Improved access to Integrated Care Cardiology services following the introduction of Healthlink referrals

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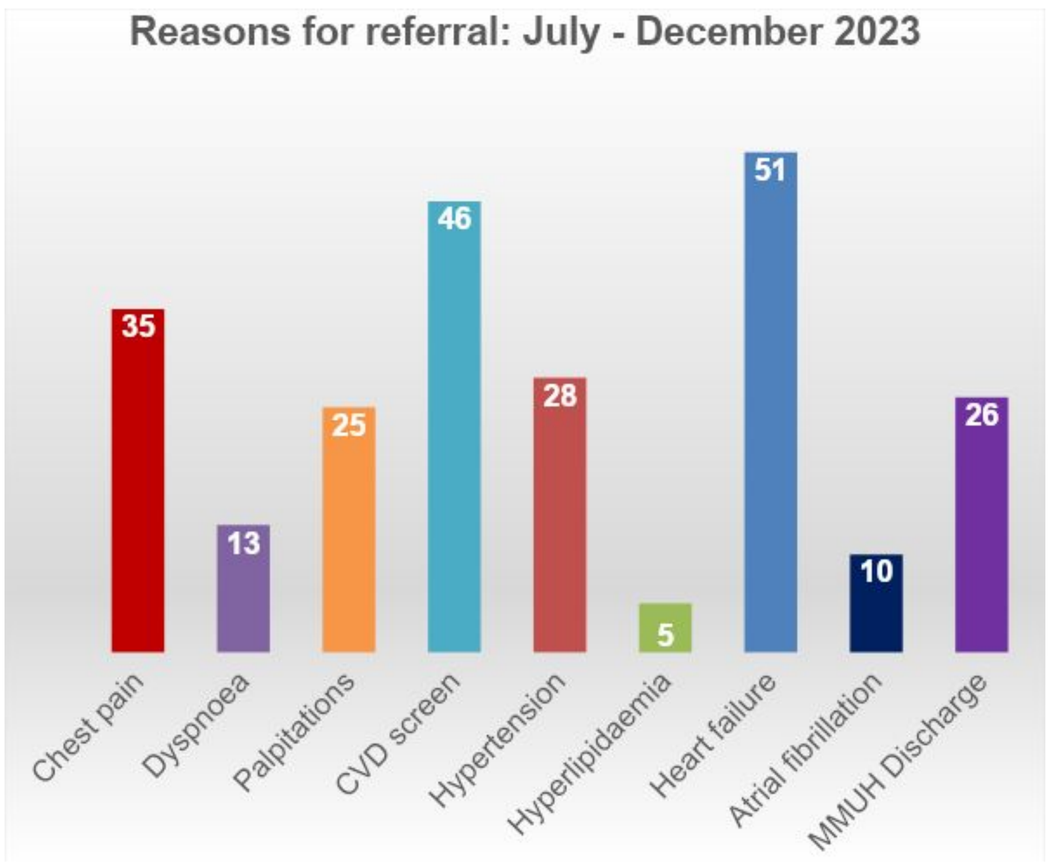
1 BACKGROUND

Integrated Care Cardiology (ICC) services were developed as part of the Slaintecare programme to facilitate early access to specialist care in the community and move care closer to the patient, thereby enhancing chronic disease management. An initial barrier to timely referral was the limited access to Healthlink for direct referrals from GPs to the available services. This potentially delayed timely review and limited the number of patients availing of this new service.

2 METHODS

All new GP referrals to the ICC Consultant clinic were included over a 6 month period from July – December 2023. The proportion of referrals received directly from GPs was compared for the 3 months prior to and the 3 months following the introduction of a Healthlink referral pathway. This was rolled out on the 18th September 2023. The time to review new GP referrals both pre- and post- Healthlink referral introduction was also assessed.

Figure 1:



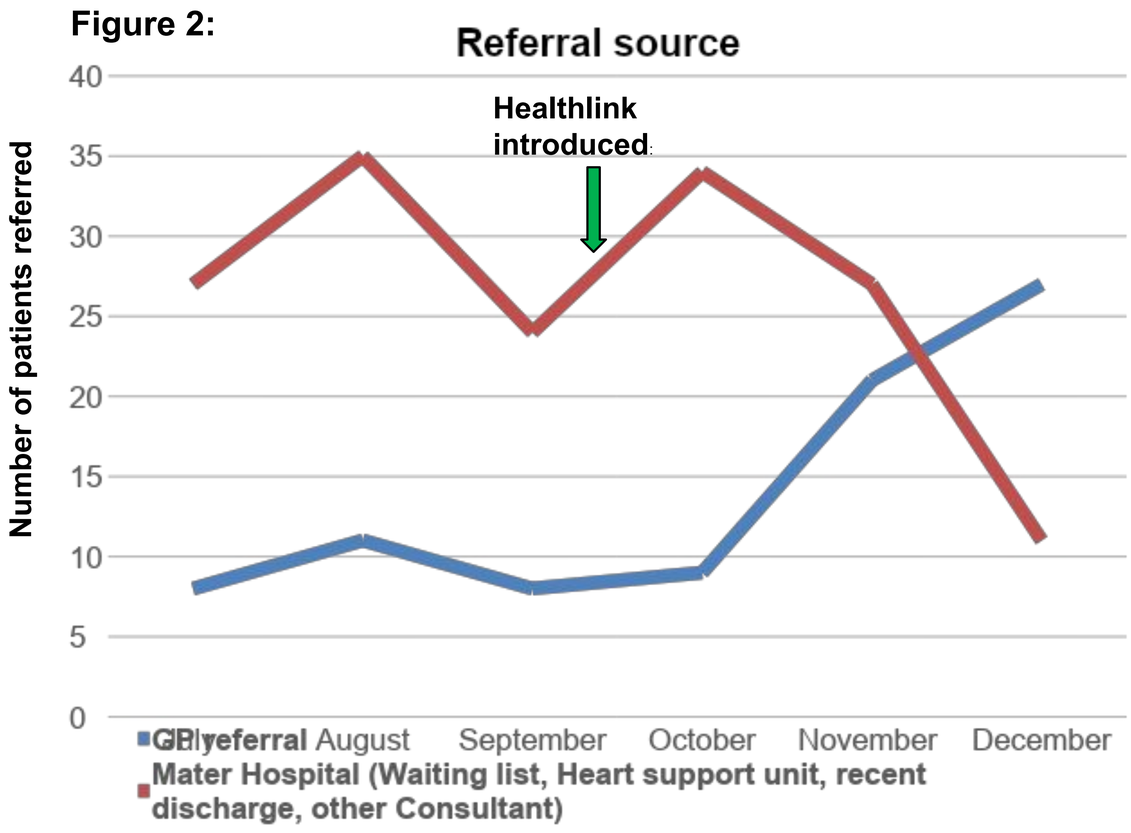
3 RESULTS

Over the six month period, 239 new patients were reviewed in the ICC Consultant clinic. The clinical reasons for referral are presented in Figure 1. The three most common indications for evaluation included heart failure follow up, cardiovascular risk screening and patients with chest pain.

Prior to the introduction of Healthlink, 108 new patients were reviewed, with 27 (25%) directly from GPs. This compared to 131 new patients with 57 (43.5%) directly from GPs. The changing pattern of referral source is demonstrated in Figure 2, with a significant increase in referrals directly from GPs and a reduction in the proportion coming from the acute hospital over time.

The average time to review was 28 days (+/- 21 days) prior to the introduction of Healthlink. This showed a significant improvement in the 3 months following and was reduced to 14 days (+/- 11 days).

Figure 2:



4 CONCLUSION

The introduction of a Healthlink referral pathway has significantly improved the timely access to specialist cardiology review for direct GP referrals, enhancing chronic disease management in the community, in line with the Slaintecare vision.

DEVELOPING THE ANP ROLE IN ICPOP, DUBLIN NORTH WEST SERVICES.

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BACKGROUND :

Ireland's population is experiencing an exponential growth. The recorded population has increased by 387,274 between 2016 to 2022 (CSO, 2022). In addition, there is a global shift in population demographics, with better education, awareness around healthy lifestyle, healthcare facilities and access to modern medicine, people are living longer and there is growing number of older population, both locally and globally. The CSO Census(2022), reported that there are around 5,183,966 older adults (over 65s) on the register, also that there is projected growth in the 'Old Age Dependency Ratio' from 25% in 2027 to 50% in 2057. Analysing our current infrastructure of Acute hospital beds and GPs, it comes as no surprise that our health infrastructure is not geared to meet the health and supportive needs of such a growing population.

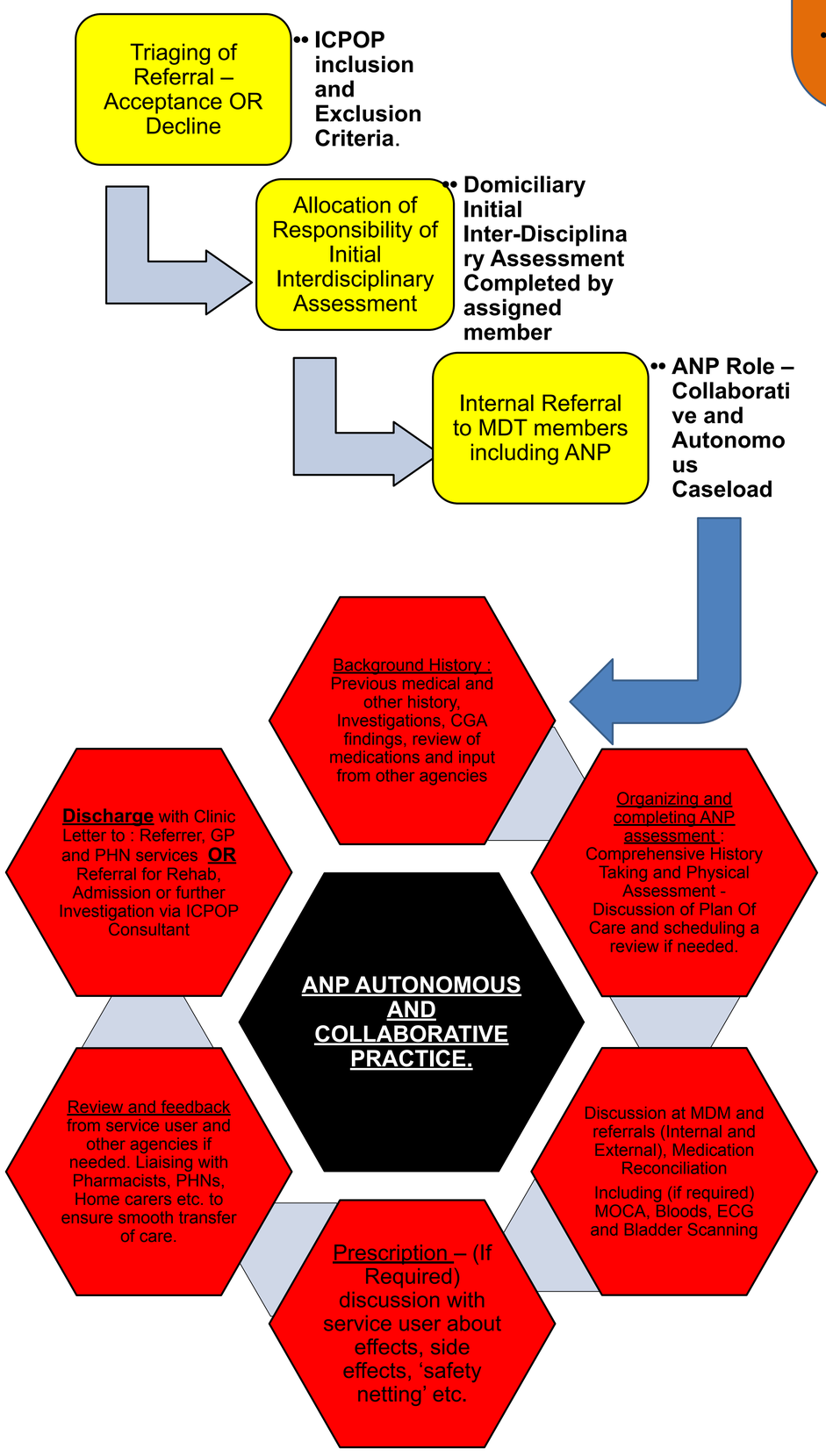
Slainte care initiative, which aims at providing 'Right Care to Right person at the Right Time' recognised that, the most effective way to create a balance between healthcare needs and healthcare services, is through provision of specialist care in the community, while still retaining pathways to appropriately access Acute care when needed. National Clinical Programme for Older People (NCPOP) designed Integrated Care Programme for Older People (ICPOP), to meet the healthcare need for older adult population in the community by providing expert specialist assessment and care in people's own homes and making appropriate referral to relevant services. This approach has been pivotal in bypassing the need to 'Reactively' present to Emergency departments for less urgent issues, OR even avoiding admissions all together, by 'Proactively' putting support structures in place. The ethos of ICPOP lies in Comprehensive Person centred Healthcare Approach, instead of illness focussed actions. NCPOP recognised that inclusion of Registered Advanced Nurse Practitioners (RANPs) Older Persons Services has the capability to support integration across Hospital Groups and CHOs contributing to hospital avoidance, enabling earlier discharge, improved quality of care and patient experience.' (NCPOP, 2019)

An Advanced Nurse Practitioners (ANP) according to NMBI is registered nursing practitioners who are "…educated to master's degree level and have the competencies to be senior decision makers that undertake a comprehensive advanced physical and/or mental health assessment of patients with complex multiple healthcare needs. They can interpret the results of multiple different assessments and investigations to make a diagnosis, and plan and deliver care".

