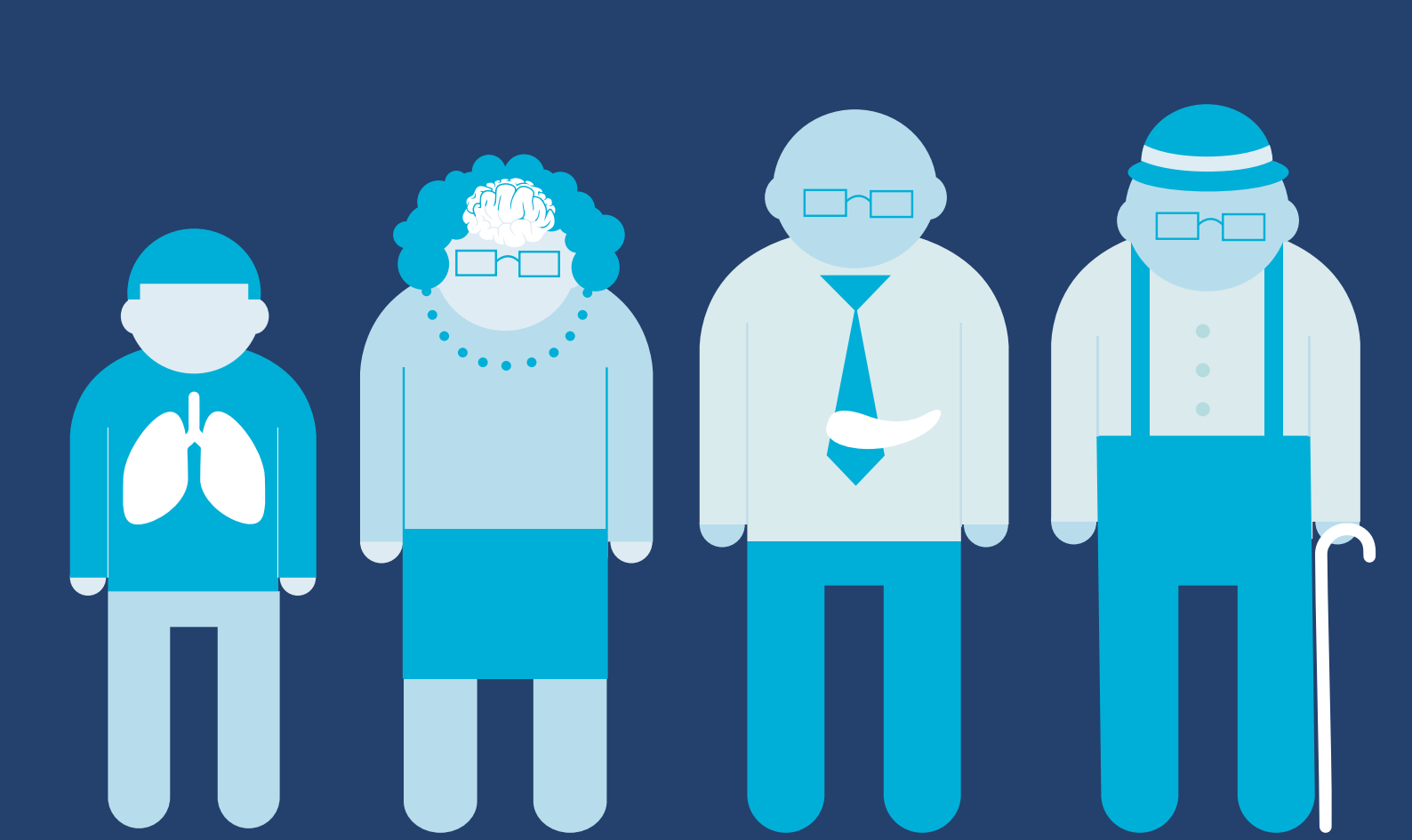


Integrated Care Partnerships
Health and Social Care

INTERIM IMPACT REPORT 2016

FOREWORD

Delivering a joined up and person centred health and care service is a huge challenge for our health system but never has it been more important, both in terms of meeting the needs of the growing number of older people with multiple long term conditions and in helping manage the demand on health and care services.

We know that in order to deliver more integrated services there needs to be an infrastructure which enables cross sectoral, multidisciplinary relationships to be built on, and for important conversations to be had in partnership with service users and carers about how services are designed and delivered.

The establishment of 17 Integrated Care Partnerships over the last three years has offered that infrastructure. However, relationships and trust are not built overnight and while there have been significant challenges to address, there has also been a considerable number of successes and these are to be celebrated.

I especially want to thank each and every member of the 17 Integrated Care Partnerships for joining in this movement, for taking up a leadership role and for being resilient and consistent in their work to improve the health and wellbeing of their local populations. My thanks also to colleagues leading the development and implementation of the programme and to the clinical and business support teams whose support and guidance has been invaluable throughout.

The challenge as we move forward will be to learn the lessons of the last three years, remove the barriers and support the scale up and spread of ideas that work.

Sloan Harper

Dr Sloan Harper
Director of Integrated Care
Health and Social Care Board

ICP chairs and members, with Valerie Watts, HSCB, Michelle O'Neill MLA, Minister for Health, and Dr Ian Clements, HSCB Chairman

CONTENTS

INTRODUCTION

Integrated Care Partnerships (ICPs) were established by the Health and Social Care Board in 2013, as a key element of the DHSSPS 'Transforming Your Care' strategy, and are a new way of working for the health service in Northern Ireland to transform how care is delivered.

ICPs are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals, local Councils and the voluntary and community sectors, as well as service users and carers, to design and coordinate the delivery of local health and social care services.

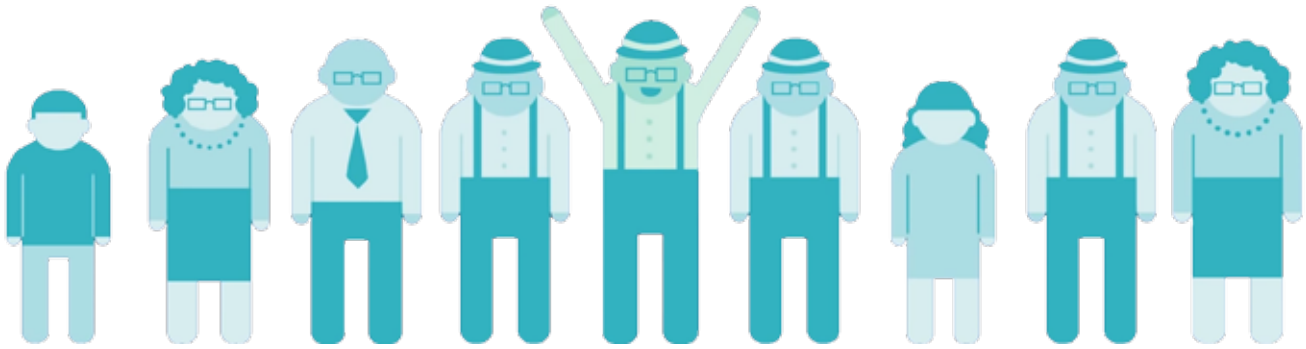
ICPs were established under a Department of Health (previously DHSSPS) Policy Implementation Framework which outlines the governance arrangements within which ICPs operate and the clinical priority areas they focus on; diabetes, respiratory, stroke and services for frail older people. ICPs have over the last three years worked to review current services and pathways of care in order to respond to Commissioning Specifications issued by Local Commissioning Groups.

