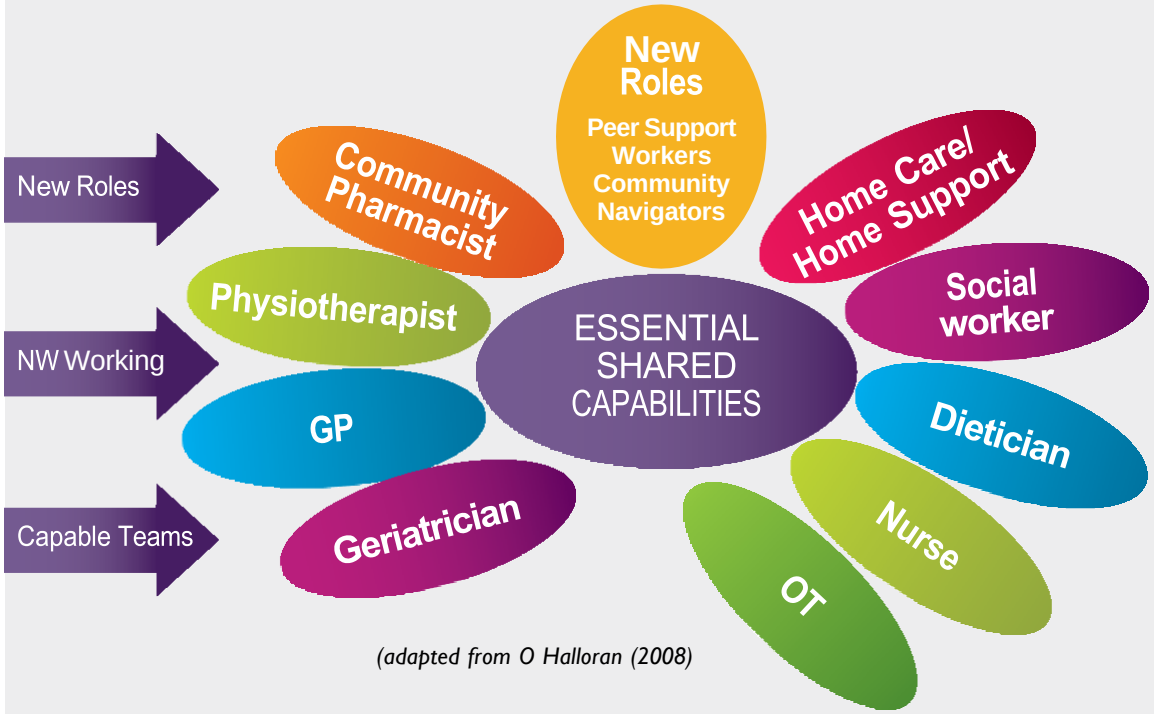
b) Support individuals and teams to adopt new ways of working and practice changes in line with evidence

c) Explore use of 'technology' to support an agile, flexible and mobile workforce.

Integrated Roles- potential developments

Current and emerging team roles will operate across the continuum of care supporting the integration framework for older people as indicated in the diagram below:

The Changing Workforce



(adapted from O Halloran (2008)

Workforce Competencies

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 recognise 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 age attuning of the workforce. Competency in interdisciplinary work and collaboration will be essential components in developing effective integrated care. Teamwork, leadership, effective communication, understanding of professional roles and responsibilities and promoting shared values are key elements of good interdisciplinary working. The Inter-professional Group of the NCPOP is preparing a framework of interdisciplinary competencies. 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 of their core client group (SCMH 2001). 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. Consideration needs to be given to:

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

Key workforce planning considerations for the ICPOP 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). The NCPOP has also developed a Frailty Education Programme for Older People in conjunction with the Irish Longitudinal Study in Ageing (TILDA) and sponsored by the Office of the Nursing & Midwifery Services Director (ONMSD) which is outlined in more detail in Chapter 5 of this document.