AIM : To demonstrate the development of RANP Role in ICPOP DNW services and to discuss RANP contribution in 'Access and Integration' in community settings.

ACADEMIC PREPARATION AND UPSKILLING: (Candidate had a Masters in Dementia Care from TCD), Completed an Registered for being a Registered Nurse Prescribing (RNP) with NMBI. PG Cert. (Advanced Physical Assessment). PG Cert (Advanced Nursing Practice). 500 supervise hours under Clinical supervision of the ICPOP Consultant. Completion of ANP Portfolio to demonstrate achievement of required Domain Competency and finally Registering with NMBI as successful RANP. Completing Certified MOCA training for Cognitive Assessments.

ACCESS AND PROCESSES OF ICPOP DNW SERVICES



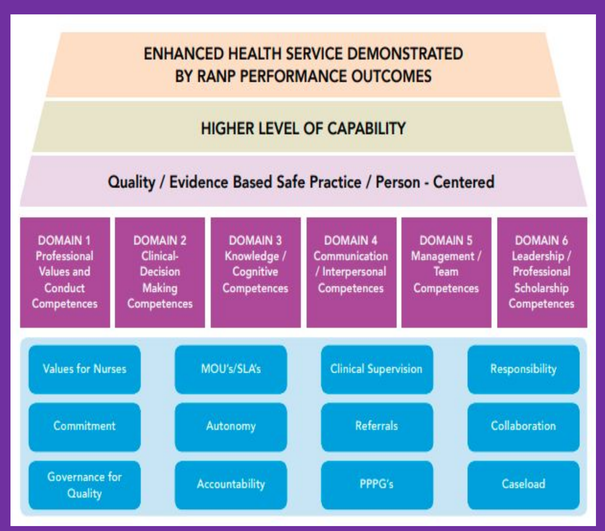
REFERRAL SOURCES :

- Frailty Intervention Therapy Team (FITT) Emergency Department
- Patients who have been admitted for up to 72 hours to the aligned acute hospital for investigations, medical review prior to ICPOP
- Out Patients Clinics (Geriatrician)
- Clinical Case Management Service (DNC/ DNW)
- Palliative Care, where the person is not active on the palliative care team caseload or contact list

INCLUSION CRITERIA :

- 65 years of age or older
- Live within the DNCC (Dublin North City & County) Area and aligned to the CHN's linked to the ICT's
- Require specialist Geriatrician MDT input
- Recent decline in physical or cognitive function leading to risk of hospital presentation/ admission/ long term care admission.
- Unmet physical/social needs likely to trigger an imminent ED visit
- Where the primary reason for referral is existing frailty, or risk of increasing frailty, with a presentation to the ED likely in the near future.
- Consent is required by the individual or where capacity is impacted, a referral will be accepted where Power of Attorney is registered or with a family member/ carer's consent once a consultant has deemed the person as requiring the ICTOP service.

ADVANCED NURSING MODEL (NMBI 2017) :



RANP Inclusion Criteria:

- Over 65 yr old
- People living in catchment area (undergoing revision)
- People with Frailty Score (CFS) – 4 to 6
- Referrals requiring assessment for Frailty reasons – deteriorating mobility, incontinence, deteriorating cognition and general deterioration including polypharmacy
- Focus on people referred to ICPOP, who have already been seen by a Consultant Geriatrician in Connolly Hospital.

CONCLUSION :

According to the Oireachtas report (2024), there are currently 148 ANPs within older persons services in Ireland, which shows considerable 'political will' to improve health care services and quality of life of the older adult population. During the past 2 years of developing ICPOP service and, in tandem, establishing the ANP role, the author has seen tangible benefits of making specialist services accessible to older adult population.
RANPs in Community care provide advanced level assessments, appropriate referrals and, are geared towards, reducing ED presentations and admissions. RANPs in older persons care also do the important role of proactive health building, bone health strengthening prescription, falls mitigation advices, identifying polypharmacy and other QOL initiatives like continence promotion and diabetes management.
Whilst a large part of the ANP role is advanced physical assessment, analysis, investigation, prescribing, de-prescribing and appropriate referrals, the ANP role is not designed to replace the Doctor's role. In fact, it complements the whole Comprehensive healthcare Model, by bringing in advanced skills and autonomous case management function.
There are certainly several challenges in this ever evolving role, but every supported Older Adult and their family are the reward in the end.

USEFUL LINKS :

1. https://www.hse.ie/eng/about/who/cspd/ncps/older-people/resources/anp-clinical-guidance-framework-2019.pdf
2. https://www.cso.ie/en/releasesandpublications/hubs/p-opi/olderpersonsinformationhub/ageingpopulation/projectedoldagedependencyratio/
3. https://www.nmbi.ie/NMBI/media/NMBI/Advanced-Practice-Nursing-Standards-and-Requirements-2017.pdf?ext=.pdf
4. https://www.oireachtas.ie/en/debates/question/2024-01-23/584/#:~:text=The%20table%20below%20sets%20out,Chronic%20Disease%20Management%20since%202020.&text=The%20HSE%20have%20advised%20that,are%20currently%2078%20ANP%20posts.

Ireland's First Community Oncology Clinic

***Noeleen Sheridan**, CNM3 CIT; **Laura Clifford**, Oncology CNS CIT*

Overview of Project

- **Ireland's first Community Oncology Clinic**
- **Improved access to treatments for patients**
- **Enables acute oncology day wards to concentrate on complex chemotherapy regimens**
- **Improves the lives of patients and contributes to hospital avoidance, in line with SlainteCare**

2700
extra patient appointments were created in acute oncology day wards due to attendance at CIT in 2023 year to date

Learning Outcomes

This initiative can be easily replicated with the right resources including;

- Staffing and clinic space
- Funding – SláinteCare, HSE/CHO support with oncology drugs budget
- Buy-in from multidisciplinary oncology team
- Effective communication pathway with patient and oncology team
- Digital health
- NCCP and ICS support

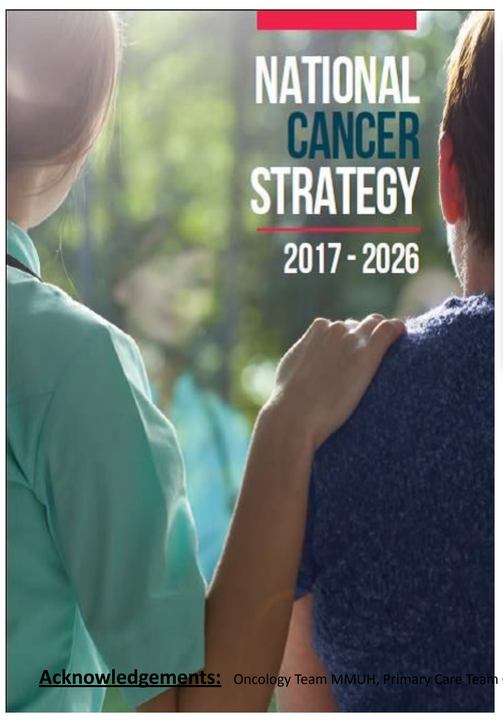
Aims

- To provide oncology care, which is accessible and close to patients home
- To establish nurse-led oncology treatment based in community
- To reduce time spent in clinics by patients, compared to acute day wards
- To offer flexible appointment times, thus accommodating work/family life
- To reduce waiting times to initiate treatment

Results

- Patients being cared for safely in the community
- Highly skilled, experienced oncology nurses, providing continuity of care
- Weekend and Bank Holiday service available for selected treatments
- Irish Cancer Society provides transport through Care to Drive, resulting in increased uptake
- Close links with hospital based teams, rapid referrals
- On site parking, free of charge

Key Contributory Factors



SláinteCare.
Right Care. Right Place. Right Time.

Coronavirus
COVID-19

Patient Feedback

- Less stressful coming to a small clinic
- I hope someday more cancer patients get some of their treatments in the community
- The staff are so good, I feel well minded there…. they ring me back promptly when I have a query…
- I get an appointment time before I start work

Acknowledgements: Oncology Team MMUH, Primary Care Team CHO DNCC

CHO Dublin North
City & County

Design & Implementation of a Standardised Interdisciplinary Evidence-based Approach to Assessment ICPOP-CST*

Authors Claire Nelson[1] Elizabeth Callaly[2] Frances Dockery[3] Crona Shields[4] Aoife Dunne[5] Joan Walsh[6] Claire Campbell[7] Sinead Knox[8] Lisa McKeon[9] Amy Reilly[10] Shalini John[11] Merin Mathew [12] Lynn Gaynor[13]

1Registered Advanced Nurse Practitioner ICPOP-CST DNCC, 2Consultant Geriatrician ICPOP-CST DNC, 3Consultant Geriatrician ICPOP-CST DN, 4Candidate Advanced Nurse Practitioner ICPOP-CST DN, 5Senior Medical Social Worker ICPOP-CST DNW, 6Senior Physiotherapist ICPOP-CST DN, 7Senior Physiotherapist ICPOP-CST DNW, 8Senior Dietitian ICPOP-CST DNW, 9Senior Occupational Therapist ICPOP-CST DN, 10Senior Senior Speech & Language Therapist ICPOP-CST DNW, DNC, 11Candidate Advanced Nurse Practitioner ICPOP-CST DNW, 12Candidate Nurse Practitioner, ICPOP-CST DNC, 13Grade IV Admin ICPOP-CST DNC.

Overarching Aim

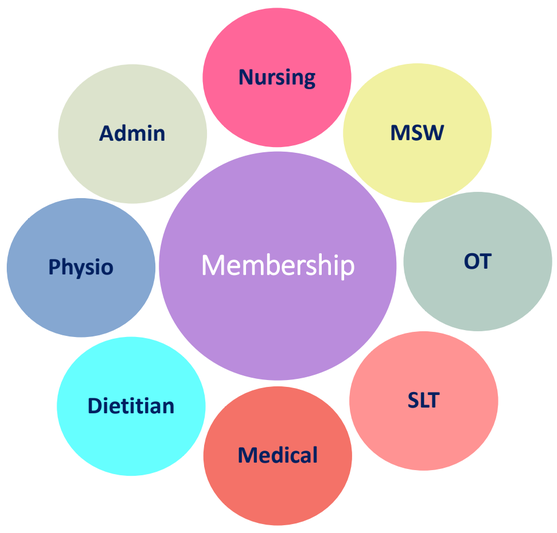
- To develop & implement a standardised interdisciplinary, evidence-based approach to assessment.
- Employ the principles of a CGA*, to assess the needs of older adults referred to the three ICPOP-CST* working across DNCC*
- Promote safe, efficient service delivery, & effective communication while avoiding duplication & fragmentation of care.