Through the ICP infrastructure, health and social care staff from a range of professional backgrounds and across a number of organisations were able to work together alongside service users and carers, and local leaders from the voluntary and community sectors in a sustained way and at a scale which is not normally feasible.

This work led to the design and implementation of a number of more integrated services, agreed with and funded by the relevant LCG. Over the last 3 years £12,747,000 has been invested in services designed and implemented by ICPs across the region (spend on ICP initiatives detailed in Appendix 2).

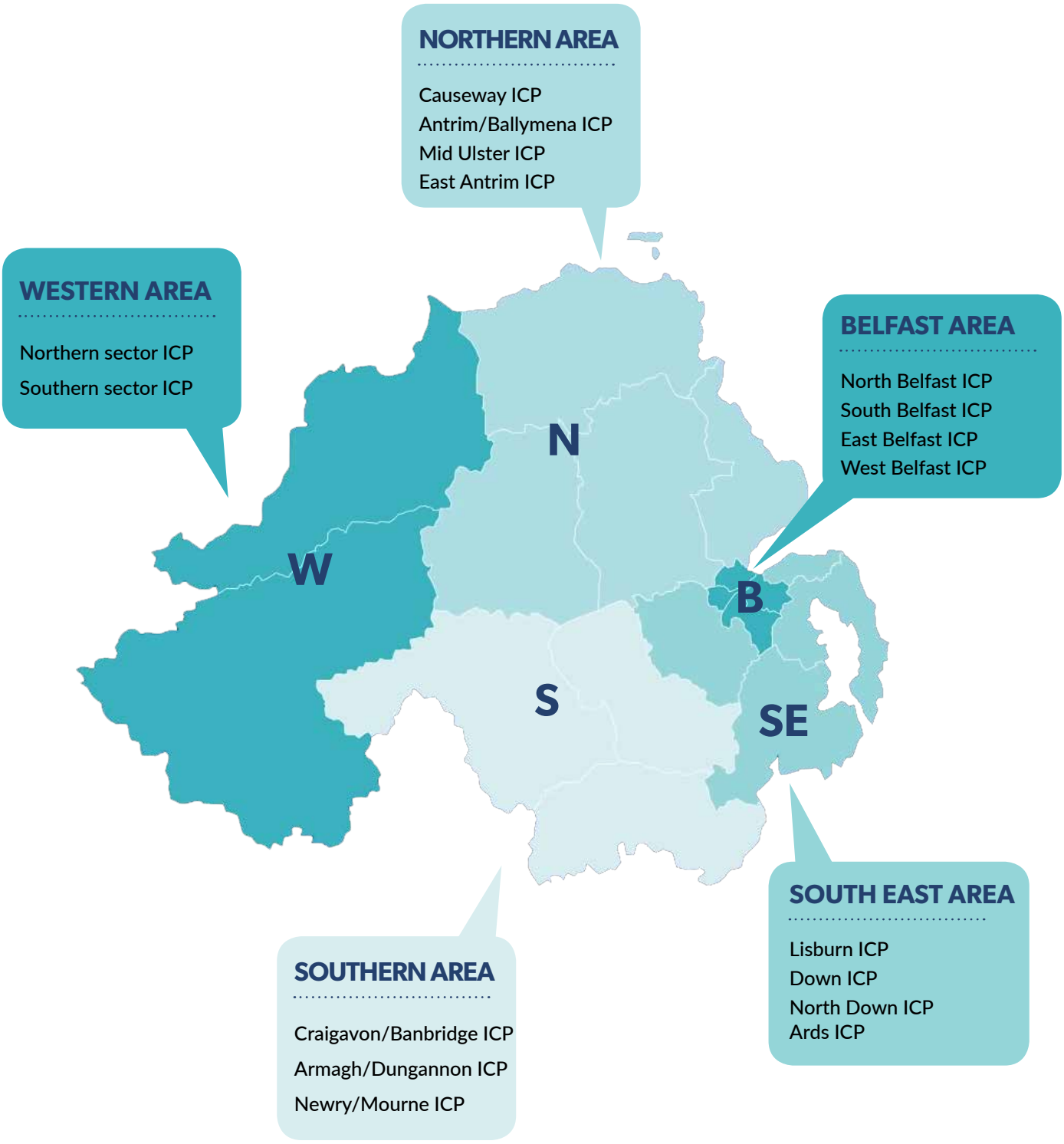
These services were focussed on preventing illness where possible, delivering more care in the community, reducing demand on hospital services and improving patient and carer experience.

This report is not intended to be a comprehensive evaluation or value for money analysis, it merely aims to highlight the early impacts being demonstrated by some of these services at an interim point in the ICP journey.



BACKGROUND

17 ICPs are now working across the five Local Commissioning Group (LCG) areas to ensure coverage of all GP practices. Each ICP is based around 25- 30 GP practices encompassing populations of approximately 100,000 people.



Each of the 17 ICPs consists of a **Partnership Committee** with 14 members from a wide range of backgrounds who meet on a quarterly basis.

- 4 members from the local Trust (hospital and community staff, to include a medical specialist, a nurse, an AHP and social worker)
- 1 member from the NI Ambulance Service
- 1 member from the voluntary sector
- 1 member from the community sector
- 2 service user/ carer representatives
- 2 GPs
- 2 Community pharmacists
- 1 Council representative

Representatives reflect the contribution which can be made by HSC Trusts, primary care independent contractors and other health and social care providers in relation to the key ICP objectives of **improving service pathways** and **patient experience** across the defined condition areas, using the **RICE approach**.

For the first time, provider organisations from health and social care are redesigning pathways alongside service users, carers, the voluntary and community sector and local government.