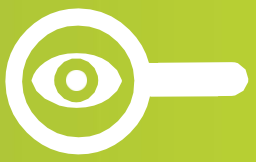
Upskilling the Workforce through the NCPOP Frailty Education Programme

Against this backdrop, The NCPOP has developed a Frailty Education Programme for Older People in conjunctionwiththe Irish Longitudinal Study in Ageing (TILDA) and sponsored by the Office of the Nursing & Midwifery Services Director (ONMSD). We are working jointly with the Integrated Care Programme for Older People, and collaborating with the National Clinical Programme for Acute Medicine (NAMP) and Emergency Medicine Programme (NEMP) on this key initiative to support early recognition of frailty, improved healthcare management and better health outcomes for older people living with frailty. The programme is currently in pilot phase, across three Hospital Groups and corresponding Community Healthcare Organisations (CHOs) areas. Initially, the aim is to develop a cohort of nurses working in Acute Medicine, Emergency Medicine, Older People's services and the community to provide healthcare professionals with an enhanced understanding of frailty and frailty assessments with integrated and interdisciplinary training education.

Deliverables from Step 9

- ✔ Single Assessment Tool (SAT) being used for assessments and care planning
- ✔ Healthlink/HealthlinkOnLine being used for secure transmission of clinical data (e-referrals, e-discharge, lab results etc.)
- ✔ Connections with Hospital PAS and other systems being made (where technically possible)
- ✔ Local innovations in technology, telehealth and assistive technologies being exploited through liaison with the Health Innovation Hub Ireland (HIHI) or the HSE OoCIO/QID programmes
- ✔ Local staff development and training plan in place.

10 Monitor and Evaluate



ACTION 10:

a. *Measure the scale of integration with ICPOP Structural measures (10 Steps framework)*

b. *Measure care process using ICPOP Clinical management indicators*

c. *Measure outcomes using ICPOP Patient recorded outcome and experience measures (PROMS & PREMS)*

d. *Measure clinical outcomes*

e. *Measure staff experience*

Measuring the impact of integrated care is a challenging task. At this stage is supporting the development of care pathways, integrated services and teams with the associated systems. This will in time develop capacity and competence, and lay the foundations for more detailed standards and expanded information systems for future measurement. The plan for monitoring and evaluation is designed to achieve the aim and objectives of the initial years of the ICPOP.

What is measurement?	What is evaluation?
✓ It is objective	✓ It is subjective
✓ Remains constant	✓ Evaluation is done on the basis of either comparison or assessment
✓ Accurate as standard variables are being compared	✓ Summarises and draws conclusions and makes recommendations
✓ Easier to implement as it is a scientific process of knowing the attributes of an object	✓ Measures can support an evaluation process

(AQuA 2014)

The challenge:

"It is often much worse to have a good measurement of the wrong thing - especially when, as is so often the case, the wrong thing will in fact be used as an indicator of the right thing - than to have poor measurement of the right thing."

