HSCP Deliver

A Strategic Guidance Framework for Health & Social Care Professions 2021-2026

Health & Social Care Professions

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

A WORD ON TERMINOLOGY

A number of terms are used to describe people when they access health services. These include patient, client, service user. It is acknowledged that different words tend to be used in different healthcare settings and that there are various views and preferences around each of these words. For simplicity, the term service user is used throughout the body of this document.

ACKNOWLEDGEMENTS

A very large number of people contributed to the co-creation of HSCP Deliver. Huge thanks are due to each and every person who engaged and contributed to the co-creation process whether through face-to-face or online workshops, facilitating at workshops, providing examples or giving feedback.

Special thanks are due to Libby Kinneen, Organisation Development Consultant, Dr Pete Thomond and team, Clever Together and Dr. Sinéad Hanafin, Research Matters.

A big thank you to the National HSCP Office team for their hard work and commitment throughout.

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MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

Health and Social Care Professions are a large and diverse group of 26 clinical professions within our workforce encompassing diagnostic, therapeutic and social domains. They make up 25% of our clinical staff, working across all services and at all stages on the continuum of care. I am very pleased to welcome and support this first overarching *Strategic Guidance Framework for Health and Social Care Professions 2021-2026* which articulates the impact of the full collective potential of this group of professions. The diversity of HSCPs is a key resource for the health services as we reshape care, continuing to address the challenges of COVID-19 and bringing care closer to home in line with the principles of Sláintecare.

This past year has seen unprecedented challenges and an accelerated pace of change where transformation that would previously have taken years has been achieved in days and weeks. We have seen innovation across the system, with notable flexibility from HSCP staff to support changes to service delivery and the implementation of new models, including adapting their services to support virtual and socially distanced care, redeploying to assist new swabbing and contact tracing services, and providing psychosocial supports to patients and staff. I have been inspired by the work and commitment I have seen from staff across all aspects of our services.

The examples included in this document demonstrate HSCP commitment to person-centred integrated care, to working to the top of their license as well as across boundaries to provide the right care at the right time and place. Also evident, is HSCP leadership in innovation and best practice, delivering quality improvements and cost savings including the adoption and integration of digital health. All of this is vital to the work we need to do collectively as a health service in the development of and transition to new models of care across a breadth of areas from diagnostics to services for chronic disease, older people, disability, children and mental health.

This framework sets out core impacts that will be achieved when HSCP work to their collective potential. The commitments HSCP make to deliver these impacts are clear as are the supports that are required. It is essential that we harness this potential by ensuring we engage with HSCP and support the implementation of this Strategic Framework.

I would like to conclude by expressing my sincere thanks and gratitude to the whole HSCP workforce for your response to COVID-19, your strong focus on service users and patients and your overwhelming commitment to deliver safe and highest quality services throughout.

Paul Reid
Chief Executive Officer
Health Service Executive

MESSAGE FROM THE CHIEF CLINICAL OFFICER

I am very pleased to welcome *A Strategic Guidance Framework for Health and Social Care Professions 2021-2026*. HSCPs make up 25% of the clinical workforce and comprise 26 different professions covering diagnosis, therapy and social care domains coming together collectively as one Group.

This framework has been created through widespread engagement of stakeholders, and inclusion of services users and patients from the outset, enriched and shaped the conversations and discussions at the face to face workshops.

This first overarching HSCP strategic framework will support the overall CCO clinical objectives and sets out to support frontline clinical services. We know that planning for health services cannot succeed unless we listen to and harness those who deliver care and so it is essential that HSCPs are involved in planning for health services. HSCPs work across all parts of the health services in acute, community, primary care, disability, older persons, and mental health settings and across the lifespan. Harnessing this resource is crucial to deliver on Sláintecare, the required shift left, care closer to home and new models of care. HSCPs are an essential part of leading and delivering the transformation needed. HSCPs are at the forefront of delivering care in an integrated and seamless way working across boundaries in line with the vision of Sláintecare

HSCPs are autonomous practitioners and can provide very specialist treatment. It is essential that we utilise all of their clinical resource, and promote and develop senior clinical decision making in these professions in line with Sláintecare recommendations.

This framework includes rich examples of the impact of the work that HSCPs have delivered and recognises the support required to enable HSCPs deliver on their full potential.

To implement this framework the National HSCP Office will lead a programme of work, and cannot do it all in isolation. It is important that the implementation involves leadership nationally and operationally as well as input from HSCP across the system. As Chief Clinical Officer, my aim is to support the implementation of this Strategic Guidance Framework.

I would like to extend my sincere thanks to the service users, and patients who contributed and engaged in the workshops. To all the HSCP and stakeholders who engaged, contributed, and facilitated workshops, and gave feedback to bring the final document to a conclusion. My particular thanks and acknowledgement to the National HSCP Lead and National HSCP Office team who led, designed, planned and organised all aspects involved in bringing this work to a final conclusion.

Finally, I would like to give a special thanks to the entire HSCP workforce for your hard work, dedication, and commitment always and for your contribution to vital COVID-19 work as well as continuing to deliver care for our patients and clients during the COVID-19 pandemic.

Dr Colm Henry
Chief Clinical Officer
Health Service Executive

FOREWORD

As National Lead I have the privilege to work with and get to know so many people across the breadth of the Health and Social Care Professions (HSCP), including those who represent, educate, regulate and manage them. I experience it as a thoroughly humbling, challenging and very rewarding role. The diversity, richness, breadth and constant expansion of their fields and roles is a testament to the professionalism of each and every discipline. However, what struck me from the outset is the fact that, despite and in fact possibly because of the huge diversity, there is more that unites the HSCP than divides. Chief among those uniting elements is the absolute passion and drive to be able to deliver of their best, problem solve, innovate, work to the top of their potential and to be seen, be visible, be recognised and allowed to provide the best possible service for the client groups they serve. *Our strength is in our unity, sharing excellent examples of HSCP work and realising the huge untapped potential.*

We are now learning to live and work in the context of the COVID-19 pandemic. The pandemic has and is having huge impacts across all aspects of our society and economy and poses significant additional challenges for delivery of health and social care services. We were already living in a time with growing demand for healthcare, demographic pressures, recruitment and retention challenges, global health workforce challenges together with the challenges of affordability, sustainability and equity.

For the first time in Ireland, we have a cross party agreed national strategy setting out how health care should be delivered called Sláintecare. We also have a range of policy documents, strategies and models of care. We know that interdisciplinary working is critical to delivery of the integrated care we aspire to and service users require. Collaborative practice within and across all disciplines, staff, services and organisations is essential.

Ireland faces many challenges in terms of delivering the type, quality and timely healthcare its population requires and deserves. It is stated policy in Sláintecare to 'shift left' to focus on prevention, wellness and delivering care at the lowest level of complexity required. The impact of COVID-19 has brought this into sharper focus and requires an accelerated pace of change. HSCP are extremely well placed to make very significant contributions to achieving these goals. They are a key and essential ingredient in bringing care closer to home. They can provide solutions to increase patient access to the right care, to improve their journey through the health system and they can free up colleagues to do the vital work only they can do. During COVID-19, HSCP have demonstrated adaptability, flexibility and innovation to quickly address demands in relation to key areas such as testing, remote monitoring and adoption of virtual solutions to deliver services.

One of the clinical leadership priorities of the HSE is to support and strengthen capacity within HSCP through strategic leadership, engagement and development of a strategic guidance framework to enable their full potential to deliver improved outcomes for service users. The development of this HSCP Strategic Guidance Framework is a key element in delivering on this priority, led by the National HSCP Office, reporting to the Chief Clinical Officer.

I took the decision at the outset of this process that this should be a *co-created* document, informed by and reflective of the collective wisdom of stakeholders, combined with a distillation of national strategy, international best practice and senior leadership views. Service users have been involved from the outset and the positive impact and energy created by their involvement in the face-to-face workshops was clear.

This large scale co-creation was enabled through a series of facilitated face-to-face workshops combined with a national online workshop. The online workshop was open 24/7 over two phases enabling anonymous engagement, sharing of ideas and discussion regardless of work pattern or location.

As National Lead I am deeply grateful to all those who engaged thoughout this process, sharing ideas and contributing to the discussion, and I sincerely thank each and every one of you. I would particularly like to thank the service users who gave so generously of their time to engage with us. The insights generated from the face-to-face and online workshops created a shared view of the key impacts that will be achieved through realisation of the full collective potential of the HSCP workforce, a collective voice about the commitments HSCP want to make to deliver these impacts and the supports/actions needed to enable them.

I am delighted to launch and champion this framework that has been directly informed by over 16,300 contributions from a range of stakeholders, including; HSCP, service users and managers. It reflects their collective voice and ambitions for each other and the services they provide. This document sets out the actions that the National HSCP Office will lead for which I will be accountable. It also sets out what HSCP individually and collectively need to focus on and importantly the actions and supports HSCP need at national and organisational level.

I urge HSCP collectively to use it as an active framework locally, to engage with leaders in their services and to support new thinking and transformation. It is deliberately designed so that services can make their own of this document. This will enable HSCP to focus their energies on what is in their control rather than other aspects that may not be.

This strategic guidance framework is designed to help policy makers, commissioners, leaders and managers better understand and, most importantly, support the transformative potential of HSCP, leading to better outcomes and satisfaction for service users and HSCP. It can support and energise HSCP themselves to come together to think, work and collaborate in new and different ways.

Jackie Reed
National Lead HSCP

EXECUTIVE SUMMARY

Background/Context

Health and Social Care Professions (HSCP) are the second largest clinical group in the Irish health service comprising 25% of the clinical workforce and 14% of the overall health service workforce. There are currently 26 Health and Social Care Professions spanning therapeutic, social care and diagnostic domains. HSCP work in all settings including acute, community, disability, specialist, mental health, older people, primary care and residential services.

Two earlier HSCP Strategies developed in 2009 and 2016 by the HSE's HSCP Education and Development Unit have been implemented. In 2017, the HSE established the National HSCP Office to strategically lead and support HSCP to maximise their potential and achieve greatest impact for the design, planning, management and delivery of people-centred, integrated care. This Office builds and expands on the original HSCP Education and Development Unit (2006-2016) and is a standalone function reporting to the Chief Clinical Officer.

Purpose of the HSCP Strategic Guidance Framework 2021-2026

Coming together as a HSCP group has led to the development of structures which make the HSCP role and impact more visible in the Irish health services. In recent years, there is increasing understanding of the diversity and breadth of the HSCP workforce and the key roles they play in delivering for service users. Realising the full impact of these roles is critical in order to deliver on the Houses of the Oireachtas Committee on the Future of Healthcare, Sláintecare Report and it is in this context that *HSCP Deliver* has been developed at this time.

HSCP Deliver was developed to:

- articulate the full collective potential of the family of 26 Health and Social Care Professions and its **impact** on our health services and most importantly, the population they serve
- describe the **commitments** that HSCP collectively make to delivering on that potential
- identify the **supports and actions** required from colleagues and other specific relevant stakeholders to realise this potential

Co-creation process

Building on the learning and experience of successful implementation of two previous HSCP Education and Development Strategies, this strategic guidance framework has been designed for action to enable HSCP, managers, leaders and policy makers to apply it in their own context, implementing in a way that supports local action on local priorities.

Key elements of the process used include:

- A co-created approach, including service users, HSCP and wider stakeholders from the outset (page 13).
- An extensive engagement and insight generation process involving both face-to-face workshops and a 24/7 online platform accessible from any location or device, representing the first such co-created online engagement workshop implemented in the HSE.
- More than 16,300 contributions, triangulated with national policy and publications as well as senior leadership engagement and involvement to inform the framework.
- Distillation of the 16,300 contributions to reflect the collective wisdom of stakeholders and represent the collective voice.

The Framework

Impacts, Commitments, Supports and Actions

HSCP Deliver is a distillation and summary of feedback from the engagement process which included more than 16,300 contributions, triangulated with national policy and publications as well as senior leadership engagement and involvement.

This high level framework diagram summarises the Impacts, Commitments, Supports and Actions needed to realise the full collective potential of the family of 26 Health and Social Care Professions. Case studies of HSCP best practice and innovation have been included throughout to illustrate HSCP Impact and Commitments. Case studies can be accessed on page 35.

Implementation of the strategic framework

The National HSCP Lead and National HSCP Office provide national leadership for HSCP in the HSE and, in line with its core purpose, will provide strategic leadership and support to the implementation of the strategic framework. Successful implementation will require support from senior leadership across the system, frontline HSCP, HSCP managers and professional and representative bodies.

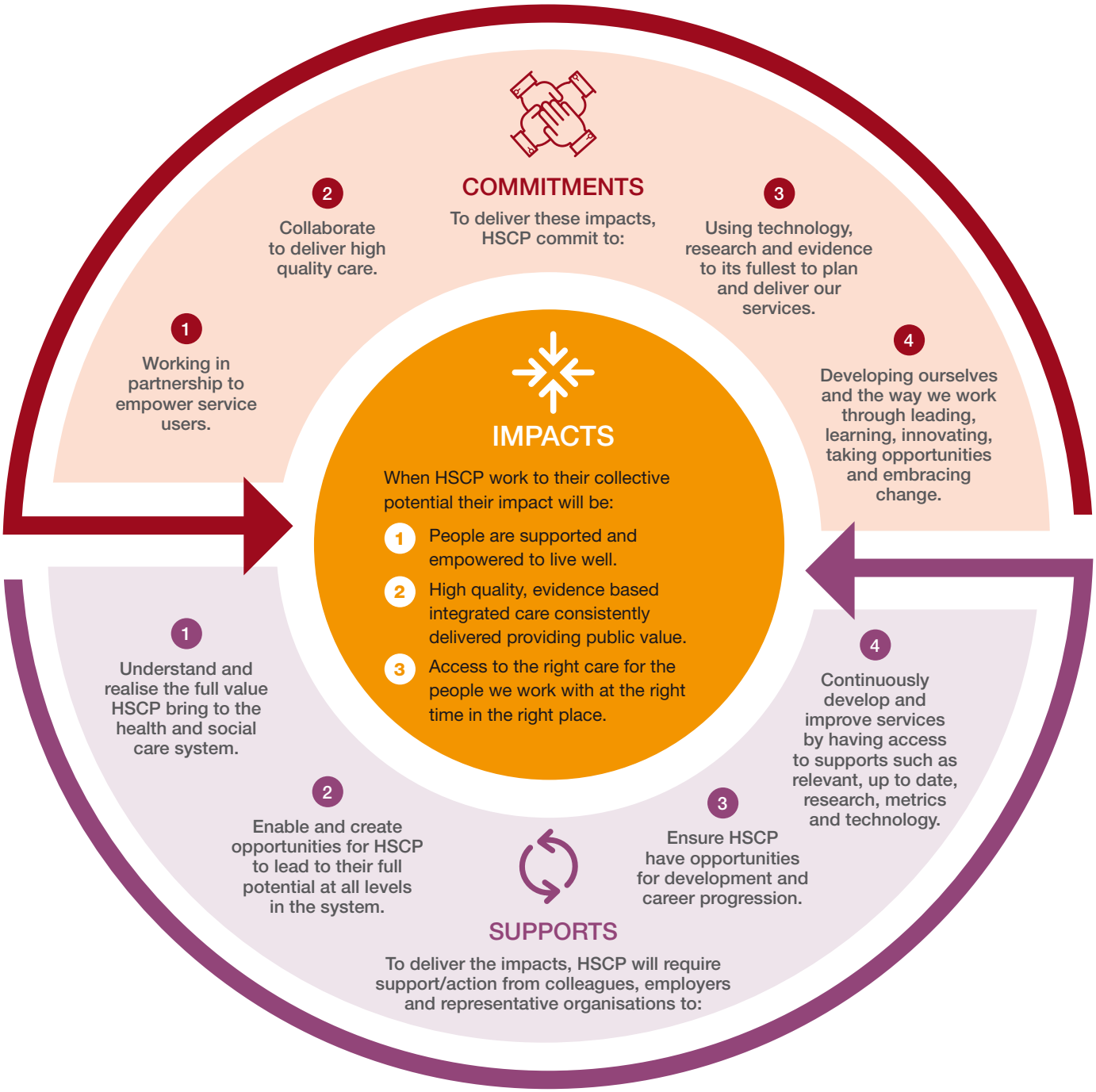
The approach to implementation has been defined in terms of:

- What the National HSCP Office will do – our commitments (page 32)
- What we need from national level leadership (page 33)
- What we need from organisation level leadership (page 34)
- What we need HSCP to do (page 34)

Overview of the Strategic Guidance Framework for Health and Social Care Professions 2021-2026

HSCP DELIVER

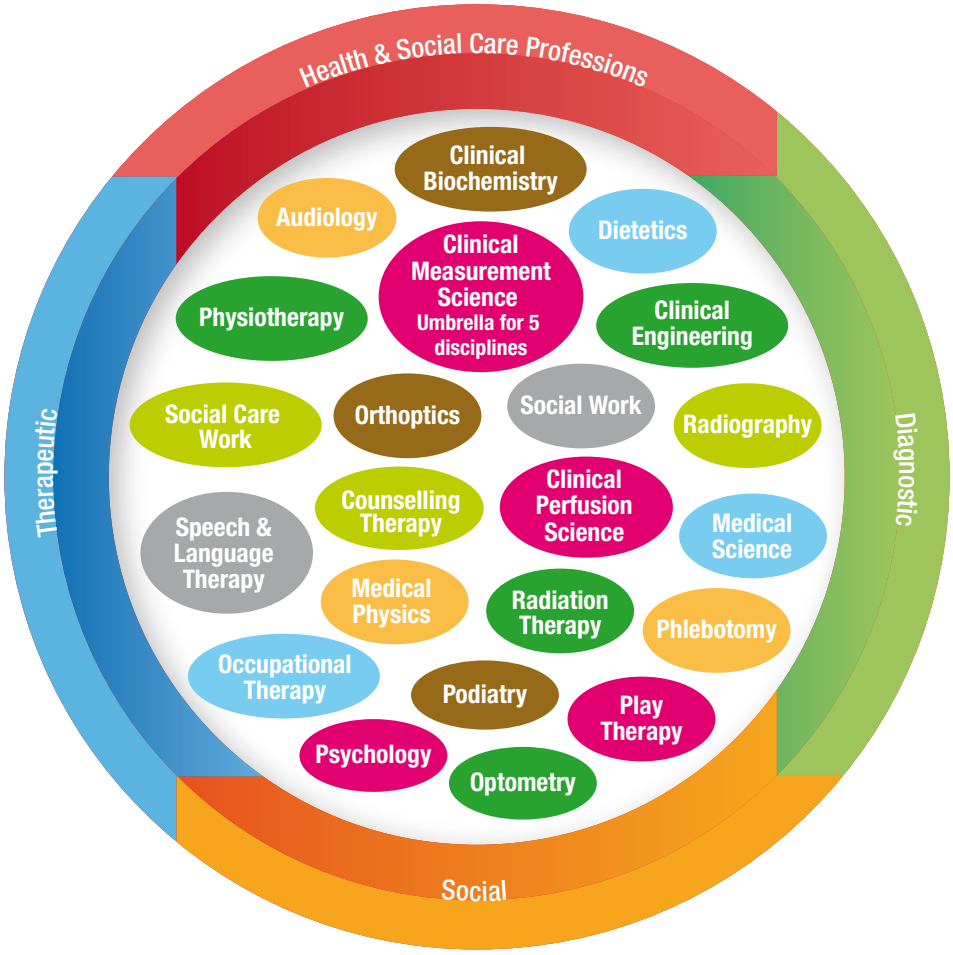
Co-created to articulate the **impact** of the full collective potential of the 26 HSCP on our health services and the population they serve. It also describes the **commitments** that HSCP collectively make to delivering on that potential and the **supports and actions** required from colleagues and other specific relevant stakeholders to realise this potential.



(Distilled from insights generated through over 16,300 contributions from HSCP across all service areas and education, service users, health care staff, managers and representative bodies resulting in a 'collective voice')

INTRODUCTION AND CONTEXT

Health and Social Care Professions (HSCP) are the second largest clinical group in the Irish health service comprising 25% of the clinical workforce and 14% of the overall health service workforce. There are currently 26 Health and Social Care Professions, spanning therapeutic, social care and diagnostic domains. HSCP work in all settings including acute, community, disability, specialist, mental health, older people, primary care and residential services. HSCP are highly qualified and skilled and play a significant role in the health, wellbeing and quality of life of the population. (For more information about the individual professions please see *A Guide to the Health and Social Care Professions* 2019[1]).



There is increasing understanding of the growing diversity and breadth of the HSCP workforce and the key roles they play in delivering for patients and service users. However, for a variety of historical and system reasons, the full potential of this workforce, and therefore their transformative value to be a significant part of delivering the outcomes desired by users of the service and envisaged in Sláintecare, is not fully realised. Coming together as a group makes it easier to include HSCP and there are structures to support that input which make it visible. A theme from the outset of engagement on development of the framework related to the strength in coming together and the benefits of working together as a group of professions while acknowledging the uniqueness of each profession. There is a strength in working together. HSCP are stronger together as a group, stronger working in partnership with service users and stronger working collaboratively with colleagues. At the end of the first large scale event to start the co-creation process, a service user made one request '**whatever you do, please do it together**'.

This all informs the reasons for a HSCP Strategic Guidance Framework at this point in time.

Reasons for a HSCP Strategic Guidance Framework now:

- Maximise the impact of HSCP for the benefit of service users and reflect service user input.
- Address the visibility issue – help ensure HSCP are at the decision-making table from the start so their expertise shapes the design and delivery of care.
- Present a strong collective vision and direction.
- Help policy and decision makers understand the resource and potential of HSCP.
- Strengthen leadership and focus in HSCP.
- Provide a framework that can be used by HSCP to shape their work and services in any setting.
- To energise and help to create a renewed sense of purpose.
- A reference to assist HSCP development in collaboration with colleagues.

Two HSCP Strategies[2,3] which focused on education and development – 2009-2014 and 2016-2019 have been implemented. In 2017 the National HSCP Office was launched and the scope of its role broadened. In 2018 the National HSCP Office moved to report to the Chief Clinical Officer. This Strategic Guidance Framework was developed in the context of this new clinically focused function. This HSCP Strategic Guidance Framework is much broader in scope than previous HSCP strategies, it is about emboldening and empowering 26 professions; it must help HSCP to achieve their greatest possible impact in the design, planning, management and delivery of person centred integrated care.

The national context in which this new HSCP Strategic Guidance Framework was developed is the Houses of the Oireachtas Committee on the Future of Healthcare, Sláintecare Report[4]. This is a national, cross party, ten year agreed approach to healthcare in Ireland. It is about a transformation of our health services and at its core is the fundamental goal of improving patient experience. The quadruple aim of Sláintecare is to:

1. Improve patient/service user experience
2. Improve clinician experience
3. Lower costs
4. Achieve better outcomes

Sláintecare objectives, as described by the Executive Director of the Sláintecare Implementation Office, are to:

- Promote the health of our population to prevent illness.
- Bring the majority of care into the community.
- Create an integrated system of care with healthcare professionals working closely together.
- Create a system where care is provided on the basis of need, not ability to pay.
- Move our system from long waiting times to a timely service.
- Drive accountability and performance in the health service.
- Deliver a health service that has the capacity and ability to plan for, and manage, changing needs.

One of the goals of this Strategic Guidance Framework is to try to describe what Sláintecare means to us as HSCP and make explicit the commitments HSCP can make to supporting its delivery. The principles of Sláintecare were reflected in all aspects of the approach taken to the development of this strategic framework.

ABOUT THIS FRAMEWORK

Building on the learning and experience of successful implementation of our two previous HSCP Education and Development Strategies, this document has been designed as a strategic guidance framework for action, something that HSCP, managers, leaders and policy makers can use and apply in their own context. The intention is that it will be implementable in a way that supports local action on local priorities, something that cannot realistically be centrally mandated across the breadth of professions, service areas and organisations involved using the usual strategic framework format and formula. As a result, this document quite deliberately does not set out to list a set of prescribed goals and actions. Having seen local adaptation and implementation of the HSCP Education and Development Strategy 2016-2019[3], the intention here is to encourage and facilitate even more organisation, service and team level ownership and implementation, within an overall guidance framework.

*This Strategic Guidance Framework for HSCP was co-created as a way of articulating the **impact** of the full collective potential of the family of 26 Health and Social Care Professions on our health services and most importantly the population they serve. It also sets out to describe the **commitments** that HSCP collectively make to delivering on that potential and the **supports and actions** required from colleagues and other specific relevant stakeholders to realise this potential*.

There is much diversity within the HSCP group of professions, both in terms of their roles, training and focus and the services in which they work. This diversity is both an opportunity and a challenge. Our online workshop provided an opportunity for any HSCP to anonymously contribute to the co-creation of the framework. Proportionate representation was used at the face-to-face events. These methods were designed to ensure a mix and diversity of professions, grades, services and locations.

It is not intended to speak to the detail of each profession in this document, that would in effect require the creation of a strategy for each discipline. Rather, the purpose of this framework is more challenging: it is about bringing the professions together to build synergies, find a collective voice and make a stronger, more cohesive, impactful statement of intent and contribution. As a result not every element is applicable or equally applicable to each of the HSCP professions.

A number of guiding **principles** underpinned the development of this process and are set out here:

- The development of the framework was based on the fundamental organisation development principle that 'people support what they help to create.'
- Service users were included and invited to be partners and were a very important part of the development.
- The process to create the strategic guidance was inclusive and modelled desired behaviours and approach.
- The end product is not prescriptive and top down, but reflective of front line and service user input.
- It is set in current and future strategic context and applicable as far as possible, in part or whole, for all HSCP and settings.
- The framework is accessible, real, meaningful and useful.
- Most importantly the framework is structured to enable HSCP to take ownership and apply in their own settings and have a life after the consultation and creation phase.
- The framework is designed with a focus on the future.

All of this is congruent with People's Needs Defining Change – Health Services Change Guide[5], see appendix 3.

THE PROCESS

The process used to develop this framework is set out below:

Review

- Previous HSCP strategy implementation.
- Literature/policy review.
- International developments and experience.

Period of co-creation

- Initial soundings about preferred methods for engagement – mixture of face-to-face and online.
- Engagement methods co designed.
- 'Confirm and challenge' workshop with 100 stakeholders (including service users, HSCP disciplines, managers from a range of service types and geographical locations, trade unions, professional and representative bodies) to agree process and approach.
- Service user input from the start and proportionate representation of professions.
- Specific invitations to all top level strategic, operational and clinical leadership and specific workshops and conversations with senior health service leaders and representative bodies.
- Comprehensive and widespread process of communication and engagement with all 26 HSCP professions.
- Face-to-face and online workshops using a crowd sourcing platform. The same questions were used at all workshops and online.
- Face-to-face sessions designed to promote engagement, interaction and discussion.
- Online workshop continuously open and accessible at any time from any location, on any device. The online platform was an interactive forum allowing participants to engage as little or as much as they wanted on one or multiple occasions – reading, liking or disliking items, commenting or adding new ideas.
- All of the material from the face-to-face workshops was recorded and entered on the online platform to create one large body of contributions.

Analysis

- All contributions, read, coded and analysed.
- Input from external expertise to validate analysis and provide counsel.
- Insights from the analysis triangulated with policy/national publications and leadership views.
- High level framework generated.
- Second online workshop to test distillation of ideas and refine framework.

Completion

- Strategy document drafted based on the analysis and high level framework.
- Document proofed with stakeholders.
- Review and sign off through Office of the Chief Clinical Officer and usual organisational processes.

