BUILDING AN INTEGRATED LEARNING SYSTEM

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Integrated Care Partnerships

Networks of providers - *Working together to deliver the right care, in the right place at the right time.*

- Nurse
- Pharmacist
- Medical Specialist
- GPs
- Social Worker
- Service user and Carer
- Allied Health Professionals
- Ambulance Service
- Voluntary and Community Sector Rep
- Local Council Reps

Population 100k

[https://vimeo.com/channels/icps/page:5](https://vimeo.com/channels/icps/page:5)
Structure of Health and Social Care

- **Political**
  - Minister for Health

- **Policy**
  - Department of Health

- **Commissioner**
  - Health and Social Care Board (inc 5 Local Commissioning Groups)
  - Public Health Agency

**Provider systems**
- 6 Health & Social Care Trusts
- Primary Care: GP/Dentists/Opticians/Pharmacist
- Not for Profit, Charity and Voluntary Sector
- Private, Independent Sector

**Integrated Care Partnerships** (as well as service users and carers and local councils)
‘If you want to make changes to hospital services then unless you take into account the social care dimensions, the community care, the primary care, it isn’t going to happen.’

Ruth Carnall, Managing Partner, Carnall Farrar
Framework on integrated people-centred health services: an overview

Vision

“All people have equal access to quality health services that are co-produced in a way that meets their life course needs and respects social preferences, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient and acceptable; and all carers are motivated, skilled and operate in a supportive environment”

Strategic Approaches

1. Engaging and empowering individuals and families
   1.1 Engaging and empowering individuals and families
   1.2 Engaging and empowering communities
   1.3 Engaging and empowering informal carers
   1.4 Reaching the underserved & marginalized

2. Bolstering participatory governance
   2.1 Bolstering participatory governance
   2.2 Enhancing mutual accountability

3. Defining service priorities based on life-course needs, respecting social preferences
   3.1 Defining service priorities based on life-course needs, respecting social preferences
   3.2 Revaluing promotion, prevention and public health
   3.3 Building strong primary care-based systems
   3.4 Shifting towards more outpatient and ambulatory care
   3.5 Innovating and incorporating new technologies

4. Coordinating care for individuals
   4.1 Coordinating care for individuals
   4.2 Coordinating health programmes and providers
   4.3 Coordinating across sectors

5. Strengthening leadership and management for change
   5.1 Strengthening leadership and management for change
   5.2 Strengthening information systems and knowledge
   5.3 Striving for quality improvement and safety
   5.4 Reorienting the health workforce
   5.5 Aligning regulatory frameworks
   5.6 Improving funding and reforming payment systems

1World Health Organisation 2017
Potential policy options and interventions

- Health education
- Shared clinical decision making
- Self-management
- Community delivered care
- Community health workers
- Civil society, user and patient groups
- Social participation in health
- Training for informal carers
- Peer support
- Care for the carers
- Equity goals into health sector objectives
- Outreach programmes and services
- Contracting out
- Expansion of primary care
- Community participation in policy formulation and evaluation
- National health plans promoting integrated people-centred health services
- Donor harmonization and alignment with national health plans
- Decentralization
- Clinical governance
- Health rights and entitlement
- Provider report cards
- Patient satisfaction surveys
- Patient reported outcomes
- Performance evaluation
- Performance based financing and contracting
- Population registration with accountable care providers
- Local health needs assessment
- Comprehensive package of services
- Strategic purchasing
- Gender and cultural sensitivity
- Health technology assessment
- Population risk stratification
- Surveillance, research and control of risks and threats to public health
- Public health regulation and enforcement
- Primary care with family and community-based approach
- Multidisciplinary teams
- Home and nursing care
- Repurposing secondary and tertiary hospitals for acute complex care only
- Outpatient surgery and day hospital
- Shared electronic medical record
- eHealth
- Care pathways
- Referral and counter-referral systems
- Case management
- Care transition
- Team-based care
- Regional/district-based health service delivery networks
- Integration of vertical programmes into national health system
- Incentives for care coordination
- Health in all policies
- Intersectoral partnerships
- Merging of health sector and social services
- Integration of traditional medicine into health services
- Coordinating preparedness and response to health crises
- Transformational and distributed leadership
- Change management strategies
- Information systems
- Systems research and knowledge management
- Quality assurance
- Culture of safety
- Continuous quality improvement
- Workforce training
- Multi-disciplinary teams
- Improvement of working conditions and compensation
- Provider support groups
- Alignment of regulatory framework
- Sufficient health system financing
- Mixed payment models based on capitation
- Bundled payments

Implementation principles

- Country-led
- Equity-focused
- Participatory
- Evidence-based
- Results-oriented
- Ethics-based
- Sustainable

Systems strengthening
Stroke Care Pathway

Pick an important problem and fix it!