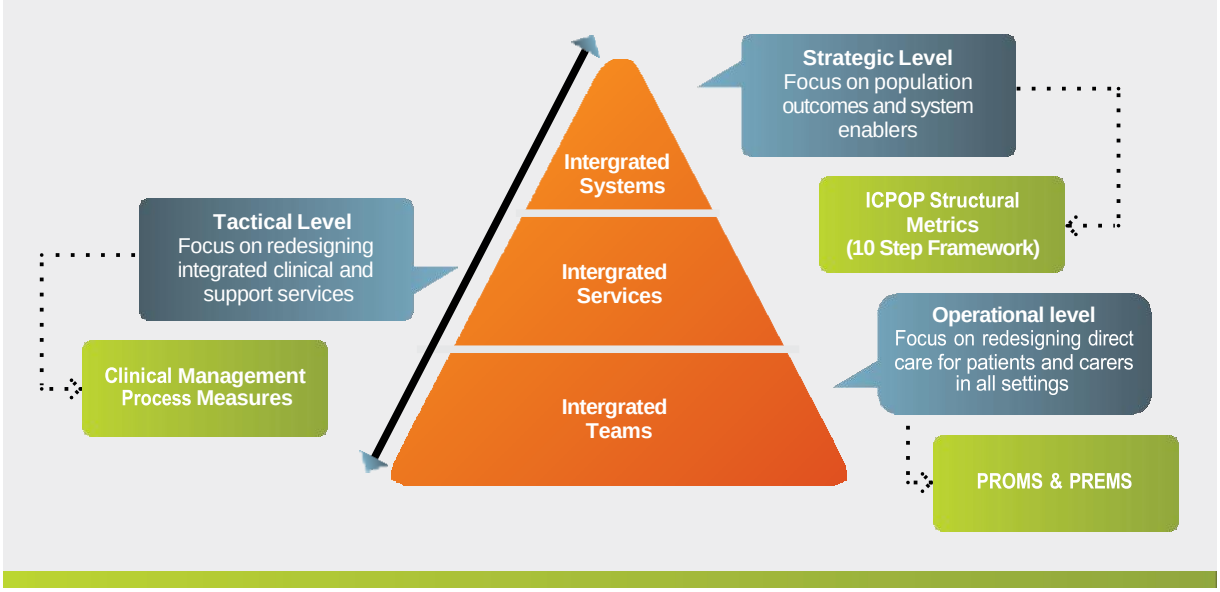
John Wilder Tukey, Statistician

When multiple health or care improvement activities are in place in one area, it is not always clear which parts improve outcomes and which do not. There is not always a straightforward link between improvements in reported outcomes and changes in the way services are being delivered. These links may exist, but they are not necessarily easy to find (Sherlaw-Johnson et al., 2016).

To attempt to measure any qualitative or quantitative outcomes for any health care programme it is essential that reliable baseline data exists from an existing data source or easily obtained from a new data source. If data collection is not part of the wider organisational performance monitoring processes it will be very hard to determine the baseline or demonstrate trends or variances.

Measures need to be developed across systems, services and teams. Health and social care economies must link strategic aims, goals and improvements across the programme as depicted in figure 1 below:

Measurement across Systems, Services and Teams.



(AQuA 2014)

What are the different types of measures?

Structural	Measures the organisation's capacity and the conditions in which care is provided by looking at factors such as an organisation's staff facilities, or health IT systems.
Process	Measures how services are provided, i.e., whether an activity proven to benefit patients was performed, such as writing a prescription or administering a drug.
Outcome	Measures the results of health care. This could include whether the patient's health improved or whether the patient was satisfied with the Services received.

(Goodwin 2016)

Using HIQA themes and standards for this type of service, priority standards have been identified for each of the 10 Steps within the framework, along with the associated structural or process indicators. (ICPOP 2016)

Levels of service activity (process measures) within integrated teams will be tracked each month; the data will be collated and fed into a wider dashboard for older persons which is currently under development. The dashboard will be populated data from information systems such as the HIPE-based National Quality Assurance Information System NQAIS, (which measures hospital activity for older persons), along with the process measures to provide a broad view of the integrated care process delivered locally. This information will be made available for all sites to view.

Structural measures will be recorded each quarter to identify progress against each of the 10 steps of the ICPOP framework. This information may be shared to disseminate good practice with other integrated care teams and will also help ICPOP and local sites identify those areas that may require additional focus. ICPOP recommends that measurement is a standing item on each local steering group agenda.

Examples of things we will measure

Structural

Governance structures and operational policies in place

Directory of services for older persons in place

Operational hubs in place

Older person's population plan completed.

Process

Referrals into the integrated care team from point of referral and source.

Older persons demographic

The interventions delivered to the older person on each case load

Discharge destinations

Clinical Outcomes

% of patients attending the emergency department aged 75 years and over

% of patients aged 75 years that were admitted into a hospital bed

Number of patients aged 75 years and over screened for frailty in the ED or AMU

Patient Outcomes

Number of patients invited for survey

Number of patients completed survey

% of patients satisfied or very satisfied with the service

Patient reported outcome measures (PROMs)

The evaluation of the integrated care programme will be informed by each of the measurement categories:

- *Structural,*
- *Process,*
- *Clinical outcomes,*
- *Patient outcomes.*

Patient reported outcome measures PROMs

PROMs are standardised validated instruments (question sets) to measure patients' perceptions of their health status (impairment), their functional status (disability), and their health-related quality of life (well-being). Quite often, patients' experience measures are used alongside PROMs to produce a more rounded picture of patients' views on both the process and the outcome of care. (Coulter et al., 2009):

- *ICPOP will be working with sites to develop a set of PROMs that can be applied to the care of older persons within an integrated care setting*
- *Patients and Carer Qualitative Surveys will be carried out to capture views of patients and carers on quality and safety of care*
- *Information will be gathered from the HSE national "Patient narrative project" which is recording patients experience of utilising healthcare resources in Ireland to inform future improvements*
- *Management and staff Qualitative Surveys will capture views of staff (acute, GPs and primary care, social care) on quality and safety of care.*

Outcome and economic evaluation

The descriptive analysis of developments, achievements and challenges in the pioneer sites will be an important component of the evaluation. An important output throughout the process will be the sharing of information between sites, and in time with services throughout the country. Given the increasing population of older people with complex care needs and the requirement to increase capacity and improve quality, the ICPOP is unlikely to result in a decrease in total costs for the population served. However improved efficiency through reduced duplication and better use of resources will improve the experience for patients, carers and staff.