R – Risk Stratification – targeting care to those most in need

I – Information Sharing – how care providers work together

C – Care Planning – coordinating how care is delivered

E – Evaluation – ensuring benefits are achieved

Members of the ICP Clinical and Business Support Team

BUILDING THE PARTNERSHIPS

Building an effective partnership to deliver more integrated care takes time, dedicated support and effort. ICPs bring together a diverse range of people from different professional backgrounds and with different organisations or communities to represent. Building an understanding of each other's knowledge, skills and perspectives is vital to ensuring that strong relationships and trust develops between members.

"We have the right people in the room and that's been the first time that's happened in my twenty plus years working in the health service. So we have our community and voluntary sector representatives; the patients and carers; consultant, nursing and social care and allied health professionals from the Trust; and then pharmacy and GP colleagues. So if we are going to improve care for patients and the population in our localities then we need that whole range of people round the table to deal with it."

Dr Grainne Bonnar, Chair and GP lead of the West Belfast ICP

The Health and Social Care Board invests £1.5 million each year in supporting the partnerships. This has allowed five small ICP clinical and business support teams to be established to facilitate the working of the partnerships and support members in their role. It has also allowed backfill payments to be made to ICP members so that they can be released from their clinical roles to fully contribute to the ICPs work.

With support from the HSC Leadership Centre a range of tailored learning and development opportunities have been made available to ICP members including, a clinical leadership development programme, one to one coaching for ICP Chairpersons and organisational development sessions for each ICP.

"The ICPs came together very easily and people weren't in dispute with one another. There weren't egos in the room and it seems to have been that everyone had a shared common purpose, working together, and challenge where challenge was required. So it's been a very positive experience".

Paula Cahalan, Belfast Trust ICP committee representative

"I think the ICP leadership course that we were on helped maintain/build relationships with other people and helped sustain us through any difficulties."

Stephen Slaine, Chair and Pharmacist Lead for the Antrim/Ballymena ICP

The Board has created a quarterly forum for the 17 ICP Chairpersons to meet and discuss challenges and share learning. An ICP Service User and Carers Forum is in place to support those representatives in their roles and a bespoke programme for ICP service users and carers was delivered by Stellar Leadership.

"I don't have a single highlight. I have a number of highlights and these are where I see a video or I hear a story or I speak to someone who has benefited from the improved services that we've been able to deliver through the efforts of the ICP."

Johnny Graham, Service User representative for the Lisburn ICP

An ICP Third Sector Co-Ordinator has been in post since 2015 to provide dedicated support to Community and Voluntary Sector representatives on ICPs.

"For us in the third sector, we're particularly interested to work with the ICPs in collaboration - people working together and looking at the whole person approach and the whole system approach. Whenever we work with people we have to look at them in a collective way – all the illnesses and all the things that make them, them and through the ICPs we see that. We see that they are actually looking at the whole system and trying to deal with people's problems as a whole, rather than individually. And we've seen some key programmes making changes. Programmes like Social Prescribing where we can work with GPs, work with the community and voluntary sector and the health service and deliver people across that pathway to the programme that suits them."

Seamus Ward, Bogside & Brandywell Health Forum:

There have also been considerable efforts to develop digital media tools; short videos, an ICP ezine and use of social media to help communicate the role that ICPs play within the HSC and to demonstrate the work that ICPs are doing.

Representatives from the voluntary and community sector attend an ICP engagement event in Causeway

RESPIRATORY

THE **CHALLENGE**

- Chronic Obstructive Pulmonary Disorder (COPD) is the second most common cause of emergency admission to hospitals.
- There are 38,530 people currently diagnosed with COPD in Northern Ireland[1].
- 25% of people with COPD are misdiagnosed[2].
- In Northern Ireland in 2012/13, there were 10,133 admissions to hospital for COPD, using 69,099 bed days and an average length of stay of 6.8 days[3].
- It is estimated that 30% of people on home oxygen derive no clinical benefit[4].
- Adults with respiratory illness may be unable to participate in employment or leisure/social activities as a result of their condition and can be at risk of becoming socially isolated[5].

IMPACT IN…
SOUTHERN AREA

The three ICPs in the Southern area secured funding from the Local Commissioning Group to pilot a **Rapid Access Respiratory Clinic** which offered a new alternative for patients, rather than the traditional pathway of GP appointment, then a referral to the Emergency Department and likely hospital admission. Referrals were made in the morning by GPs and Community Respiratory Teams for appointments in the same afternoon. The Clinic was based at Craigavon Area Hospital and comprised a Consultant Respiratory Physician, a Specialist Respiratory Nurse and a Specialist Physiotherapist operating on weekday afternoons. The Clinic enabled GPs to have a one-to-one discussion with a Respiratory Physician, and provided a series of prompt interventions and early treatment regimes in a more integrated way. The patient was then referred on to the Community Respiratory Team which provided post-clinic treatments to enable the patient to remain at home.

Respiratory service in the Northern area. Respiratory Nurse, Margo Carberry and patient Judith Gallagher

"My mother attended the new Rapid Response Respiratory Clinic in Craigavon Area Hospital. My mother felt listened to, empowered and reassured. This new clinic is an excellent service, however it is the skills of the staff which make it so invaluable. In a time when the NHS and indeed the SHSCT is under pressure I was so impressed with the personal and detailed way my mother was assessed and the extensive tests carried out in such a warm and caring manner." ***Family member of patient using Rapid Access Respiratory Clinic in the Southern area***

During the pilot, from September 2015 to January 2016 **158** patients were treated at the Clinic, avoiding a potential **78** admissions to hospital and **336** bed days. It is hoped this service will be 'mainstreamed' as part of the Southern Health and Social Care Trust Ambulatory Care Reform programme.

18 GPs and Practice Nurses have completed training and received a Respiratory Diploma, and **16** Practice Nurses have received Spirometry training in the Southern area with the long term aim of skilling up staff to deliver specialist respiratory clinics in GP practices which will provide more specialist care closer to home and avoid the need for patients to attend hospital.

70 respiratory patients were able to have a review of their medication at their local pharmacy in the Craigavon/Banbridge area on Saturday mornings to ensure they are receiving the optimum treatment and encourage effecfive self- management as part of a pilot service. The accessibility of this service encouraged patients to participate rather than waiting to see their GP on a week day or missing their review appointment and potentially experiencing a deterioration in their condition.

1000 COPD 'rescue packs' have been issued by GPs to respiratory patients in the Southern area who often experience a flare up of their condition. This proactive approach enables patients to access antibiotic treatment immediately when required.

83% of GPs taking part said the rescue pack helped them and their patients to manage the symptoms of COPD.

Representatives from the voluntary and community sector hear from Dr Bernard McCoy at an ICP engagement event in the Southern area.