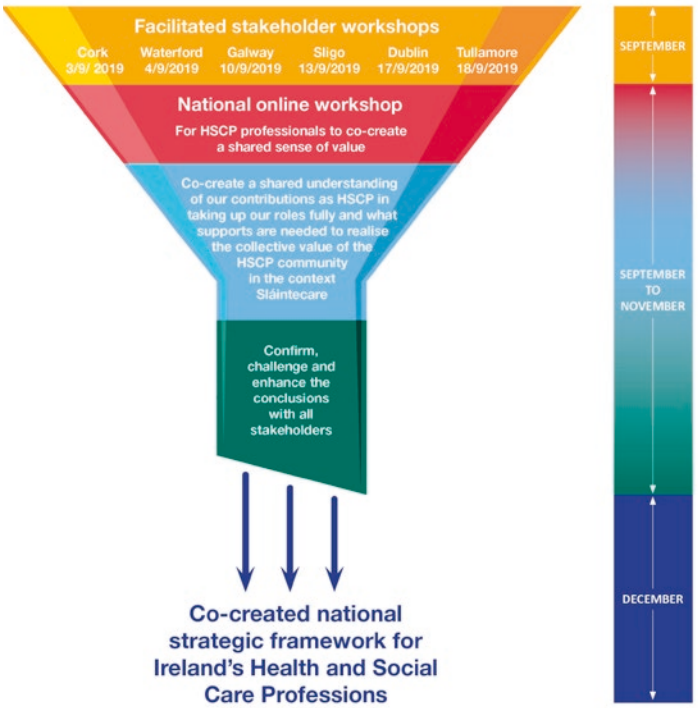
Questions posed set out to provide insight to address the following areas:

- what unites HSCP in terms of work and common ground;
- our shared values and purpose;
- what we can and are going to do to play our part in delivering the healthcare Ireland needs (as set out in Sláintecare Report[4]) from national, local and personal perspectives;
- and the supports needed from key stakeholders, such as senior management, trade unions, professional bodies and clinical leaders, to achieve the service HSCP want to be able to deliver and realise their full potential.

> *I would also say that grouping our professions together is more than just gathering and representing views. It is about design and delivery of integrated patient services, eliminating duplication/variation of practices and systems so that our operations are more efficient, collectively pushing for improvement with the resources we have – holding ourselves accountable through an internal HSCP management structure and being held accountable collectively through the corporate management structure.*

Quotation from contribution to online workshop

The diagram below illustrates co-creation process.



Co-creation processs July to December 2019

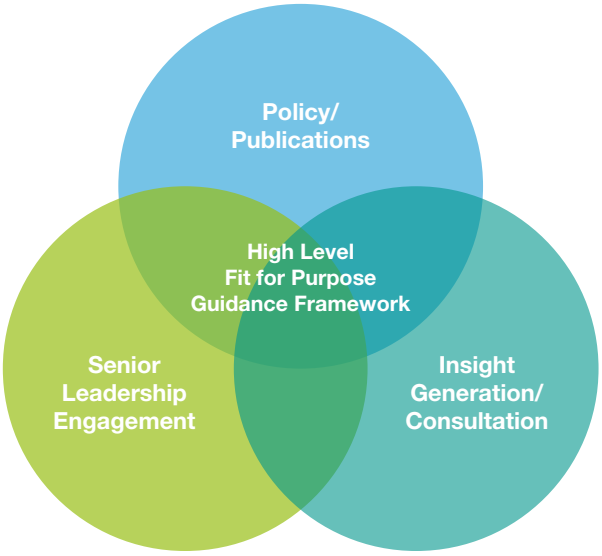
Five face-to-face workshops took place around the country during September 2019*. There was excellent engagement and huge energy and enthusiasm. However, some found it hard to engage due to work pressure and low morale. There were contributions to the online workshop that strongly refected the same pattern and gave insights to the issues of concern and morale. Data reflecting the uptake of the online workshops is included in the appendix.

There were over 16,300 contributions as well as additional ideas and insights collected at the leadership workshop and trade union engagement.

All of the insights and ideas collected through the online and face-to-face workshops were read, coded and analysed. The insights from this process were then triangulated with analysis of national policy and senior leadership views to create a series of high level statements. These statements were further tested in a second online platform. The responses, comments and ideas from this second workshop were also coded and analysed and the high level structure was further refined.

Many contributions referred to challenges progressing the role and impact of HSCP e.g. in recruitment, retention, career progression and clinical governance. Some of these issues were outside the scope of the framework. However, honouring commitments made at the outset to listen to and value all contributions, the National HSCP Office has collated, shared and discussed the material with the relevant parties.

This strategic framework is a distillation and summary of the output of the insight generation/consultation process triangulated with national policy and publications, senior leadership engagement and involvement.

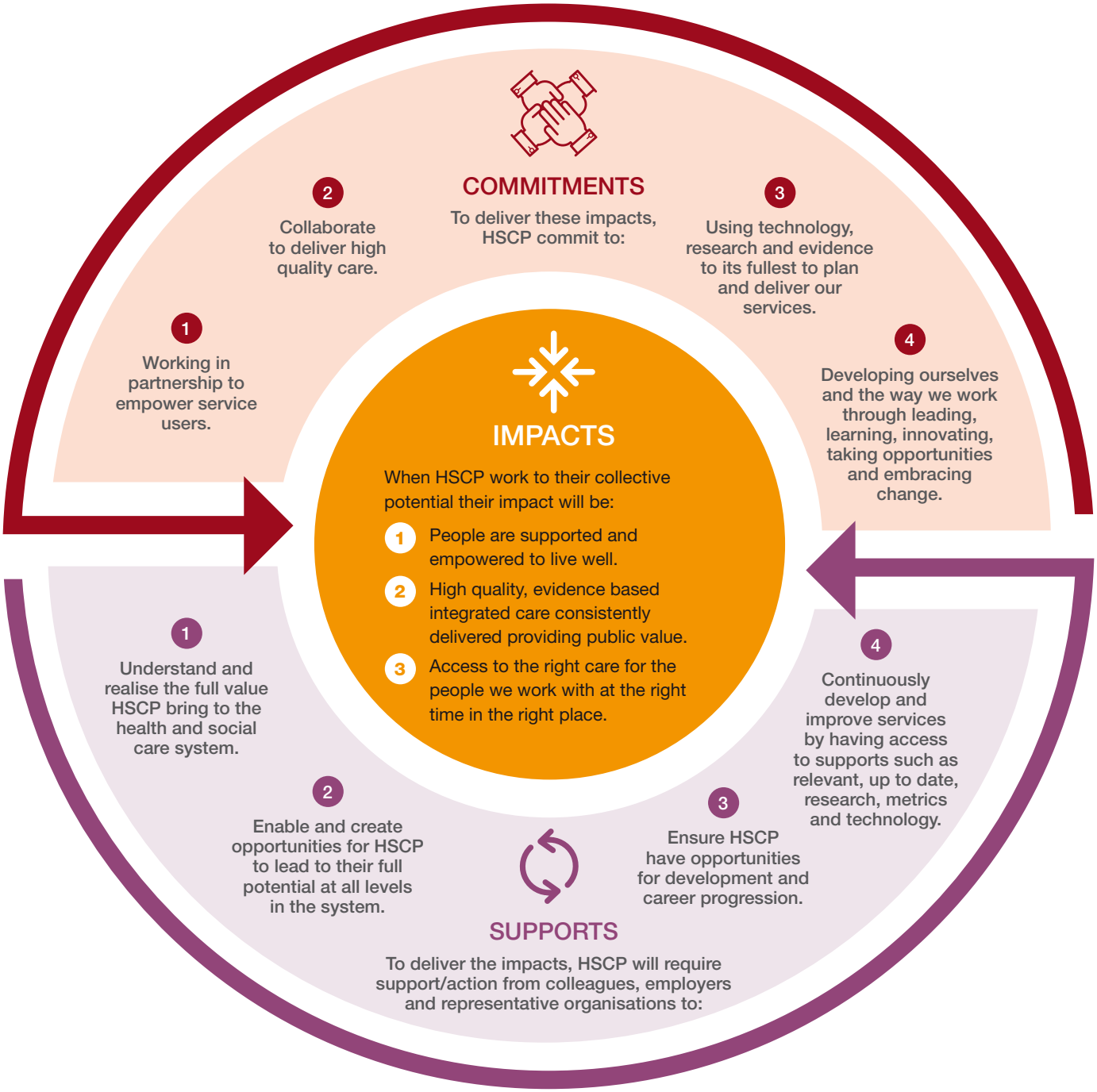


* An additional workshop was planned but due to very limited availability of participants and absence of the necessary mix and balance it was decided not to proceed.

Overview of the Strategic Guidance Framework for Health and Social Care Professions 2021-2026

HSCP DELIVER

Co-created to articulate the **impact** of the full collective potential of the 26 HSCP on our health services and the population they serve. It also describes the **commitments** that HSCP collectively make to delivering on that potential and the **supports and actions** required from colleagues and other specific relevant stakeholders to realise this potential.



(Distilled from insights generated through over 16,300 contributions from HSCP across all service areas and education, service users, health care staff, managers and representative bodies resulting in a 'collective voice')

The following sections provide more detail about each of the elements in the high level overview of the strategic guidance framework on the previous page. The sections about the impacts, commitments and supports are colour coded for ease of reference and are set out as follows.

IMPACTS
This section sets out the impacts when HSCP work to their collective potential.

COMMITMENTS
The commitments HSCP collectively make to deliver these impacts.

SUPPORTS
The supports and actions that will assist HSCP to deliver their collective commitments and impacts.

THE HSCP IMPACTS

An overview of the impacts when HSCP work to their collective potential.

The following impacts were distilled directly from the voices of service users, HSCP and all those who participated in the co-creation workshops.

Each of the three impacts start with quotations from service users recorded during the face-to-face workshops followed by:

- A description of the impact.
- Some examples of HSCP practice that illustrate ways in which HSCP are already delivering the impact.
- Some quotations from the online workshops related to the impact.
- Reflective questions to assist readers to bring the impact to life within their own team, service or organisation.

1. HSCP will support people and empower them to live well.

"Move from surviving to thriving, back into work, happier, healthier, contributing to society."

"focus on building and empowering service users."

Service user quotes from face-to-face workshop

Description of the impact

HSCP are very well placed to lead and implement approaches that take a broader perspective and to support the Sláintecare principle (appendix 2) that patients access care at the most appropriate, cost effective service level with a focus on prevention, self management and public health.

Because of the breadth and diversity of the HSCP workforce they provide services across the lifespan in diagnostic, therapeutic and social care domains and interact with and impact people across the full range of the health and social services within the public health system. Many of the HSCP professions typically build up significant relationships with service users due to the level of time and engagement they have with them.

Many of the professions within the HSCP family were trained and work within a holistic biopsychosocial model of health, encompassing psychological and social aspects, and are comfortable stepping outside the traditional medical model. HSCP are well placed to, and in many cases, already bring this holistic focus to rehabilitation, reablement, disability, mental health, older persons, community and primary care. Core to this is working in partnership with service users with a focus on 'what matters to you?'

HSCP already have a breadth of skills to support service users to stay well, self manage and live well with chronic conditions. Timely access to diagnostic services is an important element of both early detection of problems and supporting people to live well with chronic conditions. With the publication of the new national undergraduate curriculum for chronic disease management[6] all future healthcare graduates should be well equipped with the skills and knowledge to support people to manage their long term conditions effectively.

HSCP support the Making Every Contact Count programme[7] and self management approaches. HSCP collaborate across services and sectors to provide their expertise and input to universal programmes which promote well being, healthy lifestyles, physical activity and development, both for adults and children.

Universal development focused programmes aimed at preschool and school age children can impact significantly on outcomes as well as waiting lists, providing more appropriate levels of support at an earlier stage, particularly to populations more at risk of developmental delays and disorders.

Examples of HSCP practice that illustrate ways in which HSCP support and empower people to live well

- Broadening the approach to a limiting condition: Improving the way chronic pain is managed at the Mater Hospital (page 36)
- Evolving respiratory services to improve care for chronic respiratory disease patients in Donegal (page 38)
- Stay Steady Falls Prevention Programme (page 40)
- Pilot project to devise and roll out a TIERED system of SLT service provision to school age children with disabilities – starting with provision in a special school (page 41)
- Development of online resources for healthcare professionals, patients, and carers for first-line management of malnutrition in the community (page 43)
- Primary Care Occupational Therapy Collaborative Handwriting Initiative (page 45)

Quotations from contributions to the online workshops

> *Partnership with other organisations and programmes to promote health e.g. Slimming World for weight reduction, exercise classes with local sports clubs for older people, function training with local gymnasiums for people with neuromuscular conditions, hydroclasses with swimming pools, occupational therapist working with teachers in school premises to address handwriting issues, 'Happy Talk' model for speech and language development in community.*

> *There is huge potential for further development of health promotion with HCSPs leading this especially physiotherapy, dietetics, those involved in screening, psychology, OT, social care work and social work. This needs to be supported at a national strategic level to include this aspect of care as a priority so we can move to more upstream management of the health continuum.*

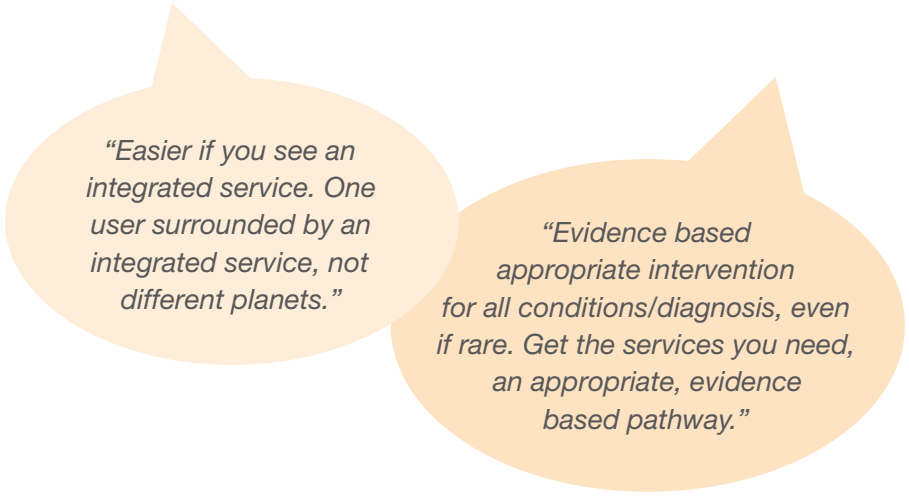
> *HSCPs are definitely doing this, but I'm not sure that it is always recognised. Our role and capacity needs to be supported in this area. Service pressures can mean that prevention has to take second place on the priority list. Models and systems need to change to capitalise on this capability.*

Quotations from contributions to online workshop

Bringing this impact to life

1. **What work is already happening in your area or service that supports people to take more ownership of their own health and wellbeing and to live well?**
2. **What opportunities are there to enhance or strengthen this impact?**
3. **Are there opportunities to utilise HSCP skills to engage in more preventative and self management focused work?**
4. **What actions are you going to take in your local area to bring this impact to life?**

2. HSCP deliver high quality, evidence based integrated care consistently providing public value.



Service user quotes from face-to-face workshop

Description of the impact

HSCP across all disciplines are committed to delivering the highest quality of care based on evidence, clinical knowledge and expertise. HSCP are committed to and required to maintain their professional competence and skills to fulfil regulatory, professional body and accreditation standards.

There is a strong and growing community of HSCP engaged in research both in practice and linked to more formal programmes, even where structural/organisational supports to enable active research involvement are limited or absent. There are many good examples of HSCP research leading directly to improved outcomes for service users.

Supporting and integrating research into HSCP clinical practice to grow a culture of practice-based research, together with strengthening collaboration with Higher Education Institutes, has the power to further shape and enhance the effectiveness of how HSCP work and what they do. Ensuring that clinical specialists have the time and opportunity to fulfil research aspects of their roles will further support practice based research.

Clinical specialists have an important role also in educating and supporting colleagues, building their competence and confidence, as well as providing senior clinical decision-making to enhance the care pathway.

HSCP are engaged in quality improvement and audit with some already having high levels of expertise in quality improvement methodologies.

HSCP recognise the importance of integrating care so that it works for service users and are well placed to lead coordination of care in complex cases where input is required from a number of disciplines or services. HSCP know that to deliver seamless care enhanced integration is needed within services, within and across disciplines and across services, sectors and traditional boundaries.

Fully harnessing and supporting the HSCP workforce has the potential to significantly improve integration and value for money, increase standardisation of processes and reduce unnecessary variation.

Innovation based on evidence combined with collaboration and integration, moving out of silos and across traditional boundaries has huge transformative potential.

The HSCP Best Practice and Innovation Awards[8] and HSE Excellence awards[9] include high quality examples of HSCP led research, service redesign and collaboration translating directly into improved care, enhanced outcomes and value for money. It is important that this work is visible so that people working on similar ideas and areas can share learning and expertise and those ideas with the strongest evidence and potential for spread and sustainability are identified and supported.

It is equally important to ensure that energy and research is targeted at key health service challenges and contributes to addressing these, in line with Sláintecare principles (appendix 2), to achieve greatest impacts for service users and value for money. Many developments have been driven by individual skills, interests and passion. We now need to ensure focus on congruence with Sláintecare together with sustainability and spread to achieve consistency of standards and access.

Examples of HSCP practice that illustrate high quality, evidence based, integrated care providing public value

- The development of a Serum Eye Drop Programme in Galway Blood and Tissue Establishment (page 47)
- The coordinated implementation and evaluation of dialectical behaviour therapy in adult and child/adolescent mental health services at a national level across Ireland (page 49)
- PremSmart™: Translating Research into a New Model of Care for Preterm Nutrition (page 51)
- Redefining and reconfiguring the Longford-Westmeath Primary Care Lifespan Psychology Service to meet the needs of Longford-Westmeath individuals and families (page 53)
- Early Supported Discharge for Stroke: Introduction of Telerehabilitation in response to COVID-19 (page 55)

Quotations from contributions to the online workshops

> *Multidisciplinary team is a minimum but I think in this age we should be expecting integrated care. I would expect that.*

> *Evidence based practice and person centred outcomes are our philosophy.*

> *We need to work collaboratively with services in the community to get a seamless continuous link from the health service in the hospital and primary care settings and with existing services in the community.*

> *Ensure service planning is integrated between community and acute services – shared resources allows for flexibility for professionals to work across boundaries to meet changes in service user needs.*

> *Clinical staff need to look for opportunities to integrate with each other. It could be education opportunities, project work or service design. Managers also have a responsibility to lead by example to their staff to show that they want to work in a more integrated way and work closely with their respective HSCP managers. If managers are demonstrating integration, then staff may follow suit.*

> *I think we need to be able to demonstrate value of our professions both in terms of better outcomes for the service users, as well as showing improved cost-effectiveness for the Health service.*

> *Standardisation of practice so there is better access for service users and satisfaction for staff.*

Quotations from contributions to online workshop

Bringing this impact to life

1. **What is already happening in your area or service that supports delivery of evidence based, integrated care?**
2. **What opportunities are there to enhance or strengthen this impact?**
3. **Are there opportunites working with HSCP to achieve greater public value?**
4. **What actions are you going to take in your local area to bring this impact to life?**

3. Access to the right care for the people we work with at the right time in the right place.

Service user quotes from face-to-face workshop

Description of the impact

HSCP have much to offer to the Sláintcare goal to achieve the right care in the right place at the right time delivered by the right person. HSCP, with their breadth of professions, are a significant resource that can directly provide and support provision of services closer to home in a timely fashion, often avoiding unnecessary hospital admissions and appointments.

Strengthened HSCP input in the community, working particularly with older people and those with chronic disease, can support interdisciplinary approaches to provide diagnostics and intervention in community settings.

HSCP working with the ambulance services manage appropriate emergency calls in the community.

HSCP have a significant contribution to make at the front door of our hospitals, providing early assessment to avoid admission, reduce length of stay and enable early discharge. The impact of senior HSCP decision-makers offers huge potential.

There are numerous other examples of services HSCP can provide, both within current scope and in extended and advanced practice roles, that enable more timely, direct access to care with less steps, relieving pressure on acute services and supporting the shift of care to the community setting. HSCP are leading a number of such projects funded through Sláintecare and there were examples in the HSCP Best Practice and Innovation Awards.

Examples of HSCP practice that illustrate ways in which HSCP support access to the right care at the right time in the right place

- Improving Ulcer Preventative Offloading Care for the At-Risk Foot – An Integrated Approach (page 57)
- Virtual fracture clinic in Our Lady of Lourdes Hospital Drogheda (page 59)
- Establishing a Reactive Home Nasogastric feeding service for Head and Neck Cancer patients undergoing Radiotherapy and/or Chemotherapy (page 61)
- Frailty Intervention Therapy Team (page 62)
- Beaumont Hospital/National Ambulance Service Alternative Care Pathway 'Pathfinder' Service (page 64)
- Primary Care Radiology Castlebar (page 66)

Quotations from contributions to the online workshops

> *For this to be achieved a key part is HSCPs working at their full potential.*

> *We need to do more linking hospital and community services and make more connections with colleagues and be more flexible about where and how service may be delivered using full skill mix.*

> *Ultimately service users or patients should have early access to the most appropriate care, from the most appropriate professional(s) working to their capacity which is best matched for the patient's current condition. This should also be delivered with real continuity of care, between all healthcare professionals but also between acute and community services.*

Quotations from contributions to online workshop

Bringing this impact to life

1. **What work is already happening in your area or service to ensure access to the right care at the right time in the right place?**
2. **What opportunities are there for HSCP to enhance or strengthen this impact?**
3. **Are there untapped opportunities to support HSCP to utilise their expertise to enable enhanced access to the right care, right place, right time?**
4. **What actions are you going to take in your local area to bring this impact to life?**

HSCP COMMITMENTS

This section sets out the commitments that HSCP have collectively agreed to make to enable them to realise the impacts set out in this document and to support delivery of the goals of Sláintecare.

The following commitments were distilled directly from HSCP contributions and as such reflect the collective voice of HSCP.

Each of the four commitments start with quotations from service users recorded during the face-to-face workshops followed by:

- A description of the commitment.
- Some examples of HSCP practice that illustrate the commitment in action.
- Some quotations from the online workshops related to the commitment.

1. Working in partnership to empower service users.

"be recognised as a service user, listen more to the service user. They have knowledge and lived experiences."

"Shift to see service user as an expert in their own care not the professions."

"more of a partnership approach."

Service user quotes from face-to-face workshop

Description of the commitment

HSCP recognise service users as the experts they are in their own lived experience, priorities and resources. HSCP will work collaboratively with service users to identify their goals and priorities and use their clinical expertise and skills to support their achievement working with other colleagues and across services as needed. This was a strong message in the workshops.

A core focus of Sláintecare is improving service user experience and putting service users at the centre of everything we do. HSCP will focus on supporting people to actively manage their own health and well being and health conditions. HSCP will work to reduce rather than create dependency in the relationships and approaches we take to working with service users. HSCP will engage with service users as active partners in their care rather than passive recipients, focusing on what matters to them, helping and empowering them to identify their own specific goals and desired outcomes. For some, this may represent a major shift from the traditional model of expert-led diagnosis, deficit identification and treatment planning.

Examples of HSCP practice that illustrate HSCP commitment to working in partnership to empower service users

- Ensuring effective person-centred care and support using a solution focused approach for Speech and Language Therapy service users in Dublin South East (page 68)
- Meaningful Moments: Facilitating sensory exposure, engagement and positive communication in the home during everyday activities (page 70)
- Empowering parents of children with autism spectrum disorder to support and maximise their children's development potential through the use of evidence based MDT delivered parent training programmes (page 72)
- The Medical Social Work Role in Patient/Family Liaison in the Mater Misericordiae University Hospital during COVID-19 (page 74)
- The First Prehabilitation Exercise Service for Cancer Surgery Patients in Ireland (page 76)

Quotations from contributions to the online workshops

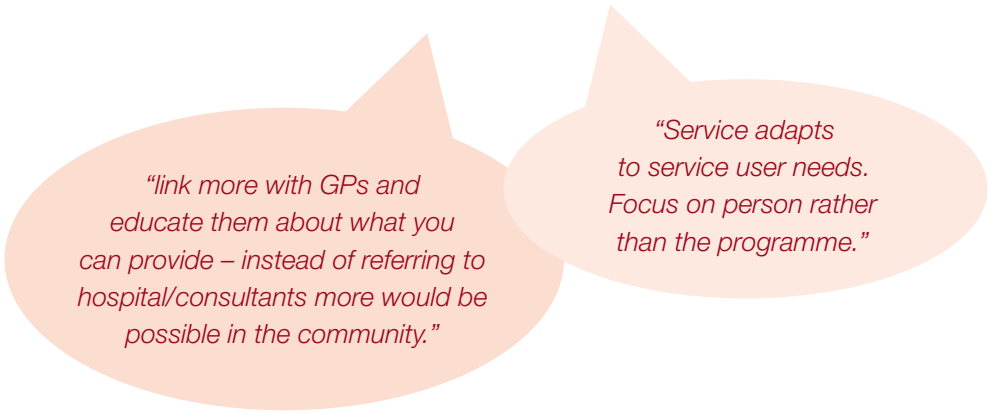
> *HSCPs recognise that the service user is the 'expert', and we facilitate, support and empower them to achieve the outcomes that matter the most to them in relation to their own health and wellbeing… 'nothing about me without me'.*

> *We should focus on secondary prevention and health promotion – no one is better placed than HSCPs, particularly in community settings to look at this. Establishing peer support groups/ education in symptoms and symptom management/red flags.*

> *HSCP colleagues in mental health services are very recovery-focused and innovative, using positive risk, promoting personal responsibility, and supporting people to live well… Evidence-based interventions such as DBT, and internationally renowned movements such as the Hearing Voices network are primarily HSCP led, and demonstrate that there are therapeutic interventions which can rival or out perform medication-only based treatment. In the long term, these HSCP-led interventions prove to be much more cost-effective to services, and sustain quality of life for service users.*

Quotations from contributions to online workshop

2. Collaborate to deliver high quality care.



Service user quotes from face-to-face workshop

Description of the commitment

HSCP are committed to collaborating across traditional service boundaries to understand the services available, cooperate around individual service users to ensure smooth transitions and plan together to create agreed end to end care pathways that work across services and settings.

HSCP are also committed to working creatively across boundaries to work with other community and voluntary services to create opportunities to support service users in community settings and in a range of contexts including rehabilitation, reablement, maintenance of wellness and function and prevention and health promotion.

Collaboration and integration at multiple levels is at the core of providing joined up seamless care for service users. HSCP are committed to working collaboratively to understand other services better. They are committed to doing this with a focus at an individual level so that they can better guide service users and colleagues to appropriate resources.

HSCP are also committed to working together nationally and organisationally so that they can continue to identify synergies and harness their collective value in contributing to strategy and service development.