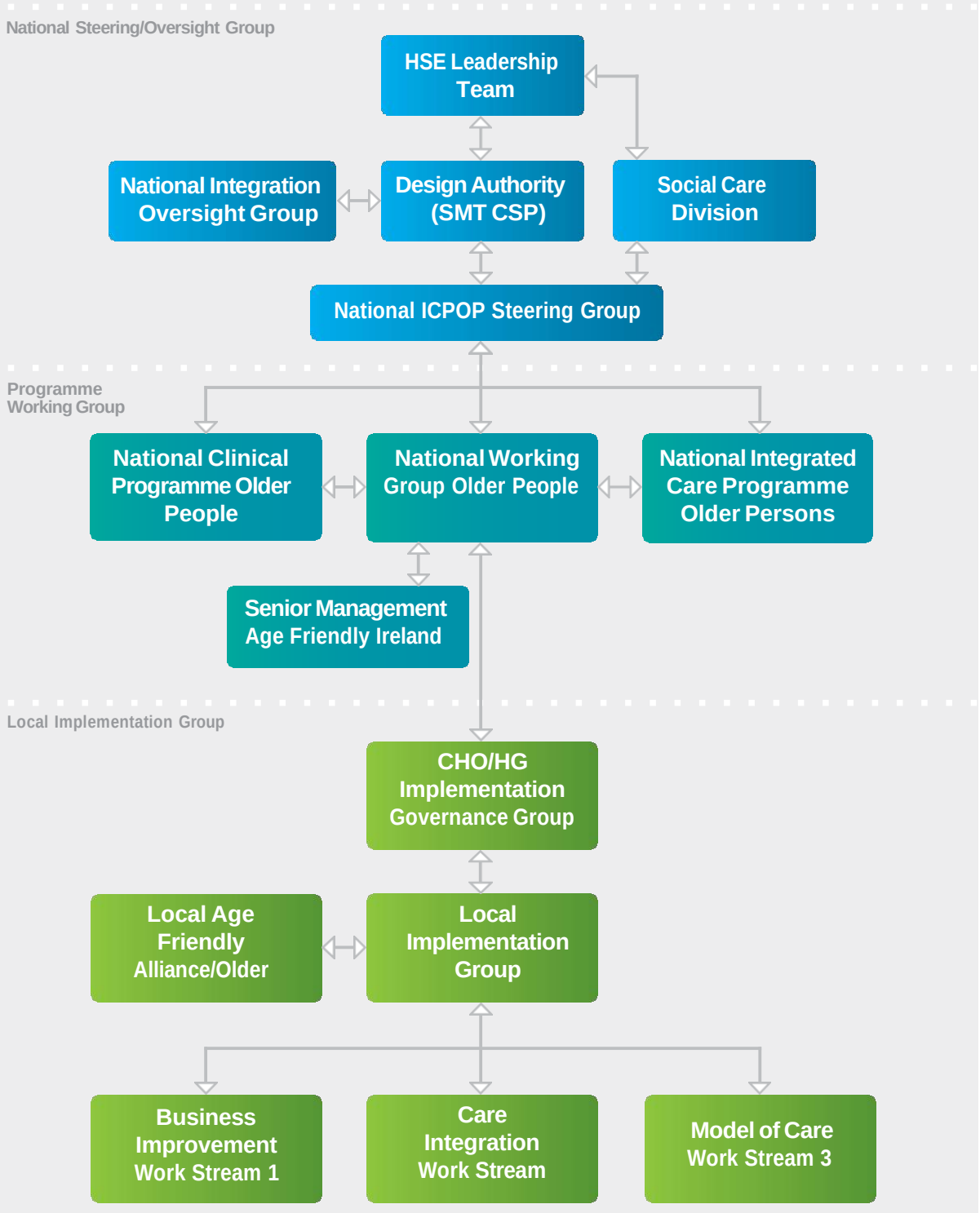
Deliverables from Step 10

- ✔ Structural measures quarterly report
- ✔ Process measures monthly report
- ✔ PROMS & PREMS twice yearly report
- ✔ Older Person Dashboard on steering group agenda
- ✔ NQAIS (OP) available to clinicians