IMPACT IN…
WESTERN AREA

The two Western ICPs secured funding from their Local Commissioning Group for three **Community Respiratory Teams**, based at Altnagelvin, Tyrone County and South West Acute hospitals, to complement the existing Western Trust respiratory service.

The teams have developed a range of diverse and integrated services to improve patient care offering clinical support, monitoring, education programmes and advice on self-management to patients and their families. The team includes 2 respiratory physiotherapists and a respiratory pharmacist. Patients can be seen in a range of settings, including their own homes, healthy living centres, clinics and GP practices. An extended service was made available from June 2015, providing access 7 days a week from 9am – 5pm.

People with respiratory conditions who experience an exacerbation, or a sudden worsening of their condition, can be cared for at home, and if they do enter hospital, the service will enable them to be discharged earlier than before, to be supported at home. From August 2015 to March 2016 **818** patients were referred to the service, avoiding **739** hospital admissions, and **4019** bed days.

The input of a dedicated respiratory pharmacist has been shown to reduce the frequency of exacerbations or flare ups from **65% to 35.1%**, and to reduce the rate of unscheduled hospital admissions from **8.4% to 3.2%**. Analysis has shown that the addition of a pharmacist has yielded a four fold financial return.

The ICP secured funding for two Respiratory Nurses to carry out assessments for home oxygen. This has resulted in the reduction of waiting time for oxygen assessment, from **13 months to 3 months** in the Northern sector of the Western locality.

"So much better than going to A&E"
Rapid Access Respiratory Clinic service user, Southern area

OTHER
LOCAL IMPACTS

- GP practices in Belfast now have a direct link to a named Specialist Respiratory Nurse which means they are able to quickly access the respiratory community team to help manage patients with an acute exacerbation in a more integrated way in the community, and therefore avoid a hospital admission.
- People at risk of developing COPD are now being identified at an early stage through proactive 'case-finding' at GP practices across Belfast and in the Northern area. This has enabled GPs to identify patients with the condition earlier and provide treatment sooner.
- Additional Pulmonary Rehabilitation clinics in Belfast and in the North have been put in place to increase the numbers of people benefitting from this treatment and provide a more integrated service. Pulmonary rehabilitation (PR) is a programme of exercise and education for people with long-term lung conditions which combines physical exercise sessions with discussion and advice on lung health, and which has been shown to significantly reduce hospital admissions.

Service user Ronnie Farrell attending a Pulmonary Rehabilitation class with Breige Leonard, Pulmonary Rehab Nurse, Western area

- **251** patients across Belfast have been able to leave hospital earlier due to an extended community-based service operating at evenings and weekends since January 2016.
- This extended 7 day community respiratory service has avoided **415** weekend admissions.

- The addition of a Clinical Psychologist to the respiratory service has provided a more integrated service and to date **45** people have been supported in managing their condition.
- A Home Oxygen Service Assessment and Review (HOSAR) service is now operating across Northern Ireland to systematically review all patients with home oxygen for the effectiveness of their treatment, and to identify people who could benefit from home oxygen. **2734** people from Northern, South Eastern and Belfast areas have been assessed in 2015/16.
- People admitted to hospital with respiratory conditions in the Northern area are now referred to the Enhanced Community Respiratory Team within 24 hours, to plan for their discharge. They agree a care plan, which is shared with the GP, to include smoking cessation, inhaler technique and Pulmonary Rehabilitation.

"Oxygen has made a great difference to me. Before I got ambulatory oxygen I did not want to go out because I had no puff. Now I have oxygen tank and a conserver and I am able to get out and about more and do a little house work, which my husband had to do before. I go to the weekly maintenance classes now after attending pulmonary rehabilitation. My quality of life is much better. "

Home Oxygen Service user, Northern area

PATIENT **EXPERIENCE**
RESPIRATORY - SOUTHERN AREA

Mr McGinn is an 86 year old gentleman who lives with his wife and has severe COPD. He had been using oxygen for a long period, and had been recently admitted to hospital with pneumonia and has not recovered fully. He reported increased breathlessness, even when dressing or undressing and it prevented him from leaving the house, which made him feel anxious and isolated.

Mr McGinn was referred by the Community Respiratory Team to the Rapid Access Respiratory Clinic at Craigavon Hospital and was assessed on the same day.

The team examined Mr McGinn and provided treatment, including a review of his oxygen dosage, and prescribed antibiotics and nebuliser therapy. He was also provided with education on using oxygen and the nebuliser, and how to manage his condition at home. He was then referred to the Community Respiratory Team for ongoing support and physiotherapy.

He said, "I received first class attention at the clinic. This was much preferable to going to A&E and being admitted. The nurses coming out to my home to give me antibiotics made me feel I was being well cared for."

DIABETES

THE **CHALLENGE**

- Diabetes care costs Northern Ireland more than £1 million per day, or 10% of the healthcare budget[6].
- The number of people with diabetes doubled between 2003- 2014[7]. Over 85,000 people in Northern Ireland live with diabetes[8/9].
- People with diabetes are 15 times more likely to need an amputation than the general population[10].
- In 2014, 1,495 people with diabetes were admitted to hospital for amputations and end stage renal disease[11].
- Approximately 150 major limb amputations are carried out in Northern Ireland every year of which about 80% could be prevented[12].
- People living with diabetes are at risk of developing health problems which can include renal disease, blindness, cardiovascular disease and lower limb amputation. People living with diabetes also have an increased rate of depression compared with the general population[13].

IMPACT IN…
NORTHERN AREA

Causeway and Mid Ulster ICPs have introduced an **Enhanced Foot Care Team** for people with diabetes consisting of a specialist podiatrist, diabetes consultant and a diabetes nurse specialist. The aim is to provide a more integrated foot care service, which supports service users to better manage their condition and their cardiovascular risk and to enable the team to work more effectively with vascular consultants across Northern Ireland. It is intended that the new care pathway will reduce emergency admissions for diabetes related foot conditions, reduce the risk of amputation and ultimately reduce the number of amputations.

Patients can be referred directly by their GP, nurse, ED or hospital to the multidisciplinary service and will be seen within 24-48 hours for an assessment and treatment. Treatment can include treating the wound and relieving pressure on the wound, treating any infection and advising on blood sugar control.

255 referrals were received by the Foot Care Team from April 2015 to March 2016. 80% of patients were seen within 48 hours.

5% of patients were treated by the Hospital Diversion Team and so avoided hospital admission, saving **344** bed days.

The numbers of minor amputations carried out on patients in the Causeway and Mid Ulster ICP areas have been reduced by **90%** from 10 in 2014/15 to 1 in 2015/16.

352 people with Type 2 diabetes in the Northern area have received **structured patient education**.