Examples of HSCP practice that illustrate HSCP commitment to deliver high quality care

- Striving for excellence in care for people with Motor Neurone Disease: The evolving journey of the multidisciplinary team (page 78)
- Development of a universal HSCP referral process within the Regional Hospital Mullingar (page 80)
- An interagency approach to prevent falls and frailty in the community (page 82)
- Covid-19 Pandemic: Formulation and validation of a virus lysis buffer to allow testing of patients to continue: an Irish multi-centred case study (page 84)
- Tracheostomy speaking valve modification in children: A standardised approach leads to widespread use, Children's Health Ireland (CHI) at Crumlin (page 86)

Quotations from contributions to the online workshops

> *As a professional and as the mother of a service user this should be priority. There are far too many appointments for families to attend and often in different areas with none of the disciplines communicating meaning that the pressure is on the parent to case manage and inform each discipline of the others plans.*

> *If we are only prepared to entertain new ways of working if given resources, our attempts at innovation will move at a snail's pace, if at all. If a new (or at least better, if not so new) service delivery model is at hand, why would we insist on keeping the old ways going rather than making a change to the new with at least some of our existing resource? Especially if we can build a new resource from multiple small contributions. Our great strength is in building relationships and collaborating, and being boundary spanners thanks to our training and employment experiences, and we should use those skills to change the system around us, not because someone has given us permission but because we have authorised ourselves to make the best and most sensible use of the resources that are within our own control.*

> *Many service users avail of services from a number of agencies. There is a need for HSCP to work together, collaborate and share skills and knowledge so that the best outcome can be achieved for the service user.*

Quotations from contributions to online workshop

3. Using technology, research and evidence to its fullest to plan and deliver our services.

Description of the commitment

HSCP deliver evidence based/informed practice and will continue to do so. HSCP want to have access to and use cutting edge research, technology and evidence to inform and shape the services they deliver and how they work together and with service users.

Technology is already an integral part of the work of many HSCP. HSCP embrace appropriate technology and seek to use it effectively to provide best outcomes for service users whether related to the realm of assistive technology, telehealth, remote monitoring, clinical equipment or electronic records.

The COVID-19 pandemic has accelerated the need for and adoption of telehealth in its broadest sense. HSCP have embraced the opportunity, rapidly adapting and developing new ways of working and delivering services.

HSCP will continue to both engage in and access research to inform and shape service delivery.

HSCP will collect and use data and evidence to evaluate their work, and use quality improvement methodologies to plan and make tests of change to continuously improve. They will harness the full impact of available evidence and technology to plan and deliver their services. This has been to the fore during COVID-19 where the flow of emerging information and evidence about a new disease accelerated the pace of change and requirement to continuously review and adapt practice.

HSCP are ready and able to take up leadership roles and contribute at organisational level to the planning and development of services.

Examples of HSCP practice that illustrate HSCP commitment to using technology, research and evidence to its fullest to plan and deliver our services

- Pen to Pad: HSCP Come Together to Lead and Drive Change from Paper to Electronic Records at St. James's Hospital (page 88)
- OPTIMEND – Optimising Early Assessment and Intervention by Health and Social Care Professionals in the Emergency Department (page 90)
- Home Based Virtual Pulmonary Rehabilitation Programme for COPD Patients. Our Lady of Lourdes Hospital, Drogheda (page 92)
- Benefits of Remote Follow-up in a Cardiac Physiologist-led Cardiac Devices Clinic (page 94)
- Clinical Engineering – finding innovative ways to promote and sustain medical device use and safety training during Covid-19 restrictions (page 96)
- Using an electronic patient record and medication barcode scanning to improve haemophilia patient care (page 98)

Quotations from contributions to the online workshops

> *Provide HSCP telehealth services in the home – support patients and their families to be more adherent with long term treatments.*

> *eHealth can enhance service users ability to make choices, e.g. self booking of appointments, access to their own health information, ability to input information to own health record via patient portal, links to useful/reliable information etc. It is important that HSCPs lead and innovate in this area to facilitate service users in making informed choices re their own care.*

> *HSCPs have strong skills in the assessment and provision of assistive technology devices (including electronic assistive technology) to their service users. They match the most appropriate technology for the service users needs taking into consideration the person, the activities/tasks the person wants or needs to be able to do and the context/environment in which the activities/tasks take place. Each area is examined independently and collectively to ensure the assistive technology device is appropriate and effective.*

Quotations from contributions to online workshop

4. Developing ourselves and the way we work through leading, learning, innovating, taking opportunities and embracing change.

Description of the commitment

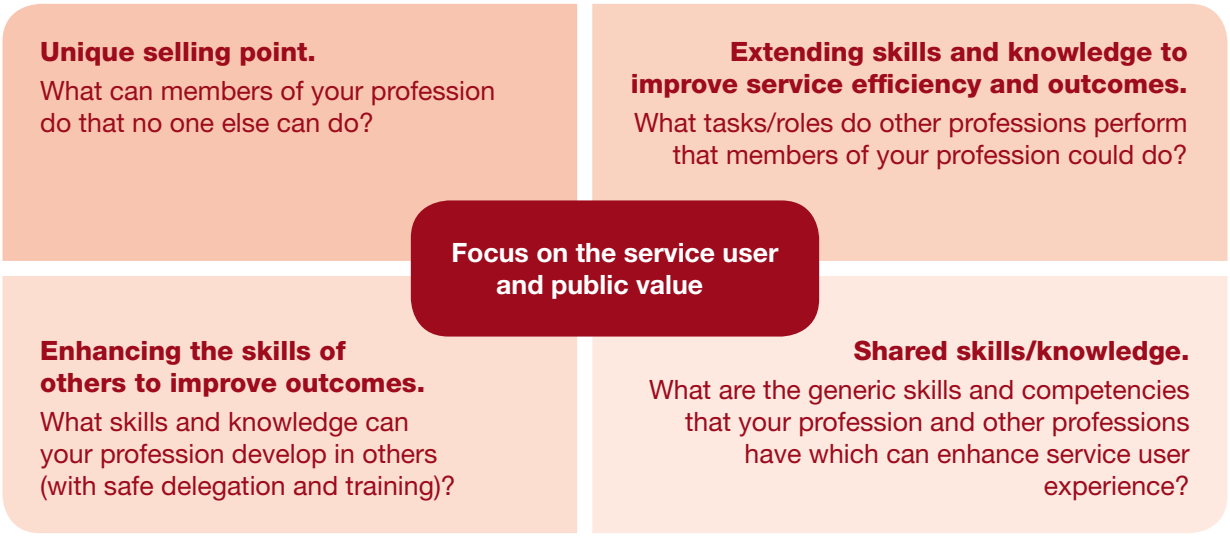
Sláintecare sets out the roadmap for Ireland and HSCP are committed to being part of the solution. HSCP will seek out and take opportunities to develop services and work in new and different ways.

HSCP are passionate about and focused on delivering for service users. HSCP 'think outside the box' and, are by their nature, problem solvers and innovators. It is internationally recognised that sustainable delivery of health and social care services into the future will not be achieved by simply more of the same (Global Strategy on Human Resources for Health, Workforce 2030, WHO[10]).

HSCP are committed to continuous professional development and life long learning. This commitment not only applies to continuing to develop their discipline specific clinical skills but also to wider domains such as clinical redesign, quality improvement and leadership, to enhance impact and outcomes.

A more systematic approach to upskilling and skill mix is needed. The following framework, adapted from AHPs into Action[11], and reproduced with permission, represents core elements to be considered.

Focusing on service users and the core principle of delivering public value should support the decisions, actions and behaviours needed to adopt a flexible approach to support each of the four aspects.



Source: Adapted from Allied Health Professions into Action[11], Using Allied Health Professionals to transform health, care and wellbeing. 2016/17 – 2020/21

Skill mix and maximisation of the value of each role in the system will be a key enabler to delivering Sláintecare. There were core messages around skill mix from the workshops. These centred around commitments to advanced and specialist practice, working with assistants, the need for administration support to free up clinical time, stepping away from traditional 'turf' boundaries to recognise and use shared skill sets and cross discipline working.

For the **unique selling point** of each profession to be effective, it is essential that disciplines are clear on what members of their profession can do that no one else can do. Individuals can also extend their skills to take on roles that are traditionally outside their scope or that are typically undertaken by another profession.

There are roles and tasks that one profession can take on from another in the interests of effectiveness and efficiency with appropriate education/training and governance. In order to deliver the Sláintecare ambition for a better patient experience, it will be essential to have professions work to the top of their license and provide timely access to the right care in the right place. HSCP are clear about the significant opportunities they see to further develop their skills and expertise to take on senior clinical decision-making roles as specialists or advanced practitioners.

Advanced practice needs to be formally developed for HSCP to realise this potential. Existing regulation under the Health and Social Care Professions Act (2005)[12] does allow for this where designated professions *'must act within the limits of your knowledge, skills, competence and experience'*. HSCP are committed to working to realise this potential and the benefits it will bring to service users and delivery of care.

There are also areas where there are shared skills and knowledge and where there may be overlap in skills. Feedback from the workshops spoke about the need to capitalise on this area rather than focusing on discipline specific territory.

There are areas where HSCP can train or develop skills in others to take on tasks/roles that can enhance service delivery with safe delegation and governance. It is also clear that access to administrative support and better use of technology can release significant front line clinical time for client care.

Putting service users and what they need at the centre of our focus will help us take the right actions and use our collective skills and knowledge to maximum effect.

Examples of HSCP practice that illustrate HSCP commitment to developing ourselves and the way we work through leading, learning, innovating, taking opportunities and embracing change

- Hand Therapy Service Provision within the Plastic Trauma service of the RCSI Hospital Group (page 100)
- Direct access to vestibular rehabilitation: A physiotherapy, audiology and ENT integrated care initiative (page 102)
- Home enteral feeding CHO DNCC (page 104)
- National Musculoskeletal Physiotherapy Triage Initiative (page 106)
- Role development of the Radiographer to screen videofluoroscopic examinations of swallowing and the resulting expansion of the videofluroscopy clinics carried out by Speech and Language Therapists (page 108)
- A pilot programme to expand the scope of practice of image guided radiation therapy (IGRT) specialist radiation therapist to include clinical responsibility for the IGRT localisation of the target at the treatment unit (page 110)

Quotations from contributions to the online workshops

> *Stop working in silos. cross competency based working to alleviate all disciplines of burden with heavy caseloads and break the barrier that OTs are for equip and physios are for mobility etc.*

> *Huge potential to deliver diagnostics, such as Cardiology and Radiology, in Primary Care Centres, so that at a minimum appts are delivered closer to home, but hopefully multiple appointments are delivered on same day. These must be delivered under the governance of the hospital to ensure seamless referral pathways and quality assurance. HSCPs have the ability to lead and deliver this shift in service but we must embrace this change.*

> *HSCP's are incredible problem solvers and have a high level of education that starts at university and continues during our work lives through CPD. We need to be brave and push into areas where we feel we can make a difference, we often have the clinical skills to do so, maybe not the confidence or support!*

Quotations from contributions to online workshop

SUPPORTS HSCP NEED TO DELIVER THEIR POTENTIAL

To deliver the impacts set out above and to support HSCP in delivering their collective commitments, HSCP will require support/action from colleagues, employers and representative organisations to:

1. Understand and realise the full value HSCP bring to the health and social care system.

To realise the impacts set out in this framework and to support HSCP to deliver on the commitments they collectively agreed, others need to understand and recognise the value that they bring and the full potential that is possible. It is only in achieving this recognition that some of the barriers can be removed. Fundamental to this will be including HSCP alongside doctors, nurses and midwives in all aspects of clinical design, planning and leadership at all levels in the health system.

2. Enable and create opportunities for HSCP to lead to their full potential at all levels in the system.

While clinical leadership is something to be fostered at all levels, there are limited formal opportunities for HSCP to lead. Leadership structures within HSCP are underdeveloped in comparison with other clinical colleagues in medicine, nursing and midwifery. This effectively creates a ceiling beyond which it is impossible to advance while still being able to maintain the HSCP professional role. The route upwards in management terms is predominantly to exit ones profession. Registration, currently, is only available for active clinicians or educators of the profession and effectively, is not possible beyond the level of discipline manager. This is different to the situation for nursing, midwifery and medicine. It is also noteworthy that a significant amount of leadership opportunities that would provide development stretch and preparation for HSCP for later more senior roles are frequently not open to this staff cohort. This diminishes the potential pool of leadership talent available to the system and is a disincentive for HSCP to remain within their professions. The report *HSCP Leadership – An examination of context, impact, supports, challenges and areas for consideration*[13] provides some insights and identifies areas for consideration at national, organisation and individual level.

3. Ensure HSCP have opportunities for development and career progression.

HSCP are passionately committed to continuing development personally, professionally and within their careers. Many of the existing career structures are several decades old and offer little opportunity for development and progression to a highly educated workforce. This has a negative impact on the development potential of this workforce and fitness for purpose for the future services required. Development opportunities for HSCP in terms of continuing professional development and access to formal academic programmes to develop skills and competencies needed for service delivery are limited with minimal resources available. This is in stark contrast to other clinical colleagues.

4. Continuously develop and improve services by having access to supports such as relevant, up to date, research, metrics and technology.

Data, research, metrics and technology are the tools that HSCP need to be able to access, to analyse, understand and further develop, enhance, measure and evaluate their services. HSCP need to access appropriate technology to enhance efficiency and effectiveness of services and will need support to identify gaps and develop standardisation in advance of introduction of an electronic health record and shared records. HSCP have embraced the opportunities provided by telehealth solutions to continue to provide services safely during the pandemic. HSCP need to be supported to manage the clinical transformation and people, processes and technology aspects necessary to successful realisation of the potential of this mode of service delivery.

(These supports and actions were distilled directly from contributions through the face-to-face and online workshops.)

IMPLEMENTATION OF THE STRATEGIC FRAMEWORK

Previous sections have described at high level the impacts that can be achieved through full realisation of the potential of the HSCP workforce.

The commitments that HSCP are prepared to make and what they have articulated through the co-creation process is also set out. There is no doubt that the focus of HSCP on these commitments will play a significant part in delivering Sláintecare. The experience of the COVID-19 pandemic has already demonstrated the kind of change that can be achieved at pace across the health and social care services.

Through the co-creation process HSCP also clearly outlined the key areas of support required to enable the realisation of the transformative potential of this workforce.

The National HSCP Lead and National HSCP Office provides national leadership for HSCP in the HSE and in line with its core purpose will provide strategic leadership and support to the implementation of the strategic framework. Successful implementation will require support from senior leadership across the system, frontline HSCP and HSCP managers, professional and representative bodies.

Next steps will include:

1. Establishment of a national steering group to support and oversee implementation. The group will be reflective of key stakeholders including service user representation.
2. Widespread sharing of the strategic framework, provision of support tools and engagement across the country to support HSCP to consider and develop collective actions and local plans to transform care.

What the National HSCP Office will do – our commitments

1. Support local adoption and implementation of the framework, facilitate and actively promote the sharing of learning, innovation and new ways of working.
2. Continue to champion HSCP skills to support Sláintecare to ensure that the potential of HSCP to support health promotion and prevention and the shift of care closer to home is realised.
3. Hold the system to account for inclusion of HSCP at all levels to ensure that the full impact of the second largest clinical group is maximised and that policy, plans, design, resourcing and development is cognisant of and based on proper understanding of the HSCP contribution.
4. Promote and champion development of advanced HSCP practice so that the opportunities to transform service delivery are achieved.
5. Develop an action plan to address HSCP leadership based on the findings of *HSCP Leadership – An Examination of context, impact, supports, challenges and areas for consideration*[13].
6. Support HSCP in working in partnership with service users to ensure a people centered focus in improvement, change and design work. Recommend People's Needs Defining Change – Health Service Change Guide[5] as a detailed reference resource and tool.
7. Work with relevant stakeholders to address HSCP workforce issues through supporting implementation of the Health Services People Strategy 2019-2024[14], with particular focus on the following aspects of the People Strategy
    a. Access to leadership opportunities, engagement and capacity building for HSCP.
    b. The workforce planning gap for HSCP so that models of care and service development can be informed by appropriate workforce data.

c. Supply, capacity and sustainability of the HSCP workforce in terms of links with:
    i. Higher Education Institutes on graduate supply and practice placements,
    ii. All relevant stakeholders to support and promote student practice placement to nurture and develop the next generation and ensure future workforce supply,
    iii. Professional bodies and system leadership to identify mechanisms to support CPD and further professional development that supports improved performance in line with regulatory requirements and evidence informed practice.

d. 'Ensure career structures are fit for purpose and aligned to new models of care and advanced levels of specialisation, keeping pace with rapidly evolving professional practices, service needs and evidence informed outcomes for service users.' (page 19, People Strategy[14])

e. Development of appropriate retention strategies through ensuring that relevant HR and service managers are aware of current issues impacting HSCP retention. Consider mechanisms to recognise and value generalist expertise while allowing for progression/development. Current progression for many is primarily into specialist or management roles.

8. Work with Clinical Design and Innovation to ensure appropriate HSCP input to all relevant clinical and integrated programmes, clinical advisory and steering groups and to develop a sustainable model to resource HSCP input to key priority areas.
9. Ensure and support HSCP input to development of the Electronic Health Record and E-health.

The National HSCP Office cannot achieve implementation of this strategic framework alone. Input is needed from HSCP and other stakeholders as set out below.

What we need from national level leadership

1. Ensure appropriate HSCP input at strategic and policy levels in order to realise the significant potential that HSCP have to offer to transformation of health service delivery and Sláintecare implementation.
2. Ensure HSCP input to design and planning of services at National Level, to include national level design and planning groups across all aspects of health service delivery as well as the National Clinical Programmes and associated Advisory Groups.
3. Support the sustainability of HSCP expert clinical input at national level so that HSCP can provide this as part of their role. Currently expert HSCP clinical input to Clinical Programmes and related work is, with few exceptions, on a volunteer basis on top of full time front line clinical jobs.
4. When new posts are created that require clinical expertise but not delivery of a defined clinical skill set, open them to all appropriately qualified clinical personnel with relevant experience including HSCP.
5. Ensure opportunities for HSCP access to leadership development opportunities including both formal programmes and other leadership competency development opportunities outside of their discipline specific stream.
6. Ensure development opportunities and progression routes that enable and encourage HSCP to remain within clinical roles if they wish. Current pathways lead to exit to management or academic roles.
7. Support creation of joint clinical/academic appointments for HSCP to enable closer links and collaboration with Higher Education Institutes and strengthen research capacity.
8. Ensure HSCP input in development of metrics to ensure development of relevant metrics and access to relevant data and metrics to inform service improvement and development.
9. Support HSCP services to evidence the quality and value for money of their services to drive further innovation and improvement.
10. Some of these recommendations will coincide or overlap with other organisational strategies and therefore it will be important to ensure that HSCP are included in their planning and implementation.

What we need from organisation level leadership

1. Ensure appropriate HSCP leadership and input at organisation level in order to realise the significant potential that HSCP have to offer to transformation of health service delivery and Sláintecare implementation.
2. Support and ensure HSCP have access to relevant data, research, and technology to further develop and improve their services.
3. Ensure HSCP have access to the relevant tools and resources to apply and maximise the potential of technology and informatics in their work.
4. Support and encourage an improvement mindset and ensure HSCP access to quality improvement training and supports.
5. Foster a culture of collective leadership and encourage clinical leadership at all levels.
6. Consider opportunities to support HSCP staff to progress, develop and be recognised and fulfilled to improve retention, engagement and satisfaction.
7. Review and consider actions arising from *HSCP Leadership – An Examination of context, impact, supports, challenges and areas for consideration*[13]. Specifically:
    a. Consideration should be given to the establishment of a HSCP Leadership post at institutional level, positioned at executive level to ensure full harnessing of HSCP potential and transformative value.
    b. Ensure, where they exist, that HSCP Leads/Heads of Clinical Services (HSCP who lead multiple HSCP Heads of Discipline) at organisation level are included at executive level.
    c. Consideration should be given to establishment of HSCP networks within individual institutions. These could form a basis for a representative approach for HSCP as well as joint educational and service initiatives.
8. Consideration should be given when advertising new leadership roles which may traditionally be restricted to certain professions to opening to appropriately qualified HSCP candidates.
9. Create development opportunities for HSCP at Head of Discipline level to lead on organisational or cross organisational projects to provide leadership development opportunities that will broaden skill sets and experience.

What we need HSCP to do

1. Use the opportunity that this national strategic framework offers to inform and influence leaders in your organisations to ensure they understand the contribution and potential of their HSCP.
2. Use the document as a framework against which to review and consider your own service and discuss with colleagues and identify areas for action.
3. Embrace an improvement mindset and take opportunities to develop and enhance improvement knowledge and application.
4. Utilise available data and metrics to understand the services being provided and seek opportunities to further enhance effectiveness, outcomes and value for money.
5. Seek out up to date research and technology developments and seek to apply as appropriate to your work.
6. Work together to have a clear voice and clear collective input.
7. Continue to take every opportunity to measure and demonstrate your value and effectiveness and share learning.
8. Seek out development opportunities both within and outside your normal clinical stream to broaden outlook and skills. Actively seek out and engage in processes such as professional supervision.
9. Actively seek out leadership development opportunities, both formal and informal to build capacity and skills.
10. Actively support collective leadership within your own teams and seek to support each others development and leadership.
11. Actively nurture clinical leadership and development at all levels. Tap into the ideas, skills and potential of fellow HSCP colleagues at all levels.
12. Seek out opportunities to be involved in interdisciplinary strategic developments and groups at organisation and national level.
13. Ensure maintenance of professional standards as set out by CORU and/or relevant professional bodies.

EXAMPLES OF HSCP PRACTICE

BROADENING THE APPROACH TO A LIMITING CONDITION: IMPROVING THE WAY CHRONIC PAIN IS MANAGED AT THE MATER HOSPITAL

Understanding the Problem

Prior to 2013, Chronic Pain (CP) patients attending the Mater Hospital received specialist nursing and medical input, but were not able to access adjunctive psychological or physiotherapy services directly, despite best practice international guidelines emphasising these disciplines within the context of chronic pain management.

Quality Improvement

An interdisciplinary model of care was developed and tested, provided through reconfiguring existing resources, in collaboration with the Consultant in Pain Medicine in the Mater Hospital Pain Clinic, the Physiotherapy and Psychology Department Managers. The pilot project was evaluated after one year and deemed a resounding success, leading to the hospital executive decision to fund two half-time, permanent, Psychology and Physiotherapy positions on the pain clinic team.

Evaluation

- Over 90 patients have received a multidisciplinary team assessment, where the patient, whose issues are typically complex, meets with the entire team in order for a clear and comprehensive treatment plan can be formulated.
- Ten supported self-management groups have been run, benefiting over 90 patients, three of who have completed the training to run these groups in the hospital.
- Over 250 patients have benefited from individualised physiotherapy and psychology, during their pain management attendance.
- The psychologist and physio have also successfully run more than 25 inter-disciplinary pain management programs, benefiting over 200 patients.
- Research activity has grown out of these clinical interventions, resulting in three peer-reviewed scientific journal publications to date, and multiple oral and poster presentations at both domestic and international conferences.
- A randomised control trial has since been completed, examining and comparing two standalone HSCP interventions for chronic pain patients: an exercise/education only arm versus a combined psychology and exercise/education group. This RCT is the basis of a HRB fellowship award, data collection was completed in December 2018, and publications are due in late 2020.

Key Learning

- CP patients benefit from a biopsychosocial approach to treating their condition
- CP patients also benefit significantly from the input provided by HSCPs representing psychology and physiotherapy.
- CP patients benefit from different configurations of HSCP led group interventions, including single-discipline (physiotherapy only), combination-of-disciplines (psychology and physiotherapy) or professional-and-patient led (psychology and CP patient).
- Group programmes and team-based interventions are an efficient and beneficial way of treating patients whilst operating within a half time role.
- The success of this initiative is largely attributable to the full participation of hospital executive and the pain clinic team members. There is an atmosphere of mutual respect, team unity and a collective openness to mutual learning and growth.

Scope to Grow

Further peer-review journal publications, arising from the pilot investigation and HRB funded RCT, are expected in due course. Additional innovations to reduce waiting times are being developed by the clinic HSCP. Interest has been expressed by pain clinics in other hospitals regarding the initiative.

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EVOLVING RESPIRATORY SERVICES TO IMPROVE CARE FOR CHRONIC RESPIRATORY DISEASE PATIENTS IN DONEGAL

Understanding the Problem

Chronic Obstructive Pulmonary Disease (COPD) is the most prevalent respiratory disease in adults with the lowest estimates showing a prevalence of 6% in the adult population (GOLD 2015), though many with mild COPD are undiagnosed until a later stage when health interventions are less effective and more costly (National Clinical Programme for COPD, 2016).

Following the introduction of a hospital based pulmonary rehabilitation (PR) programme in 2007, it became apparent there was poor referral and uptake for PR in areas furthest from Letterkenny due to the travel time and distance. Patients with advanced stage COPD and Pulmonary Fibrosis found this particularly arduous due to symptom impact, and oxygen therapy, medication regimes and homecare support.

Quality Improvement

Since 2012 the respiratory services in Co. Donegal have been restructured incrementally to offer timely specialist interventions as close to the patient's home as possible, increasing accessibility and equity of services within a large geographical area, using finite resources.

Community services are provided by the Pulmonary Rehabilitation team (PR) and the Respiratory Integrated Care (RIC) team which both consist of a Respiratory Senior Physiotherapist and Respiratory Clinical Nurse Specialist (CNS). The guidance and support of the Respiratory Working Group and Respiratory Steering group and the dedication and enthusiasm of the clinical staff enabled the service developments to be achieved.

- Pulmonary rehabilitation services expanded into 3 Primary Care networks (2012).
- Referrals accepted from non-Respiratory Consultants, COPD Outreach (2012), GPs (2016) and Respiratory Integrated Care (RIC) (2017).
- Additional services provided in Primary Care setting: Respiratory assessment and management clinics; Ambulatory oxygen assessment clinics; Clinical review appointments; Respiratory Physiotherapy and CNS clinics (2015).
- Respiratory screening commenced within 2 Primary Care networks (2017 & 2018).
- A maintenance exercise programme was developed in Letterkenny (2014) and in Inishowen (2018).

Evaluation

- Clinically significant differences in symptoms, quality of life and exercise tolerance, and reduced hospital admissions, inpatient-bed days and length of stay were achieved in patients who attended the PR programme.
- The direct referral pathway enables earlier intervention and patients no longer have to wait up to 4 years to see the Respiratory Consultant before accessing Physiotherapy and Respiratory CNS clinics or PR.
- A significant reduction in travel time and distance for patients was achieved with the expansion of Respiratory services into 3 Primary Care networks.
- The realignment of the PR and RIC teams into two geographical areas ensures patients now have greater continuity of care with one point of contact for ongoing support and advice.

Key Learning

- Service user feedback and focus groups were essential in ensuring patient centred care.
- The Respiratory Working group and Respiratory Steering group enabled collaboration, communication, and, the development of weekly multidisciplinary respiratory education meetings facilitates interdisciplinary learning.
- Restructuring of services and provision of clerical support achieved improved efficiency of clinicians' time.
- Recording of KPI's and outcome measures for regular reflection, evaluation and audit of service is critical in development of the respiratory service.

Scope to Grow

The development of a third community respiratory team would allow expansion of GP screening into three further Primary Care Networks ensuring equity of access to services. Owing to the success of the Letterkenny exercise maintenance class in terms of clinical outcomes and peer support, development into other primary care networks in collaboration with community centres is planned. The development of a COPD support group in Donegal is being explored.

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STAY STEADY FALLS PREVENTION PROGRAMME

Understanding the Problem

The number of older persons in the county of Mayo is increasing. Census data 2016 shows 13.3% of the population was between 65-79 years of age and 4.2% over 80 years, the third highest after Roscommon and Leitrim. Data from TILDA 2014 stated the prevalence of falls increased by 7% since 2011 and 30% of people over 65 years and 50% of those over 80 years would have at least one fall per year. Older people have the highest risk of death and serious injury resulting from a fall. Community Physiotherapists identified the need to address Falls Risk in the community.