Voluntary & Community Sector eg Chest Heart & Stroke

Social Care

Ambulatory Care

A&E

ACUTE WARD

HSC

Public Health Agency

Belfast Health and Social Care Trust

CITIZEN

PATIENT

Social Care
What is the focus?

Risk Stratification

Information Sharing

Care Planning

Evaluation

Frail Elderly, Respiratory, Diabetes, Stroke

Improve Flow

Develop leadership
Power of Networks

small actions × lots of people = BIG CHANGE
TEAM
Together everyone achieves more
Integrated Care Partnerships-Progress

- Social Prescribing
- Ambulatory Coronary Care
- Acute Care at Home
- Integrated Community Respiratory Service
- Nursing Home In-Reach
- Co-ordinated Falls Pathway
- Community Health & Wellbeing Hub
- Integrated Community Diabetes Service
- Advanced access for GPs to Diagnostics
ICP IMPACTS: HIGHLIGHTS

Throughout Northern Ireland, 17 Integrated Care Partnerships (ICPs) are working in local areas to reshape how health and social care services are planned and delivered and to keep people well in local communities. Health professionals are working collaboratively with service users, carers, the community and voluntary sector and local government to ensure people receive care they need, in the right place, at the right time.

Some of the early impacts ICPs are demonstrating in the areas of frail older people, stroke, diabetes and respiratory care include:

- **60 doctors, nurses and pharmacists in the Southern area have had specialist respiratory or diabetes training**
- **2,734 people in the Northern, South Eastern and Belfast areas have had a home oxygen assessment or review**
- **1,232 hospital admissions for respiratory problems have been avoided across NI**
- **3 months waiting times for home oxygen assessment in Derry-Londonderry, Limavady and Strabane areas have reduced from 13 months to 3 months**
- **167 people in the South East who have fallen at home have avoided being admitted to hospital**
- **90% reduction in the number of diabetes-related minor amputations in the Causeway and Mid-Ulster areas**
- **Improved community care in the Ards Peninsula has reduced emergency admissions to hospital for people with palliative care needs by 64%**
- **1/3 reduction in the number of nursing home residents in Antrim and Ballymena attending the emergency department and avoiding 1519 days in hospital**
- **460 frail older people have received enhanced or acute care at home in the Belfast and South Eastern areas, avoiding 4,102 days in hospital**
- **136% increase in the number of stroke patients in the Western area who have had a visual defect identified has increased by 5.6 days**
- **3 months waiting times for home oxygen assessment in Northern Ireland have reduced from 13 months to 3 months**

A full report and further information is available at www.hscboard.hscni.net/icps

Follow the #ICPchange conversation

* (as of June 2016)
Population Health

- The wider determinants of health
- Our health behaviours and lifestyles
- An integrated health and care system
- The places and communities we live in, and with
Lessons Learned

• Integrating providers alone will not deliver integrated care

• Need for integrated planning/ commissioning

• Need for improved data analytics and meaningful measurement based on agreed outcomes

• Need to allow local ownership and innovation but ensure consistency in outcomes regionally

• Procurement/contracting challenges in changing service models to allow more to be delivered outside Health & Social Care

• Few short term incentives for working collaboratively and delivering integrated care

• Opportunities for improvement in how ICPs operate
Strategy, Policy, Standards, Planning & Commissioning Regional Hospital & Specialist Services

Northern Area Planning Forum
HSCB – Trust/PC Provider Partnership – PHA

Northern Area Network (Currently LAN)
(Facilitated by Trust/Primary Care Provider Partnership, NIAS, C&V, Councils, Stakeholders…)

Trust/Primary Care Provider Partnership

Locality Integrated Care Partnerships

Neighbourhoods Integrated Services

REGION

AREA

LOCALITY

PLACE

POPULATION

1.87 million

Population

480,000

100,000 – 150,000

35,000 – 50,000
More information

• Subscribe to the ICP E-zine
  E-mail integratedcarepartnerships@hscni.net

• Visit the ICP pages of the HSCB website
  http://www.hscboard.hscni.net/icps/