Methods

Timeline June 2022 – Dec 2022

- Establish a multidisciplinary working group
- Identify & agree on the scope of the working group
- Apply PDSA* cycles - design & implementation phases
- Share knowledge, experience, & expertise
- Network with local, regional, & national teams
- Review literature & existing assessment documents
- Consensus Questionnaire
- Analysis of responses to questionnaire
- Consensus building workshops
- Determine & agree format
- Design & develop the document – aligned to the principles of a CGA*
- Consultation with the wider ICPOP-CST*
- Evaluation of feedback post-consultation
- Identify learning needs to support implementation

The Team



Results

February 2023 — The initial Interdisciplinary Assessment Document was implemented into practice

1,204 — Number of older adults who were assessed using the initial interdisciplinary Assessment Document in the first 16 months

Feedback From Colleagues

The Effectiveness of Initial Interdisciplinary Assessment Document

"Facilitates the planning & delivery of a person-centred plan of care for each individual"
Bernie Murphy, Clinical Nurse Specialist ICPOP CST DN

"Allows for a holistic & collaborative assessment with an older adult, with the individual is a key participant in their care whereby identified goals & action plans are person-centred & meaningful for the person"
Laura Quinn, Clinical Nurse Specialist ICPOP-CST DNW

"Facilitates multidisciplinary & interdisciplinary working as it allows each team member to screen for the potential requirement of another discipline, giving the service user a more holistic episode of care"
Ciarán Daly Senior Physiotherapist ICPOP-CST DNC

"Allows the identified concerns to be highlighted to the appropriate specialist in a timely manner, ensuring integration, & avoidance of duplication"
Lisa McKeon, Senior Occupational Therapist ICPOP-CST DN

"Provided an opportunity for disciplines across DNCC to come together & produce a document that promoted a consistent approach to CGA, as well as an opportunity to measure the quality of the assessment in practice, and develop learning outcomes"
Donnchadh Whelan Operational Manager, ICPOP-CST DN

"User-friendly document, allowing all disciplines to undertake a comprehensive assessment & to identify targeted interventions based on the identified need"
Sinead Knox, Senior Dietitian ICPOP-CST DN

"The structured approach of the CGA really helps the team to set treatment goals & to work in a collaborative way to achieve these with the patient"
Joan Walsh Senior, Physiotherapist ICPOP-CST DN

"promotes interdisciplinary working by ensuring all members of the team can screen for issues within another disciplines realm, streamlining assessment & intervention to the benefit of service users"
Aoife Dunne, Senior Medical Social Worker DNW

Key Learning

- The importance of teamwork, agreeing on a shared vision from the outset, knowledge sharing, collaboration, effective communication, agreeing on milestones, & planning.
- The success of reaching the implementing phase is attributed to the commitment & active participation of the sub-group members & the contribution of the wider ICPOP-CSTs*

Next Steps

- Evaluate use of the document in practice - regular audit cycle incorporating feedback
- Document Sub-group to analyse audit results & facilitate the action plan
- Development of an electronic template

***Abbreviations**
*ICPOP Integrated Care Programme Older Persons
*Community Specialist Team
*DNCC – Dublin North, City, & County
*DN Dublin North; *DNW Dublin North West, *DNC Dublin North Central
*CGA Comprehensive Geriatric Assessment
*PDSA Plan, Do, Study, Act

Acknowledgements

The design, implementation, and delivery of the assessment document is accredited to all members of the 3 ICPOP-CST's*, working across DNCC*

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Skinnovate phase 2: Alternatives to traditional OPD clinics in managing routine skin referrals

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Dr. Patsy Lenane[1] Consultant Dermatologist

1. Department of Dermatology, Mater Misericordiae University Hospital, Dublin
2. Mater Transformation, Mater Misericordiae University Hospital, Dublin

Get in contact: plenane@mater.ie

The problem

47000 adults are waiting for an outpatient Dermatology consultation in Ireland. In 2021, using lean methodology, the Mater Dermatology department streamlined internal processes and achieved a 40% reduction in its waiting list. However, due to factors such as population growth and increasing skin cancer prevalance, the rate of referrals has accelerated rapidly (30% increase in the previous 3 years alone). Projection analysis indicated that without radical intervention, the waiting list would return to its original levels within 3-5 years.

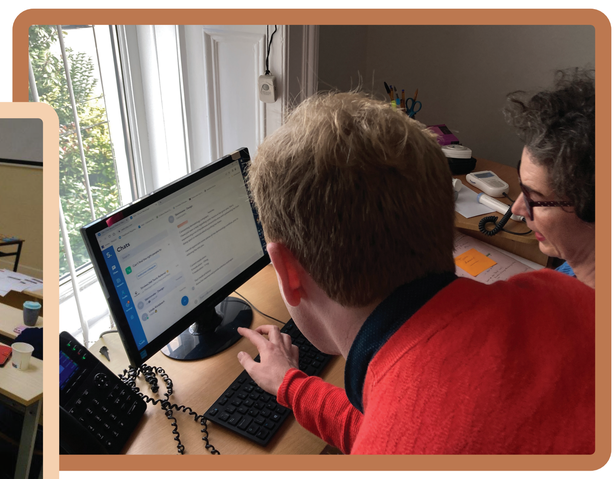
Increasing Population Growth

Increasing Skin Cancer Prevelence

return visits
take up slots that could be used to deal with new urgent cases

25%

25 % of routine referrals
are by sent in by 3% (27) of GPs

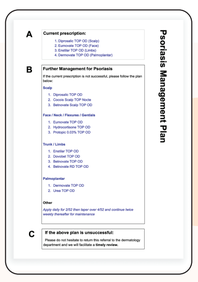


Methodology

Currently if a GP has uncertainties with regard to management of skin conditions, the only option is to refer to an outpatient clinic. Our team used a Human Centred Design led approach, working with local GPs to co-design a suite of solutions that will provide them with novel options for accessing support, reducing reliance on OPD clinics.

Results

We have collaboratively designed and are currently testing a range of options as follows:

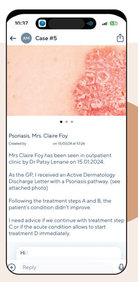


Active Discharge Letter

Patients are seen once at the Dermatology clinic and then discharged back to the GP with guidance for further dermatology management of routine conditions (such as Psoriasis, Acne, Eczema), reducing the number of follow up appointments in the hospital. The GP has the option to rapidly access an outpatient appointment if required.

Pilot results

Since its introduction, only **5 patients** have returned to clinic for further acute follow up, within 12 month of their initial clinic visit! (n=59)

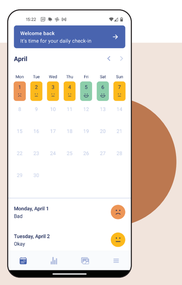


Siilo for routine Dermatology queries

We have developed a GP to acute Dermatologist channel using Siilo, an encrypted messaging app. This enables GPs to share photos and access specialist advice from a dermatologist - without having to wait for an outpatient consultation.

Pilot status
Testing currently with 3 local GPs. 1 GP is working closely with the homeless.

Through this pilot we expect a reduction in the GPs need to refer to acute dermatology. In the piloting with GPs working in homeless services we are simultaneously developing inclusive services for our local area needs.



Derma diary

DermaDiary is a GDPR compliant app to be prescribed to help patients keep track of skin flares and what triggers an outbreak. Aimed at routine conditions - this information is valuable for both patient, their GP and Consultant.

Pilot status
The app is in the process of being approved by Google Play Store / Apple App Store. Once live we aim to user-test the app with patients to feed back into its design.

We aim for patients to be empowered in monitoring their skin condition & help them, their GP and Consultant to understand their skin flares.

GP with extended role in Dermatology

Since July 2023, A GP training in dermatology has been present in the outpatients clinic 1 day per week seeing routine patients from the Mater waiting list & carrying out surgery with support from Mater Dermatologists. Ultimately this GP will take referrals directly from other GPs in the community while linked back with the hospital.

Pilot results
A qualified General Practitioner has taken part in the post. In his first year he has seen 171 patients. This experience will enable the GP to return to community with enhanced dermatology knowledge – which he can share with other GPs and Community healthcare workers.

Conclusion

There is a clear need to provide GPs with alternatives to the traditional OPD clinic for specialist support. Co-designing these alternatives ensures that they are acceptable for stakeholders across the system.

- **40% reduction** in Mater Dermatology wait-list since 2020 (see Skinnovate phase 1 poster)
- **Sustained improvement** 3 years later despite a 30% increase in referrals
- **Solutions that bridge the hospital walls** The Mater team continues to work with a network of local GPs to co-design innovative alternatives to outpatient clinics facilitated by Mater Transformation with expertise in design & lean.
- **Continued piloting & iteration** These pilot results have significant opportunity for embedding and scaling both within the Mater Dermatology service and in the wider healthcare system

IMPLEMENTATION OF A JOINT TRANSFER OF SERVICE LETTER IN THE COASTAL AREA NETWORK.

Louise Goulding & Sinéad English,

Community Healthcare Network Manager & Childrens Disability Network Manager, Coastal Area Network, CHO 9.

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Introduction

- The Coastal Local Childrens Services Forum was established in 2023 to allow the Primary Care and Childrens Disability Teams in the Network work collaboratively to ensure children access the most appropriate service for their needs.
- Through discussion at the forum, it was acknowledged that as the services operated separately, families were sometimes receiving confusing or contradicting information when their child transferred from one service to another, or were actually declined from both services.
- It was agreed by Forum members that a joint transfer of service letter would improve service quality and streamline service delivery by:
    1. Demonstrating the coordinated and integrated work of the childrens teams in the Network to determine the most appropriate service for a child.
    2. Ensuring a 'no wrong door' approach is upheld and that a decision on appropriate access is made and communicated for every child.
    3. Providing parents and families with a single, clear communication on decisions made at the forum and next steps for their child when transferring between services.

Development

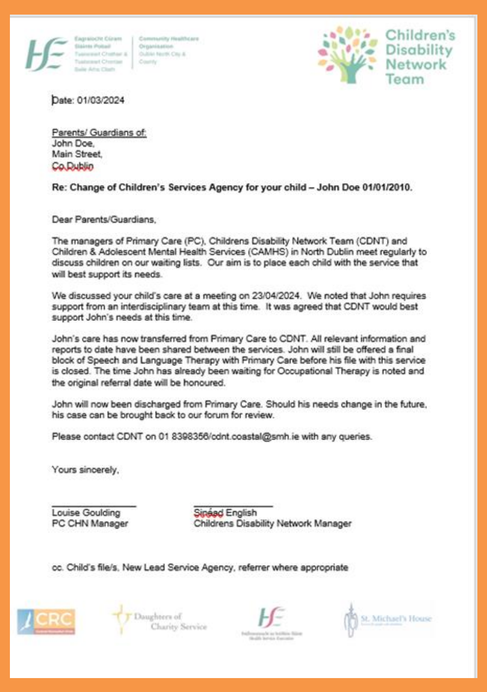
The Community Healthcare Network Manager and the Childrens Disability Network Manager worked together initially to review existing drafts of joint letters within the CHO. Following this, we determined the key elements to be communicated to parents/guardians in the Joint Transfer of Service Letter:

- Explanation of the Local Children's Services Forum and it's purpose.
- Decisions made at the Forum regarding which service can best support a child at that point in time.
- Next steps for that child: confirmation of what will happen next in terms of transferring the child's information and the specific services they are being transferred to.
- Reassurance for parents/guardians that a child will not be disadvantaged by transferring between services, and that previous time spent waiting to access services will be honoured.
- Contact details for the new lead service for their child.