Quality Improvement

A Falls Prevention Exercise Class 'Stay Steady' was set up, targeting older people living in the community who were at risk of falling. This group exercise programme is based on the evidence-based Otaga Exercise Programme to improve strength, balance and function. The class runs weekly for 8 weeks with a follow-up phone call at week 12 and final review at 16 weeks. Referrals are received from G.P.'s, Public Health Nurses, Acute Services and MSK Physiotherapist working in the catchment area. The criteria for referral are: have fallen, have fear of falling, unsteady gait or balance issues. This programme is run by community Physiotherapists and involves the multidisciplinary team with educational talks given by the Dietitian, Pharmacist, Occupational Therapist and Continence Nurse.

Evaluation

- The 'Stay Steady' class resulted in significantly reduced falls risk and improved balance.
- Berg Balance Scale: 69% of participants in '100% Falls Risk Group' moved out of this category after 8 weeks and this reduced to 54% at 16 weeks.
- 60% of older persons in the 'At Risk' category moved out of this category and this increased to 78% at 16 weeks.
- Of those at the high end of Berg Balance Scale, 61% had a real change in balance at 8 weeks which increased to 69% at 16 weeks. Improvements were also seen in the Timed Up and Go test (TUG), more than 12 seconds is shown to be predictive of falls in community dwelling older people. After 8 weeks, 39% with a pre-class test over 12 seconds improved to less than 12 seconds.
- Reduction in the fear of falling was noted and measured using the Short Falls Efficacy Scale.
- In addition to the improvements in risk of fall and improved balance, participants enjoyed participating in the class.

Key Learning

- The best predictor of success is the participants own motivation to improve. People do better when they can attend group classes
- For higher risk older persons, continuing beyond 8 weeks may help to maintain benefits.
- Access to transport could enable older persons to benefit from the programme.
- Links to a Consultant-led MDT Falls Clinic, for cases that are more complex, would enhance the service.

Scope to Grow

- Roll out this programme in south and west Mayo.
- Link as a community resource with new Elderly Day Hospital opening in Castlebar as part of the Integrated Care Programme for Older People.
- Plan to link with Mayo Sports Partnership to provide step down programme in the community.

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PILOT PROJECT TO DEVISE AND ROLL OUT A TIERED SYSTEM OF SLT SERVICE PROVISION TO SCHOOL AGE CHILDREN WITH DISABILITIES – STARTING WITH PROVISION IN A SPECIAL SCHOOL

Understanding the Problem

Resources for the speech and language therapy (SLT) service for school age children with complex needs/disabilities in South Tipperary have always been limited. Of about 600 children, half attend the mainstream schools (some in ASD units) and the others attend one of two special schools. Providing an SLT service was very challenging. Problems included:

- Inadequate prioritisation system for children with disabilities
- Increasing demand due both to rising numbers and to rising demand for services
- Ongoing reliance on one to one therapy and reduced understanding of the wider role of an SLT.

Quality Improvement

Additional posts enabled a review of the SLT service. New evidence recommending a tiered service provision inspired us to reshape our practice. This model provides intervention at an increasing intensity based on the strengths and needs of the child. It promotes prioritisation, equity and assists management of a large caseload. We started by running a pilot of this system in one of the special schools (for those with mild learning disability/ASD).

The team:

- Mapped the 3 tier levels idea onto the service for the school
- Wrote to parents explaining the new SLT service levels and invited feedback
- Completed updated assessments on as many children as possible and updated parents using a standard report format. Again, sought feedback from parents
- Delivered treatment for tier 3 (groups or 1:1) as assigned.
- Trained Teachers and special needs assistants (SNAs) in best practice for communication and becoming a ‘Communication friendly school’.
- Introduced the ‘BLANK’ language model for whole school use and linked it with the national oral language curriculum.
- Adapted a disability prioritisation document which now helps to support every child’s proposed level (tier) of SLT intervention.

Evaluation

- The tiered system of service provision was piloted successfully and has begun further roll-out to a second special school and to those in ASD units in mainstream schools.
- The system reduced staff anxiety and stress over huge caseloads.
- Contact with parents has increased. Feedback from parents and teachers has been positive.
- It led to a person centred, evidence based method of service provision.
- Teachers were trained which allowed a better working relationship and a deeper understanding of roles. Teachers and parents took on that they could to implement aspects of the service.
- This system improved clarity of role for new SLT staff.

However, caseloads are still too large to provide sufficient service at any tier. More resource is needed to educate parents in the journey of their child’s needs. Complex needs invariably lead to the need for more interdisciplinary team work.

Key Learning

- Disability is complex, and a visual 'map' such as the tiered system is very helpful for staff, parents and educators.
- Strong relationships and trust help systems to flourish – work together and listen to others.
- Paperwork should be clear, short with achievable goals for home/school.
- Some confusion persists regarding the SLT role and this needs further discussion.
- Language work can be supported in class and through indirect parent work, speech work needs direct SLT plus parent input.
- Augmentative & Alternative Communication (AAC) and Feeding Eating Drink and Swallowing difficulties (FEDS) are SLT specific and time-intensive.

Scope to Grow

- The initiative was shared with other SLTs in South East Community Healthcare (CHO 5).
- There is a high degree of transferability to primary care.
- This project was highly commended in the HSE Excellence Awards 2018.

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DEVELOPMENT OF ONLINE RESOURCES FOR HEALTHCARE PROFESSIONALS, PATIENTS, AND CARERS FOR FIRST-LINE MANAGEMENT OF MALNUTRITION IN THE COMMUNITY

Understanding the Problem

Estimates suggest 145,000 people in Ireland are at risk of malnutrition. While malnutrition is generally caused by illness, reduced mobility, substance abuse, depression, and isolation can play a role. Malnutrition is unrecognised as a serious health issue. Malnourished people are more likely to be admitted to hospital, have longer stays and need more healthcare supports on discharge. Better management of malnutrition reduces risk of developing sarcopenia, frailty, pressure ulcers and falls. General practitioners (GP), community nurses and others play an important role in identifying and treating malnutrition, and referring to a dietitian.

While hospitals and residential care facilities are a focus for people at risk of malnutrition, the majority live at home, and many would benefit from practical supports to manage this condition. People discharged from hospital need practical supports e.g. recipe ideas to implement advice recommended by their team.

The response to this problem was to develop an online toolkit of resources to support management of malnutrition for patients, carers and healthcare professionals.

Quality Improvement

A multidisciplinary group developed content with input from experts in specialist areas e.g. Community dietitians working in palliative care, research dietitians (UCC) developed cancer resources, informed by feedback from patients and families.

Patient Resources

- Short easy-read leaflets for high protein high energy diet, appropriate use of oral nutritional supplements, and nutritional care in late stages of palliative care.
- A high protein high calorie recipe book ‘Making the most of every bite’.

GP Resources

- Guidance for initiation and renewal of oral nutritional supplement (ONS) prescriptions for GP (with HSE Medicines Management Clinical Programme).

A central hub on the HSE website was developed for these resources and was promoted in media (national TV, radio, newspapers) and through HSE social media.

Evaluation

Feedback was received from patients and family members in a pilot prior to launch:

> *The cookbook has made mealtimes fun again.*

> *It’s hard to think of meals that are nutritious and it helped me to think outside the box.*

> *…thought it was brilliant, would highly recommend it to other families.*

> *It is so hard to find material on weight gaining… having all this information, recipe and calories contained in one book will be so much easier for me!*

Engagement with www.hse.ie/nutritionsupports between December 2017 and September 2020:

- 13,400 Individual users
- 11,600 document downloads to date
- 15,000 high protein high calorie recipe books ordered.

Key Learning

Challenges included low awareness among healthcare professionals about the serious effects of malnutrition, and confusion about the difference between high protein high calorie dietary advice for those at risk of malnutrition and healthy eating messages for the general population. Raising awareness regarding malnutrition improves understanding of the dietitian's role in its management – from food first, to ONS, and enteral and parenteral nutrition.

An online toolkit can:

- Increase awareness of the issue of malnutrition in the health service and wider community
- Support prevention of sarcopenia, frailty, falls, and pressure ulcer development
- Support person-centred care, better self-management and appropriate referral to community dietetic services.

Scope to Grow

- hse.ie/nutritionsupports expanded to include nutritional care information for dementia, wound healing, and during COVID-19, nutrition support in residential care facilities for Older People.
- Content and links incorporated in the National Frailty Education Programme Nutrition Module
- Paediatric (5-10 year olds) high protein high calorie recipe book in development with CHI and UCC.

Resources developed in collaboration with HSE Primary Care Strategy and Planning, and HSE Medicines Management Programme.

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PRIMARY CARE OCCUPATIONAL THERAPY COLLABORATIVE HANDWRITING INITIATIVE

Understanding the Problem

Despite inclusion policies advocating for collaborative working between education and health professionals to support children with needs there has been limited implementation in practice.

Handwriting difficulties were the primary reason for referral to Occupational Therapy (OT) at over 40% and are the most common functional difficulty reported in children with additional support needs. Handwriting difficulties impact significantly on school achievement and future participation in education and employment.

The relationship between writing, literacy, language and cognitive skills is evident in the inclusion of handwriting in new curriculum guidelines in response to falling standards in literacy (1 in 10 children experiencing significant difficulties with writing).Teachers report reduced confidence in teaching handwriting despite research indicating a need for explicit systematic instruction.

Limited collaborative practice alongside inconsistent application of evidence informed approaches to handwriting across disciplines of Occupational Therapy, Teachers and Educational Psychologists impacts on outcomes (Kennedy et al, 2012).

Quality Improvement

The project was informed by a growing body of research advocating for the development and delivery of sustainable and equitable models of practice to address children's handwriting difficulties using collaborative school based outcomes focused models of practice. This project is also guided by the recommendations in the Sláintecare Report, for delivery of an integrated people-centred model of service.

Specifically this project aims to apply a school based model of practice to

- Eliminate lengthy existing waitlists
- Change from referral based caseload model to workload model
- Provide more accessible pathways
- Support early identification and intervention
- Increase the reach and impact of the service
- Improve outcomes for all children including those with needs
- Distribute finite resources more effectively
- Support Universal design for learning educational models of practice

The focus of this project was delivery of universal strategies, and building capacity of practitioners to prepare for using a partnership model of practice for targeted and specialist interventions.

Key success factors for these models:

- Information provision and training is not effective on its own
- Collaborative practice improves outcomes for children and requires the development of learning communities
- Working within the school environment promotes collaborative practice, improved relationship building, knowledge translation and development of a framework for shared language, understanding and enhancing capacity.

Evaluation

- Universal Support Resources provided to 165 primary schools
- 52 in-school workshops delivered
- Improved consistent evidenced informed OT practice and confidence
- Handwriting referrals reduced – currently 24%
- Formal Interdisciplinary Working Forum Established
- Relationship Development Through Collaborative Learning Processes
- Resource Development

Key Learning

- A phased approach to this project has been important in ensuring achievable shared outcomes that facilitated collective engagement in further project objectives.
- The project involves a significant change process to OT service delivery and requires continued review to maintain a consistent evidenced informed approach.
- Leadership and dedicated time is required to facilitate a practice change project.
- The use of a partnership model of practice requires practitioners to gain confidence in using collaborative problem solving coaching approaches.
- Developing relationships with experts nationally and internationally improved the confidence of the forum.
- Ensuring project objectives were aligned with educational system e.g. developing resources that were used by the National council for curriculum and assessment.

Scope to Grow

- International and National services have requested information on this evidence based initiative which provides an effective, sustainable and equitable approach to addressing children's handwriting difficulties.
- Replication of this approach is enhanced by the initiatives alignment with current health and education models of service delivery.
- The knowledge gained from this project can inform more effective interdisciplinary and interagency collaborative practice to support children's participation in schools.

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THE DEVELOPMENT OF A SERUM EYE DROP PROGRAMME IN GALWAY BLOOD AND TISSUE ESTABLISHMENT

Understanding the Problem

Serum Eye Drops (SEs) are a serum derived product used to treat a range of conditions including severe dry eye, Sjorens syndrome, neurotrophic ulcers, stem cell deficiencies, chemical burns and Graft Versus Host Disease (GVHD). Autologous Serum Eye drops (ASEs) are produced from the patient's own serum, yielded from a unit of donated blood. Allogeneic Serum Eye drops (ALSE's) are produced from a whole blood donor unit sourced from the National Blood Centre. ALSE's are used to treat patients who may be unsuitable for donation of a unit of autologous blood.

Serum contains a large variety of growth factors, fibronectin, vitamins and immunoglobulins, some in higher concentrations than in natural tears. These substances contribute to the therapeutic effect of serum in Serum Eye Drops. ASE's and ALSE's are prepared by diluting the serum with sterile normal saline within a controlled environment. Prior to 2011, all patients prescribed ASEs in Ireland had their serum shipped to Liverpool for processing. The product was then returned to the National Blood Centre (NBC) and issued to the patient.

Quality Improvement

The SE team in Galway Blood and Tissue Establishment (GBTE) carried out extensive research into the manufacture of this product in various sites worldwide and also the therapeutic benefits of the treatment, and felt that they had the resources, skill and knowledge to address this service need in Ireland. GBTE validated every step of the process, developed a stringent acceptance criteria and assessment process, devised standard operating procedures, service level agreements and sourced all consumables suitable for manufacturing the product. All documents were encompassed into the well-established and licensed GBTE Quality System.

Following 3 inspections from the Health Products Regulation Authority (HPRA), the license to produce ASE's using the controlled environment was granted to GBTE in December 2011. In 2015, an extension to this license was obtained to produce allogeneic serum eye drops (ALSE's). The programme has expanded rapidly, producing batches for GUH, RVEEH and more recently for St. James' Hospital and Beaumont hospital.

Evaluation

- GBTE have produced over 330 batches of serum eye drops since its introduction.
- GBTE remain the only hospital based laboratory to maintain a GMP license in order to manufacture this product and look forward to expanding the programme further in the future.
- The majority of patients who travel to GUH for donation in the phlebotomy department are very satisfied with the service.
- The product has greatly improved quality of life for patients; many report increased comfort and lubrication in the eye and an improvement in clinical signs and symptoms has been reported from Ophthalmologists in the majority of cases. There are over 40 patients currently receiving regular treatment with SE's.

Key Learning

- The system has been thoroughly validated and improved to ensure the safety and efficacy of the product.
- The SE team have gathered significant clinical evidence of the benefits of the treatment in improving symptoms of severe dry eye and ocular surface defects over the last 10 years.

Scope to Grow

- The Programme won two HSE National Excellence Awards in December 2017 for ‘Best Team’ and ‘Popular Choice’. The system was presented in poster format at the National Excellence Awards Showcase Event in May 2018.
- The programme was presented at Biomedica 2018 and at Staff Information Sessions in GUH.
- The GMP license granted for ASE production enabled GBTE to participate in clinical trials using the controlled environment. Expansion and moving to a new GBTE building in the near future is expected to offer further opportunities.

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THE COORDINATED IMPLEMENTATION AND EVALUATION OF DIALECTICAL BEHAVIOUR THERAPY IN ADULT AND CHILD/ADOLESCENT MENTAL HEALTH SERVICES AT A NATIONAL LEVEL ACROSS IRELAND

Understanding the Problem

Borderline personality disorder (BPD) is a mental health diagnosis characterised by patterns of cognitive, emotional and behavioural dysregulation that often manifests in self-harm and suicidal behaviours. Participation in DBT is associated with reductions in suicidal behaviour and ideation, BPD symptoms, depression and reduction in health service utilisation.

The effectiveness of DBT in routine clinical settings required consideration. Barriers to DBT implementation include lack of financial support, absence of management buy-in, lack of prioritisation of DBT as a treatment, inadequate planning for programme delivery, competing therapeutic priorities, staff attrition and insufficient time.

Quality Improvement

Members of the North Lee Adult Mental Health (Community) Service completed DBT training in the U.K. and began delivery of their DBT programme in 2010. Evaluation showed significant reductions: in service users' borderline symptoms and suicidal ideation from pre-to post-intervention; in the number of emergency department visits; inpatient admissions and inpatient days. Successful expansion of the DBT programme to the wider population of County Cork followed.

In 2013, the National DBT Project was established with funding from the National Office for Suicide Prevention, and a nationwide annual training process began.

Adherence to the DBT model and continually improving skills is achieved through: monthly clinical supervision with an expert DBT therapist, advanced training with international DBT experts and ongoing evaluation of DBT.

Evaluation

- 23 new teams were trained (13 Adult and 10 Child/Adolescent Mental Health teams).
- Additional multi-disciplinary staff have been trained each year to sustain/enhance existing teams' provision of DBT.
- Research outcomes on 109 adult and 84 CAMHS participants found reductions in suicidal ideation, depression, frequency of self-harm, the number of Emergency Department visits and inpatient admissions, during the programme and several months after completion.
- This resulted in improved quality of life for participants and savings to the health service.

Key Learning

- The 'champion' role is critical. In order to imbed an evidence-based treatment such as DBT in a national system, the leader or 'champion' requires knowledge of the organisational culture, expertise in the treatment model, and the ability to recognise system readiness for change, to persuade, influence and gain required system and political support.
- The project co-ordinating team provided a critical role as facilitators and supporters in anticipating potential barriers that impact on successful implementation.
- Provision of annual training to replace staff on existing team, lost to promotions, maternity leaves and transfers is vital in sustaining DBT teams.

Scope to Grow

- 'Skills Only' programme; typically used for those with emotion dysregulation, but no history of self-harm. Research is showing positive outcomes.
- Staff in the Brothers of Charity Intellectual Disability service in Galway were trained and a sustainable DBT programme is available for those attending this service. Collaboration with an addiction service; Arbour House (Cork) trained several addiction counsellors as DBT therapists who work with the mental health teams in their area to deliver programmes including one for dual diagnosis (mental health and addiction). Early results show increased emotion regulation and decreased substance misuse.
- Family Connections; a programme which provides information, skills and a support network for family members of individuals with personality disorders is now available in seven counties.
- Engagement with Post-primary schools, NEPS, CAMHS and HSE Health and Wellbeing on the implementation and introduction of a schools based teacher delivered programme – DBT STEPS-A. Students showed significant reductions in measures assessing depression, anxiety and social stress.

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PREMSMART™: TRANSLATING RESEARCH INTO A NEW MODEL OF CARE FOR PRETERM NUTRITION

Understanding the Problem

In Ireland, ~1 in 100 babies (~600 babies per annum) are born preterm and very low birth weight (<1500g). Preterm babies can be dependent on parenteral nutrition (PN) for up to 10 days of life until full milk feeds are established, provided as daily individualised PN prescriptions (IPN) or as fixed, standardised formulations (SPN). Appropriate nutrition during this time is critical for healthy brain development, yet 1 in 4 four preterm babies has evidence of developmental delay by the time they reach school-age. Traditionally, IPN is used to provide key nutritional support for preterm babies. However, this system is resource intensive and prone to prescribing errors. In addition, the 2015 move by the sole PN manufacturer from a 7 to a 5 day service compromised nutrient supply. This reduced service leads to increased PN wastage and inappropriate use of clinical staff time. Emerging evidence supports SPN but efforts to increase SPN use were constrained by the current nutritionally inadequate preterm SPN products.

Quality Improvement

Collaboration between CUMH, UCC and industry in the area of preterm nutrition led to the development of a new Model of Care (MOC) for preterm nutrition: PremSmart™ (Preterm Standardised Modeled Regimens for Transitional Nutrition). Led by Dr. Ann-Marie Brennan, Clinical Specialist Neonatal Dietitian, CUMH, the PremSmart™ MOC includes two new nutritionally superior SPN products produced by industry with an accompanying evidence-based protocol. This MOC has been designed to deliver better and safer care for preterm babies.

Dr. Brennan conducted her research initially on the BabyGrow Preterm Study which revealed nutrient deficits and growth failure in preterm babies, partly due to nutritionally suboptimal PN. Her analysis of PN was a transformative piece of research, which led to the development and implementation of the PremSmart™ MOC. Using the BabyGrow data, an innovative nutrient modeling technique was employed to determine the composition of two new data-driven SPN regimens that would safely deliver recommended levels of nutrients to support growth without providing excess, as babies transition from PN onto milk feeds. This is the first time nutrient modeling has been used to determine the composition of PN that fully meets the needs of preterm babies. Following a dietitian-led implementation strategy, this innovation has been in operation in CUMH since 2018 and first time, clinical validation of the PremSmart™ MOC was completed in 2020.

Evaluation

The PremSmart™ MOC has resulted in:

- Improved nutrition and growth outcomes.
- Improved patient safety due to increased use of SPN.
- Optimum use of clinical staff resources due to the simple to use prescribing protocol (>90% compliance).
- Annual cost savings of €100,000 to CUMH due to a 92% reduction in IPN use.
- Four international peer-reviewed publications and Dr. Brennan was awarded a PhD by UCC.

Key Learning

- Collaboration between clinical dietitians, neonatologists, pharmacists and academic nutrition scientists can deliver improvements in clinical care.
- Successful implementation of the PremSmart™ MOC required a comprehensive implementation strategy.

Scope to Grow

- The National Clinical Programme for Paediatrics and Neonatology PN Expert Group has endorsed the PremSmart™ MOC for national roll-out which is scheduled to begin in 2020 and will move our current complex and individualised system to one which is standardised and data-driven with superior clinical and economic outcomes.
- As part of the PiNPoINT (Personalised Nutrition for Preterm Infants) study, the same team will conduct detailed growth, developmental and neurological assessments in babies receiving the MOC.
- The innovative nutrient modeling approach could inform future development of nutritional products and nutritional support in intensive care settings.

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REDEFINING AND RECONFIGURING THE LONGFORD-WESTMEATH PRIMARY CARE LIFESPAN PSYCHOLOGY SERVICE TO MEET THE NEEDS OF LONGFORD-WESTMEATH INDIVIDUALS AND FAMILIES

Understanding the Problem

Increasing number of referrals and 40% reduction in staffing were leading to growing waiting lists and it was no longer tenable to offer individual sessions without increasing waiting times to over 18 months. Prolonged waiting times meant that clinical presentations could potentially become more entrenched and severe. It was clear from referrals that not everyone referred required one to one sessions. The title reflects the experience of changing an existing system of service delivery to one that better meets the needs of our clients, whilst also addressing the reality of reduced staffing, resources, and multiple locations for service delivery.

Quality Improvement

Prior to this initiative referrals were processed by individual psychologists, and clients were typically offered a one to one clinical intervention. Now a range of interventions are available which work from least intensive (monthly Advice Clinics accessed through self/GP referral); through to a diversity of group interventions; and on to more intensive individual interventions.

Once received, all referrals are triaged, then formally processed at a weekly referrals meeting by a rotating team of two Psychologists. Decisions about the most appropriate level of intervention are taken – which can involve direct collaboration with clients, to ensure the service best meet their needs. Referrals to groups are directed to the L-W Assistant Psychologists who operate as group coordinators, contacting clients, providing information about the group intervention and when and where they will operate. Referrals not suited for a group are waitlisted for individual intervention. Both group and individual client progress is monitored via pre-post intervention measures. If clinically indicated additional interventions/supports are offered.

Evaluation

- Average wait time reduced from 52 to 22 weeks (Aug 17 vs. Aug 18).
- Number of DNAs fell from 94 (Jan-Aug 17) to 38 (same period in 2018).
- Majority of clients (80%) attended group intervention or advice clinic as their first step in their care pathway.
- More individual cases opened due to greater time efficiency.
- Number and range of groups offered increased fourfold.
- Greater choice of evidence-based interventions.
- Equitable access across Longford-Westmeath to group interventions.
- Timely interventions can prevent problem escalation and entrenchment.
- By attending group interventions, clients can gain a social support network.

Key Learning

- It is possible to provide a quality, timely and evidence-based assessment and intervention service: even with reduced resources and increased demands.
- Given a choice many people opt for, and benefit from, less intensive interventions.
- Group provision has reduced mental-health stigma and increased attendance of people traditionally reluctant to attend psychology services.

- Change in service delivery, if managed properly and with buy in from colleagues can happen quickly, and lead to more dynamic work practices.
- It is essential that team members work collaboratively and are open, willing and committed to change service delivery to provide a more responsive service.
- Excellent administrative support is required to provide responsive delivery.

Scope to Grow

- Additional group interventions will be offered.
- Build capacity by training other health professionals/volunteers to deliver specific programmes e.g. Paths to Wellness group intervention.
- Enhance further the Assistant Psychologist role.
- Consolidate links with universities & provide additional clinical placements.

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EARLY SUPPORTED DISCHARGE FOR STROKE: INTRODUCTION OF TELEREHABILITATION IN RESPONSE TO COVID-19

Understanding the Problem

Early Supported Discharge (ESD) Stroke teams aim to accelerate discharge home through intensive home-based rehabilitation for stroke survivors. The arrival of the COVID-19 pandemic significantly reduced the Cork ESD teams' ability to provide the service. Stroke continued to occur at the same or greater rate during the pandemic. While there was a greater need to expedite hospital discharge, increase bed capacity and enforce social distancing, stroke survivors and their carers still required essential rehabilitation services. An alternative to direct contact visits was urgently required.

The Cork ESD team, introduced telerehabilitation through video calling via online platforms. A small number of studies regarding telerehabilitation have revealed positive benefits; however there is little evidence in ESD services and it was new to the team members.

Quality Improvement

Committed to providing a dedicated stroke rehabilitation service, the ESD team turned to telerehabilitation, developing clinical, technical and organisational processes and skills, and setting clear aims to develop a safe, effective and person-centered service. The team engaged with key stakeholders including other ESD teams and the National Stroke Programme. This facilitated sharing experience and learning in managing stroke related deficits safely and effectively through virtual means.

Cross sector collaborations and new working relations were developed with the local IT department and the national HSE Office of the Chief Information Officer to incorporate IT quality and safety considerations in the design, implementation, and operation of the telerehabilitation service. International collaborations were established with stroke rehabilitation services in the UK to produce a joint UK and Ireland collaborative statement on the rationale for maintaining ESD teams during COVID-19. In conjunction with colleagues in their referring sites and other local outpatient services the ESD team developed a standardised protocol and operating procedure. This reduced variation between specialities and disciplines.

Evaluation

As many health care providers are now developing, deploying, and delivering telehealth, there is a requirement to examine and evaluate the structure, process and outcome of this service model.

The benefits reported by patients, family members and clinicians include:

- Continued rehabilitation in the patient's own home enabling goal focused functional therapy.
- Reduced anxiety for patients and caregivers regarding COVID-19 transmission.
- Improved access to specialist stroke services for patients living in geographical areas outside of the traditional catchment area.
- Clearer communication with patients as no face mask was required in sessions.
- Supported involvement of family members in the therapy sessions.

Key Learning

- Telerehabilitation is rapidly expanding. As we prepare for the future, telerehabilitation *must* be safe, effective, efficient, timely, equitable, and patient-centered.
- Telerehabilitation, as an alternative form of rehabilitation for people with stroke is useful and is an appropriate remote service delivery model for some patients.
- This model of practice provided flexibility to the ESD team to continue treating stroke patients at home and provide essential rehabilitation services while following best practices and social distancing guidelines.
- Our experience to date has demonstrated a significant positive impact on patient's overall health and improvements across functional performance domains.

Scope to Grow

- There is a need to standardise practice within telerehabilitation.
- Clinician, patient and carer feedback is vital to drive improvement.
- Data should be measured and shared in a transparent manner to provide quality assurance and for collective learning.
- The Cork ESD team aim to conduct both qualitative and quantitate research on this service delivery model in the Irish context engaging with stakeholders including higher education institutions.