"I have nothing but praise for the foot pathway team. Anytime I'm there I'm seen quickly, always seems to run to time, never running late – it's a good service. They will always say to give them a ring if I've any problems and to come back to them – very happy"

Diabetic Footcare Pathway service user, Northern area

Northern area Enhanced Footcare Team with Florence Findley-White, Diabetes UK and service user Reg Crozier

IMPACT IN…
WESTERN AREA

The two ICPs in the West have reformed the entire diabetes pathway to ensure a more integrated service by introducing a number of measures:

Patient registers in hospitals and GPs practices have been reviewed to ensure that people with diabetes are receiving the right care in the right place at the right time.

A more efficient **referral system** has been introduced using a single point of contact and electronic triage which has enabled consultants to spend more time on patient care and on supporting GPs to manage more patients in primary care. Lower risk patients can now be managed in the community in partnership with GPs.

Multidisciplinary clinics have been established in 6 locations to bring specialist integrated diabetes care closer to the community and to date **838** people have been seen. Of those, **72** newly diagnosed patients were then referred to urgent access clinics across the Western area. 150 of the people attending clinics were identified as at high risk of developing Type 2 diabetes and preventative measures were put in place. This integrated approach and the introduction of a centralised referral system has reduced the waiting time for an Outpatient Consultant review from **9 months to 1 month** as patients can treated by the multidisciplinary team in the community.

546 people with Type 1or Type 2 diabetes have received **structured patient education**.

An integrated **Diabetic Foot Care Pathway** has been put in place to ensure early identification of problems and access to a multidisciplinary assessment for people with diabetes at risk of developing foot conditions. The integrated approach involves GPs, community nursing, Diabetes specialist teams and Allied Health Professionals in primary and secondary care, and specific cooperation between medical and surgical teams for patients with acute diabetic foot problems.

OTHER
LOCAL IMPACTS

- In Belfast all patients with Type 2 diabetes are given access to a structured patient education programme. Structured patient education empowers the patient with diabetes to better understand and manage their condition and medication on a day to day basis, and is especially beneficial to carers who may be managing tables and insulin on behalf of the person with diabetes.
- Diabetic patients in Belfast at risk of foot complications and amputation have access to a multidisciplinary Foot Protection Team to manage and reduce the risk of complications which can result in amputation.
- **26** GPs, Practice Nurses, Pharmacists and Nutritionists in the Southern area have achieved a 'Diabetes Management in Primary Care' Diploma which will enable them to tailor treatment to each patient in line with best practice and prevent the need for referrals to hospital.
- **179** children with diabetes have been supported over 16 months by an out-of-hours Diabetic Specialist Nurse service in the Southern area, where families can ring a nurse for advice at any time of day or night, to avoid a potential attendance at the Emergency Department.

"The service is a lifeline for me if something happens to my child … it gives me peace of mind and reassurance – the staff are a pillar of support"

Parent of child with diabetes, Southern area

"A brilliant service – next best thing to having a nurse living with us"

Parent of child with diabetes, Southern area

- ICPs across Northern Ireland have rolled out an awareness campaign to highlight the main symptoms of Type 1 diabetes in children, which can lead to a life threatening condition if left untreated. 'The 4 T's' promotional material has been distributed to schools, GP practices and community pharmacies to enable earlier diagnosis of Type 1 diabetes.

Launch of the Diabetes UK 4Ts campaign in the Southern area.

PATIENT **EXPERIENCE**
DIABETES - NORTHERN AREA

In July 2015 Mr Johnston was referred by his GP to the Enhanced Foot Protection Team for a diabetes-related foot ulcer and was seen within 24hrs.

The team assessed him and referred him to a Vascular Consultant. He received information on managing his condition and was provided with antibiotics. Mr Johnston was then seen twice a week and the ulcer in his foot was prevented from deteriorating.

He was very happy with the standard of treatment he received, stating; "The team's work is carried out in a very caring, professional manner. I would be lost without them".

FRAIL OLDER PEOPLE

THE **CHALLENGE**

- The population in Northern Ireland aged 65 and over increased by 2.4 per cent from 2013 to 2014[14].
- 53,206 frail older people (over 75) were admitted to hospital as an emergency from April 2015 – March 2016 which is an increase of 4% compared to the same period the previous year[15].
- Frailty in older people is associated with increased hospital admissions due to falls, confusion and loss of mobility and with increased length of stay once admitted to hospital[16].
- Studies of association have shown that falls[17] polypharmacy[18], poor nutrition[19] and lack of exercise[20] are all associated with increased hospital bed use in older people.

IMPACT IN…
BELFAST AREA

The '**Acute Care at Home**' service was designed and implemented by East Belfast ICP in May 2015 and was subsequently rolled out across Belfast. The service aims to provide people aged over 75 with expert medical and social care in their own home, to avoid admission to hospital.

An integrated team of healthcare professionals work together to help older people manage conditions such as chest infections, urinary tract infections, cellulitis and dehydration. Patients have, within their own home environment, the same access to specialist tests as hospital inpatients, and receive a Consultant-led assessment and treatment.

The average length of stay in the service at home is **6** days, compared to an average 11 day stay in hospital for older people in Belfast.

In 2015/16 **274** older people were provided with care in their place of residence and therefore avoided a hospital admission, saving **3014** bed days.

IMPACT IN…
WESTERN AREA

A **Social Prescribing** programme was piloted in the North West to help older people address social, emotional or practical needs by linking them to sources of support and activities within their local community. The pilot involved Aberfoyle Medical Practice and Eglinton Medical Practice and was delivered by Bogside & Brandywell Health Forum, in conjunction with Rural Area Partnership in Derry (RAPID).

Older people referred to the service by their GP were visited by a Social Prescribing Coordinator to discuss suitable options including social clubs, physical activity, self-help groups, volunteering, learning, counselling, and advice and guidance services. The Coordinator then supports the older person to access the necessary services and remains in contact with the person to review progress. The majority of people referred have a long term condition, have emotional problems or feel lonely. Most referrals were made to exercise opportunities or older people's social clubs.

From April 2015 to May 2016 107 people were referred to the programme with **82** people going on to participate in social activities delivered by the community and voluntary sector. Feedback from patients shows that the programme had positive impacts: in changing their health behaviours, by losing weight or stopping smoking; in integrating the new activities into their daily routine; increased confidence and willingness to try other activities; and less visits to their GP. An evaluation report is available and work is underway to trial the programme on a larger scale.

ICPs in the Western area also established a **new referral pathway** for older people who are at risk of a fall or who have fallen, referrals are made by GPs to strength and balance classes delivered by Oak Healthy Living Centre in the Fermanagh area. **209** people have attended these classes, which have been shown to reduce the likelihood of a further fall.