An initial draft of the letter was designed and multiple versions reviewed before the final letter was agreed.
The letter was shared with members of the Coastal Local Children's Services Forum for review and feedback.
Consideration in terms of health literacy and clear communication was given throughout this process as per HSE guidelines.[1]

Implementation

The joint transfer of services letter was piloted in the Coastal Network in March 2024.



Date: 01/03/2024

Parents/ Guardians of:
John Doe,
Main Street,
Co Dublin

Re: Change of Children's Services Agency for your child – John Doe 01/01/2010.

Dear Parents/Guardians,

The managers of Primary Care (PC), Childrens Disability Network Team (CDNT) and Children & Adolescent Mental Health Services (CAMHS) in North Dublin meet regularly to discuss children on our waiting lists. Our aim is to place each child with the service that will best support its needs.

We discussed your child's care at a meeting on 23/04/2024. We noted that John requires support from an interdisciplinary team at this time. It was agreed that CDNT would best support John's needs at this time.

John's care has now transferred from Primary Care to CDNT. All relevant information and reports to date have been shared between the services. John will still be offered a final block of Speech and Language Therapy with Primary Care before his file with this service is closed. The time John has already been waiting for Occupational Therapy is noted and the original referral date will be honoured.

John will now been discharged from Primary Care. Should his needs change in the future, his case can be brought back to our forum for review.

Please contact CDNT on 01 8398356/cdnt.coastal@smh.ie with any queries.

Yours sincerely,

Louise Goulding
PC CHN Manager

Sinead English
Childrens Disability Network Manager

cc. Child's file/s, New Lead Service Agency, referrer where appropriate

Once agreement is reached at the forum, the joint transfer of services letter is issued by the transferring agency to parents/guardians.
A copy of the letter is shared with all relevant services.

Outcomes

The joint transfer of service letter has been operationalised for 6 months (September 2024).

Benefits:

- Simplified, streamlined communication to
- families providing clarity around their childs' care pathway.
- Provides confirmation that access is ensured to the most appropriate service.
- Provides reassurance to families that children's services in the Network are working collaboratively to meet their child's needs and are working in an integrated way as part of the ECC model of service delivery.

Next Steps

Child and Adolescent Mental Health (CAMHS) team now also attending Coastal Local Childrens Services forum and will also be included in joint letter.

Copies of joint transfer of service letter to be shared with Central Referrals Office in CHO 9 to improve traceability of referrals across children's services.

Acknowledgements:
We would like to thank Niamh Maher, Community Healthcare Network Manager, Swords, for her work on the initial drafting of a joint transfer of service letter.
We would like to thank all the members of the Coastal Network Local Childrens Services Forum for their input.

Citation:
1. Health Service Executive (2017) *Guidelines for Communicating Clearly using Plain English with our Patients and Service Users. A resource to improve quality and consistency of our communications.*

Integrated Care Team for Older Persons
Dublin North West
Does an inpatient rehab admission via community prevent hospital readmissions?

Claire Campbell (claire.campbell3@hse.ie) and Dr Ruth Martin (ruth.martin1@hse.ie)

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

Introduction

Rehabilitation interventions are essential in supporting frail older adults recover following periods of decompensation. Previously they could only access intensive inpatient rehabilitation via an inpatient stay in an acute hospital.Within the Integrated Care Team (ICT) in Dublin North West(DNW) a rehabilitation pathway to two inpatient rehabilitation units from the community exists for older adults .We retrospectively evaluated patients (age > 65 years) admitted to two rehabilitation unit's in the DNW area and looked at their readmission to acute hospitals 90 days from when they commenced inpatient rehab.

Objectives

1. Identify older adults who were readmitted to acute care within 90 days after their admission to a rehab facility .
2. Identify causes for readmission and readmission rate.

Method

- 17 Rehab Referrals were received from three pathways ; Holly day clinic, Community (GP and Primary Care) and Connolly Hospital's Frailty Intervention Team(FITT).
- Each referral received a comprehensive geriatric assessment and review from both the ICT Physiotherapist and Geriatrician. Clients falls risk (as per the world falls guidelines) and sarcopenia status as per the European working group on sarcopenia were recorded prior to admission.(See figure 3 for pathway process)
- Onward referral was then made to the consultant geriatricians in the rehabilitation units and admissions to rehab were completed within 7 days.
- Acute readmissions within 90 days were collected from the hospital electronic database

Figure 1: Inpatient rehab referral sources

Holly day clinic	FITT	Community
4	5	8

Results

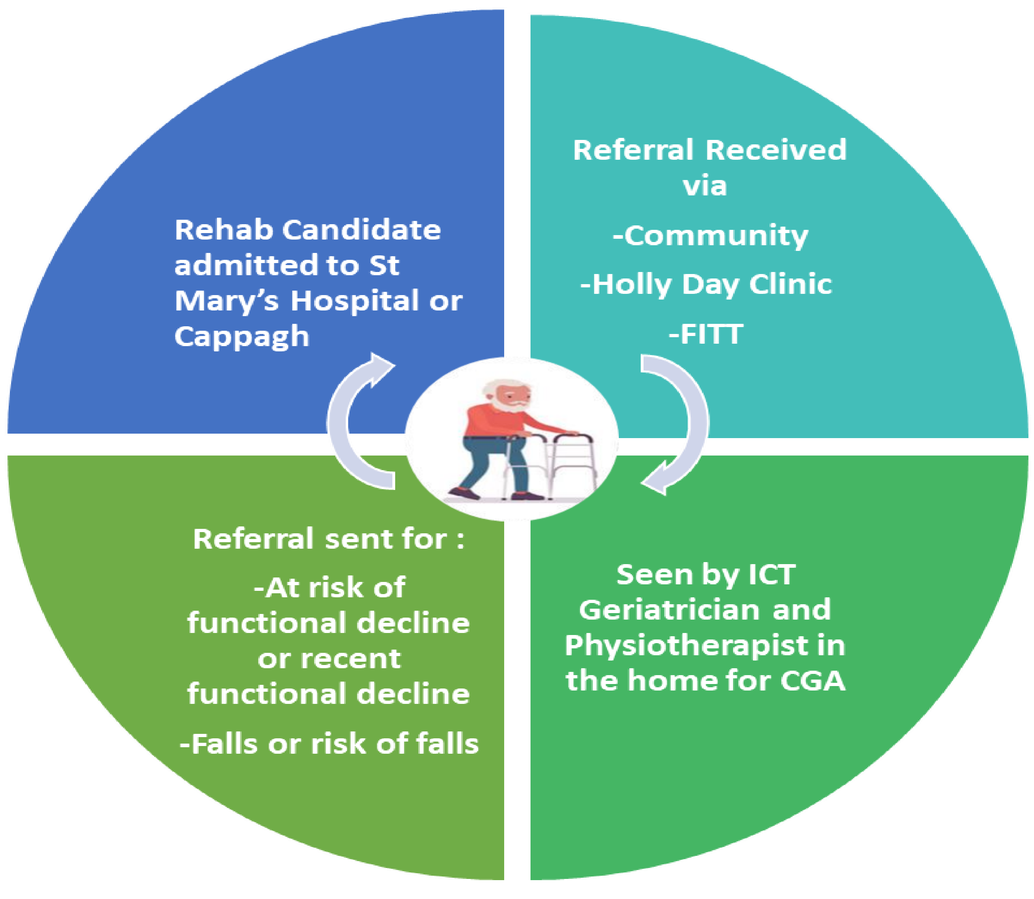
From January 2023 to July 2023 a total of 17 patients were reviewed. Clinical frailty scores (CFS) ranged from being mildly frail to severely frail and all were identified as at a high risk of falls and functional decline as per the world falls guidelines. 16 out of the 17 clients were identified as sarcopenic.

The 90-day readmission rate was 11% . 5.5% of these were due to falls and the other 5.5% were due to the exacerbation of a pre-existing condition.

Figure 2: CFS Scores of rehab candidates

5(Mild Frailty)	6(Moderate Frailty)	7 (Severe Frailty)
5	10	2

Figure 3: Rehab referral pathway process



Conclusion

Readmission to acute care is not common in our patient cohort and shows the involvement of the ICT Geriatrician and Physiotherapist in identifying and referring frail older adults for inpatient rehab is successful.

Ongoing development of interagency pathways and further referrals is needed to further progress this pathway and measure its efficacy in preventing readmission to an acute hospital. A 90 day and 180 day follow up and falls risk outcome measure pre and post admission would further demonstrate the success of this initiative and help measure the efficacy of this initiative in reducing the risk of preventable hospitalizations in older adults.

THE IMPACT OF A DIRECT ADULT TONSILLECTOMY PATHWAY ON PATIENT WAITING TIMES

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INTRODUCTION:

Patients (pts) suffering with recurrent tonsillitis are referred to ENT departments by their General Practitioner (GP) to assess their candidacy for tonsillectomy. These referral letters are generally marked as **routine**.

Patients who meet the criteria for tonsillectomy face **two obstacles**: 1) Long Outpatient Department (OPD) Waiting Lists
2) Long Inpatient Waiting Lists for the Operation.

In **April 2021** the ENT department at OLOL initiated a quality improvement project: **The Direct Adult Tonsillectomy Pathway (DATP).**

The project included: 1) a Patient Questionnaire, (QN)
2) a Virtual OPD Appointment,
3) Review of Tonsillectomy Patient Information at home by the patient with a chance to opt in or out of the surgery
4) Directly Booking for a Tonsillectomy once the above is complete.

This review compared two patient groups: 1) Traditional Pathway Group prior to April 2021 (TPG).
2) DATP group prospectively triaged to the pathway between 1 April 2022 and 31 December 2023 (DATP).

OBJECTIVES:

- **Confirm the effectiveness of the DATP in reducing waiting times for outpatient consults and surgery for adult patients with recurrent tonsillitis.**
- **Compare waiting times against national guidelines and other published Irish research.**
- **Make recommendations regarding further future improvements for the DATP.**

METHODOLOGY:

For both groups (the TPG and the DATP) the following were collected: Demographics, Gender, Age, and Waiting periods.

The periods for the following were calculated in months:

- Date of Referral by the GP (RD) to Date the Questionnaire (DQ) sent.
- Date of Questionnaire (DQ) sent to date of the Virtual Outpatient Appointment (OPD).
- Date of Referral (RD) to Virtual Outpatient Appointment (OPD).
- Date of Virtual Outpatient (OPD) to the Date of Surgery (SD).
- Date of Referral (RD) to the Date of Surgery (SD).

RESULTS:

Table 1: Gender and Age distribution of the DATP and TPG.