Progress	CH0 XXXX	Month 6 Stocktake																	
Complete	Hospital Group XXXX	PHASE 1						PHASE 2					Pipeline 2018						
Underway		CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..	CHO..
Not started																			
Deliverable	**Step 1 Establish Governance Structures**																		
1	Steering Group Terms of reference	Complete	Complete	Complete	Complete	Complete	Complete	Underway	Not started	Complete									
2	Memorandum of understanding between service providers	Underway	Complete	Not started	Complete	Not started	Underway	Not started	Not started	Complete									
3	Steering group and implementation sub group(s) organogram(s) (with names and designation)	Underway	Complete	Complete	Complete	Underway	Underway	Underway	Underway	Underway									
4	Operational Policy in place	Underway	Complete	Complete	Underway	Complete	Underway	Not started	Underway	Underway									
	Step 2 Undertake Population Planning for Older Persons																		
5	Population plan report and map of community health networks	Underway	Underway	Underway	Underway	Not started	Underway	Not started	Not started	Complete									
	Step 3 Map Local Care Resources																		
6	Local Directory of Service	Underway	Underway	Underway	Underway	Underway	Not started	Not started	Not started	Complete									
	Step 4 Plan and Develop Services and Care Pathways																		
7	User Survey	Not started	Underway	Not started	Not started	Underway	Not started	Not started	Not started	Not started									
8	Care Pathway Mapping process underway (graphic)	Not started	Underway	Underway	Underway	Underway	Not started	Not started	Not started	Underway									
9	Quality and risk issues addressed through local QI processes	Not started	Complete	Complete	Complete	Not started	Not started	Not started	Not started	Underway									
	Step 5 Develop New Ways of Working																		
10	National Frailty Education Programme (NFEP) initiated	Not started	Underway	Underway	Not started	Underway	Underway	Underway	Underway	Underway									
11	NFEP governance structure in place	Not started	Complete	Underway	Not started	Complete	Underway	Underway	Complete	Complete									
12	Attendance at NFEP is multidisciplinary	Not started	Underway	Not started	Not started	Underway	Not started	Not started	Underway	Underway									
13	MDT Staffing List reflecting case management and assertive outreach/in-reach function	Not started	Complete	Underway	Complete	Underway	Not started	Not started	Not started	Underway									
	Step 6 Develop Mutli-disciplinary Teamwork and Create Clinical Network Hub																		
14	Operational Hub in situ	Underway	Complete	Complete	Complete	Underway	Underway	Underway	Not started	Underway									
	Step 7 Person Centred Planning and Delivery of Care																		
15	User questionnaire/survey and survey outcome report annually	Not started	Not started	Underway	Not started	Not started	Not started	Not started	Not started	Underway									
16	Name of user/carer on steering group	Not started	Not started	Underway	Underway	Complete	Not started	Not started	Not started	Underway									
17	Two quality initiatives using co-production per annum	Not started	Not started	Not started	Not started	Not started	Not started	Not started	Not started	Underway									
	Step 8 Supports to Live Well																		
18	Shared CHO H&W Lead plan in place	Not started	Not started	Not started	Underway	Underway	Not started	Not started	Not started	Underway									
	Step 9 Enablers																		
19	Staff development and training Plan	Not started	Not started	Underway	Not started	Not started	Not started	Not started	Not started	Underway									
20	IT hardware distributed and IT training delivered	Not started	Not started	Not started	Not started	Underway	Not started	Not started	Not started	Underway									
21	Healthmail in place and being used by the team	Not started	Underway	Underway	Underway	Not started	Not started	Not started	Not started	Not started									
22	SAT being used for care coordination	Not started	Not started	Not started	Underway	Not started	Not started	Not started	Not started	Not started									
	Step 10 Monitor and Evaluate																		
23	Structural measures quarterly report	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete									
24	Process measures monthly report	Underway	Complete	Complete	Complete	Complete	Not started	Not started	Underway	Underway									
25	PROMS & PREMS twice yearly report	Not started	Not started	Not started	Not started	Not started	Not started	Not started	Not started	Not started									
26	Older Person Dashboard on steering group agenda	Not started	Not started	Not started	Not started	Not started	Not started	Not started	Not started	Not started									
27	NQAIS (OP) available to clinicians	Not started	Not started	Not started	Not started	Not started	Not started	Not started	Not started	Complete									

Appendix 1

ICP Older Persons Governance Structure



Appendix 1a

Waterford Integrated Care for Older People (W.I.C.O.P.)