A strength and balance class taking place in the South Eastern area

IMPACT IN…
SOUTHERN AREA

ICPs in the Southern area have enabled the extension of the Southern HSC Trust **Acute Care at Home** service to provide support until 10pm on weekdays and from 8am to10pm on weekends. In total the extended service has received over 1084 referrals, half of which are from nursing homes.

ICPs also introduced a dedicated Acute Care at Home pharmacist in the Southern area to enable swifter dispensing of medication to patients using the service and to review medications being taken by patients. Between September 2014 and April 2016 **175** patients have had their medications reviewed to ensure best practice is being followed.

IMPACT IN…
NORTHERN AREA

The '**Nursing Home In-reach**' initiative focusses on very frail older people living in nursing homes, who commonly experience a high level of attendance at hospital Emergency Departments.

The aim was to develop and deliver a specialist education, training and development programme for staff working in nursing homes in the Antrim / Ballymena area to enable them to provide more care for their residents in the home, rather than in hospital.

Two members of staff from each of the 20 participating nursing homes took part in training including: long term conditions management; dementia car; recognising /managing the deteriorating patient; medicines optimisation; end of life care; catheter management; Peg Tube management; syringe driver management and venepuncture. These staff then cascaded this learning to their colleagues within the home.

A Practice Development Facilitator provides a 'case finder' function – to track patients who do attend ED to determine the appropriateness of that attendance, and then to provide follow up support to the home, such as additional staff training, to avoid a reoccurrence.

The increased knowledge and skills of nursing home staff in the pilot has resulted in a **25%** reduction in the number of visits from Marie Curie staff out of hours; a **21%** reduction in the number of calls made to district nursing services compared to the same period in the previous year and a **48%** reduction in the number of calls to the hospital diversion nursing team relating to PEG tube issues.

The numbers of older people attending the Emergency Department from nursing homes in the Northern area has reduced by up by **a third** due to the enhanced skills of nursing home staff, down from 1016 attendances in 2014 /15 to **706** in 2015/16, and avoiding **1519** bed days.

IMPACT IN…
SOUTH EASTERN AREA

The ICP has established a new **Coordinated Falls Service** for people who have fallen at home, and have been attended to by the NI Ambulance Service (NIAS). In 2012/13 NIAS responded to 4239 falls in the South Eastern area.

Unless the person requires hospital admission for an injury, NIAS staff can now refer the person directly to the Falls Prevention Service and enable them to receive treatment at home. Previously anyone who had fallen at home would have been taken to the Emergency department. NIAS has referred **167** patients to the service from June 2015 to May 2016.

ICPs have secured funding for an additional four Falls Assessors who respond within 24hours of a NIAS referral to assess the patient and their environment to identify the likely cause of their fall and ways of reducing the practical risks of them falling again. The Falls Assessors may also refer the person onwards to other sources of support, such as Occupational Therapy, Physiotherapy and Podiatry, nursing services, GP or community and voluntary sector services.

From April 2015 to May 2016, **1373** falls assessments have been carried out in patient's homes.

Patients who have been prescribed four or more medicines are at risk of falling, and a dedicated pharmacist has been put in place to review those patients' medicines.

An **Enhanced Care at Home** service has been rolled out across the South East since September 2015, providing specialist medical care to **186** older people at home rather than in hospital. 1088 bed days have been avoided from January to April 2016.

"What an excellent service! – it made a world of difference to her being able to have excellent care in the comfort of her own bedroom surrounded by the people she knows, instead of a distressing hospital admission in an unfamiliar surrounding"

Family member of a patient using the Enhanced Care at Home service in the South Eastern area.

251 older people have been supported in a time of crisis by the new **Social Care Response** service in the South East. The ICPs in the area secured funding from the Local Commissioning Group to recruit 2 care workers for a 6 month pilot period to provide person-centred social support to older people from 6pm to 12am. This service is flexible in meeting the needs of people whose caring situation may have broken down, or who require short term care upon discharge from hospital, and can include personal care, help with taking medicine, or changing dressings.

An evaluation of the pilot has been completed, and discussions are underway with Commissioners to further develop the service.

"Without the service I was sleeping in an armchair as I needed assistance to get into bed."

Service user, Social Care Response service, South East

"It made a lot of difference because someone came to check on me as my family was away"

Service user, Social Care Response service, South East

PATIENT **EXPERIENCE**
ACUTE CARE AT HOME, BELFAST

Miss Jones is an 86 year old lady who has Multiple Sclerosis and a sight loss. She was referred to the Acute Care at Home service by her GP as she was becoming increasingly confused and agitated. Miss Jones had family members from England staying with her but they were struggling to meet her increased needs.

At the time of referral she had been bed bound for three weeks and was not eating or drinking.

The Acute Care at Home team carried out a full assessment in consultation with the family and diagnosed delirium, and conditions associated with dehydration, including a urinary tract infection.

The team provided immediate treatment to Miss Jones and the agitation settled within 24 hours. By using this service Miss Jones was able to remain at home and is now mobile with the help of a stick.

Her family were provided with support and education on caring for Miss Jones and are very satisfied with the service she received.

STROKE

THE **CHALLENGE**

- There are approximately 4000 strokes in Northern Ireland every year[21].
- From April 2015 to March 2016 30,955 bed days were used for patients with a diagnosis of stroke[22].
- Stroke care costs the NI Health Service around £260m per year[23].
- Atrial fibrillation (AF) causes the heart to beat irregularly, and often speed up. Atrial Fibrillation increases risk of stroke by up to 5 times[24].
- It is estimated that around 2% of the Northern Ireland population live with AF[25].
- Stroke is one of the largest causes of disability – half of all stroke survivors have a disability[26].

IMPACT IN...
WESTERN AREA

The Western ICPs established a **Specialist Orthoptic Service** for people with stroke in April 2015 to provide early diagnosis and treatment of visual problems associated with stroke. An orthoptist is an eye care specialist who can assess and treat a range of eye problems, particularly problems with eye movements.

Often hospital ward staff may have concerns about a patient's vision following a stroke which is delaying their treatment and/or discharge. An orthoptic assessment can ensure the appropriate treatment and may mean the patient can return home sooner.

In 2013-14, only 19% of stroke survivors in Altnagelvin Area Hospital (AAH) were found to have a visual defect. Since the introduction of specialist orthoptic screening, **45%** of patients have been found to have a visual defect.

The average length of stay for the stroke survivors with an identified visual defect in 2013-14 was 24.9 days while the average length of stay for the patients who underwent orthoptic screening in 2015 was 19.3 days - a difference of **5.6** days per patient.