	Total Patients	Age (average)	Age (range)	Female	Male
DATP	292	24.97	16-66	229	63
TOPRef	32	21.8	16-39	22	10

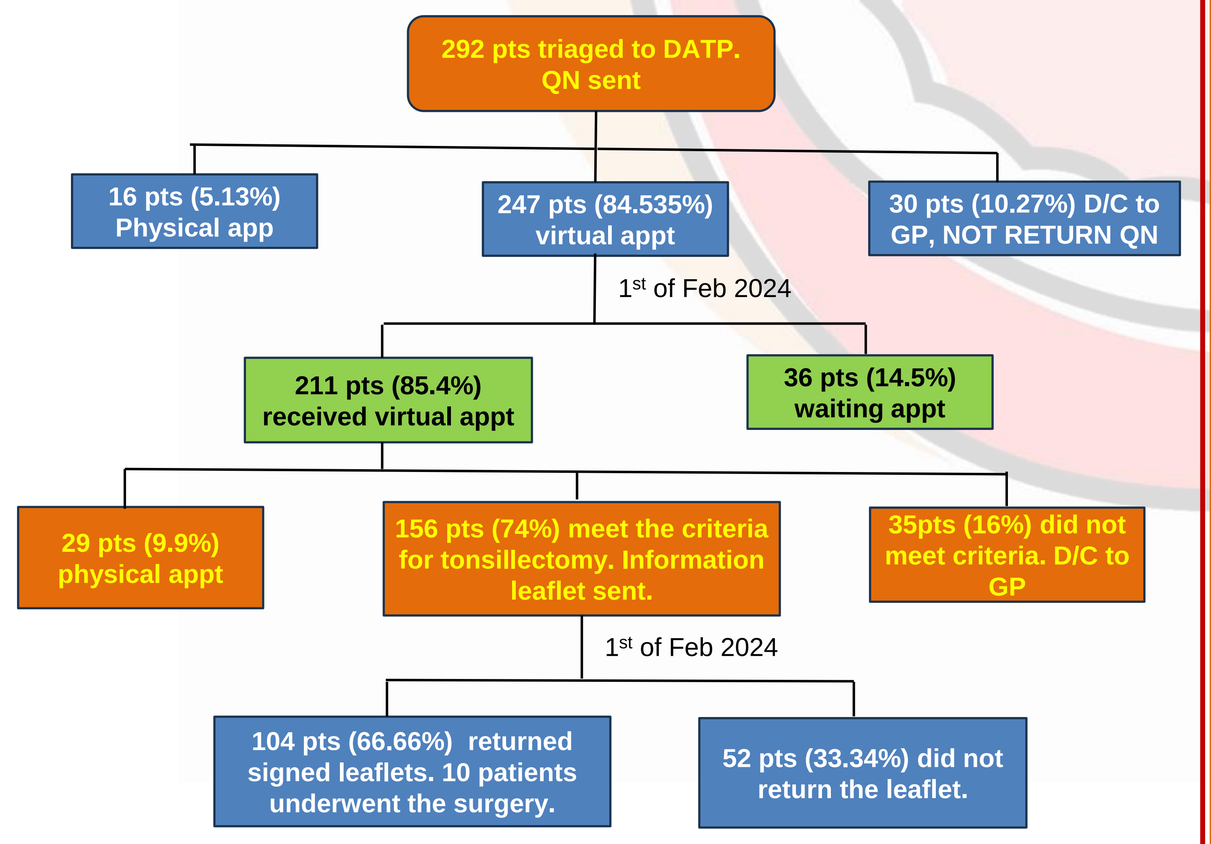


Figure 1: DATP result.

Table 2: Averages Waiting Times for DATP.

	Number of patients	Average (months)	Range (months)
RD–DQ	247	0.56	0.5 -7
RD-OPD	211	5.94	1- 17
DQ-OPD	211	4.92	0.5-17
OPD-SD	10	7.3	2 -9
RD- SD	10	13.8	9 - 18

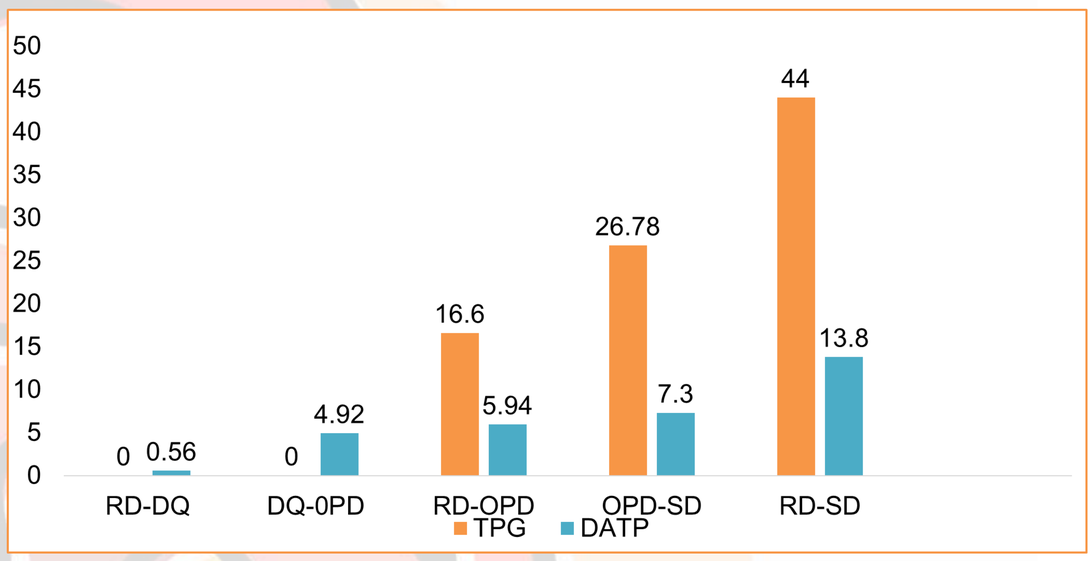
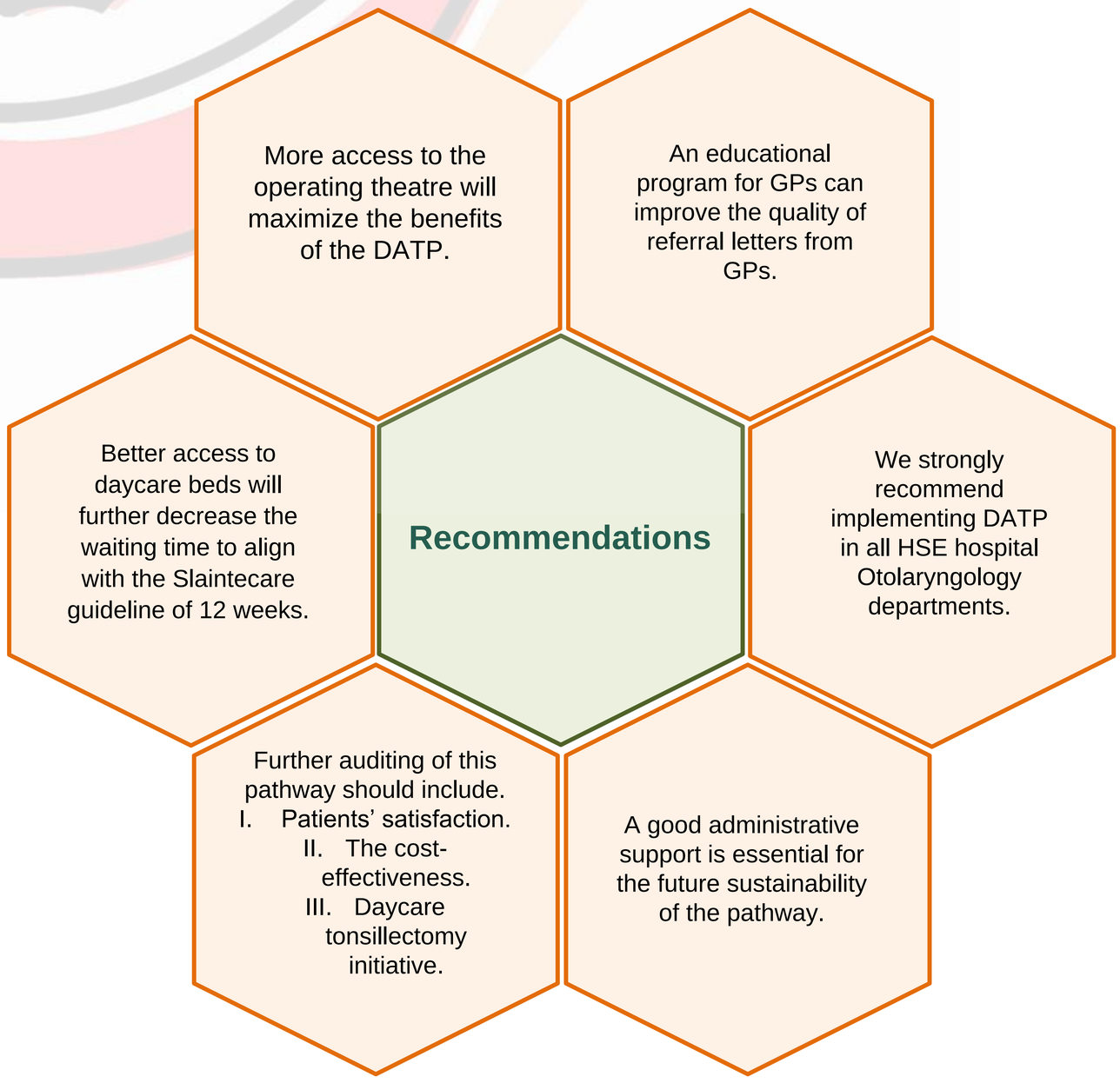


Figure.2 The chart summarizes the waiting times for DATP and TPG.

CONCLUSION:

- The DATP initiative in the Otolaryngology Department at Our Lady of Lourdes Hospital in Drogheda has significantly improved waiting times for recurrent tonsillitis patients. A reduction in RD to SD from the traditional referral (44 months) to 13.8 months.
- A reduction of the over-all waiting times is a reflection on good admin support.
- The DATP also helped to improve the environmental and economic sustainability within the ENT department, as 85% of appointments were conducted virtually, reducing travel emissions, equipment use, nursing hours, and lost time off work for patients. This reduced both the expense for the patient and the hospital.



ENTegrate – An integrated pathway for managing routine ENT conditions

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INTRODUCTION

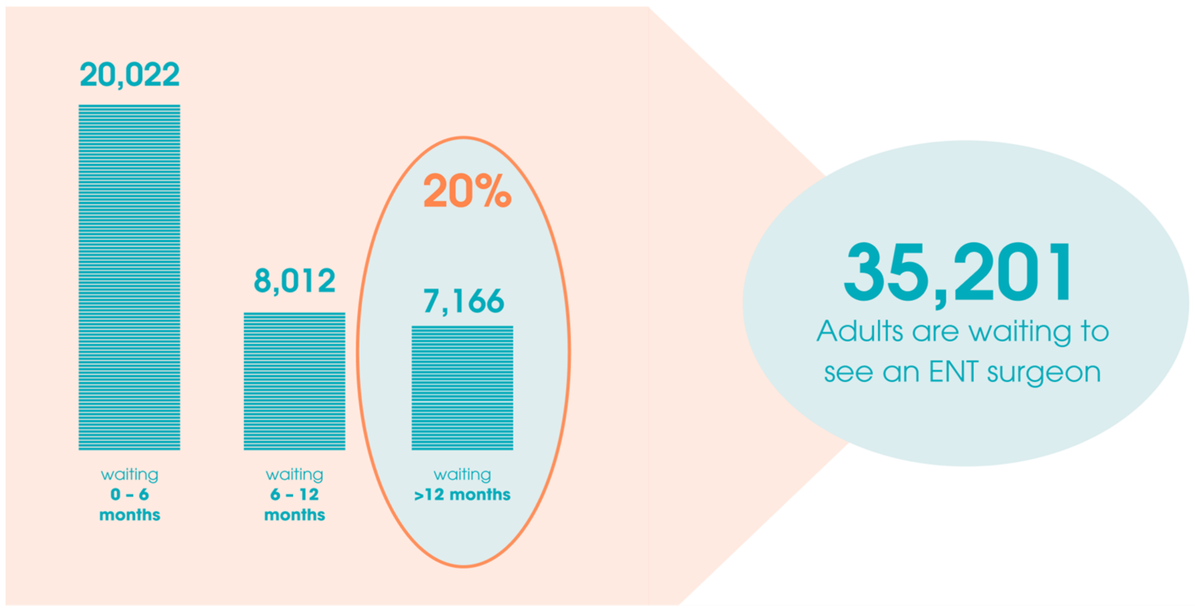
Nationally, over 35,000 adults are waiting for an ENT outpatient appointment, with 20% waiting over 12 months (Fig 1). In this context outpatient resources are almost completely consumed in seeing urgent referrals. Those with conditions deemed as "routine" frequently wait years or even indefinitely. It is predicted that this problem will be compounded by an increasing, ageing population, with the waiting list in the Mater Hospital ENT forecasted to see a 50% increase in the next 4 years if no action is taken.