Steering Committee Terms of Reference

Document Version: 2

Authors

This document was prepared by:

Dr. John Cooke
Consultant Physician (Medicine for the Elderly)
Project Lead, Waterford Integrated Care for Older People (W.I.C.O.P.)
University Hospital Waterford

Version History

Date	Document Version	Document Revision History	Document Author/Reviser
April 4, 2017	1.0	Initial Draft	John Cooke
June 27, 2017	1.1	Revised Draft	Riona Mulcahy/George Pope

Approvals

Date	Document Version	Approver Name and Title	Approver Signature

Table of Contents

1. Background

Waterford Integrated Care for Older People (W.I.C.O.P.) is a pioneer project of the national Integrated Care Programme for Older People (ICP OP).

Integrated Care Programmes emphasise the importance of orientating health and social care services around specific complex patient groups. Older adults are particularly complex consumers of health and social care with responsibility for this care falling within the ambit of many different clinical professionals.

W.I.C.O.P. aims to provide a state of the art model of integrated care for older adults in Waterford.

2. Role of the W.I.C.O.P. Steering Committee

The role of the W.I.C.O.P. Steering Committee is to oversee the development of integrated specialist medical & social care services for older adults in Waterford. This role will include:

- To ensure the project remains focussed on providing patient-centred care for frail and complex older adults
- To ensure the project remains aligned with the 10-step framework approach to Integrated care described by the ICP-OP (Appendix 1)
- To oversee the operation of the working groups and to ensure their individual workstreams are not conflicting and remain aligned with the model of integration described by the National Clinical Programme for Older People (Appendix 2)
- To ensure the project makes the most of existing resources for older adults
- To agree the strategic progression of business cases to ensure that the “Hub” and “spokes” develop in parallel avoiding asymmetrical development of services
- To assess project progress and report to the project sponsors
- To agree key performance indicators (KPIs)
- To ensure that national education programmes relevant to the care of older adults are offered to key staff locally and to provide a governance structure for consequent service developments (e.g. National Frailty Education Programme 2017).

3. Responsibilities of the Steering Committee Chair

The Steering Committee Chairperson is Professor Ríona Mulcahy. Should the Chairperson be unable to attend a meeting, Dr. George Pope will serve as Committee Chair. Note that the Project Leads and Sponsors should not serve as Committee Chair in the absence of the above.

The responsibilities of the Steering Committee Chair are as follows:

- To set the agenda for each meeting
- To ensure that the agenda and supporting materials are delivered to members in advance of meetings
- To make the purpose of each meeting clear to members and explain the agenda at the beginning of each meeting
- To clarify and summarise what is happening throughout each meeting
- To keep the meeting moving by putting time limits on each agenda item and keeping all meetings to two hours or less
- To encourage broad participation from members in discussion by calling on different people
- To end each meeting with a summary of decisions and assignments
- To follow up with consistently absent members to determine if they wish to discontinue membership
- To find replacements for members who discontinue participation.

4. Responsibilities of Steering Committee Members

Individual Steering Committee members have the following responsibilities:

- To understand the goals, objectives, and desired outcomes of the project
- To maintain the frail older adult as the focus of all project developments
- To understand and represent the interests of project stakeholders
- To take a genuine interest in the project's outcomes and overall success
- To act on opportunities to communicate positively about the project
- To check that the project is making sensible financial decisions – especially in ensuring that services are developed symmetrically across the W.I.C.O.P. network
- To check that the project remains aligned with the organisational strategy described by the ICP-OP and NCP-OP. The project should also remain aligned with emerging national strategy documents
- To actively participate in meetings through attendance, discussion, and review of minutes, papers and other Steering Committee documents
- To support open discussion and debate, and encourage fellow Steering Committee members to voice their insights.