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IMPROVING ULCER PREVENTATIVE OFFLOADING CARE FOR THE AT-RISK FOOT – AN INTEGRATED APPROACH

Understanding the Problem

This initiative was prompted when a patient was admitted into hospital with an infected foot ulcer. It was discovered that 9 months earlier he had been assessed and prescribed foot orthoses to off-load the area which had now ulcerated. This infected ulcer could have been prevented by improving the service of offloading care for the at risk foot and the provision of orthotics. There were 1,297 hospital stays for Diabetic Foot Ulcer management in Ireland in 2008 with a conservative cost estimated at €23,489.63 per stay. The National Model of Care for the Diabetic Foot recommends the use of pressure relieving/offloading measures such as foot orthoses to be prescribed as a preventative measure to reduce the development of foot ulcers and their recurrence once they have healed. Offloading services have presently been delivered locally by multiple private providers without any clear governance structure.

Quality Improvement

A review of how the service delivery for foot orthoses existed in the Wicklow Primary Care and St. Columcille's catchment area, was undertaken by Anita Murray, Senior Diabetes Podiatrist and Alison Wellwood Senior Community Physiotherapist. Long waiting times (over 52 weeks), lack of clarity regarding procedures, clinical risk of a patient's condition deteriorating and requiring in-patient care were some of the challenges observed. Lack of communication and collaboration between hospital referral and community care follow up, and uncontrolled costs due to outsourcing to external companies was found. The scope to improve service for the patient through implementation of the National Model of Care for the Diabetic Foot in relation to improving ulcer preventative offloading care was identified and with the support of management and budget holders the team began to make changes around the patients' needs.

Evaluation

- Objectives were achieved having an impact on both quality and cost.
- Waiting times reduced from 52 week to 6 weeks, patient journey steps significantly reduced due to the ability of the practitioner to assess and prescribe on the same day.
- 95% patient satisfaction.
- Direct cost savings of 72% from €18,214 to €5,175.50 for 20 patient interventions.
- Indirect cost savings achieved through hospital avoidance estimated at €30,000 per patient inpatient stay avoided
- All these efficiencies were achieved without additional staffing or other resources to the service.

Key Learning

- A gap for the need of MSK Podiatrist was identified during the project implementation, an outside source provided the podiatry MSK support needed to carry out the project.
- A need to explore opportunities for further reduction in cost and wait times by prescribing and making orthoses locally on the same day as the initial assessment.
- Continuous evaluation of the care delivery model is required to ensure optimal patient journey and continued improvement in care delivered as close to home as possible & at the lowest level of complexity needed.
- 6 monthly review of Functional, Quality of Life and Patient Satisfaction is required to ensure quality of service for the patient.
- Mentoring – both lead clinicians agree on the value of structured and supportive mentoring that was received by local management as an essential component to the progress of the initiative Service models.
- Care Pathways and effective governance were put in place for sustainable care.
- Hospital and Community Collaboration.
- Engagement with service users.
- Sharing of knowledge and expertise.

Scope to Grow

- Through presentations to General Management in Primary Care, G.P's, Diabetic teams, Best Practice National Study Day for the At Risk Foot
- Community Physiotherapists and Podiatrists in other CHO areas; North Dublin, Nenagh, Ballyfermot, Ballymun are in regular contact in relation to service development in their areas
- Build on relationships established through the working group to explore further integration of services between the Physiotherapy and Podiatry teams in the Community to manage other chronic conditions which put the foot at risk of ulceration – such as Rheumatoid Arthritis, Neurological and Orthopaedic conditions

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VIRTUAL FRACTURE CLINIC IN OUR LADY OF LOURDES HOSPITAL DROGHEDA

Understanding the Problem

Our lady of Lourdes Hospital Drogheda is the trauma centre for the north east region of Ireland with 7 fracture clinics per week seeing 17,000 to 20,000 patients annually. Clinics can have up to 100 attendances with patients waiting up to 3 hours to be seen. There is not enough time to manage complex cases while many patients do not require review as they have simple, stable, self-limiting injuries. Further potential improvements identified include: the use of modern splints which promote functional rehabilitation and self-care; optimal use of competencies of physiotherapists, plaster technicians and nursing; and collaboration and opportunity for learning between staff members.

A re-designed fracture clinic process creates the opportunity for simple fractures to be managed by the multi-disciplinary team via a protocol driven Virtual Fracture Clinic (VFC).

Quality Improvement

The aim of this project was to reduce the number of consultant led clinical reviews from 100% to 85% percent in Our Lady of Lourdes Hospital (OLOLH) fracture clinic by March 2017.

The HSE Framework for quality improvement was used to guide the initiation, planning and implementation of the project. Data was collated to determine condition trends, which demonstrated that many patients can be safely managed by self-care or physiotherapy rather than the need to see a consultant. The voice of the patient was captured to ensure any re-design meets the needs of the service user. Protocols were agreed with all health-care providers for conditions suitable to be managed in a re-designed patient pathway. Stakeholders were engaged with the planning and formation of project. Each suitable patient is treated in the emergency department (ED) and thereafter x-rays and ED notes reviewed virtually by the consultant. The patient does not need to attend the clinic, but is contacted by phone and a plan of care initiated.

Evaluation

- The new process is evaluated by auditing the numbers attending the virtual fracture clinic and analysing patient satisfaction and experience.
- Results to date indicate a positive trend towards reduced number of consultant led appointments with 3,000 patients successfully managed in the new pathway.
- These patients are all spared at least one unnecessary attendance to hospital.
- Data indicates an enhanced patient experience, with a difference of 4 points in median scores on a 10 point Likert scale, between a virtual clinic group and a traditional fracture clinic group.

Key Learning

- The impact on the service user is apparent by the positive results from satisfaction and patient experience data.
- Interdisciplinary collaboration sustained the project. Relationships between ED, orthopaedics, physiotherapy, nursing, clerical staff and plaster technicians has been enhanced.
- The implementation of the pilot study has been resource neutral. The time it takes the physiotherapist to call and advise the patient about the outcomes of the virtual clinic is no longer than a face to face interaction.
- The impact of COVID-19 has been a factor in mainstreaming the process across all regional sites which has led to a significant upward trend in virtual care.

Scope to Grow

This process has the potential to be implemented on a national scale.

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ESTABLISHING A REACTIVE HOME NASOGASTRIC FEEDING SERVICE FOR HEAD AND NECK CANCER PATIENTS UNDERGOING RADIOTHERAPY AND/OR CHEMOTHERAPY

Understanding the Problem

The incidence of malnutrition at diagnosis in Head and Neck Cancer patients is estimated to be 30-50%. Treatment toxicities from radiotherapy and chemotherapy exacerbate the risk of malnutrition during treatment and as a result patients frequently require artificial nutrition support. Current literature suggests that compared to reactive enteral feeding, prophylactic enteral feeding does not offer advantages in terms of nutritional outcomes, interruptions to radiotherapy or survival.

Nasogastric (NG) feeding is the preferred choice if artificial nutrition support is expected to be required for 6 weeks or less. Even though medically stable, these patients often remain inpatients solely for their nutrition via NG feeding.

Quality Improvement

This project aimed to assess whether it was feasible to manage patients with reactive nasogastric (NG) feeding in an outpatient setting with input from the acute multidisciplinary team only.

Head and neck cancer patients were screened for suitability for home NG feeding. Suitability criteria included clinically significant weight loss, dysphagia, meeting <65% of dietary requirements for more than 72 hours and enteral feeding anticipated for <6 weeks. Patients needed to demonstrate that they would be able to care for the NG tube at home either independently or with family support. Initial results were reviewed after the pilot phase which demonstrated that patients were successfully managed on NG feeding as outpatients without any adverse events. A policy and procedure document was developed and implemented. Data collected was analysed using Microsoft Excel.

Evaluation

17 patients were successfully managed at home on NG feeding over a 40 month period (Dec 2014 – March 2018). 15 patients were male and 2 female. 16 patients had their NG tubes placed due to <65% requirements for more than 72 hours and had at least 5-10% weight loss. 1 patient was placed nil by mouth and discharged home on NG feeding whilst awaiting a RIG placement.

The cost of a patient at home on NG feeding for 1 day was estimated to be €11 versus €800 euro per day if the patient remained in hospital. The mean home feeding time period was 21 days resulting in a total cost saving of €283,251.

Key Learning

- This was a Dietetic led project with close collaboration with medical and nursing staff.
- A key learning point was that a small change can make a difference to the quality of life of a patient with limited impact on resources.
- However, it is vital that patients are selected on a case by case basis as home NG feeding is not suitable for all patients.

Scope to Grow

- Training for Dietitians on placing NG tubes has the potential for advancing scope of practice for the profession.
- This initiative is transferable to other Dietetic Departments in Ireland especially centres which specialise in radiotherapy and chemotherapy.

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FRAILTY INTERVENTION THERAPY TEAM

Understanding the Problem

Emergency Department (ED) crowding is associated with increased: mortality, length of stay (LOS), patient harm and reduced staff morale. Frail older adults, who are discharged following ED attendance, are at risk of re-attending and readmission within three months (AMP, 2010). From 2015 to 2019, the number of patients ≥75 years presenting to the ED, Beaumont Hospital (BH), rose by 41.8% (n=7,320 to n=10,381). This places significant pressure on the ED and organisation. In 2019, of the 28 patients aged ≥75 years who presented to the ED per day, 14 required admission.

Quality Improvement

The FIT Team is a HSCP Team consisting of Physiotherapy (PT), Occupational Therapy (OT), Medical Social Work (MSW), Speech and Language Therapy (SLT), Dietetics and Pharmacy and has strong links with the ED Nursing and Medical teams. All patients ≥75 years are screened for frailty on arrival in ED during core working hours with the aim of assessing patient need, arranging care at home where this will avoid admission.

FIT Team function in the ED

1. Identify frail older people
2. Early generation of HSCP referrals with immediate response
3. Initiate a Comprehensive Geriatric Assessment (CGA)
4. Maintain an ethos of ‘every hour counts’ for frail older people
5. Stream to the appropriate destinations as soon as possible:
    a. Admission: assist with selection of appropriate patients for the Specialist Geriatric Wards (SGW’s).
    b. Home: may link the patient with community services i.e. Primary Care Teams (PCT’s), Day Hospital.

Evaluation

Since 2015, the FIT Team contributed to a positive culture towards addressing the needs of the older person in the ED. 59% of patient’s ≥75 years who present are seen by the FIT Team (n=6,212) yet the team’s working hours are 22% of a 7 day week. The impact of FITT:

1) Coordinating each discharge carefully, minimising future crisis, FITT input improves patients’ ability to remain at home for longer before representing. A pre-(2014) and post-(2018) FITT data review showed that patients in April 2018 remained at home significantly longer at day 7, 30, 60 and 90. Cumulatively, these ≥75 year old patients remained at home an extra 2,698 days before representing. Extrapolating to one year, this figure is 32,376 days.
2) FITT positively impacts LOS for admitted patients by assisting in the selection of appropriate patients for the SGW’s. Comparing 2016 to 2019: shows 34% increase in the number of patients ≥65 years discharged whilst requiring 2.7% less bed days.
3) FITT is one element in the overall system change within the Care Of the Elderly services which assisted in reducing the Longterm Care (LTC) conversion ratio, through measures above and day hospital management of patients with complex needs between community and the acute setting.

Key Learning

- Coordinated, interdisciplinary working is necessary and increases capacity within the FIT Team.
- Embedding FITT within the ED and hospital systems is necessary to influence change and spread.
- Key enablers: timely access to medical review and diagnostics, access to community services outside of traditional hours to support discharges.
- Clinical Specialist level HSCP with significant clinical experience in care of the elderly are needed to lead senior decision making on the acute floor.
- Quality Improvement methodology is engrained within the culture and service design of FITT.

Scope to Grow

- Development of an Acute Frailty Unit so care continues over a 24 hour period to reduce LOS. A recent test of this joint approach improved discharges by 20%.
- Develop the interface with the Sláintecare funded Pathfinder service and cANP in Gerontology.
- All patients' ≥75 years to be triaged for frailty regardless of when they present.

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BEAUMONT HOSPITAL/NATIONAL AMBULANCE SERVICE ALTERNATIVE CARE PATHWAY 'PATHFINDER' SERVICE

Understanding the Problem

Older people are at high risk of experiencing adverse events due to Emergency Department (ED) presentation (e.g. pressure ulcers, infections, functional decline, delirium and falls). A prolonged ED length of stay (LoS) can cause increased hospital LoS and increased mortality. 17,708 people aged ≥65 presented to Beaumont Hospital's (BH) ED in 2019 and approximately 47% were admitted. In 2019 the average LoS for these patients was 15 days. A third of people with dementia admitted to hospital are discharged to nursing home care.

Typically, every person attended by the National Ambulance Service (NAS) and the Dublin Fire Brigade (DFB), after phoning 999/112, are transported to ED unless they decline.

Quality Improvement

Pathfinder is funded by the Sláintecare Integration Fund and commenced in March 2020. The current service design is informed by tests carried out in 2019, using existing resources from both organisations.

Pathfinder service:

- The 'Rapid Response Team' consists of an Advanced Paramedic (AP), Clinical Specialist Physiotherapist (PT) and a Clinical Specialist Occupational Therapist (OT), and operates 8am-8pm Monday-Friday.
- The 'Follow-Up Team' consists of a Senior PT and Senior OT and operates 8am-4pm Monday-Friday.

The Pathfinder Rapid Response Team attends low acuity 999/112 calls dispatched by the National Emergency Operations Control (NEOC) centre to people meeting the criteria: specific dispatch determinant code, or a crew referral, or a special-services call; age ≥65; and within the BH catchment area.

Instead of ED conveyance, the person is assessed at home. This involves a clinical assessment by the AP (including medical history, vital signs, ECG) and a functional assessment by the OT/PT (including frailty, cognitive and home assessments). Where appropriate the older person is treated and discharged by Pathfinder, or referred to an appropriate service. Decisions are reached regarding conveyance to ED in consultation with the patient e.g. for required investigations or treatment.

The Pathfinder team liaises with ED teams, including the Frail Intervention Therapy Team, to reduce the LoS in the ED, and where possible, enables safe same-day discharge.

The Pathfinder Follow-Up Team supports patients at home through further assessment and interventions e.g. providing equipment, linking the patient with appropriate community health and social care services.

Evaluation

- Older people receive care in the most appropriate place, improving access to healthcare, satisfaction and outcomes.
- People may be referred to the Geriatric Day Hospital, GPs, Public Health Nursing, the Community Intervention Nursing Team, Integrated Care Team, Primary Care services and voluntary agencies reducing risk of older people experiencing adverse events, due to unnecessary ED attendances and admissions.
- Older people, who do need to attend ED, can be supported by one team pre-hospital, in ED and on discharge.

Data is being collected to enable evaluation and replication:

- Primary outcomes for each patient e.g. ED conveyance, treat and discharge at home, treat and refer to follow-up services at home,
- Secondary outcomes e.g. referral options utilised, follow up visits completed, same day discharge from ED, ED representation,
- Patient Experience,
- Cost benefit analysis.

Key Learning

- Shared clinical governance across both organisations is essential.
- Engagement with all stakeholders is key: knowledge and integration of pre-hospital, ED, geriatric, acute, community and voluntary services is vital.
- Clinical Specialist HSCP with significant Geriatric and ED clinical experience are needed to lead senior decision making.
- Continuous use of QI methodology in service-design and reconfiguration.

Scope to Grow

- Increase awareness of Pathfinder service with NEOC, NAS and DFB to increase referrals.
- Widening skill-set of clinical team and access to point-of-contact, and/or satellite clinic, diagnostic equipment (e.g. bloods, suturing, and antibiotics).
- This model of care could be replicated, with local adaptation, across Ireland.

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PRIMARY CARE RADIOLOGY CASTLEBAR

Understanding the Problem

County Mayo has one of the most geographically dispersed populations in the country. The Radiology Department in Mayo University Hospital (MUH) provides X-ray, CT, Ultrasound, MRI, Fluoroscopy & interventional radiology to in-patients, out-patients and GP referred patients.

Waiting times for general radiography (x-ray) service for GP referred patients in MUH was approximately eight weeks in the main (hub) radiology department in MUH.

The department was operating at capacity and the infrastructural changes required to provide additional capacity would cause significant disruption to the work.

Quality Improvement

The use of primary care centres integrated with local acute radiology services enables a large volume of less complex radiology exams to take place in community, avoiding unnecessary hospital attendance.

Off-site (spoke) general radiography services were provided in Belmullet Community Hospital and Ballina District Hospital, reported and coordinated from the hub via National Integrated Medical Imaging System (NIMIS).

A new Primary Care Centre opened in Castlebar and from May 2017 a daily satellite X-ray service commenced. 5,192 X-rays were provided in 2018. This resulted in an immediate drop in waiting times.

LEAN management principles were applied throughout and there was constructive support from management in Primary Care and the Saolta University Healthcare Group.

Evaluation

Benefits of Integration of Primary Care Radiology with Hospital Radiology Service:

- This new innovative service offers a faster, more efficient and higher quality service to patients & GPs while releasing greater diagnostic capacity in MUH for patients with acute illnesses.
- For patients, attending primary care centres means they avoid hospital attendance and the centres are often closer to home and easier to access.
- Existing resources IT/PACS infrastructure can be utilised.
- Existing consultant resources utilised and consistency in reporting assured.
- Increased Radiographer WTE for core service.
- Turnaround times for reporting of these examinations are exceptionally low with most reported by a consultant radiologist on the same day.
- Reduced presentations in ED and AMAU to access imaging.
- Integrated into the existing acute service if acute treatment or follow-up imaging is required.
- Radiographer vetting of referrals allows patients to be accommodated in hospital as appropriate.
- Cross cover of staffing allows minimal closures due to annual leave etc.
- Consistency in radiation safety, clinical protocols, image quality etc., is assured across the service.
- This increase in radiography capacity was realised without any disruptive and expensive building or retrofitting in the radiology department.
- Assess to routine diagnostics in acute hospital settings during the Covid-19 crisis has been challenging. The availability of X-ray and Ultrasound in Primary Care maintained a separate stream of activity.

Key Learning

- Involving all stake holders early to ensure they understand the potential “wins” for them.
- Direct more complex cases and modalities to main service.
- IT and infrastructural requirements ideally need to be considered at design or building stage as retrofit can be difficult.
- Staff resources/skill set in core services need to be protected to ensure sustainable increase in capacity is realised.
- Close coordination between community and acute staff is required.
- Not a “walk-in” service – too unpredictable/complex.

Scope to Grow

- The success of this initiative led to funding for mammography and ultrasound services in the same site. Ultrasound and Mammography services successfully commenced in 2019, and are also integrated with the Radiology department in MUH. The mammography service is a satellite component of the symptomatic breast service in Galway University Hospital.
- Plan to commence ultrasound in Claremorris Primary Care Centre in Q3 2020 to further increase scanning capacity outside the hospital.
- Other modalities possibilities – DEXA & MRI.
- Potential for role expansion for radiographers/sonographers (reporting).

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ENSURING EFFECTIVE PERSON-CENTRED CARE AND SUPPORT, USING A SOLUTION FOCUSED APPROACH, FOR SPEECH AND LANGUAGE THERAPY (SLT) SERVICE USERS IN DUBLIN SOUTH EAST

Understanding the Problem

Interventions for service users with speech, language and communication needs (SLCN) have traditionally been based on a medical model, implying a reductionist approach to health problems-viewing them primarily in terms of fundamental constituents.

The department recognised the need to move away from the medical model, and to adopt a bio-psychosocial model of service delivery. This model looks beyond impairment and responds to the rights, needs and preferences of service users, enabling them to make informed decisions about their care, and collaborating with them to work towards results that matter most to them.

Quality Improvement

The department received training in the 'Solution Focused Approach', and learned how to establish clients 'best hopes', empower people towards progress, and creatively make best use of resources. Following further exploration and understanding of this approach, service delivery was adapted and areas and stages for introduction were explored.

A solution focused approach is now used in targeted, specialist and universal care to ensure collaborative engagement with clients and other professionals. As equal stakeholders with our clients, we operate from a strengths-based perspective and support service users in active participation in their own effective care, which has real and meaningful outcomes.

The following initiatives were introduced:

- 'Ask the right questions' – encourage services users to express their needs and wishes. Value and integrate this information with the SLT's evidence based-knowledge and expertise to co-design intervention.
- Design of Person-Centred interventions: e.g. 'Parent Implemented Intervention' using strengths-based and solution focused facilitation.
- Defined Clinical Pathways.
- Universal service delivered through solution focused interactive workshops for professionals including Public Health Nurses, teachers and 'early years' practitioners.
- Monthly 'drop-in' clinics.
- Person-centred, solution focused written documentation, using Plain English, to clearly outline clients' needs, aspirations, agreed goals and supportive strategies.
- Annual service user feedback; regular feedback following workshops and interventions.
- Focus groups with service users and professionals to inform service delivery plans.

Evaluation

- 2017 paediatric service user feedback: 96% agreed/strongly agreed that they worked jointly with the therapist, 96% agreed that therapy was helping their child.
- Modernising our approach, and maximising our use of resources, maintained paediatric initial assessment waiting list at a maximum 4 months; first steps towards meaningful outcomes for clients are taken at that first point of contact.
- Integrated interdisciplinary work and collaboration has increased.
- Qualitative research with SLT faculty NUIG 2016 highlighted successful outcomes of particular solution focused interactions and supported balancing of the expert role between client and clinician.

Key Learning

- Inclusion of service users in decision making, regarding their current and future needs, is vital to the achievement of meaningful outcomes for them and for effective use of resources.
- Being explicit and sharing responsibility in the therapeutic relationship is important.
- Focusing on solutions, rather than solely on the problem, is key to providing a quality, efficient, effective and responsive service that respects the values and dignity of service users.
- Changing a mindset can be challenging but not impossible. Peer support is important in supporting service delivery change.

Scope to Grow

- The innovation has been shared locally and nationally – 29 workshops conducted (570 SLTs).
- Solution Focused Approach training-delivered by team members – facilitated by IASLT.
- Emerging evidence that Solution Focused Approach supports further application in multidisciplinary settings for positive outcomes.
- Highly commended at the National Adult Literacy Agency Awards for Plain English, 2017.

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MEANINGFUL MOMENTS: FACILITATING SENSORY EXPOSURE, ENGAGEMENT AND POSITIVE COMMUNICATION IN THE HOME DURING EVERYDAY ACTIVITIES

A collaborative programme created and facilitated by speech and language therapy, dietetics and occupational therapy.

Understanding the Problem

The “Meaningful Moments” programme was initially implemented in a large residential service which supported adults with moderate to severe/profound levels of intellectual disability (ID). This service was in the process of decongregating. The “Meaningful Moments” programme targeted identified occupational deprivation and a lack of meaningful interactions in the lives of adults with an ID. The word *Meaningful* is used to encourage the removal of tokenistic and inaccessible communications and to highlight a lack of valued social roles and active participation in home making and other activities of daily living. The word *Moments* is used to capture the fact that it is a sequence of small segments in time which combine to create an overall task/activity or interaction. The aim of the programme was identifying which small intentional changes in these everyday moments might improve the quality of a task/activity or interaction for an individual (thus cumulatively increasing the quantity and quality of moments of positive interactions and purposeful engagement).

Quality Improvement

Senior management approached a local HSE MDT for support in responding to an identified need to engage individuals residing within their service during meal preparation. Members of the MDT including practitioners from the areas of speech and language therapy, dietetics and occupational therapy recognised a broader focus was required and devised a programme to provide support across a range of activities of daily living. Existing MDT resources were used to devise a flexible programme comprising 5 sessions which would be delivered in community based homes with adults with an ID and their staff support teams. To ensure a person-centred programme, adults with an ID and their staff support teams were engaged in collaborative goal setting at the outset and collaborative evaluation and forward planning at the close of the programme.

Evaluation

- The programme delivered good outcomes by developing staff capacity to support adults with ID to interact with others and to participate in everyday tasks and activities which reflect the skills and interests of individuals.
- Programme facilitators supported staff in identifying SMART goals and written feedback to establish a baseline which can be evaluated at the end of the programme.
- Research guided the development of an onsite, client focused, mentor-guided programme, which documented and shared effective strategies with key stakeholders ensuring good outcomes were sustained.
- The programme encouraged a shift away from a “care for” to an “actively support” model of practice, thus impacting positively on mental, physical, sensory and emotional health.
- The programme allowed for collaborative team-work in relation to clinical needs that arise for adults with an ID during the programme. This may have decreased waiting time for adults with ID in accessing relevant MDT support.
- The success of the initial delivery of the programme led to demand outweighing the capacity of the MDT to provide the programme across settings.

Key Learning

- The importance of ensuring interdisciplinary working, to ensure person centred care and best possible outcomes for each individual from the programme.
- The necessity for collaborative goal setting, including the individual roles of the HSCP involved, was highlighted to ensure meaningful individualised person centred outcomes.

Scope to Grow

The programme is person-centred and focused on individual needs, strengths, opportunities and barriers. As such it is responsive and flexible, relevant and immediately transferrable to many people within the adult ID population.

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EMPOWERING PARENTS OF CHILDREN WITH AUTISM SPECTRUM DISORDER TO SUPPORT AND MAXIMISE THEIR CHILDREN'S DEVELOPMENT POTENTIAL THROUGH THE USE OF EVIDENCE BASED MDT DELIVERED PARENT TRAINING PROGRAMMES

Understanding the Problem

Challenges faced by the School Age Disability Team and by children and families who are served by St Gabriel's Children's Services include large caseloads and limited resources. The multidisciplinary team (MDT) reviewed the service delivery model for working with children with Autism Spectrum Disorder (ASD) and their families and considered the difficulty for parents implementing strategies recommended by clinicians in the home setting.

Quality Improvement

The initiative was to design, develop and deliver parent training programmes (PTP) led by Clinical Psychology, Speech and Language Therapy and Occupational Therapy. Models of service delivery, parent training, coaching, family centred practice, natural learning environments and learning in context were researched to provide an evidence base for the PTP. This informed the shift from direct therapy to a model that considers the child's specific needs, level of functioning, age, and focuses on empowering parents to support their child at home.

- Parent and Child priorities for intervention were identified throughout to inform the content of the PTP
- PTP have been incorporated into the ASD care pathway in use by the School Age Disability Team.
- The programmes last for 2.5 hours and run over 6 weeks with two follow up sessions to evaluate and review goals.
- A home visit is completed between the first set of six sessions and the follow up sessions.
- Parent coaching, which is embedded in family centred practice discourse, offers a basis for determining the approach in devising PTP
- A suite of programmes were developed including "Understanding Autism", "Emotional Regulation and Well-Being"

Aims of the PTP:

- Empower parents to support their child/children with a diagnosis of ASD in developing skills across a number of functional skill areas
- Use a MDT approach to address parent questions, utilising the diverse skill base of the team to support and coach parents to find solutions relevant to their child
- Provide parents with an opportunity to form peer networks and problem solve together

Evaluation

- Parents reported satisfaction and increased confidence levels supporting their child and satisfaction with the peer networks.
- More families have received intervention.
- Although the approach is group based, it is person and family centred through goal setting and problem solving specific to the parent's own child and their context and resources.
- Children with complex needs often find clinic visits distressing. Providing training to parents allows parents to support their child in their home environment.
- Feedback from parents informs redesign and continuous development of the programmes.
- Children are consulted regarding what their parents need to know to support them with ASD.