Over the course of this pilot project the ENT team at the Mater identified a patient cohort on their outpatient waiting list, with a subset of conditions that are suited to a community review, rather than a hospital outpatient clinic visit. These patients, with chronic ENT conditions, wait extended lengths of time for assessment and treatment thus impacting their quality of life.

This pilot "ENTegrate" tested a novel pathway for patients with these selected ENT conditions, improving their access to care, whereby they are first seen by a GP with specialist ENT skills in the community who is supported by a hospital consultant only where necessary.

"ENTegrate" was designed to be a Slaintecare compatible solution to the ENT waiting list crisis.

Fig 1. **Otolaryngology (ENT)** · Adults waiting



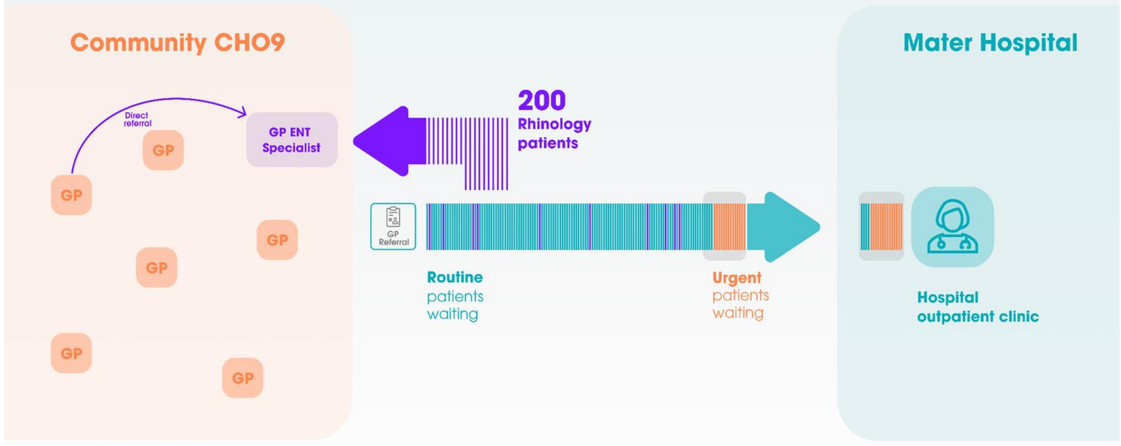
METHODS

The pilot project "ENTegrate" phase 1 received funding through the 2022 HSE Spark Innovation Community Innovation fund. For this pilot the Mater ENT Consultant identified 200 suitable referrals with specific non-surgical complaints for the new community clinic (Fig 2). The patients were advised of the new pathway and offered an appointment to see the GP with specialist ENT skills. Over 6 months in 2023, the patients were seen, treated and discharged where appropriate by the weekly GP clinic, while those who required further investigation were seen at a joint clinic in the hospital. These joint clinics took place monthly, with the Consultant and GP in attendance, allowing a bidirectional learning opportunity and further building the GPs skillset and capability with the intent of ultimately reducing the volume of referrals to hospital.

Mater Transformation carefully facilitated the collaboration between the Consultant, the administration team at the Mater Hospital, the GP and the administration team at Grangegorman family practice. All stages of the pilot from patient selection, communication and education, sourcing of equipment and design of signage and way finding elements in the clinical environment required planning and consideration to ensure efficient delivery of this new service in a safe and efficient way. Healthcare staff have minimal time to assign to new initiatives when they are already prioritising daily clinical and administrative tasks. Mater Transformation, in this facilitative role continuously managed the project to completion, unblocking obstacles and keeping the team solution focused as problems emerged during the pilot.

Acknowledgments:
HSE SPARK Innovation Programme

Fig 2. **ENTegrate I**



RESULTS

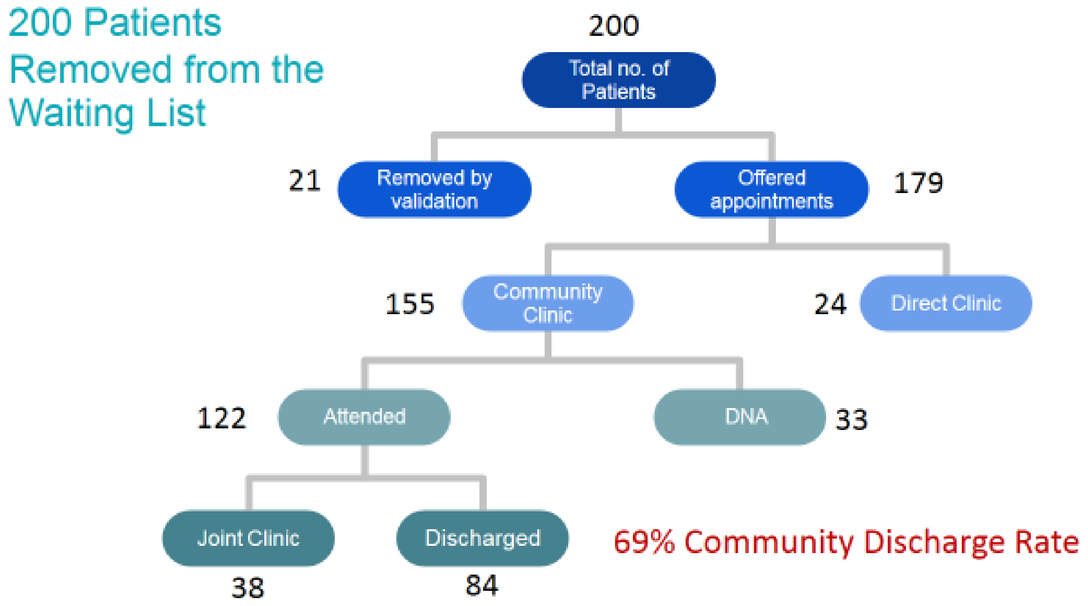
200 referrals were removed from the waiting list. Of those seen by the GP, 69% were discharged.

38 patients were seen in the joint clinic (Fig 3) . The number of patients requiring referral to the joint clinic reduced as the pilot progressed demonstrating significant learning over time as the GP became more familiar with the presenting conditions. For the first two months 19 patients were referred to the joint clinic, this reduced to 6 patients for the final two months These clinics were also invaluable in building capability in community.

Wait times were vastly reduced as the majority would have waited >12 months or indefinitely.

Patients who attended the ENTegrate clinic and completed the feedback survey (n=25) all rated their experience as "excellent" including comments: "delighted with the service and the management of their condition" and "an excellent service to have in the community".

Fig 3.



CONCLUSION

Community based specialist services are in use in other jurisdictions. The ENTegrate pilot provides evidence of the potential benefit in an Irish context, enabling "right care, right place, right time" ideology.

- A supported, GP-led clinic was acceptable to patients
- Patients experienced improved wait times
- This model offers a promising approach to removing routine non-surgical conditions from ENT waiting lists.

ENTegrate 1 tested in its infancy an integrated pathway developed from scratch between Mater and Community. 200 rhinology referrals were successfully removed from the wait list and the GP discharged 69% of patients seen in community. Additionally a GP - GP ENT Specialist pathway was established so GPs could refer patients directly. ENTegrate II seek to further explore a larger sample size, explore the maximum potential for GP direct referrals and could other ENT presentations be seen in this pathway.

The ENTegrate pathway is designed as a long-term solution, as a new model of care to work alongside the traditional pathway and not a "stop-gap" solution to long waiting lists.

Acute bed avoidance, direct admissions from Frailty at the Front Door to Rehabilitations Beds

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1 Background

A key priority outlined in the Programme for Government is to support the older person to live in dignity and independence in their own home. The Integrated Care Programme for the Older Person (ICPOP) Community Specialist Teams provide services for older people who have complex needs and who require Specialist Multidisciplinary intervention to help maintain their independence and for them to live well at home.

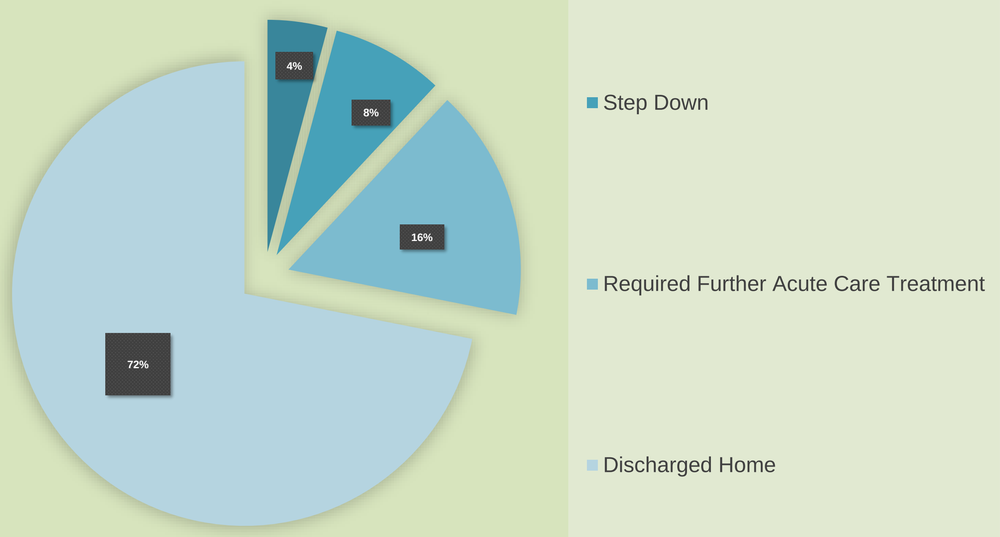
In line with the Sláinte care vision for easier access of **Right Care, Right Place and Right Time** Clontarf Hospital have developed a pathway with the ICPOP Team/ FITT Team admitting patients directly from the front door of the Acute hospital to a more appropriate environment, thus avoiding acute hospital admission or admitting directly from the community thus avoiding the Emergency Department presentation. The patients are over 65 year of age with multi comorbidities and complexities.

2 Methods

Both pathways have been developed and embedded. The ICPOP Consultant Geriatrician and the Patient Flow Teams in both Clontarf Hospital and the Mater Hospital collaborated to establish a seamless FITT to Rehab pathway which is person centred. An electronic communication group was instated to refer patients directly from the Emergency Department MMUH to Clontarf Hospital. This use of technology makes the process more efficient. The Comprehensive Geriatric Assessment Tool is utilised to refer and handover all patients. Patients being admitted directly from the ICPOP Teams in the community. The ICPOP team complete an online Clontarf Hospital referral. Clontarf Hospital Patient Flow Department contact the patient directly and arranges admission. The data is collected on Clontarf Hospital Electronic Dash Board since the introduction of the service including:

1. Source of admission either Community/Ward/FITT/ED
2. Number of Admissions
3. Age profile
4. Length of Stay
5. Discharge Destination

Patient Discharge Outcome



3 Results

Since the start of the service, mid-2022, 196 patients have been admitted via the ICPOP pathway. Over 5943 acute hospital bed days have been saved. 10.8% of admissions came directly from the community and 89.2% from the FITT Emergency Department Team. The MLOS is 22 days and ALOS is 27 bed days.

Over 70% of patients are discharged directly home, 4% of the patients were transferred to residential care, 7.6% of the patients were discharged to step down facilities and 16% required further treatment in the acute hospital. There has been significant positive feedback from patients and families.

Conclusion

4

The establishment of a direct admission pathway from the Emergency Department and the community to a rehabilitation hospital has demonstrated positive patient outcomes and overall benefits to the healthcare system. Resulting in both ED and acute bed avoidance.