5. General

5.1 Overview of W.I.C.O.P. governance structures

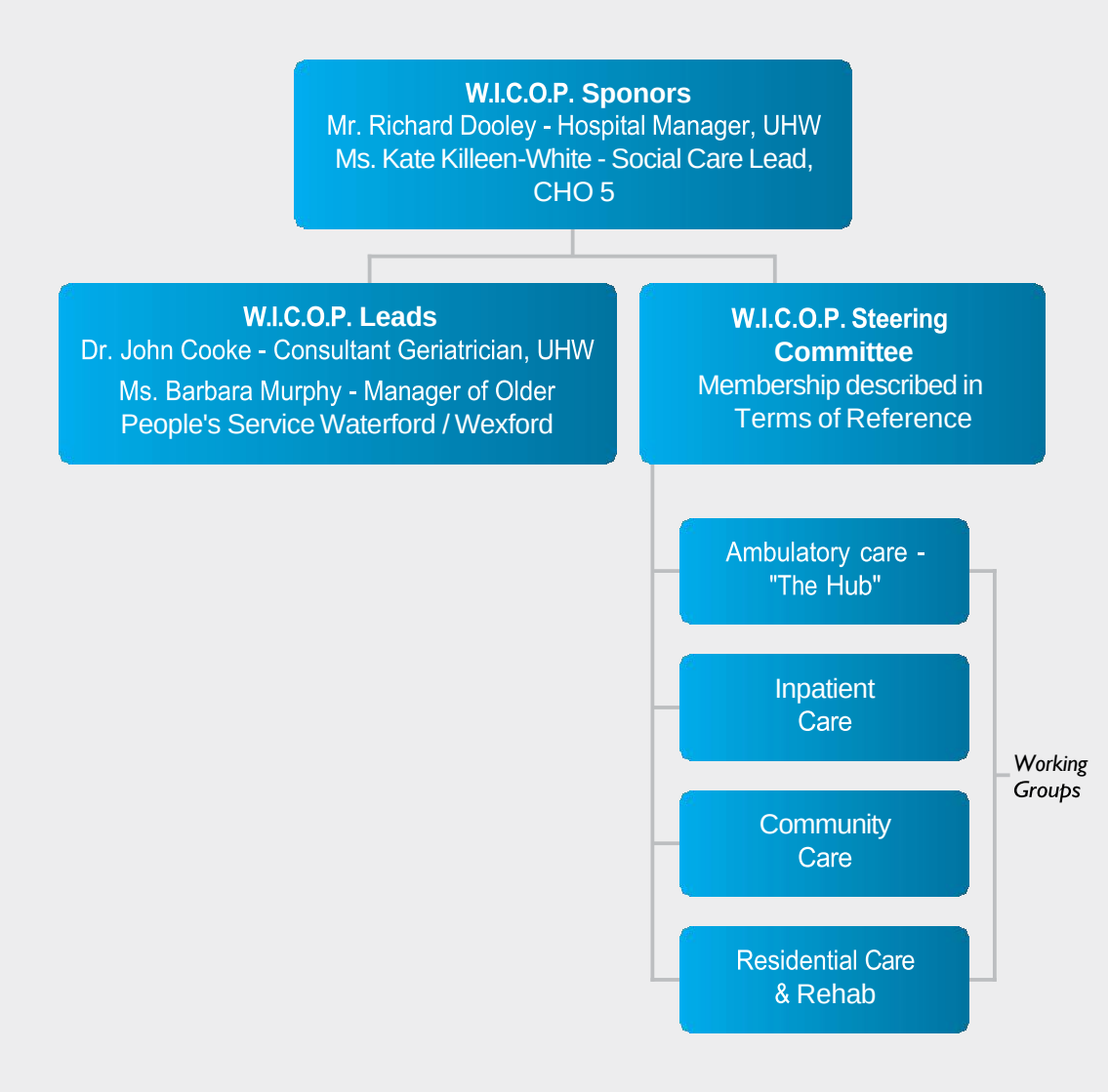


Figure 51: Overview of governance structures for the Waterford Integrated Care for Older People project including operational position of W.I.C.O.P. steering committee.

5.2 Membership

The table below lists the membership of the Steering Committee.

W.I.C.O.P. project leads (Dr. John Cooke & Ms. Barbara Murphy), W.IC.O.P. sponsors (Ms. Kate Killeen White, Mr. TJ Dunford & Mr. Richard Dooley) and the W.I.C.O.P. project support officer (Ms. Linda O'Kane) are not committee members but are invited to attend committee meetings.