Key Learning

- This interdisciplinary collaborative model, utilising the diverse skills of the MDT has been highly beneficial in maximising functional goals and quality of life for children and their families.
- Moving from time consuming, centre based therapy aimed at “fixing” difficulties, to a parent empowerment model has improved outcomes. Therapy in clinic is often not transferred to home.
- Evidence based materials and resources add to the quality of the service.

Scope to Grow

- The team evaluate the effectiveness of the programmes with a view to continuously enhancing them.
- The content of programmes is transferable to other services.
- The PTP were shared with MDT in CHO3 and presented at the inaugural Progressing Disability Services conference in 2017.
- An abstract was accepted for publication in National Institute of Health Research Bulletin (Spring 2018).

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HSCP BEST PRACTICE AND INNOVATION DURING COVID-19 – THE MEDICAL SOCIAL WORK ROLE IN PATIENT/FAMILY LIAISON IN THE MATER MISERICORDIAE UNIVERSITY HOSPITAL

Understanding the Problem

Government imposed restrictions to protect vulnerable people during the COVID-19 pandemic prohibited visiting in acute hospitals. This increased the fear and upset for patients and families caused by a hospital admission. The required restrictions increased workload and demands on ward staff. Medical Social Workers (MSW) have traditionally acted as a liaison between patients and clinical teams and worked to facilitate and improve communications.

The MSW developed a formalised, pro-active liaison service to enable families to get daily updates on their loved ones and to deliver pertinent information to wards to support their clinical work. The service originally ran from 8am-8pm seven days per week in the Emergency Department and on COVID-19 wards.

Quality Improvement

- The designated MSW links with the Clinical Nurse Manager (CNM) on their assigned ward to get an update on patients including current status, basic clinical information and care plans.
- Consent is sought from the patient where possible and one designated family contact person is identified.
- The MSW makes contact with the nominated persons to pass on the information and to gather questions or concerns for ward staff. All interventions and actions are recorded by the MSW.
- The MSW provides feedback to the ward, medical team or patient following the call and seeks to answer any questions that have arisen.
- Where questions are outside the clinical remit of the MSW an effort is made to facilitate a phone/video call between the clinical team and family.
- Both tablets and phones were used; tablets were kindly donated to the hospital.

Evaluation

The MSW Department response to COVID-19, including the ward liaison service, was reviewed after 1 month including patients & families, ward staff and MSW and revealed:

- Patient and family feedback was very positive with specific acknowledgement of the importance of a key link person for consistent contact, certainty regarding timing of feedback and comfort of being able to speak with or see their loved one as close to “in the flesh” as possible.
- The ability to send in photographs, poems etc., was also noted as a positive.
- Staff reported that the daily presence of a named MSW was greatly reassuring for them and the reduction in phone calls to the ward meant that they were freed up to carry out other clinical duties.
- Developing ward based structures enabled greater MDT communication
- A change in profile of patients being admitted to COVID wards: initially patients were younger, more technologically independent people who needed accommodation supports and practical assistance. Later, the patient cohort was older with different support needs.
- In many cases information sought by families, was quite clinical and more appropriately delivered by the medical team.
- Understanding of the role of social work was enhanced on some wards.

Key Learning

- MSW provide an essential service to patients and families during the pandemic.
- MSW training in crisis intervention enables MSW to adapt quickly to new ways of working and meet changing needs.

Scope to Grow

- This patient liaison and support work model was rolled out in many hospitals and hospices nationally where social work departments exist.
- The Mater MSW SOP was shared with the National Head MSW Forum.
- MSW engaged with The Irish Association of Social Workers and others, to develop a National Model of Care which provides liaison support for end of life care and bereavement during COVID-19.

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THE FIRST PREHABILITATION EXERCISE SERVICE FOR CANCER SURGERY PATIENTS IN IRELAND

Understanding the Problem

It is well established that optimising an individual's physical function before cancer surgery can result in decreased postoperative complications, reduce length of hospital stay (LoS) after surgery and decrease the rate of mortality. The American College of Sports Medicine recommend 150 minutes of physical activity per week, plus two sessions of resistance training for people living with cancer. It has been reported that only 21.4% to 53% of people with cancer are meeting these guidelines, and 29.8% reported doing no physical activity at all.

Prehabilitation means increasing an individual's exercise capacity to physically prepare for surgery. The OpFit prehabilitation programme is a pre-operative exercise programme developed using a co-design model with patients scheduled for cancer surgery in St. James' Hospital.

Quality Improvement

During a pilot study (October 2018-May 2019), 20 patients were surveyed and their input led to changes e.g. the importance of early referral was communicated to the referring teams as patients recommended doing the programme longer before their surgery and for patients receiving neoadjuvant treatment, it was agreed that they could be referred during this period.

- Patients are referred to the programme by their surgical teams.
- The physiotherapist assesses patients including fitness, strength, BMI and frailty, and provides advice on lifestyle factors.
- Patients attend daily classes including resistance, aerobic and chest clearance.
- Patients can attend monthly talks by a Psychologist on coping with cancer diagnosis.
- Patients unable to attend the programme see the physiotherapist for a fitness assessment and an individualised home-based exercise programme with weekly follow-up.

Covid-19 led to cancellation of all out-patient classes. The programme was delivered virtually, with 2 exercise classes running daily via Zoom. Initial assessment and screening for suitability is carried by phone. Patients are given advice on exercising safely during Covid-19.

Evaluation

In the first 6 months,

- 309 patients were referred.
- A total of 118 patients attended the Prehabilitation programme, median classes attended = 3 (range 1-15).
- An additional 63 patients attended 1:1 physiotherapy appointments,
- Further 49 patients were supplied with educational materials (post/email).
- Preliminary data shows that the Prehabilitation programme can decrease hospital LoS for patients undergoing thoracic surgery by up to 5 days (mean 8.5 vs 13.5 days).

Patient feedback has been very positive:

> *"I was amazed by the option to do physio before surgery. My God it's so good. Really gets you into the mind frame on how to progress your recovery without looking for a pill. Keep it up, it's a great medicine.*

> *"I think the exercise programme is a great idea, I met with some other patients within the group which was nice.*

Key Learning

- The pivot to virtual care has been a key learning for the programme.
- The virtual programme is very beneficial to these patients as they can engage in treatment without having to leave their own home, reducing risk of infection with SARS-CoV-2.
- As cancer surgeries continued during the crisis, it was important that patients continued to receive prehabilitation in preparation for this.

Scope to Grow

- The plan is to continue virtual classes alongside face to face classes to allow patients living outside Dublin to participate.
- Further plans for the service include: securing devices to provide to patients who do not have access so they can engage in the online programme from home, and to investigate the use of remote heart rate monitoring for the online programme.
- This project was highly commended for Excellence in Quality Care in 2020 Health Service Excellence Awards

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STRIVING FOR EXCELLENCE IN CARE FOR PEOPLE WITH MOTOR NEURONE DISEASE (MND): THE EVOLVING JOURNEY OF THE MULTIDISCIPLINARY TEAM

Understanding the Problem

MND results in rapid decline in muscle function, speech, swallowing and breathing, with cognitive and behavioural change in 30% of patients; necessitating prompt identification of issues and management by the multidisciplinary team (MDT).

The HSE Neurology Model of Care (2016), specifies centralised MDT care as best practice for MND. The challenge is:

- to provide flexible, integrated care from diagnosis to end of life with limited resources.
- To ensure high quality communication between the clinic, community and palliative care settings.

Prof. Orla Hardiman, Consultant Neurologist, leads the MND team which includes 3 nurses and physicians, and a Speech and Language Therapist, Dietitian, Occupational Therapist, and Physiotherapist who attend the clinic 3 days per month. The clinic engages with approximately 300 people living with MND, with 90 patients seen in clinics monthly (3-4 new patients per clinic). There is no waiting list and reviews are flexible.

Quality Improvement

- HSCPs maintain a high level of CPD in best practice management of MND and promote clinical research e.g. HSCP attend/present at national/international conferences.
- HSCPs disseminate this learning to HSCP managing MND patients in other settings:
  - Annual MND MDT study day
  - Site visits
  - Telephone/email based advice.
- HSCPs have introduced specialist services:
  - Physiotherapy: Advanced practice physiotherapists administer Botulinum Toxin for patients with spasticity and corticosteroid injection for shoulder pain.
  - SLT: Assessment for electronic communication aids reduces need for referral to assistive technology services.
  - Dietetics: Change of radiologically inserted gastrostomy (RIG) tubes performed in clinic.
  - Occupational Therapy: Innovative head collars provided through collaboration with UK researchers.
- HSCPs aim to optimise the patient experience.
  - Pre-clinic meetings to prioritise and plan patient visit, patient flow whiteboard, patient passport.
  - Adoption of telemedicine solutions including video clinic consultations and a patient app were rapidly implemented in response to Covid-19 restrictions.
- HSCP ensure high quality, novel interventions are maximised:
  - Audit against 2016 NICE guidelines, demonstrated key HSCP services are provided.
  - Clinical interventions are adapted e.g. joint SLT and dietetic sessions

Evaluation

- HSCP provide a high quality, innovative, evolving service that is evaluated continuously.
- Irish patients attending the MDT clinic live significantly longer compared to devolved care (Rooney et al 2015).
- QOL evaluated pre and post RIG insertion: people with RIG report improved wellbeing.
- Post shoulder injection evaluation showed significant improvements in pain and sleep quality.
- The prescription processes and patient experience with cough assist has been evaluated as an MSc research project.
- Patient resources were produced and are available to patients and HSCPs throughout Ireland.

Key Learning

- The HSCPs benefit from a strong leader and advocate for the MDT in Professor Orla Hardiman
- MDT working and communication is essential to maximise patient outcomes.
- Communication pathways with colleagues in primary care are vital for integration.
- Need for continuous service evaluation and PDSA cycles
- Patients' perspectives guide development of services.
- A culture of research promotes innovation and excellence.

Scope to Grow

- Physiotherapy Guidelines for management of MND were produced jointly with primary care and clinic based physiotherapy and disseminated freely online https://imnda.ie/wp-content/uploads/2014/09/MND-guidelines-on-Physiotherapy.pdf.
- Team members share research findings internationally.
- HSCPs deliver guest lectures to 3rd level students and CPD and client-specific management advice to colleagues in practice.
- The HSCPs are regular contributors to the IMNDA newsletter.

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DEVELOPMENT OF A HSCP UNIVERSAL REFERRAL PROCESS WITHIN THE REGIONAL HOSPITAL MULLINGAR (RHM)

Understanding the Problem

The absence of an integrated HSCP prioritisation system and interdisciplinary referral process, led to disjointed, untimely referrals on acute wards. This directly impacted upon patient care, leading to increased costs (inappropriate & duplicate referrals) and delayed patient management. Poor response times directly impacted on patient interventions, safety and quality of patient care, and outcomes e.g. length of stay (LoS) delayed discharges and patients discharged before seen.

Quality Improvement

The aim of this initiative was to reconfigure the whole referral & assessment process for four disciplines: speech & language therapy, physiotherapy, occupational therapy & dietetics with the support of the service improvement division of the IEHG & hospital management.

The project was a HSCP led solution and was selected as a Rapid Improvement Event (RIE) in RHM. The team was led by a Senior SLT. The scope included adult unscheduled care admissions including the emergency department, intensive care, medical and surgical wards, the acute medical assessment unit and the acute stroke unit. The design & production of a Single Universal Referral & Common Screening Tool was completed during the RIE week in consultation with all members of the MDT including medical, nursing, HSCP and administrative staff. It was piloted immediately, rolled out and evaluated hospital wide over a 90-day period using the PDSA approach.

The team formally expanded referral criteria scope, reconfigured prioritisation criteria, creating a single Interdisciplinary Prioritisation Protocol and streamlined referrals to a single point of contact, eliminating non-value added steps. This improved efficiency, saves money, provides safer better care and directs resources where they are most needed.

Evaluation

- By coming together as four disciplines, inappropriate referrals reduced from 20% to 3% and duplicate referrals from 18% to 8%.
- Inappropriate referrals costing an average of €4,457.28 per year, reduced to €405.44.
- Numbers of patients discharged before seen reduced from 18% to 8%.
- Improved waiting times for initial assessment for urgent referrals from 27.4 hours to 5 hours
- Patients now receive person centred coordinated care with our staff working across traditional boundaries with a single comprehensive referral & assessment process.
- The leadership skills of the team were developed through RIEs and Lean white belt training and led to successfully influencing outside our usual clinical sphere, delivering better outcomes for patients.

Key Learning

- A collaborative team of HSCPs can adapt and influence how services are shaped. The team worked together to re-design services to provide value for money and improved outcomes.
- Leadership development within the team enabled implementation of major changes to service design across four different disciplines.
- The success of the initiative depended on agreement, achieved through engagement, collaboration, and communications.
- Training was a key enabler and included medical, surgical, nursing, administration and HSCP staff members.

- Engagement of senior management and HSCP managers with the HSCP team was a critical success factor; enabling changes in HSCP departments and outside their usual spheres.
- Ensuring the project achieved target metrics relied on continual PDSA cycles, audit and feedback from stakeholders involved.
- The long-term feasibility of the work was supported by the NHS sustainability framework, which examined the project in terms of the process, staff and the organisation, initially as a diagnostic measure it is used quarterly to re-focus and ensure sustainability.

Scope to Grow

- Learning was shared with other hospitals: the project was presented at the HSCP forum receiving very positive feedback.
- The project won an award at the IEHG Lean symposium 2017.

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AN INTERAGENCY APPROACH TO PREVENT FALLS AND FRAILTY IN THE COMMUNITY

Understanding the Problem

Census 2016, reports the number of people over 65 years is increasing by over 20,000 yearly and over the next 20 years, the number aged 85 and over is projected to increase by approximately 6,000 per year. The Irish longitudinal Study on Ageing (TILDA 2020) reports that frailty affects 80,600 adults aged over 70 years and, 12,200 adults over 70 years old are living alone with frailty. Frailty is a risk factor for single and recurrent falls, fear of falling and disability among adults aged 50 and over. The six month Otago exercise programme (OEP) is proven to reduce falls in frail older adults. OEP's in the UK provide a cost effective return on investment.

Quality improvement

CHO 1 & 9 Primary Care Physiotherapy Services worked collaboratively to develop an interagency approach to the provision of 6 month Otago Exercise Programmes. This involved using the Later Life Training Cascade model to train Physiotherapists and Fitness Instructors as Otago Exercise Programme Leaders.

A Quality assured framework was developed by HSE Primary Care Physiotherapy to facilitate Otago exercise programmes collaboratively across agencies including:

- Standardised referral pathways: right person, right pathway, right time; Physiotherapy working group – screening and criteria and embedding the classes within the service.
- Collaborative implementation: memorandum of understanding agreed across agencies to ensure governance; health and safety; data protection.
- Exit strategies: develop continuum of exercise options.

Significant networking, restructuring and quality assurance frameworks across agencies were necessary.

Evaluation in CHO DNCC:

- Total number of participants =21 (3 groups)
- Ratio of instructor to client = 1:8
- Average Rockwood score = 4
- Average age = 80 years
- Average attendance Group 1= 81%, Group 2 = 60%, Group 3 =75%
- Early Improvements in 30 second Sit to Stand test and 4 point balance test
- Focus group carried out with OEP leaders and participants
- Feedback from participants: *"I like the pace of the class and the small numbers" "I felt confident enough to take bus into town for first time in 2 years" "I feel I rely less on my stick" "I am getting back gardening again"*

Key Learning

- Interagency training is hugely beneficial to developing trust, understanding and governance structures.
- Physiotherapy screening of referrals is key to ensure 'right person, right service, right time'
- Time commitment and expertise for training, planning, implementing, embedding and evaluating programmes warrants an Exercise Specialist Post in Falls Prevention to facilitate up scaling and sustainability.
- Otago is most suitable for frailer people at risk of falls.
- Access to specialist training across agencies for primary prevention of falls is also needed, e.g. Postural Stability Instructors, to ensure quality and standardisation.
- Exercise is for life, so need exit strategies into community programmes across the spectrum of needs and preferences.

Scope to Grow

- 7 HSE Physiotherapists trained as cascade trainers in 2017 have so far trained 50 physiotherapists and 16 fitness instructors as OEP leaders nationally. These Otago programmes are running in CHO 1 and 9, and other CHOs have been in contact to set up similar type programmes.
- AFFINITY, the National Falls and Bone health project, has secured funding from the Department of Health to significantly expand the current number of OEP leads nationally to enable implementation of local exercise referral pathways between HSE Physiotherapists and exercise professionals trained in Otago.
- AFFINITY is including the interagency delivery of Otago in the development of National Guidance for Community Exercise Programmes.

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COVID-19 PANDEMIC: FORMULATION AND VALIDATION OF A VIRUS LYSIS BUFFER TO ALLOW TESTING OF PATIENTS TO CONTINUE: AN IRISH MULTI-CENTRED CASE STUDY

Understanding the Problem

The global demand for reagents for real-time reverse transcriptase PCR (RT-PCR) diagnostic tests for COVID-19 caused a bottle neck across Ireland and the UK during March and April 2020, in efforts to follow the World Health Organisation's advice to "Test, Test, Test". Normally, hospital laboratories buy in reagents that allow them to concentrate on the business of diagnosis of patients, the preparation of their own reagents is rare. However, an exponential increase in demand resulted in a shortage of numerous reagents, not least the lysis buffer required to extract the viral RNA and to simultaneously inactivate the virus. A shortage of lysis buffer threatened to seriously undermine our ability to test for the virus in Ireland as evidenced by notifications of looming shortages coming from hospital laboratories from Donegal to Cork.

Quality Improvement

This case study and validation represents an immediate and self-selected response from the scientific community, following a call by both the Academy of Clinical Science and Laboratory Medicine, the professional body for medical scientists in Ireland and, by the Laboratory Manager at CUH to help to avert a crisis in healthcare.

Our team of scientists comprised of Dr Martina Scallan[1], Ms Catherine Dempsey[2], Dr John MacSharry[1,3,4], Ms Isabelle O'Callaghan[2], Dr Paula O'Connor[4,5], Dr Conor Horgan[6], Dr Edel Durack[7], Dr Paul Cotter[4,5], Dr Sarah Hudson[8], Dr Humphrey Moynihan[6] & Dr Brigid Lucey[9,10].

We describe a rapid collective effort by medical laboratory scientists, academic researchers and the biopharma industry to generate a validated lysis buffer. We formulated a 4M Guanidinium thiocyanate (GITC)/Triton X-100 Lysis buffer (among other prototypes) which provides comparable results with the recommended reagents.

Evaluation

Within two weeks:

- We tested four formulated buffers for use with patient samples and selected the optimal one.
- We generated a risk assessment for others who wished to prepare our formulation.
- We wrote a scientific paper outlining how to formulate the lysis buffer together with its performance characteristics and put it on the Biology open-access site BioRxiv (see updated version: https://www.biorxiv.org/content/10.1101/2020.04.05.026435v2).
- We generated sufficient amounts of lysis buffer for transport elsewhere from CUH as required.
- This virucidal buffer eased the burden on hospital labs in their heroic efforts to diagnose a large population of patients rapidly.
- The publication generated a number of communications from elsewhere in the world, the furthest away being Australia. During the month of May alone the paper had 100 downloads, worldwide, suggesting the wider need for preparation of lysis buffer.

Key Learning

Always ask for help. As scientists in Ireland we have diverse expertise and a desire to help. The quality of the selected reagent was assured by medical scientist experts in the department of clinical microbiology, CUH. From need, besides the solution, came solidarity and meaningfulness.

Scope to Grow

A benevolent relationship was developed by hospital/third level institutions/industry during this effort. This case study may provide a model for replication with other problems and settings.

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TRACHEOSTOMY SPEAKING VALVE MODIFICATION IN CHILDREN: A STANDARDISED APPROACH LEADS TO WIDESPREAD USE, CHILDREN'S HEALTH IRELAND (CHI) AT CRUMLIN

Understanding the Problem

Tracheostomy is a life-saving intervention in infants and children predominantly performed under the age of two. It is typically for long-term airway management. It has significant negative impacts on the development of voice, speech, feeding. A speaking valve is a positive closure one-way valve fitted on the tracheostomy tube allowing inhalation, redirecting expiratory airflow upwards to the glottis creating voice. It promotes safer swallowing, cough, smell and taste which benefits feeding. Many contraindications exist for speaking valve use, due to the generation of high transtracheal pressures (TTP) induced by wearing speaking valves.

At CHI there were no clear pathways to guide selection of individuals suitable for speaking valves. A majority of the caseload were deemed ineligible due to high TTP. Valve modification (drilling small holes of varying size in the valve housing to alleviate TTP) has been reported by other researchers.

Transitional Care Unit (TCU) is a ward for children who are long term ventilator (LTV) dependent. The Passy Muir Valve (PMV) is the valve of choice internationally.

Quality Improvement

A standardised multidisciplinary approach to the selection of patients suitable for speaking valves was introduced, including a process of tracheal pressure assessment, valve modification and prescription. A multidisciplinary group was established between Clinical Engineering, Respiratory Medicine, Paediatric Otolaryngology and Speech and Language Therapy. Clinical Engineering developed a technique for bespoke valve modification on site, assembled the components and developed the procedure for assessment of TTP. In February 2014 structured assessments of inpatients commenced, and outpatients reviewed later that year.

Evaluation

- Over 70% of patients required modified PMV, 62 children since 2014.
- Children get speaking valves earlier, average 17 weeks (20 days – 74.14 weeks) post tracheostomy insertion and for LTV 27 (4-4.14) weeks. Previously 98 (0-424) weeks and 98.4 (5-424) weeks for LTV children.
- Oral feeding improved in a sub group of children on ventilation leaving TCU: 2014-2018 (N=17) 82% with modified speaking valves, 88% had oral feeding skills (7 full oral/7 tube & oral) and 3 non oral. For 2005-2013 (N=32) 21% had speaking valves, 59% oral feeding skills (3 full oral feeders, 16 tube and non-oral, 9 aversive non-oral)
- Online evaluation surveys in 2016 to parents of children using standard valves (n=12) and modified valves (n=24). Response rate 83% (n=30) (50% of standard valve group and 100% of modified valve group). Of the Modified valve group 77% felt their child had made progress with communication, 81% felt suctioning was reduced, 47% reported improved feeding. Most respondents attributed the improvements to the modified valves. Overall, respondents felt the introduction of the modified valve had a significant positive impact on the child (79%) and on the family (74%)
- Identified Cost Savings include reduction in suction equipment, ventilator weaning, cheaper assessment packs, reduction in enteral feeds

All children are considered for speaking valve at the earliest possible time post tracheostomy. Communication and feeding skills develop earlier as a result. Sprinting from ventilation promotes free time to play and engage in therapy activities.

Key Learning

- Multidisciplinary collaboration is essential to sustain the programme
- Modifying one small low costing piece of equipment has a significant impact on patient outcomes

Scope to Grow

Peer reviewed publications drive service progression with rollout to CHI Temple Street envisaged for 2020. Community Nursing and SLT support is ongoing with HSE community links established in several areas. This project received a very highly commended award at the Health Service Excellence Awards 2020.

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PEN TO PAD: HSCP COME TOGETHER TO LEAD AND DRIVE CHANGE FROM PAPER TO ELECTRONIC RECORDS AT ST. JAMES'S HOSPITAL

Understanding the Problem

In 2012, the majority of documentation was paper based, processes and standardisation was variable across SCOPe. There was duplication of notes in discipline specific charts and patients' medical chart. Processes such as triage involved a lengthy paper process, including retrieval of relevant medical information from the patient medical chart to assist clinical decision-making. Data retrieval for reporting to the HSE, carrying out quality improvement initiatives, service planning and to back up business cases was arduous. Storage facilities were increasingly under pressure. At this time national and organisational focus was shifting to electronic systems of documentation. Recognising the potential of e-health solutions to improve the quality and safety of healthcare provision, SCOPe HSCPs were early adopters, starting in 2005 with the development of text reminders for OP appointments.

Quality Improvement

The aims of this project were to improve documentation efficiency and effectiveness for the clinical staff, improve accessibility of patient information for other members of the multidisciplinary team, improve quality and consistency of documentation with positive impacts on patient safety, flow and experience. For the transition to electronic healthcare records, a project management approach was taken and a Quality Improvement Microsystems group worked to further evaluate and optimise the system. This process started in 2012 with the development of a business case aligning to the hospital strategy. The transition was piloted in a single HSCP department (Speech and language Therapy SLT) in 2014. By the end of 2016, all SCOPe patient documentation had been transitioned to electronic records. This included: referrals, triage processes, clinical assessments, notes, outcome measures, patient reported questionnaires, some standardised assessments, discharge documentation/onward referral to PCCC/other services & follow-up by encrypted emails.

Detailed planning took place including engagement with key stakeholders, development of business cases and close links with the IT department. Staff/patient surveys were conducted to identify and address issues arising.

Evaluation

Electronic documentation is now used across SCOPe; in ED inpatients, outpatients, outreach services including e-referrals, triage, clinical assessments, notes and outcome measures. Multiple users can access patient information at point of care and data is available for service development, business cases and research. Surveys demonstrated patient and staff satisfaction with electronic records. The surveys highlighted patient concerns regarding access to records and staff concerns regarding streamlining processes and ergonomics of using devices. These issues have been managed using Quality Improvement methodology. SCOPe are viewed as leaders and were actively involved in the transition to electronic documentation of all inpatient nursing and medical records in SJH, acting as a resource to other healthcare professionals.

Lessons Learned

- Have a clear vision and objectives.
- Work with what you have.
- Prove the concept and get as much done as possible within resources.
- Highlight early successes.
- Promote ownership by including representatives from each department.
- Get clinical engagement from the start.
- Have one lead with clinical expertise.

Scope to Grow

The vision is to continuously improve the current system in a number of ways:

- Implement patient self-booking of appointments
- A patient portal which would allow supported self-management options and sharing of reference material pre & post attendance
- Add documentation for new services

Electronic documentation/eHealth is a key part of Sláintecare and national strategies and SCOPe group input to initiatives such as the electronic patient summary, shared record and any community and acute EHR developments will be valuable. SCOPe can share the learning regarding the process as well as from patient and clinician feedback.

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OPTIMEND – OPTIMISING EARLY ASSESSMENT AND INTERVENTION BY HEALTH AND SOCIAL CARE PROFESSIONALS IN THE EMERGENCY DEPARTMENT

Understanding the Problem

Emergency departments (EDs) face significant challenges in delivering high quality and timely patient care with increasing patient numbers and limited hospital resources. ED crowding contributes to a reduction in the quality of patient care, delays in commencement of treatment and poorer adherence to recognised clinical guidelines. Evidence suggests that interdisciplinary teams of Health and Social Care Professionals (HSCPs) working in ED can contribute to enhanced outcomes for older adults with complex needs. However, evidence on the clinical effectiveness of this model of care is scarce.

Quality Improvement

This study was a single site randomised controlled trial (RCT) which aimed to test the impact of an ED-based HSCP team on the quality and safety of care of older persons as compared to usual care in the ED of University Hospital Limerick.

Primary outcomes included ED length of stay (LoS) and rates of hospital admissions from the ED. Secondary outcomes included: hospital LoS for admitted patients; ED re-visits, hospital and healthcare utilisation at 30-days, four months and six-months follow-up; patient functional status and quality of life (at baseline and follow-up); and patient satisfaction. The HSCP team (senior medical social worker, senior occupational therapist and senior physiotherapist) provided: a holistic assessment of functional, mobility, cognitive and psychosocial needs; as well as interventions to promote a safe discharge for the patient.