Western ICPs also secured funding for 2 **Occupational Therapy Technical Instructors** to provide intense therapy to people who have recently had a stroke. The therapy sessions are provided in hospital and in the community to enable the person to return home from hospital as soon as they are able.

The Instructors took up post in October 2015 and delivered 115 therapy sessions in the first month. This is an increase from the average of 86 sessions delivered per month in 2014-15. People who have received support from the Technical Instructors demonstrate an increased ability to carry out a range of daily living tasks.

The average number of days from referral to OT assessment has been dramatically reduced from 6.8 to an average of 1 day, and the average number of bed days from referral to the completion of treatment by OT has reduced from **42** days to **14** days.

OTHER
LOCAL IMPACTS

- ICPs in the South East secured funding for the development of a seven day Early Supported Discharge service for stroke patients. A co-ordinated planned discharge and continued specialist rehabilitation at home within 24 hours is provided. This will reduce unnecessary hospital stay and facilitate increased access to the acute stroke unit. From January to April 2016 27 people in the South Eastern area have been discharged early from hospital as a result.

- The Southern ICPs have led on the implementation of an integrated and improved electronic referral process for patients who have had a TIA (Transient Ischaemic Attack or mini stroke). A more detailed and accurate electronic referral form is now in use to refer patients to hospital. The improved information enables hospital staff to better prioritise and triage the patient in line with the severity of their TIA in advance of the patient's arrival at the clinic to ensure patients are seen promptly for investigations and treatment to prevent further TIA's or strokes.

PATIENT EXPERIENCE STROKE ORTHOPTIC SERVICE - WESTERN AREA

Mr Anderson was admitted to Altnagelvin Area Hospital following a stroke in September 2015. Although his eyesight was tested upon admission and 2 days later and deemed to be normal, a specialist non-verbal test carried out by the stroke orthoptist found Mr Anderson to have a significant visual field defect and a loss of 3D vision.

Mr Anderson was given ongoing assessments during his stay in hospital and he, his family and ward staff were given advice on rehabilitation, taking into account his visual difficulties. Following his discharge from the ward, he has been reviewed by the stroke orthoptist at the orthoptic outpatient clinic.

Mr Anderson got new glasses from his optician and his visual acuity improved to a good level on review, His family note that he is now managing well in his own home and has no difficulties safely navigating as he has adapted well to his remaining partial field defect. He remains under orthoptic review at present.

END OF LIFE

THE **CHALLENGE**

- Studies show that the majority of people with a terminal illness would prefer to die at home[27], however approximately 50% of all deaths in Northern Ireland still occur in hospitals.
- 1012 people aged over 85 died in hospital from April to September 2015[28].
- Approximately two thirds (9,570) of people dying in Northern Ireland every year would benefit from a level of palliative care during the last year of life but for reasons of diagnosis are excluded[29].

IMPACT IN…
WESTERN AREA

An **enhanced Day Hospice** pilot gives patients and families access to a specialist palliative care service on an outpatient basis in the Northern sector of the Western area.

ICPs in the West secured funding for a medical officer and a nurse to enhance the existing Day Hospice team at Foyle Hospice to provide specialist palliative medicine review and nursing assessment for new patients, and a review of existing patients to advise on how to best manage symptoms and other support. Patients could also access respite from home for a day a week to socialise with others, and take part in other activities provided by Foyle Hospice.

From September 2015 until March 2016 **48** new patients were assessed and **201** existing patients were reviewed by the team. **32** people took up the opportunity to create an advanced care plan, and **19** of these people established and documented preferences for their end of life care.

'**Compassionate Communities'** is a Public Health approach to end of life care. It encourages communities to support people and their families who are finding life difficult due to having chronic or end of life conditions. A Compassionate Communities pilot was delivered through the ICP and led by Foyle Hospice in the Waterside area of Derry/Londonderry. The pilot was a partnership between Hillcrest House and Caw/Nelson Drive Community Groups and the 3 GP practices based in Waterside Health Centre from July 2015 to March 2016.

Trained Compassionate Neighbours provide weekly contact to people who have become isolated as a result of illness. It might be as simple as going for a cup of tea, enjoying a shared interest, doing a bit of shopping or a trip to the local community centre. The aims of the project were to reduce social isolation; to enable people to remain living independently at home if that is their wish and to help people stay connected with and involved in their community. The project also aimed to raise awareness of issues relating to end of life, death, dying and loss, and to reduce dependence on primary care.

15 volunteers have been trained as befrienders and **16** people have been referred for support. The Hospice has created a dedicated website, hosted an art exhibition, and a professional conference to raise awareness of the issue.

ICPs in the Western area secured funding to extend the **Macmillan GP Facilitator** role, which aims to improve the quality of palliative care provided by primary care teams. The GP Facilitators carry out GP training, produce resources, build relationships across sectors, and raise awareness of palliative care. The funding extended the role from September 2015 to March 2016. The majority of primary care teams involved agreed that the Facilitator was a valuable resource, provided a strong link between primary and secondary care and increased their confidence in responding to patients with palliative care needs.

IMPACT IN…
SOUTH EASTERN AREA

In order to identify patients with palliative care needs, and to ensure they can exercise choice in their care, treatment and place of death, the **Peninsula End of Life project** provided GPs with the opportunity to have dedicated time to discuss palliative and end of life cases with colleagues, and to access training focussing specifically on clinical management of palliative care needs.

The pilot was delivered between May 2014 and May 2015 and involved four GP practices in the Ards Peninsula area.

GPs attended monthly multidisciplinary meetings to identify and discuss palliative and end of life cases, to target care, advice, and proactive planning to specific patient groups and their carers to avoid unnecessary hospital admissions. GPs from the practices involved also participated in 2 days of training.

The LCG provided funding to remunerate GP practices for time taken out of practice to attend these sessions.

As a result of the provision of adequate medical care in the community the number of emergency admissions to hospital/hospice decreased by **64%** in 2014/15 from 2013/14. An evaluation report has been completed and discussions are ongoing to further develop the project.

PATIENT **EXPERIENCE**
END OF LIFE - COMPASSIONATE COMMUNITIES, WESTERN AREA

Katherine is a 78 year old woman living on her own in the Waterside area. She suffers from numerous medical conditions which means she tires easily and her mobility is severely restricted. She is matched to Pauline, a Compassionate Communities volunteer. Katherine explains that she feels reconnected to her community because of Pauline's visits and that it reduces the loneliness she experiences and is something she enjoys.

"You may have got up in the morning and think 'not another day'. Then you realise she's going to come in the afternoon and that suits fine. It's something to look forward to – a wee cup of tea and a chat and finding out what's happening".