Date	Title	Organisation
Prof. Ríona Mulcahy – **Chair**	Consultant Geriatrician	University Hospital Waterford
Dr. George Pope – **Co-Chair**	Consultant Geriatrician	University Hospital Waterford
Ms. Jennifer Hardiman	Service Improvement Manager	Integrated Care Programme – Older People
Ms. Eileen Long	Lead Physiotherapist (Hospital)	University Hospital Waterford
Ms. Sarah Neville	Lead Physiotherapist (Primary Care)	CHO 5
Ms. Joanne O'Leary	Lead Occupational Therapist (Hospital)	University Hospital Waterford
TBA	Lead Occupational Therapist (Primary Care)	CHO5
Ms. Siobhán Maher	Social Worker (Safeguarding Team)	CHO5
Mr. X	Chair of patient focus group	
Mr. Mark Doyle	Clinical Director (Medical) & ED Consultant	University Hospital Waterford
Ms. Jean O'Keeffe	Director of Public Health Nursing	CHO5
Ms. Claire Tully	Director of Nursing	University Hospital Waterford
Ms. Dorcas Collier	Community Intervention Team	CIT Nurse Manager
Dr. Michael Kirby	Consultant Psychiatrist	Psychiatry of Old Age
Dr. Tadhg DeBarra	General Practitioner	High Street Medical Centre, High st. Dungarvan
Dr. Robert Bourke Dr. Padraig Bambrick	Registrar , Medicine for the Elderly	University Hospital Waterford
Ms. Pauline Kehoe	Current title	
Ms. Millie O'Gorman	Assistant Director of Nursing	St. Pat's & DCH
Ms. Trish Curran	Nursing Homes Ireland Representative	Havenwood Retirement Village.
Mr. Declan Quinn	ICT Expert	University Hospital Waterford
Ms. Linda Ennis	Business Manager (Medical Directorate)	University Hospital Waterford
Ms. Gillian Cashman	Public Health Nurse Liaison	University Hospital Waterford
Ms. Maggie Bolger	CNS – WICOP	University Hospital Waterford

5.3 Quorum and Decision-making

5.3.1 Quorum

A quorum will be half the regular membership plus one. This number cannot include the project leads, sponsors or support officer. A quorum of Steering Committee members is required for decision-making purposes.

5.3.2 Decision-making Process

Decisions will require support from a majority (more than 50%) of Steering Committee members who attend the meeting provided there is quorum.

Out-of-session decisions may be made by Project leads & Working Groups. All such decisions must be reviewed at the next meeting of the Steering Committee.

5.4 Frequency of Meetings

The Steering Committee will meet quarterly for the first year. Thereafter, Steering Committee meetings should be timed to coincide with key milestones. This schedule will be agreed by the Committee at the close of the first year.

5.5 Agenda, Minutes, and Decision Papers

An email or postal package will be sent to members three to five working days in advance of a Steering Committee meeting. This will include the following:

- Agenda for upcoming meeting.
  - All agenda items must be forwarded to the Project Support Officer by close of business ten working days prior to the next scheduled meeting.
- Minutes of previous meeting.
  - These will be compiled by the Project Support Officer within five working days of each meeting and will be available on request thereafter.
- A progress report for the project.
  - The joint project leads will compile this.
- Decision papers.
- Any other documents/information to be considered at the meeting.

5.6 Proxies

Members of the Steering Committee can send proxies to meetings. Proxies are entitled to participate in discussion but are not allowed a role in decision-making.

Steering Committee members will inform the Chairperson as soon as possible if they intend to send a proxy to a meeting and no less than two working days before the scheduled meeting.

Appendix 2

National Steering Group Members List

Name	Division
Dr. Siobhán Kennelly (NCAGL)	Clinical Lead (ICPOP)
Michael Fitzgerald Asst. National Director	Executive Lead (Chair)
P.J. Harnett	Programme Manager (ICPOP)
Dr. Diarmuid O'Shea	Clinical Lead (NCPOP)
Mary Day	Hospital Group Representative
Angela Fitzgerald	Acute Hospitals Division
Dr. David Hanlon (NCAGL)	Primary Care Division
Rhona Gaynor	Department of Health
Siobhán Ní Bhriain	Psychiatry of Old Age
Martin Dunne	National Ambulance Service
Pat Bennett	Chief Officer CH08
Fergal Marrinan	Office of CIO
Dr. Breda Smyth	Health & Wellbeing Division
Prof. Valerie Walshe	Finance
Anne Harris	Quality Improvement Division
Mary Manning	National Dementia Office
Mary Wynne	ONMSD
Helen Whitty	Programme Manager (NCPOP)
Aileen Killeen	System Reform Group
Mairead Gleeson	Health & Wellbeing Division
Eileen Moriarty	Falls & Fracture Prevention HSE Services for Older Persons
Philippa Ryan Withero	Office of the National Director of Human Resources

updated 17.10.17

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Notes

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Seirbhís Sláinte
Níos Fearr
á Forbairt