Evaluation

- Considering the first 238 participants, the intervention group spent significantly shorter time in the ED than the control group (7.33 vs. 14.15 median hours, $p<0.001$) and experienced lower admission rates (18.64% vs. 60%).
- At 30-day follow up, healthcare utilisation rates were higher in the intervention than control group (72.92% vs. 58.51%, $p=0.04$).
- There were no significant differences between the groups regarding satisfaction with their ED visit, function, quality of life of incidence of adverse outcomes at 30 days. Our cost-effectiveness analysis is on-going.
- In this RCT, having a dedicated HSCP team who provided early assessment and interventions to older adults in the ED led to a shorter length of ED stay and reduced rates of hospital admissions when compared to usual care.

Key Learning

- This study advances the knowledge on the clinical effectiveness of HSCP teams caring for older adults with a variety of complaints in the ED and supports the viability of this model of care.
- The HSCP team is now fully embedded into the ED of University Hospital Limerick and members are seen as frontline, senior decision-makers in terms of older persons' care.
- Preparation for submission for ethical approval across two sites was time-consuming and the process differed across sites. Methods to streamline this process should be explored at national level.
- Efforts were made to meaningfully involve patients throughout this research process including a novel methodology to co-design our proposed intervention. This ensures the approach is both evidence-based and user-informed.

Scope to Grow

- The overarching knowledge translation initiative proposed is translating evidence-based knowledge in emergency medicine research. The project is designed to develop and implement structures, processes and systems to support knowledge transfer regarding HSCP screening, referral, assessment and intervention of targeted populations in the ED which are clear and focused.
- The collaborative nature of the project will serve to raise the profile and reputation of the research team for innovative knowledge transfer nationally and internationally, through dissemination of research findings, skills and expertise.
- Throughout the project, external opportunities for further collaboration will be explored.

References available on request.

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HOME BASED VIRTUAL PULMONARY REHABILITATION PROGRAMME FOR COPD PATIENTS

OUR LADY OF LOURDES HOSPITAL, DROGHEDA

Understanding the Problem

Pulmonary rehabilitation (PR) has established itself as a key management strategy in the treatment of chronic respiratory disease and has been shown to reduce hospital admission rates particularly for people with Chronic Obstructive Pulmonary disease. Despite the proven benefits of PR referral, uptake and adherence remains universally low. Travel and transport are consistently identified as barriers to both participation and completion.

Quality Improvement

Alternative models of PR have demonstrated non-inferior clinical outcomes and safety when compared to traditional face to face classes. Remote delivery of PR is an innovative model improving equity of access particularly for those in rural areas negating the inconvenience and cost of travel and preventing service interruption due to restrictions imposed in response to COVID-19.

This initiative started with collaboration between the HSE and the European funded Interreg project mPower, to enable patients over the age of 65 with chronic conditions to take control of their health at home by using technology. By maximising this collaborative opportunity and expert support, leveraging existing technology and integrating resources in the primary and secondary care setting with the patient's own resources, virtual PR enables patients to receive the 'right care in the right place at the right time by the right team', a fundamental goal of Sláintecare.

Traditional PR best practice guidelines form the basis for virtual PR. Video conferencing equipment is used to deliver live and interactive group exercise classes under the guidance of a physiotherapist to patients, while they remain in the comfort of their homes. It includes all components of a traditional PR programme, and supports inter-professional collaborative practice through the provision of MDT education for patients.

The programme has adapted and evolved in part due to the restrictions and risks pertaining to COVID-19 e.g. validated outcome measures appropriate for telehealth usage have been selected to ensure presentation avoidance of this high-risk cohort to the acute hospital setting.

Evaluation

Preliminary results from two completed groups have demonstrated 100% completion rates with significant clinical improvements in both exercise capacity and quality of life status comparable to a traditional PR programme. Additional benefits include:

- 3,436km travel saved
- 72 hours travel time saved
- Savings on fuel and parking
- Reduced carbon emissions
- Potential to run a PR class with 50% less staff
- Positive patient experiences reported

Virtual PR has allowed patients continued access to a safe and effective exercise programme during the COVID-19 pandemic supporting self-efficacy while alleviating the strain on acute service resources and infrastructure capacity limitation issues.

Key Learning

- Stakeholder collaboration has been a necessary component contributing to the continued innovation and development of the programme.
- Continuous evaluation of the programme through patient feedback and service review leads to modifications resulting in enhanced service user experience.

Scope to Grow

- Ongoing collaboration with academic institutions in evaluating telehealth will allow for measurable improvements ensuring an effective service with high patient acceptability.
- Collaboration with the National Clinical Programme Respiratory has allowed virtual PR to become a valuable resource for colleagues nationally in navigating PR services during the Covid19 pandemic.

Further specific detail on the programme can be accessed at: https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/ncp-respiratory-guidance-on-setting-up-virtual-pulmonary-rehabilitation-for-asthma-and-copd.pdf

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BENEFITS OF REMOTE FOLLOW-UP IN A CARDIAC PHYSIOLOGIST-LED CARDIAC DEVICES CLINIC

Understanding the Problem

The Cardiac Physiologist-led Cardiac Devices Clinic in Galway University Hospital saw nearly 400 patients in 2020. The technology for remote follow-up of these patients has been in place for a period of time and has significant benefits for patients.

Quality Improvement

The team as a whole discussed potential benefits, pitfalls. Process mapping was carried out to ensure the processes were streamlined and safe with appropriate care pathways in place. We realised patient education and engagement in the new approach was vital and give patients a guarantee “if you don’t like it we’ll go back to the old way” (of visiting the hospital every 3 month).

When this technology was introduced in GUH we enrolled patients with Implantable Defibrillators (devices which shock the patient from a fatal rhythm into a normal one) onto remote follow-up, with the aim of 80% enrolment. We subsequently enrolled all patients with Implantable Loop Recorders (devices which record abnormal heart rhythms).

At the eight week check, patients are educated regarding home monitoring and given a small unit which sits in their bedroom. This unit can talk wirelessly to their implanted device and transmit the information to a secure internet site where we can review all device data as if the patient was in clinic. Three monthly scheduled transmissions replace hospital visits for checks.

The remote follow-up system also has the benefit of early notification of clinically significant events. If there is such an event the system automatically sends an automatic transmission, coupled with text message and email notification to the Cardiac Devices Clinic of an alert.

Following each check, the patient is contacted by phone to check symptoms and relay the results.

Evaluation

The Remote Monitoring aspect of the service has been evaluated through a number of research audits and also via patient feedback.

An audit of our service showed that there were 544 Early Clinical Alerts in a seven year period. These included:

- 21 devices where battery replacement was indicated
- 11 lead fractures – early notification of this prevents inappropriate painful shock therapy being delivered
- 512 treated episode of dangerous heart rhythms such as ventricular tachycardia or fibrillation

Aside from the clinical benefits, the removal of the need to visit the hospital for checks saves patients, on average €1,492 in travel costs. Remote follow-up was of huge benefit during COVID-19 restrictions as we were able to continue to provide normal, uninterrupted care for these patients.

Key Learning

- This well-established service shows clear benefit of mobile health technology in improving patient safety, quality and experience.
- It is vital that patients are clearly educated in the benefits, trust the process and are engaged.
- The team reviews processes to ensure new procedures are robust and evolve with changes to technology. For example more recent technology allows these devices to give earlier indication of worsening Heart Failure and we are currently devising care pathways with our Heart Failure nurses and doctors.
- Appointment of Remote Follow-Up Champions amongst staff gave robust oversight of system.

Scope to Grow

This technology has been adopted by many Cardiac Physiologist-led Cardiac Devices Clinics with similar results and outcomes. As new telemedicine opportunities arise, it is vital that systems and processes are robust with clear care pathways.

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CLINICAL ENGINEERING – FINDING INNOVATIVE WAYS TO PROMOTE AND SUSTAIN MEDICAL DEVICE USE AND SAFETY TRAINING DURING COVID-19 RESTRICTIONS

Understanding the Problem

The Covid-19 outbreak has forced the health system and innovators to pivot and adapt quickly. It became clear during the early phases of the pandemic at Galway University Hospital, that the commissioning and reconfiguration of clinical areas with medical technology by the Department of Medical Physics and Clinical Engineering would be essential to the success of the response.

A key priority was to understand the emerging service requirements, communicate issues and priorities, and assign responsibility to clinical engineering lead teams focusing on medical device related problems. A number of innovative solutions were developed and rolled out.

A critical responsibility of Clinical Engineering is to work with clinical colleagues, and external service providers, to promote and facilitate user training on medical equipment. Easily accessible medical device operator training is paramount to safety.

Medical device training is usually provided by the manufacturer training specialists who provide on-site scheduled face-to-face instruction, and interactive device demonstrations. Covid-19 disrupted this model. Visitor and travel restrictions, along with social distancing requirements in training locations, changed the nature of in-situ device training. Training needs increased significantly due to introduction of new equipment such as respiratory ventilators, ultrasound scanners and renal dialysers. In addition, Nursing, Medical, HSCP, and support staff relocated to Covid-19 wards and critical care units, require comprehensive induction training on unfamiliar medical equipment, whilst existing staff require refresher type training.

Quality Improvement

The clinical engineering team at GUH examined how to leverage existing video conferencing technologies, how they could be configured and rapidly deployed to provide accessible, high quality and cost effective medical device use training. Working with clinical colleagues and wider MedTech industry, the clinical engineering team established a working group to provide medical equipment clinical users with an interactive training session from a remote location, so called ‘Telepresence’.

The solution is to integrate high quality medical device display images, e.g. from an ultrasound scanner, with a video conferencing solutions via video and gaming/streaming software, to provide the participants with multiple high quality audio and video views. Early prototype testing demonstrated that the single camera passive view, typically associated with teleconferencing was not sufficient. In this solution, participants have access to multiple environmental views as well as close up camera equipment views. The technology also allows the trainer to interact with the audience, as if they were physically present.

Evaluation

The medical device telepresence training system was tested and refined through a number of training sessions, where participants accessed the system from PCs and smartphones from home, and across the hospital site.

The team worked with colleagues from the department of Anaesthesiology to provide critical care Intensivists training on echo cardiology ultrasound scanning techniques. The knowledge of digital imaging technologies allowed clinical engineers to fuse these various tools into a bespoke solution. This training programme registered participants from hospitals across Ireland and the UK.

Lessons Learned

The solution meets obligations to provide high fidelity medical device use and safety training remotely.

The project illustrates the important subject matter expertise and skillsets that the Clinical Engineer professional contributes patient treatment and safety.

Scope to Grow

The medical device telepresence training system has been rapidly deployed using readily available, scalable, open-source and cost effective components.

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USING AN ELECTRONIC PATIENT RECORD AND MEDICATION BARCODE SCANNING TO IMPROVE HAEMOPHILIA PATIENT CARE

Understanding the Problem

Although the development of clotting factor infusions in the 1970s and 1980s was lifesaving and life changing for people with Haemophilia, tragically contamination of blood products in this period meant that the majority of regularly treated patients with haemophilia were infected with HIV and/or hepatitis. Due to the ineffective manual methods used to record, track and trace the medication, patients were exposed to infection even after a product recall was initiated.

Quality Improvement

A comprehensive integrated programme based on Continuous Quality Improvement (CQI) to improve patient care composed of four strands:

- Electronic Health Record (EHR): A national EHR fulfils a dual role as a record and facilitates a National registry accessible by all treatment centres
- Cold chain delivery service: A medication delivery service to patients' home
- GS1 Standards: the application of GS1 barcodes on all medication facilitates tracking and tracing through the supply chain, and a comprehensive real-time recall if necessary
- Smartphone scanning App: enables patients to ensure that medication is safe to take and to record their medication usage (medication compliance recording)

Evaluation

- The EHR allows access to patient records instantly at any treatment centre eliminating the need to fax, e-mail or transport records.
- Standardised data entry (SNOMED, Questionnaires, patient tracking through their appointment) have been used to drive CQI schemes
- Medical staff can now access patient's records from home when on call, greatly improving the quality of care they provide patients, especially important for haemophilia patient care, since it is such a rare condition
- A pre and post service audit of the validated Cold Chain delivery service was undertaken to assess the impact of implementation. Product wastage due to failure of either cold chain conditions or delivery issues reduced from €90,216 in the period July 2003 – July 2004 to zero wastage for the period August 2004 – August 2005
- An audit of medication ordering trends by patients showed a substantial decrease in demand, achieving an estimated saving of €5 million per year
- Because patient infusion data is collected in real-time using the smartphone App and GS1 barcode scanning, clinical staff can view consumption trends and advise the patient if they feel they are treating themselves inappropriately (over treating or not treating at the appropriate time). This lead to saving of €70,000 over a 4-month period, based on the first 20 patients using the App in 2010. The service has now over 100 patients using the App.
- From a patient point of view the data collected will help improve their safety by providing important information on their medication status such as alerts for prescription errors or out of date medication.

Key Learning

The use of traditional paper chart provided retrospective and often incomplete data and was not always available out of hours. The implementation of an EHR and scanning App allows for the standardised "once only" capture of key clinical information, in addition the electronic data is more accessible, accurate, and useful in the overall management of haemophilia and related disorders.

Scope to Grow

- This project could be adapted to provide a systematic approach to improving health care for people with other chronic diseases such as inherited metabolic disorders, hepatitis and diabetes, allowing healthcare to be delivered more effectively and efficiently to other chronic disease groups.
- It could also be used in areas such as vaccine distribution, where forecasting and recall are critically important.

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HAND THERAPY SERVICE PROVISION WITHIN THE PLASTIC TRAUMA SERVICE OF THE RCSI HOSPITAL GROUP

Understanding the Problem

In 2016 the delivery of Plastics Trauma Surgery Service for the North East was reconfigured to place governance for these patients within the RCSI Hospital Group (population 800,000). Clinical Specialist Hand Therapists currently lead on service provision within Beaumont Hospital and Connolly Hospital Blanchardstown for the entire catchment area.

The Plastic Trauma Service recognised the need for a regional therapy network for the post-op management of patients who have undergone skilled surgery on the hand/upper limb. Specialist post-operative therapy protocols are necessary to prevent complications such as adhesions, tendon rupture and hand stiffness. Extending patient access to HSCP services is expected to lead to reduced incidences of complications and improved clinical outcomes.

Quality improvement

A full-time Senior Occupational Therapist post specialising in Hand Therapy was created in the Louth County Hospital, Dundalk to provide service to patients in Counties Louth and Monaghan. The aims were:

- to improve patient experience and outcomes through Hand Therapy Clinic intervention delivered to the patient locally within the RCSI Group North East Region.
- the provision of timely access to hand therapy, utilising standardised protocols across the RCSI Hospitals Group.
- to provide appropriate staffing levels within the region to manage caseload locally in line with best practice guidelines, which in turn would maximise efficient use of therapy resources in the Trauma Centres.

Evaluation

Early successes included increased responsiveness to referrals and more timely access to skilled Hand Therapy for patients. In 2019 there were 97 referrals, of which 92.7% met the KPI of commencement of therapy within the early timeframe specified per diagnosis. There were reduced non-attendances and patient feedback indicated satisfaction that the demand on time and family resources required to attend appointments was reduced.

Key Learning

- Close collaboration and integration between the Trauma Centres and the local HSCP is essential to ensure timely and seamless transfer of care from Trauma Centre to regional centre.
- Having a local point of contact for the patient if problems arose has facilitated early detection and management of complications.
- Re-educating and re-communicating with staff in the Trauma Centre regarding the availability of and importance of early referral to the regional HSCP has proven effective in maintaining close collaboration.

Scope to Grow

The HSE publication ‘National Model of Care for Trauma and Orthopaedic Surgery 2015’ states that ‘It is nevertheless recognised that physical capacity for treating trauma and orthopaedic patients is limited, and the geographical location of services does not always match the distribution of patients presenting. Therefore, plans to add more capacity should be developed.’(page 59)

The success of this post supports the benefits of adding capacity to regional HSCP hand therapy networks and is in keeping with the Sláintecare Implementation Strategy goal to address current capacity challenges and increase integration between the hospital sector and community-based care. (Goal 2, Strategic Action 5)

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DIRECT ACCESS TO VESTIBULAR REHABILITATION: A PHYSIOTHERAPY, AUDIOLOGY AND ENT INTEGRATED CARE INITIATIVE

Understanding the Problem

Dysfunction of the vestibular system, located in the inner ear, can result in distressing symptoms of vertigo, dizziness and imbalance. These problems are common among adults, with a lifetime prevalence of 7.4%. Vestibular disorders can be successfully managed with a specialised form of physiotherapy, known as vestibular rehabilitation, which has a strong evidence base. Access to specialised audiology assessment is a key element of the diagnostic process. Unfortunately, access to this form of assessment and rehabilitation is limited and many patients live for years with unresolved symptoms, resulting in anxiety and limited participation.

People with vestibular issues are often referred to Ear Nose and Throat Surgeons (ENT) and can wait up to 3 years for an initial consultation. Nationally there are over 4,800 patients waiting for consultation for an 'ear or sense organ' problem. The HSE Otolaryngology Head & Neck Surgery Model of Care (2019) recommends implementation of acute vestibular assessment and rehabilitation clinics in each hospital group and better access for primary care practitioners.

This initiative aimed to implement the ENT Model of Care recommendations, to expedite access to vestibular rehabilitation for patients referred with vestibular dysfunction, through direct access to an integrated specialist physiotherapy, ENT and audiology service.

Quality Improvement

A pilot 0.2 WTE physiotherapy post was secured in late 2018. Criteria for direct triage to the physiotherapy service were agreed with ENT. Referral and communication pathways were agreed with audiology. Funding for a Video Head Impulse Test was secured from Beaumont Hospital Foundation, which improved the assessment process.

Appropriate patients were selected from Prof Rory McConn Walsh's waiting list. Prof McConn Walsh also triaged appropriate new patients to the service. Selected patients attended the ENT clinic and were seen by the clinical specialist physiotherapist. Preliminary audiological assessment was also completed at the first visit. Assessment findings are discussed with the ENT team and a management plan agreed.

Evaluation

- In the first 11 months, 56 patients were assessed and underwent rehabilitation and 51 were discharged. Of these, 44 patients were seen directly by the Physiotherapist, rather than an ENT doctor.
- The waiting list backlog was cleared, with the longest waiting patient referred on 24/6/16. By year end 2019, all new patients were seen within 3 months of referral.
- Patients expressed satisfaction with the service and objectively improved on standardised outcome measures.
- The majority of patients seen via the direct access Physiotherapy pathway were appropriate for the service.
- Patients referred with vestibular dysfunction benefitted from access to vestibular assessment and rehabilitation and now avoid lengthy waiting periods for their initial consultation.
- The majority of patients improved significantly with vestibular rehabilitation and returned to normal activities.

Key Learning

- Clear triage criteria enabled identification of appropriate patients.
- Administrative support was key to the success of the service.
- A physiotherapist working in an integrated service with ENT and audiology can directly manage patients referred with vestibular dysfunction.

Scope to Grow

- ENT services have one of the largest waiting lists with significant numbers of patients waiting long periods for initial consultation. This pilot service has demonstrated the efficiency and cost effectiveness of direct access to a specialist physiotherapy service for people with vestibular conditions.
- It has the potential for replication in ENT centres nationally.
- Education and training is required for Physiotherapists, Audiologists and Otolaryngologists as well as for GPs and this is a priority for the ENT programme.
- The service has innovated further in response to COVID-19 and telemedicine solutions are currently being implemented and evaluated.

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NORTH DUBLIN COMMUNITY DIETITIANS – ADVANCED PRACTICE ROLE

Understanding the Problem

The key issues for adult patients who require short or long term feeding tubes are:

- Lack of care pathway and single point of contact for adults in the community with tube related queries and problems with feeding tubes e.g. blocked/broken tube.
- Accidental dislodgement of a feeding tube, which if not replaced within 3-4 hours can require emergency re-siting of new feeding tube if the stoma closes over.
- For some patients, elective feeding tube replacement is needed every 3-6 months.
- Patients potentially at risk of malnutrition owing to lack of access to/having to travel long distances to see a dietitian.

For many patients, this means travelling long distances to hospital or requiring an ambulance transfer to attend crowded EDs unnecessarily since trained community dietitians can meet their needs.

Quality Improvement

In CHO DNCC, there is now a streamlined process for transferring patients with feeding tubes from hospital dietetic services to community services including the ordering of appliances. A team of trained community Home Enteral Nutrition (HEN) dietitians review patients with feeding tubes in their homes. They monitor not only their nutrition and weight but also tube and stoma care, tube related complications and facilitating tube replacements when necessary. HEN Community Dietitians repair and unblock feeding tubes, resize and replace tubes when indicated. Collaboration with other staff e.g. public health nurses enables troubleshooting stoma problems.

Evaluation

- An Intervention Audit undertaken in 2018 over 17 weeks in North Dublin demonstrated the numbers of weight checks (298) training interventions (164) feeding regimen checks (308) feeding tube repairs and maintenance (279) and feeding tube replacements (42) all undertaken by the HEN community dietitians.
- It is estimated that approximately €42,000 was saved by avoiding hospital admissions for just the gastrostomy tube replacements performed during the study period, suggesting significant healthcare savings.

Lessons Learned

A key lesson is the importance of having a single point of contact for the patient if problems arise. Close collaboration and integration between hospital and community services is essential to ensure person-centred care, seamless transfer and inclusion of all relevant health care professionals.

Scope to Grow

The Home Enteral Feeding service model delivered by Community Dietitians in CHO DNCC could be replicated in other CHO's and delivered to both adult and paediatric patients. The Community Dietitians in DNCC have delivered practical training sessions to support Community Dietetic Teams who are developing similar services in their local areas. The development of national PPPGs on the management of patients on Home Enteral Feeding is underway.

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NATIONAL MUSCULOSKELETAL PHYSIOTHERAPY TRIAGE INITIATIVE

Understanding the Problem

In 2012 there were lengthy outpatient (OPD) waiting times for patients with musculoskeletal (MSK) conditions to see either a Consultant Orthopaedic Surgeon or a Consultant Rheumatologist. Advanced Practice Physiotherapists (APPs) are physiotherapists trained in diagnosing and triaging treatment for patients with common MSK disorders. Acting as first contact practitioners in the management of MSK patients, they can select the most appropriate care pathway for selected groups of patients on orthopaedic and rheumatology waiting lists and improve the efficiency of care.

In 2012, as part of a joint initiative between the National Clinical Programme for Trauma and Orthopaedic Surgery (NCPTOS) and the National Clinical Programme for Rheumatology (NCPR), 24 APPs were employed nationally to provide Orthopaedic and Rheumatology triage clinics, aid clearance of waiting lists and improve long term MSK referral management.

Quality Improvement

APPs assess patients to establish a diagnosis and triage patients along the most appropriate care pathway according to their diagnosis, allowing consultant time to be used more effectively. Each APP has a target to remove 73 NP off waiting lists per month. An expected ratio of orthopaedic to rheumatology patients of 80:20 was given based on waiting list numbers.

A capacity/demand analysis and a review of the waiting lists per hospital informed decisions on locations of posts.

Data is collected monthly, analysed through bespoke metric collection sheets and run charts, respectively. This data is reviewed by the national MSK steering group and quarterly reports are sent to all sites.

In 2017, a National MSK Planning and Performance Lead Physiotherapist was recruited to assist the MSK Steering Group in improving and expanding the MSK physiotherapy initiative, with a focus on developing an integrated patient pathway at the interface between primary and secondary care through liaising with sites, key stakeholders, and analysing data collected by the programme.

The national MSK steering Group also hold an annual conference aimed at raising awareness of the initiative and upskilling healthcare professionals in the management of MSK conditions.

Evaluation

- From January 2012-December 2019, 147,600 patients have been removed from orthopaedic and rheumatology waiting lists nationally.
- In orthopaedic clinics APPs reviewed 97,906 new patients and in rheumatology clinics APP's reviewed 24,476 new patients.
- Seventy-one per cent of patients seen at both Orthopaedic and Rheumatology clinics were discharged to the care of their GP after their clinic visit.
- In 2017-2018 96% of patients surveyed (n=107) who attended an MSK clinic across sites nationally reported they were satisfied seeing an MSK Physiotherapist in place of seeing a Consultant for their MSK complaint. Ninety-nine per cent of these patients reported that they would return to an MSK clinic if they required a review for a MSK complaint in the future.
- This initiative positively impacts on two waiting lists and ensures more effective use of consultant time across two specialties while also improving outcomes and experiences.

Key Learning

- Strong governance structures and working relationships are key to collaborative projects.
- Robust data is fundamental to the effective development of a new service.
- Feedback from those working on the frontline is invaluable in refining and streamlining new practices.

Scope to Grow

The cross-programme initiative has a vision to develop integrated clinics/consultations between primary and secondary care services managing people with MSK conditions as close to their home as possible. The operational model of the initiative outlined in this application is readily transferable to other primary and secondary care settings.

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ROLE DEVELOPMENT OF THE RADIOGRAPHER TO SCREEN VIDEOFLUOROSCOPIC EXAMINATIONS OF SWALLOWING AND THE RESULTING EXPANSION OF THE VIDEOFLUROSCOPY CLINICS CARRIED OUT BY SPEECH AND LANGUAGE THERAPISTS

Understanding the Problem

A video fluoroscopic examination of swallowing (VFSS) is an instrumental assessment of oropharyngeal dysphagia carried out by Speech and Language Therapists (SLTs). There are two, two hour VFSS clinics held per week. It is not possible for an SLT to operate the radiological equipment. Screening of each procedure was provided by a Radiology registrar, who changed at each clinic and was covering other procedures at the same time. This resulted in delays, a lack of standardisation and reduced the number of patients seen.

To improve the quality and efficiency of the service, it was decided that Radiographers would train to screen the procedure. The radiography management team had to educate and train sufficient numbers of radiographers to provide the screening service required. This change initiative was developed in collaboration between the Radiology and SLT services.

Quality Improvement

There is an increasing interest in advancing the role of the radiographer in Ireland. It was clear that Radiographers have sufficient knowledge and skill to competently perform fluoroscopic screening for the assessment of oropharyngeal dysphagia by SLT, a role previously performed by a Radiology registrar. By changing this practice, the Radiology registrars could be deployed elsewhere. For the Radiographers this provided an opportunity to work multi-professionally, the potential to contribute towards the patient's final report and the therapeutic aspect of the service lent a new dimension to a Radiographer's work. Finally the aim was to improve the service offered to patients, by increasing the number of procedures completed, reducing appointment wait times and improving the quality of the service.

The Radiographic Services Manager assessed the time and costs required for training, a Speech & Language Therapist and Radiographer to deliver Beaumont's Videofluoroscopy Service, including the proposed number of VFSS examinations per week, the case mix and the required staffing levels.

Next step was agreeing standards; in order to carry out VFSS, SLTs and Radiographers must undertake specific training including: radiation protection Course for Non-Radiology staff training, Dysphagia, specific training in screening procedures, in-house training in VFSS:

- The Radiology and Speech and Language Therapy departments jointly arrange appointment times for VFSS.
- The consultant Radiologist is responsible for being available within the radiology department for medical advice and other medical matters during the procedure.
- Only Radiographers who have completed a Videofluoroscopy course or those who have undertaken the appropriate practical and theoretical training under the direction of a trained Radiographer/Radiologist in conjunction with a SLT, and completed the pre-requisite objective/competency sheet may independently screen VFSS.
- Finally a Videofluoroscopy policy and Videofluoroscopy protocols were written and signed off prior to commencing the service.