Pauline visits Katherine every Monday for an hour or two and is from the local area. She tells how she was a bit worried before the first meeting about whether they would get along. Now she feels there is a friendship growing between them and that they were well matched at the beginning of the befriending process.

"She's the type of woman that once you get talking you feel like you've known her for a long time. You ever meet somebody and you just click and you get on? I love going to visit"

Pauline says that volunteering has benefits for her and makes her feel she is doing something worthwhile.

IMPACT ON THE REFORM AGENDA

ICPs are also supporting a number of other Regional Strategic priorities including the Regional Unscheduled Care Group and Outpatient Reform projects.

Unscheduled Care is when someone accesses health and social care services unexpectedly and can require treatment at any time of day or night. In Belfast unscheduled care accounts for 61% of all hospital admissions.

ICP Clinical leads are contributing to the Regional Unscheduled Care Group which is working to understand the unscheduled care needs of local populations and plan for the capacity needed to establish sustainable year-round delivery.

ICPs in Belfast and in the West have been involved in **Outpatient Reform** work which aims to reform hospital-based outpatient services focussing on a range of clinical specialities. This reform work hopes to improve how demand from GP practices for the use of secondary care is managed, and to increase integration across services.

ICPs have tested an approach to multi-disciplinary **Proactive Management** for specific groups of patients who are at high risk of deterioration or of hospital admission. This involves identifying those patients and putting in place an effective wrap around service to support them to stay well for longer. Further refinement of that approach will be needed in order to provide truly integrated and person centred care.

LOOKING TO THE FUTURE

It is clear that ICPs can be an effective vehicle for delivery of more integrated and joined up services.

More integrated services are now being delivered across a number of localities and condition areas leading to positive patient experiences.

It's fair to say that successes have been hard fought for and in some areas initiatives have taken longer to secure Commissioner support and to put into practice than first envisaged. There are a number of ICP initiatives which are still at an early stage in terms of implementation and which have not been featured in this report.

> *"We're joining up the dots. The services are there – we just never spoke to each other. So to eliminate duplication, to make sure that we get a wrap around service, and a coordinated approach – this is the way to do it."*
>
> ***South East HSC Trust representative***

There have been a number of short term funded ICP initiatives which require sustained funding and there is still significant work to do in terms of the development of the model of working through ICPs, and in the delivery of more integrated and person centred care.

Looking to the future it is important that ICPs share their learning across the wider HSC so that lessons are learned and barriers to scale up and spread are addressed. The ICP Stocktake recently undertaken by the HSC Leadership Centre and the Department of Health Evaluation of ICPs currently underway will provide direction in this respect.

Valuable experience of adopting a Quality Improvement approach to guide the work of ICPs has been gained through the support of the Institute of Healthcare Improvement and the Triple Aim principles which are now embedded in the work of Integrated Care Partnerships.

The Commissioning Specifications which ICPs were asked to deliver against are currently being refreshed to ensure that they reflect the ever changing evidence and policy base and also to reflect the need to take a longer term and more outcomes focussed approach. Moving forward, the Department of Health has indicated that there is potential for ICPs to take a fuller role in the delivery of end of life care, and to extend into the realm of chronic pain management and mental health.

> *"I think the round table experience has brought a qualitative difference to the whole concept of partnership development and partnership working that you won't find in any other regard in my experience of working in health and social care."*
>
> ***Western area Community Sector representative***

We must ensure that we learn from the growing Integrated Care movement across the world and closer to home and develop learning networks with our colleagues in the NHS and the Health Service Executive. We must explore new ways of working which can help align incentives across the HSC system and offer opportunities for ICP networks to maximise their impact.

Obstacles to continuity of care and integration are systemic and complex, the ongoing review of HSC structures and the report of the Expert Panel for the remodelling of health and social care in NI will reflect this challenge but also present a huge opportunity for change. Ultimately, the success of ICPs will depend on people, their ability to recognise the opportunities and to lead through this change, keeping the patient and client at the heart of everything they do. We must all be relentless in pursuit of that goal.

Martin Hayes
ICP Project Director
Health and Social Care Board

APPENDIX 1

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APPENDIX 2

Table of spend

Area	Service Change	14/15 Actual Spend £000's	15/16 Actual Spend £000's	16/17 Planned Spend £000's
Belfast	Frail Older People	52	909	1999
	Respiratory	100	588	646
	Stroke		350	501
	Diabetes		164	164
Total		**152**	**2011**	**3310**
South East	Frail Older People	64	432	1652
	Respiratory	19	95	116
	End of Life Care	3		
Total		**86**	**527**	**1768**
South	Advanced Access to Diagnostics		33	82
	Frail Older People	104	344	
	Respiratory	36	136	
	Community Pharmacy Pilot	5		
	Diabetes	91	88	148
	Diabetes & Respiratory Training		46	
Total		**236**	**647**	**230**
North	Respiratory	30	431	739
	Nursing Home In Reach	11	80	86
	Diabetes		186	189
Total		**41**	**697**	**1014**
West	Stroke	9	64	107
	End of Life	29	151	200
	Diabetes	160	140	59
	Respiratory	119	331	281
	Frail Older People	22	122	149
	Ambulatory Cardiac Care	18	212	212
Total		**357**	**1020**	**1008**
Regional Total		**515**	**4902**	**7330**

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

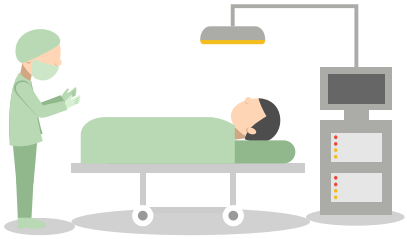
people in the Northern, South Eastern and Belfast areas have had a home oxygen assessment or review

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**



90%

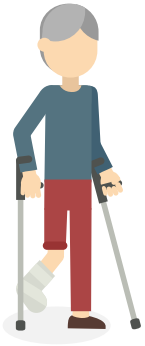
reduction in the number of diabetes-related minor amputations in the Causeway and Mid-Ulster areas

Improved community care in the Ards Peninsula has reduced emergency admissions to hospital for people with palliative care needs by

64%

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



167

people in the South East who have fallen at home have avoided being admitted to hospital

1/3 reduction

in the number of nursing home residents in Antrim and Ballymena attending the emergency department and avoiding **1519** days in hospital

The number of stroke patients in the Western area who have had a visual defect identified has increased by

136%

The length of stay in hospital in for stroke patients who have had a visual defect identified in the Western area has reduced by

5.6 days

The average bed days per stroke patient from OT referral to completion of OT treatment has reduced in the Western area by

66%

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

Follow the #ICPchange conversation

* (as of June 2016)

Integrated Care Partnerships

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