References

Department of Health (2012) *Future Health: a Strategic Framework for reform of the Health Service 2012-2015*

Using Lean to Deliver Integrated Cataract Pathway across the North East Region (NERIECS)

Presenters: *Caroline Pigott, Change Project Realisation Manager, NERIECS*

People's Needs Defining Change
Service Users, Families, Citizens, Communities & Staff

Introduction

Brief description of the change initiative:

A collaboration between three CHOs (CHO 1,8 & 9), three hospital groups (IEHG, RCSI & CHI), voluntary partners, and patient groups in the North East region comprising 1.2m population, transforming the delivery of ophthalmology services. Using Lean improvement methodology, innovative operational and clinical governance aligned to Sláintecare to deliver the

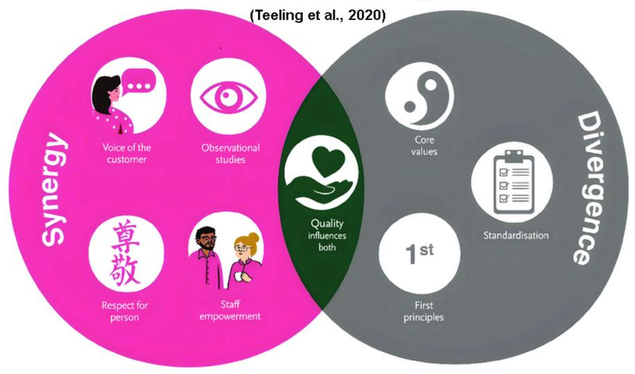
Right Care, Right Place, Right Time, Every Time

Shifting left – Cavan cataract hub

People & Culture Change Platform
CREATING READINESS

Methodology

Person-centred Lean Six Sigma model
(Teeling et al., 2020)



- Customer defines value
- Standardise to solve and improve

The How

- Deliver value on demand without waste / Flow the process
- Manage for daily improvement / Relentless pursuit of perfection
- Mutual respect and shared responsibility enable higher performance

Engagement

Development of a novel integrated accountable care organisation (vACO) for Ophthalmology for the North East region

What and How of the vACO

Vision and Strategy	Re-run EVSA update SD	International Benchmarking to drive next level of improvement	Yearly Showcase				
Governance inc. Clinical	Consensus approach to decision making (and someone makes the decision) and its ours!]	We live our Team rules	Roles defined, membership fixed, frequency and length of meetings fixed	Independent critical friend	SD, Tracker and Reviews with standardwork	Patient advocate (non-service provision perspective)	Document Clinical Governance Routes – so all know how to escalate/solve and ACO has overview to share/learning	Patient Reported outcome measures
Change and Transformation	ACO can "sign off" on pathway redesign	Sponsor and approve All's for pathways/enablers	"Cash" or realise the benefits	Single source of truth for data and dashboard to make easy to use	Leaders developed to lead and deliver transformation	Create standard method to operate and transform	There will be "SLA" between all elements of the pathways. "No defect travels".	
Coordination, Influence, Partnership Working	Showing up as leaders "modelling collaborative" develop leadership model for vACO	Sharing data, information knowledge freely	Live and obey team rules	Do change and transformation together	No stakeholder left behind (RACI)			
Accountability and Trust Building	RACI to identify stakeholders	Open report outs at the end of every improvement event	Quarterly report to "CEO/ Chief's" and professional bodies	Patient and professional communications based on RAG -Newsletter -Learning sets -Etc.	Given Account of progress against key metrics and national targets	Receive feedback from people in NERIECS "systems"		
Finance and Resources	Build and maintain an accurate picture of cost of eye care in the NE Region (for future derivation)	Develop and submit integrated business cases "collectively" for region (and national approach)	Create a Standard "Model" to demonstrate the € benefit					

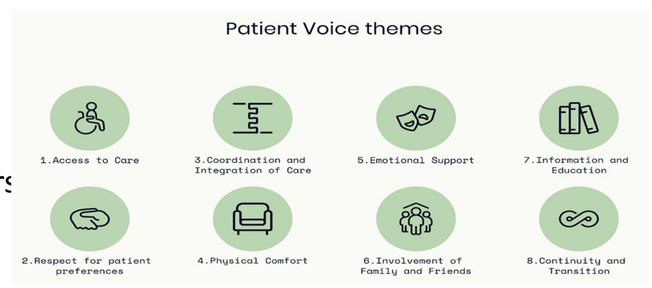
DEFINE

Why was change needed?

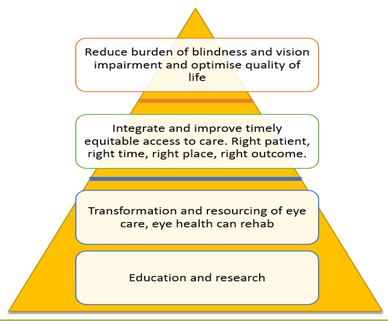
- 2nd longest waiting time nationally*
- 43,478* awaiting 1st Outpatient appt.
- > 20,000* awaiting 1st Community appt.
- Demographic demand – 200%↑ next 30yrs
- Latent demand following pandemic

* June 2022

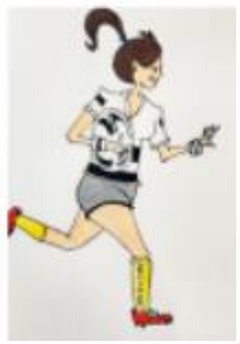
Aims and Objectives



Purpose pyramid



One integrated team with team shirt wearing club socks – Barbarian analogy



DESIGN

Methodology, Evidence and Planning

- Value Stream Analysis
- Rapid Improvement events

Our 'True North'

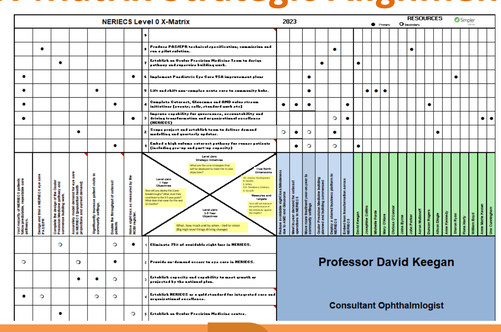
1. 4R's – Right Patient, Right People, Right Place, Right Time
2. Referrals are Standardised with minimum agreed data set
3. Co-Location of MDT Personnel/ Equipment/ Triage Stream
4. Universal Access to Electronic Medical Record
5. Self-Help
6. Self – Service
7. Education/ Information to Make/Inform the Best/Right decision [Continuous]
8. Not Individual People dependent – will work at all times
9. Person Centred. Patient and Staff are equal…
10. Up to Date/linked and shared equipment in the "right" space
11. Clear definition of roles/ responsibilities (pathways and catchment areas)
12. Equity in accessing of care
13. Referrals are 'managed' as one [one system]
14. Safe virtual platform wherever possible (quality is as good as face to face) *clear definition of virtual
15. Clear discharge pathways (its ok to say bye… for now) but simple way to 'get back in'
16. Work within professional workforce planning constraints
17. I/we know where we are in my care journey/pathway [electronically]
18. Patient can get to where they need to go
19. Money Follows patient/activity and incentivised
20. Locally with MDT where possible
21. Education/induction in adjacent steps in pathway
22. Integration of care – it's a whole 'thing' (thinking as a system)
23. Training/ development to retain and grow our own talent
24. Value based – quality is as important as anything else
25. It needs to be safe and reliable
26. Robust clinical governance

DELIVER

- Lean leadership – Go and See
- Daily layered accountability
- Structured problem solving – A3 Thinking, PDSA Cycles
- Continuous Improvement
- Coaching
- Strategic alignment – Strategy Deployment X Matrix

Daily Management Huddle

X-Matrix Strategic Alignment



Safer Better Healthcare, and Staff & Public Value
CHANGE OUTCOMES

Outcomes

Demonstrates efficiency and Value for Money

- Regional Optometrist first referral model has returned time to ~GPs ~141 days and consultants~71 days.
- Conversion rate to surgery improved by 28%.
- Theatre optimisation on-time starts ≤15 minute (90.9% from 37.2%).
- Bilateral same-day cataract efficiency (saves 2 appointments)
- Shift left to community 45%
- Professions working to top of license.

Demonstrate measurable outcomes to make the service better

- Care closer to home. Cataract visits/patient ↓ from 4.5 to 1.2
- Time returned to acute care – 38%↑new OPD attendances, 8%↑EED.
- Bilateral simultaneous cataract surgery delivering optimised care for patients (>100 to date) saving 2.78 tonnes of CO_2 emissions.
- Equitable access regionally to cataract and glaucoma care.
- Waiting times ↓25%

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Acknowledgements: NERIECS Regional Ophthalmology Partners

People's Needs Defining Change
HEALTH SERVICES CHANGE GUIDE
www.hse.ie/changeguide

References: The application of a person centred approach to process improvement in Ophthalmology Services in the North East of the Republic of Ireland, Teeling, Keown et al 2023, *International Practice Development Journal*
A discussion of the synergy and divergence between Lean Six Sigma and person-centred improvement sciences, Teeling et al 2020 International Journal of Research in Nursing

DIRECT AUDIOLOGY –VESTIBULAR PHYSIOTHERAPY (DAVP) PATHWAY: MORE THAN JUST A WAITING LIST INITIATIVE

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INTRODUCTION

Traditionally, patients with vestibular symptoms referred to ENT experienced lengthy waiting times, additional radiological and external vestibular function testing and multiple ENT clinic visits.

A new "one stop shop" multidisciplinary pathway, led by audiology and physiotherapy was introduced to the hospital in September 2022 in line with the Model of care for Otolaryngology, Head and Neck Surgery for Ireland (2019)[1].

To ensure quality was not solely defined as a reduction in waiting time and cost, the STEEEP principles of quality: **S**afe, **T**imely, **E**ffective, **E**quitable, **E**fficient and **P**atient centred were applied. Patient feedback was sought to determine if the change in service delivery was received favourably by patients.

The aim of this study was to compare the two pathways, to determine the effect on patient waiting times, hospital resources utilisation and patient satisfaction.

STEEEP PRINCIPLES: PATIENT CENTRED CARE

Figure 1: Institute of Medicine STEEEP dimensions of quality[2]

METHOD

A mixed methods retrospective study was performed incorporating a patient questionnaire. The traditional ENT pathway was compared with the DAVP pathway for patients with vestibular symptoms seen between 01/10/2022 and 31/10/2023.

Data was collected on: Demographics, waiting time, number of clinic visits, diagnostic investigations, MDT involvement and diagnosis.

The questionnaire had two open questions and two individually validated patient reported outcome measures; the Patient Enablement Instrument (PEI) and Short Assessment of Patient Satisfaction (SAPS), which captured patients' enablement and satisfaction levels following discharge.

RESULTS

Seen Quicker

DAVP Pathway: Waiting Time

1. Shorter waiting time for assessment (9 months; n= 140, range 2-39 months) compared with the traditional pathway (22 months; n= 35, range 6-71 months).

Start rehab sooner

2. Vestibular rehabilitation commenced on the same day while traditional pathway patients waited on average 8 months (n=35, range: 1-18 months) before their physiotherapy commenced.

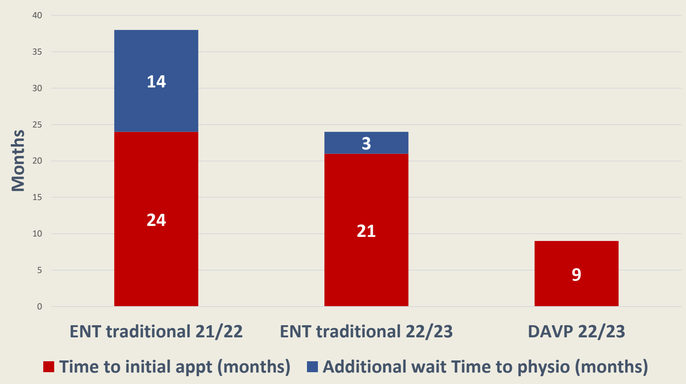


Figure 2: Waiting Times for ENT vestibular patients

Reduced investigations

DAVP Pathway: Resources

1. Reduced referrals for videonystagmography (VNG) (16%; n=19) and imaging (12%; n=14), compared with the traditional pathway (47%; n=16 and 41%; n=14 respectively).