Evaluation

- 7 Beaumont Hospital radiographers are trained to perform VFSS examinations alongside the SLTs and provide a service for patients once a week, with the aim of covering both clinics in the week.
- In Q1 2017, 58 VFSS procedures were carried out, in Q1 2018, this increased by 40% to 81.
- For the SLT's, greater awareness of radiation awareness and screening equipment.
- For radiographers greater awareness of dysphagia and an increase in skills and knowledge

Key Learning

- Role extension for the radiographer can have a positive impact for the service user.
- Strengthening interdisciplinary work can result in new services and improved quality for the service user.

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A PILOT PROGRAMME TO EXPAND THE SCOPE OF PRACTICE OF IMAGE GUIDED RADIATION THERAPY (IGRT) SPECIALIST RADIATION THERAPIST TO INCLUDE CLINICAL RESPONSIBILITY FOR THE IGRT LOCALISATION OF THE TARGET AT THE TREATMENT UNIT

Understanding the Problem

Radiotherapy treatment planning and delivery is a complex multi-step process involving multiple disciplines across multiple platforms. As a result, there are multiple uncertainties associated within the processes which could compromise the efficacy of the intended treatment if left uncorrected. Traditionally these uncertainties are accounted for by adding a 'safety' margin around the area to be treated. However, this margin will now encompass unaffected 'normal' tissue and nearby organs at risk.

For virtually all solid tumour types, there exists a clear dose-response relationship which predicts that the larger the dose delivered to the target the greater the 'tumour control probability'. However, there also exists a dose response relationship which predicts that the greater the dose received by normal tissue the greater the risk of toxicity. Image guided radiation therapy (IGRT) provides the best opportunity to reduce uncertainties in the radiotherapy pathway. The ability to reduce margins safely is also a prerequisite to certain clinical trials and crucial to the implementation of new specialist techniques such as Stereotactic Radiosurgery (SRS) or Stereotactic Ablative Radiotherapy (SABR).

Additionally, in specialist areas such as SRS and SABR there is an increased workload for both radiation oncologists (RO) and radiation therapists (RT) as IGRT is a key component. The demand on RO time is a limiting factor in expanding radiotherapy services and achieving international best practice guidelines for cancer wait times.

Quality Improvement

A dedicated IGRT Advanced Practitioner Radiation Therapist (APRT) can quantify uncertainties in the radiotherapy pathway, facilitate evidence based margin application and explore options to reduce these uncertainties e.g. more complex IGRT strategies or investigating alternative immobilisation devices. This can lead to smaller margins, which could improve patient outcomes through reduced toxicity levels or improved local control through dose escalation.

An IGRT APRT could also potentially reduce the need for consultant radiation oncologist attendance at the treatment unit for specialist services such as SRS or SABR.

In January 2016, a pilot training programme was developed in order to expand the scope of practice of the IGRT specialist radiation therapist to carry out a number of tasks traditionally undertaken by the radiation oncologist, including the clinical responsibility for the IGRT localisation of the target at the treatment unit.

Evaluation

- The number of treatment slots is much less constrained by RO availability as clinical specialist is on site 5 days a week
- A reduction in appointment time for non-first fraction SABR patients from 60 minutes to 45 minutes (25% improvement) was achieved.
- This increased treatment capacity, provided more timely access to radiotherapy patients and increased throughput.
- An increase in the referral rates and patient numbers was demonstrated by the sharp rise in fractions treated (2016-2017).
- Service user experience improved due to reduction in the time spent in an uncomfortable position.
- The increased capacity has resulted in additional cost benefits as many of these patients would otherwise have been funded by the HSE to attend a private hospital for treatment.

Key Learning

This pilot programme demonstrated that radiation therapists can expand their scope of practice using expert clinical decision-making skills and working autonomously to provide tangible benefits to both the patient and overall service provision.

Scope to Grow

Further work is planned to expand data collection, to derive evidence based treatment margins as part of a quality improvement initiative.

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APPENDIX 1
QUESTIONS USED IN THE WORKSHOPS AND DEMOGRAPHICS OF PARTICIPANTS

The following are the questions used in the face-to-face and first online workshops. All of the responses at the face-to-face workshops were recorded on flipcharts and transferred on the same day onto the online platform. The first online workshop was open 24/7 for a month. At the end of the first phase of engagement all of the data was read, reviewed, coded and analysed. Out of this analysis and distillation, a series of statements were written to create an initial high level framework. These were then validated in a second online workshop which was open for more than two weeks. The responses to the second online workshop were read, coded and analysed to further refine and create the framework of impacts, commitments and supports contained in this document.

Questions used in the online and face-to-face workshops

1. If HSCP were recognised for their full potential and could take up their roles fully:
    a. What would be different for service users?
    b. What would be different for HSCP?
2. What do HSCP need to start doing, stop doing, do differently?

    This question was asked in relation to the following five Sláintecare related areas:

    a. Patient is paramount – person centred care
    b. Access – shift to care closer to home, from hospital to community, timely, equitable.
    c. Increased role in prevention/health promotion.
    d. Appropriate workforce – flexible and accountable, well-resourced, supported and valued.
    e. Response to challenges of chronic illness

    (Participants at face-to-face workshops were asked to consider their answers at national, work setting and individual levels).
3. Workshop participants were asked to share examples of good HSCP practice and specific examples of things that are not working.
4. What supports do HSCP need to deliver on the above. Workshop participants were asked to identify some immediately doable actions.

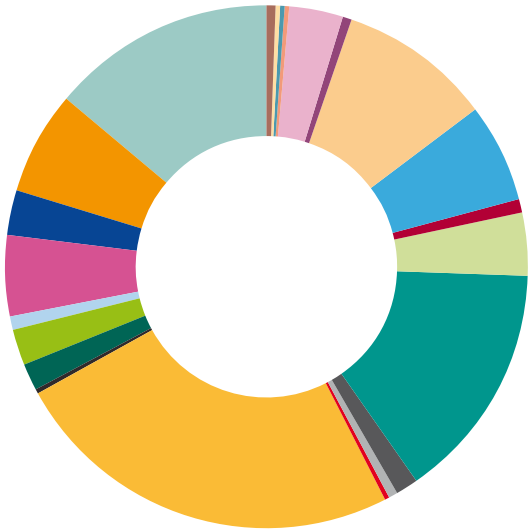
Demographics of participants

The charts below show the following in relation to participation in the online workshops:

a. Percentages of each profession that participated in the online workshop
b. Percentage of each profession in the publicly funded health service at the time of the workshops.
c. Workplace setting
d. Employer organisation
e. Geographical spread of participation

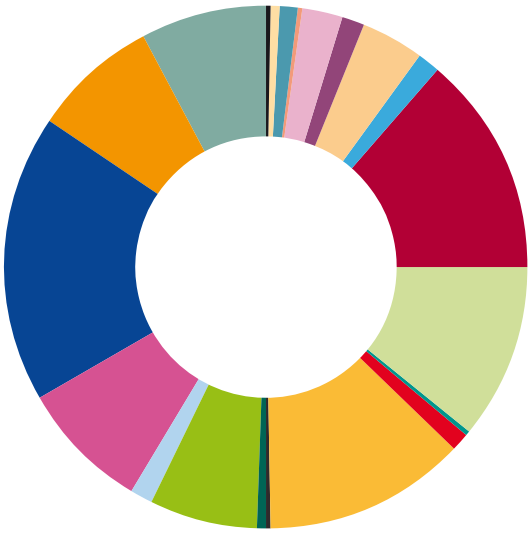
A significant campaign of communication was conducted from June to November to encourage engagement and participation which was targeted based on participation statistics. Considerable effort was made to encourage increased participation in professions with lower rates of engagement.

a) Percentage participation of professions



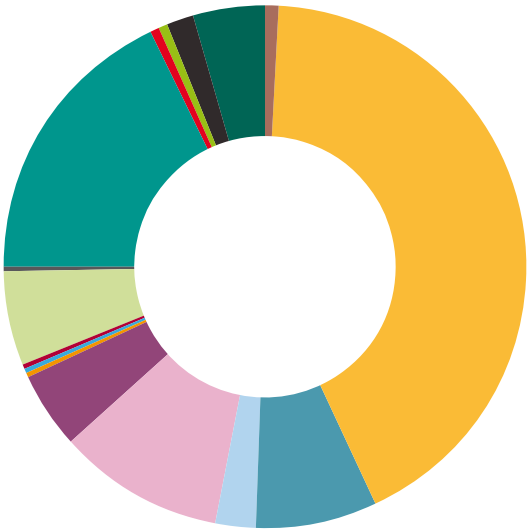
0.6	Audiologist
0.3	Clinical Biochemist
0.3	Clinical Engineer
0.2	Cinical Perfusion Scientist
3.6	Clinical Measurement Physiologist
0.3	Counsellor Therapist
9.5	Did Not Specify
6.3	Dietitian
0.9	Medical Physicist
3.9	Medical Scientist
14.6	Occupational Therapist
1.4	Optometrist
0.5	Orthoptist
0.5	Phlebotomist
24.5	Physiotherapist
0.2	Play Therapist
1.7	Podiatrist
2.1	Psychologist
0.8	Radiation Therapist
5.1	Radiographer
2.7	Social Care Worker
6.6	Social Worker
13.7	Speech and Language Therapist

b) Percentage of each profession as per Health Service Staff Census at time of the workshops



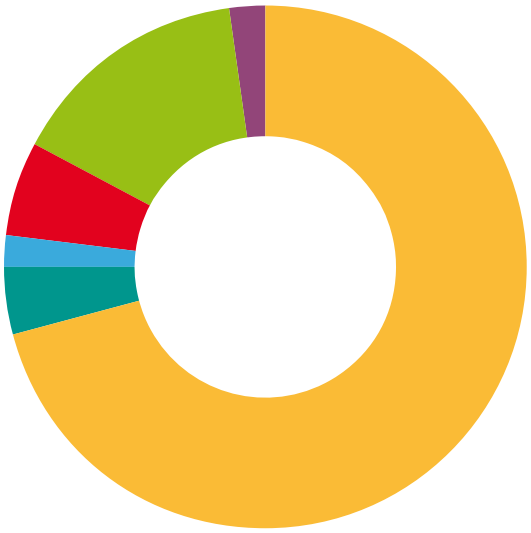
0.52	Audiologist
0.55	Clinical Biochemist
1.09	Clinical Engineer
0.13	Cinical Perfusion Scientist
2.51	Clinical Measurement Physiologist
1.51	Counsellor Therapist
3.89	Dietitian
1.27	Medical Physicist
13.76	Medical Scientist
10.73	Occupational Therapist
0.01	Optometrist
0.23	Orthoptist
1.09	Phlebotomist
12.58	Physiotherapist
0.31	Play Therapist
0.49	Podiatrist
6.74	Psychologist
1.36	Radiation Therapist
8.09	Radiographer
17.65	Social Care Worker
7.9	Social Worker
7.59	Speech and Language Therapist

c) Workplace setting of participants



1.1	Across Settings
42	Acute
7.6	Community
2.4	Corporate
10.3	Disability
4.7	Education
0.4	Independent Practice
0.3	Integrated Care
0.3	Maternity
5.7	Mental Health
0.3	Palliative Care
17.9	Primary Care
0.4	Professional Body
0.7	Rehabilitation
1.7	Social Care
4.2	Other

d) Employing organisation of participants

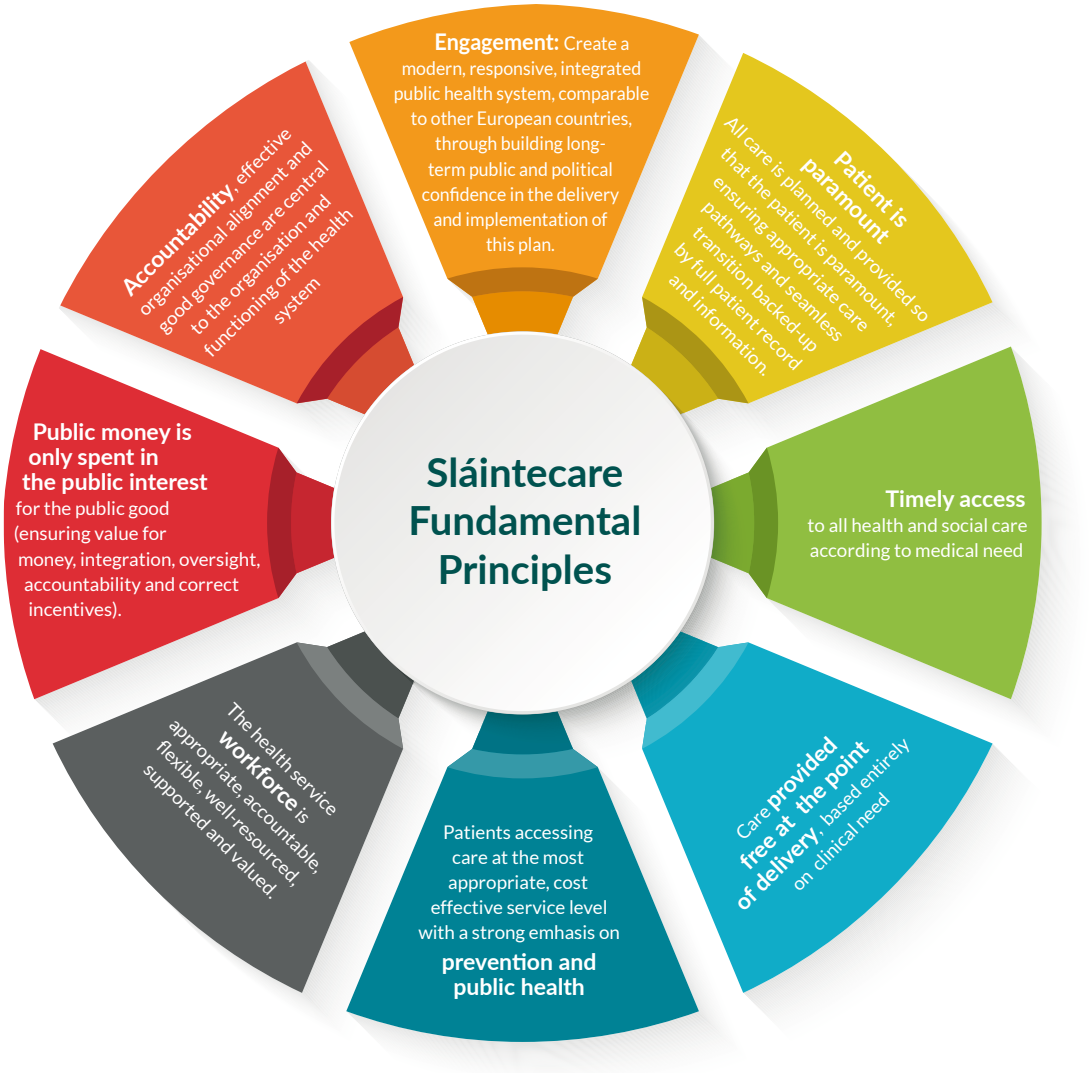


71	HSE
4	Higher Education Institutions
2	Professional Body
6	Private Sector
15	Voluntary Body
2	Other

e) Geographical spread of participants

APPENDIX 2
PRINCIPLES OF SLÁINTECARE

Figure 1: Principles set out in the Sláintecare report[4]



APPENDIX 3
HEALTH SERVICES CHANGE FRAMEWORK AND RELATED GRAPHICS

Figure 2: Health Services Change Framework[5]

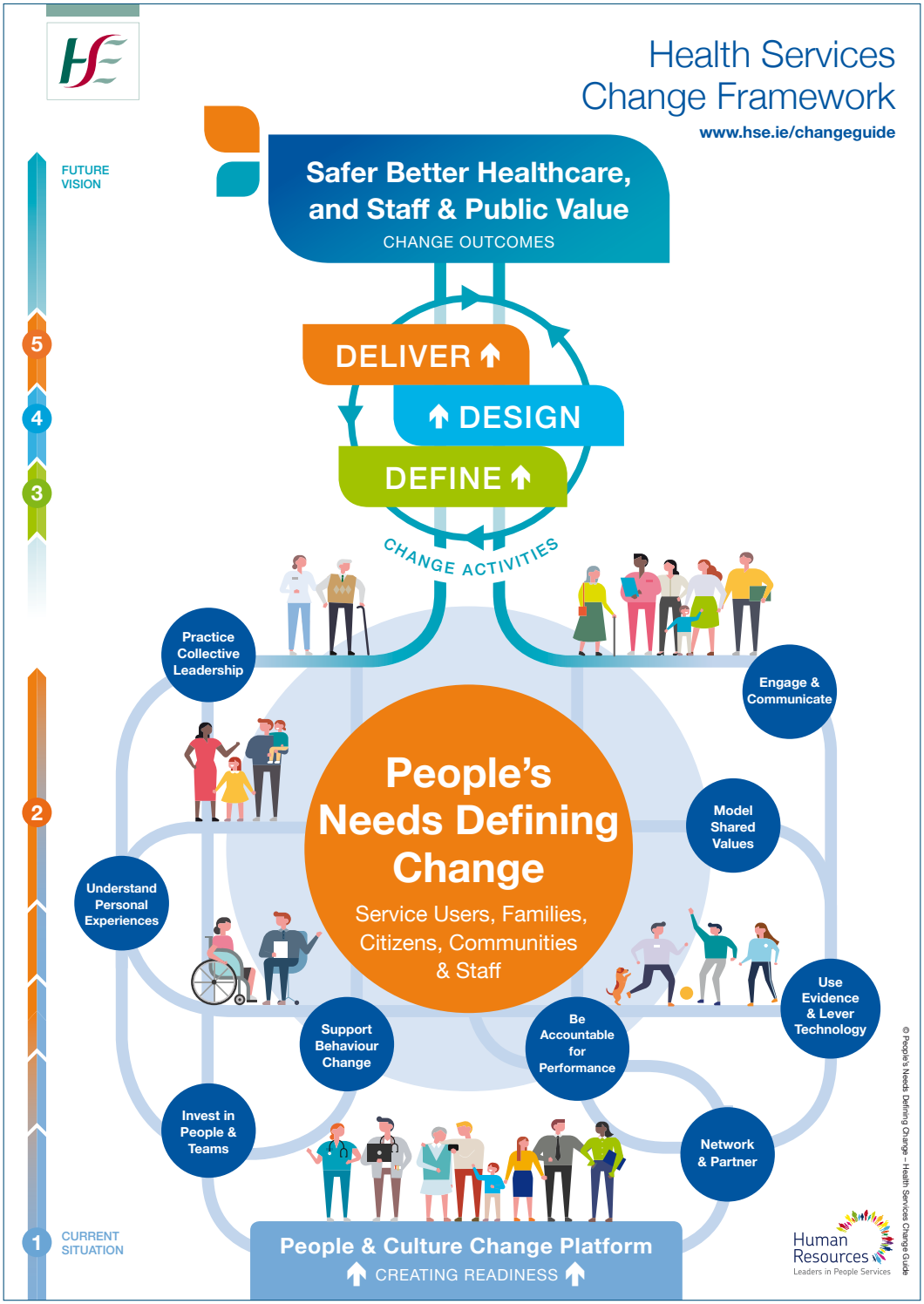
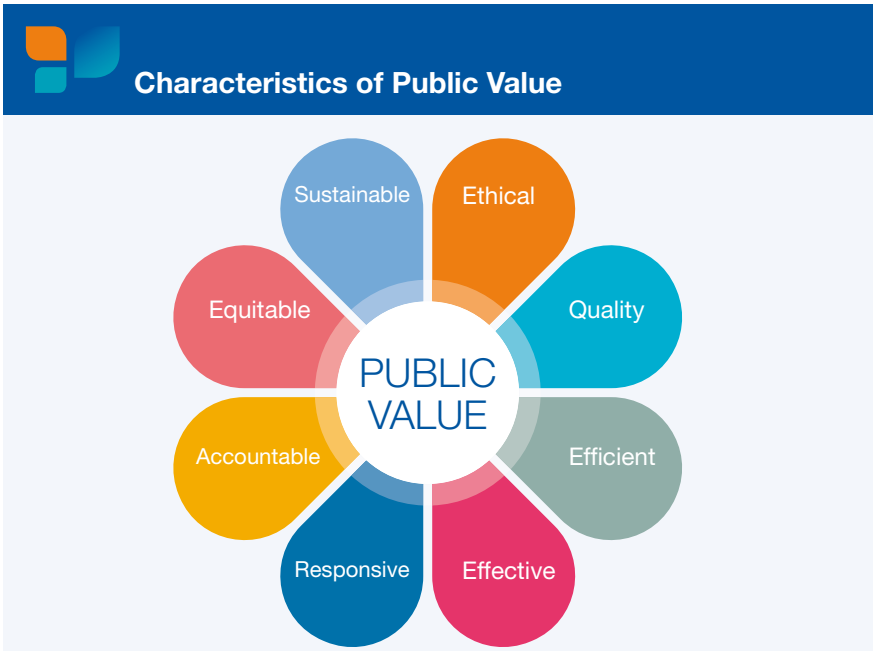
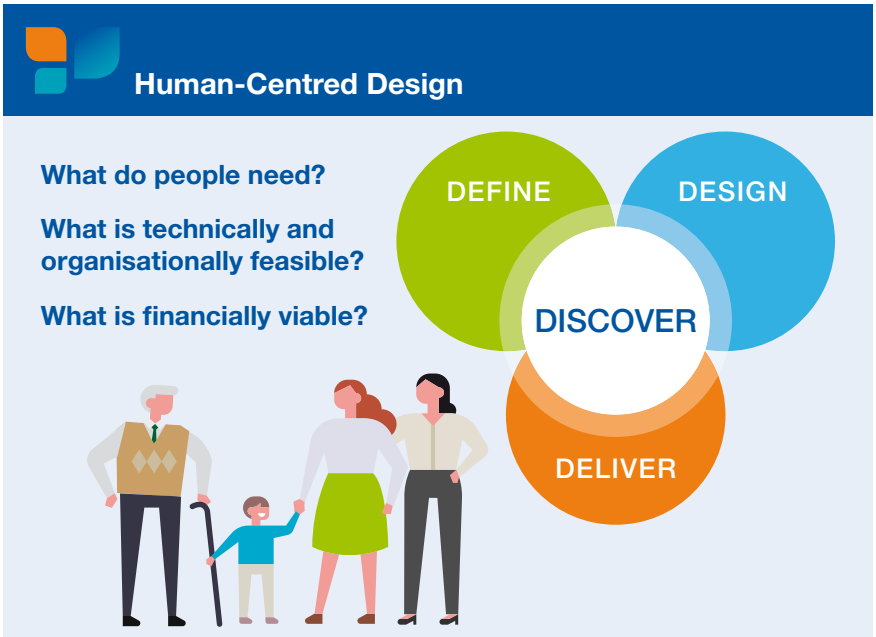


Figure 3: Characteristics of Public Value[15,16,5]



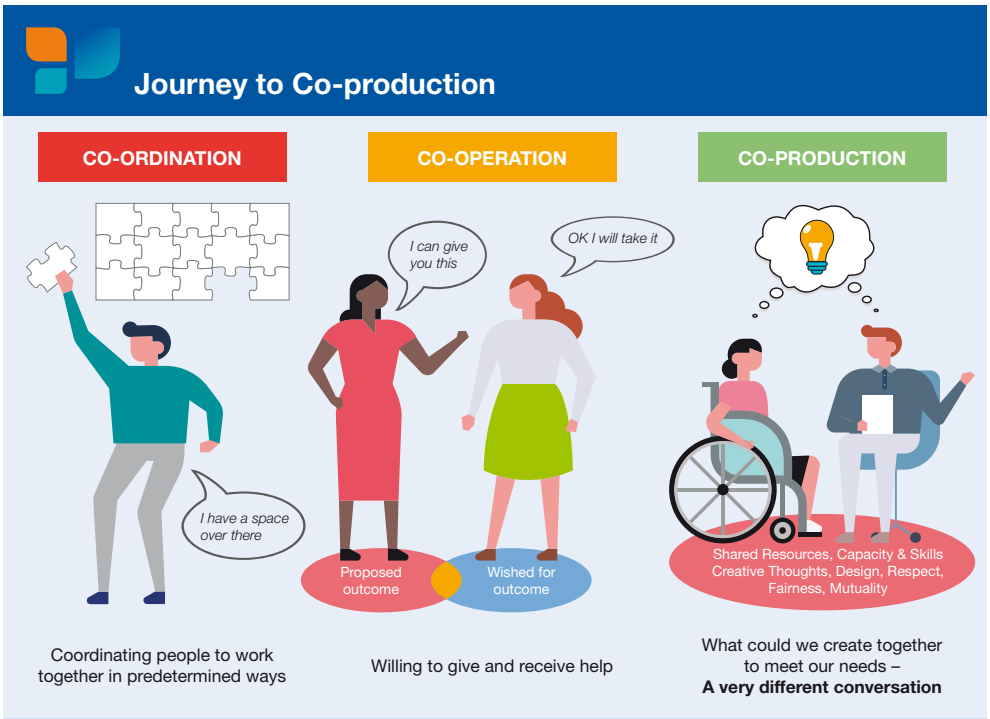
Adapted from: *O'Connor, N. (2017: 21); Moore, M. H. (2013)*
People's Needs Defining Change – Health Services Change Guide (2018: 33)
www.hse.ie/changeguide

Figure 4: Human-Centred Design[5]



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

Figure 5: Journey to Co-production[17,5]

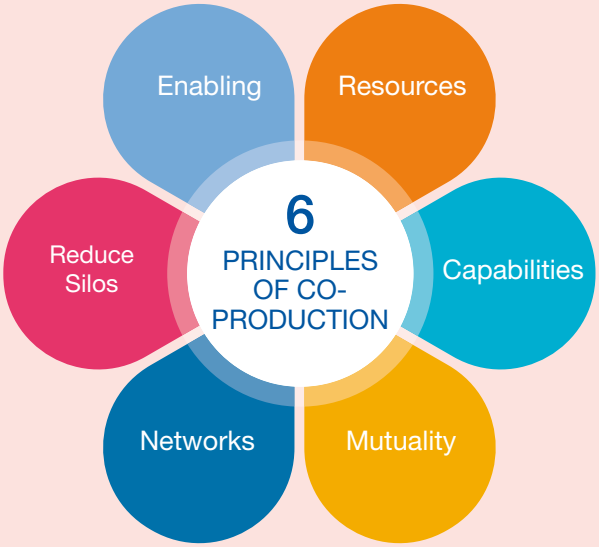


Adapted from: *The Edge NHS (2016)*
People's Needs Defining Change – Health Services Change Guide (2018: 28)
www.hse.ie/changeguide

Figure 6: Six Principles of Co-production[18,19,5]

Six Principles of Co-production

1. Seeing people as a valuable resource: working with people's expertise and experience
2. Building on our capabilities: supporting people to put their skills to use
3. Mutual responsibilities and expectations: developing two-way relationships
4. Supporting networks and growing peer supports
5. Reduce silos: removing tightly defined boundaries to enable shared responsibility and control
6. Enabling people to achieve their own goals: facilitating self reliance and prompting action



Adapted from: *Slay, J. and Penny, J. (2014: 31)*
Adapted from: *Malby, B. (2014: 8)*
People's Needs Defining Change – Health Services Change Guide (2018: 39)
www.hse.ie/changeguide

Figure 7: Model of Collective Leadership[20,5]

Source: *Department of Health – Northern Ireland (2017: 9)*

People's Needs Defining Change – Health Services Change Guide (2018: 11)
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