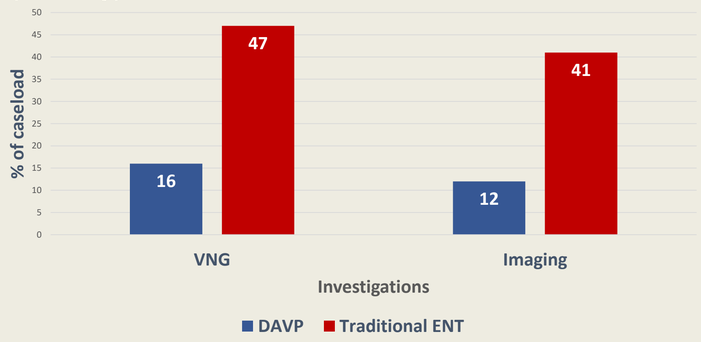


Figure 3: Assessment Resources

Reduced review appointments

2. Reduced number of appointments patients needed from 4.8 (n=34, range 2-14) with the traditional pathway to 2.5 (n=122, range 1-8) with DAVP pathway

COST SAVINGS

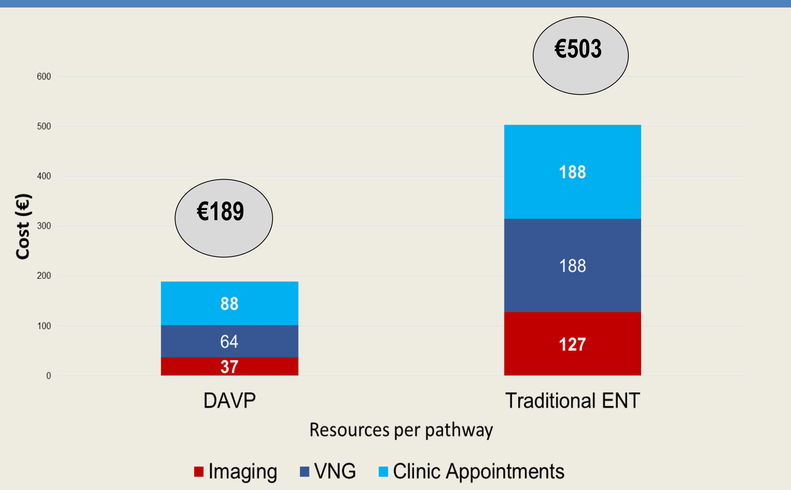


Figure 4: Average cost of resources per patient

IMPACT: WHAT THE PATIENTS SAID

Questionnaires issued to 120 DAVP patients and 22 traditional ENT patients with response rates of 50% (n=60) and 55% (n=12) respectively, showed encouraging empowerment levels and high rates of patient satisfaction.

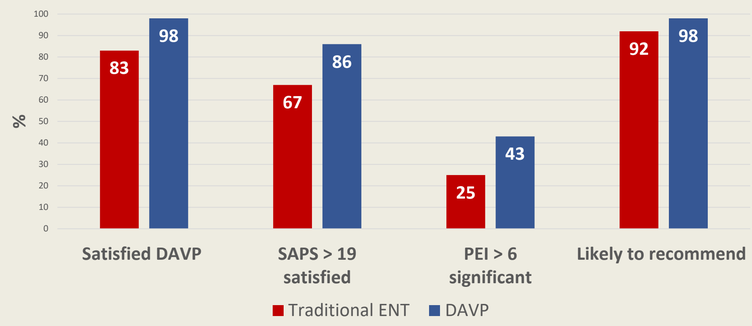


Figure 5: Questionnaire Results

"Felt seen and heard in this pathway"

"I was treated with the greatest respect … I was spoken to and not spoken at. Everything was explained clearly to me. I felt I got the utmost care and attention"

"Explained to me that the problems I had were real, and with the help of the service, I was able to cope with everyday life and had the tools to cope with the problems"

"Explained everything to me and made me feel so relaxed….I felt normal again after suffering for so long"

AREAS TO IMPROVE

45% (n=55) had imaging before initial DAVP appointment	Reduce unnecessary imaging: Improve links with referrers Support decision making for ordering imaging
42% (n=25) unsure of diagnosis	Improve patient education: Patient information leaflets Discharge Letters
22% (n=13) did not know they were seen by physiotherapy	Improve staff identification: Titles on doors ID badges
5% difficulty re-accessing services	Develop pathway for patient initiated follow up

CONCLUSION

The DAVP pathway provided an alternative pathway with timely assessment, diagnosis, and treatment for patients with peripheral vestibular pathology while decreasing the burden on diagnostic resources and otolaryngology clinics.

Applying the STEEEP principles of quality ensured high patient satisfaction levels were not compromised with this alternative approach to treatment.

REFERENCES

1. Otorhinolaryngology Head and Neck Surgery (2019). *A model of care for Ireland.* Dublin: RCSI.
2. Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. *Framework for Effective Board Governance of Health System Quality*. IHI White Paper. Boston: Institute for Healthcare Improvement; 2018. (Available at ihi.org)

IMPACT 1

85% (n= 104) of vestibular patients managed without any formal ENT appointments.

IMPACT 2

Reduced cost € 314 per patient x 240 per year

Annual Saving: € 75,360

IMPACT 3

Releases 408 ENT clinic appointments/ year = 102 hours or 12.75 clinic/ surgery days

Skinnovate phase 1: Reducing the Dermatology waiting list through redesign of internal systems .

P.Lenane[1], A. Wolinska[1], A. MacFarlane[2], L. Klotzbach[2], S. Manning[2], MMcGuirk[2] and A.Igoe.[2]

1. Department of Dermatology, Mater Misericordiae University Hospital, Dublin
2. Mater Transformation, Mater Misericordiae University Hospital, Dublin

Get in contact: plenane@mater.ie

Introduction

- In September 2020 there were 3736 patients waiting for a Dermatology Outpatient Appointment. Routine patients were waiting up to 2 years to be seen and there was 2000 patients on the waiting list with no appointment.
- The referral and triage process was variable and disjointed with individual waiting lists operated by each Consultant. This resulted in variation in wait time for patients, lengthy routine wait lists without appointment dates and an underutilisation of capacity in the system.

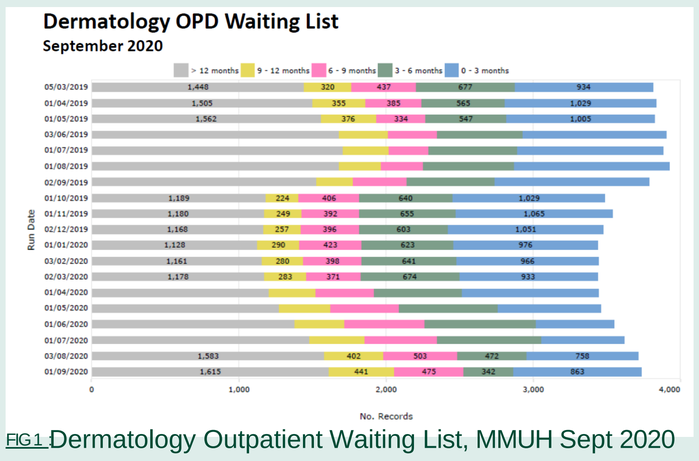


FIG 1 Dermatology Outpatient Waiting List, MMUH Sept 2020

September 2020
3736 patients waiting
1,615 waiting > 12 months

Voice of the Patient
"The waiting is really hard and it is difficult but when you get there and get in they mind you really well"

Voice of the Dermatologist
"*The service is struggling with the volume of referrals. We have limited new patient capacity which is often consumed by urgent skin cancer referrals*"

Voice of the GP
"*I know the wait times are long and would consider sending my patient referral elsewhere to try to access Dermatology services*"

Goals and Objectives

1. **Standardise - Triage criteria Time to triage**
2. **Reduce** waiting time for all patient cohorts
3. **Break cycle** of soon & routine patients becoming long waiters
4. **Improve** quality of referrals (Tertiary)

Methods

Using Lean Six Sigma methodologies the team carried out:
Desktop exercises
Gembas / observational studies on triage and booking processes
Analysis of waiting lists
A deep dive on referral data over a one-month period reviewing triage categories, nature and extent of referrals, time from referral received to first appointment.

Insights

1. **Triage Categories varied** – for example: 3 consultants used 5 triage categories (U1, U2, U3, soon, routine). 1 consultant used 3 categories (Urgent, Soon, Routine)
2. **Variations in time from triage to appointment** for urgent, soon and routine which meant instances where less critical patients were given appointments before more critical patients
3. **Differences in volumes of referrals received per consultant**
4. **Patient's triaged as soon and routine remained on the waiting list without appointment**

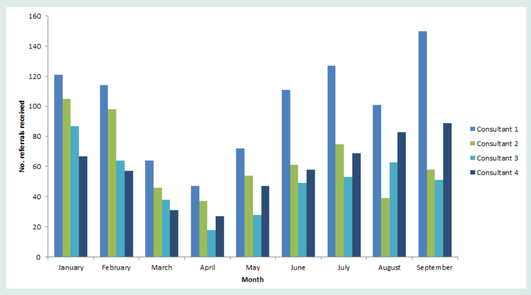


FIG 2: Distribution of Referrals by month and Consultant, Jan- Sept 2020

Median Waiting times
Sept 2020

Urgent – 81 days
Soon – indefinite
Routine – indefinite

What was implemented

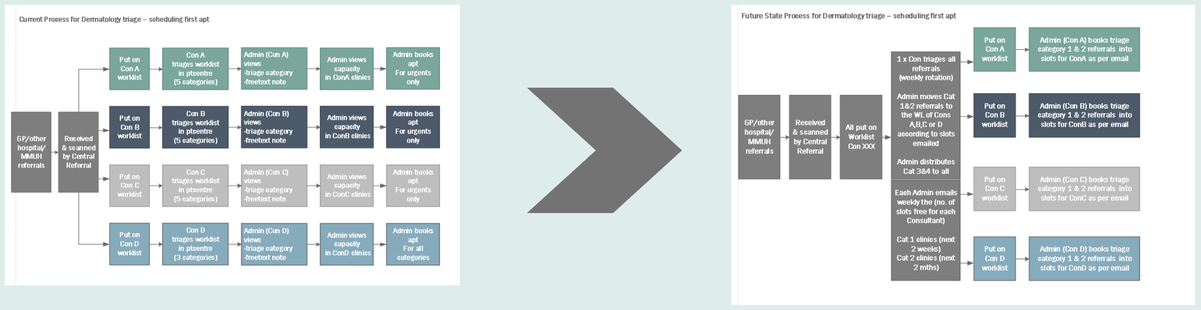


FIG 3: Process maps showing restructure of the triage system- from individual consultant triage processes and waiting lists to a single list, with management and oversight by one consultant from a centralised position

Centralised Triage & Booking system

- Triage categories were standardised and agreed with all consultants
- All referrals were directed to one list with one consultant carrying out triage
- Urgent, Soon and routine referrals distributed equitably and in line with patient demand
- Target to have all referrals triaged and appointment booked within 1 week

Audited the waiting list using '5S' methodology and removed:

- Benign diagnosis no longer accepted as per Royal College of Physicians, Ireland
- Patients that already have appointments & that no longer required appointment
- Duplicate referrals (more than 1 speciality)
- Wrong - hospital /speciality / service / age group/ private referrals
- Implemented strategy for Long waiting patients- booking into specific clinics
- Implemented system of returning incomplete referrals to GPs

Redesigned Referral forms for most common presenting conditions
(Non Melanoma Skin Cancer| Inflammatory Conditions| Acne)

Results and Conclusion

The design of a centralised system with single mode of referral and central management has resulted in:

1. A 40% reduction in the Dermatology Outpatient waiting list
2. Significant reduction in wait times across all categories (see results box)
3. Consistent patient wait times in accordance with urgency
4. All patients now have an appointment date
5. Capacity in system fully utilised
6. Time to triage now within hours -appointment booked within 1/52
7. Centralised management has enabled understanding of system to design referral forms that produce meaningful information to triage.
8. Enabled understanding of demand to influence re-design of clinic structure.
9. Enabled increased liaison with GPs in whole system

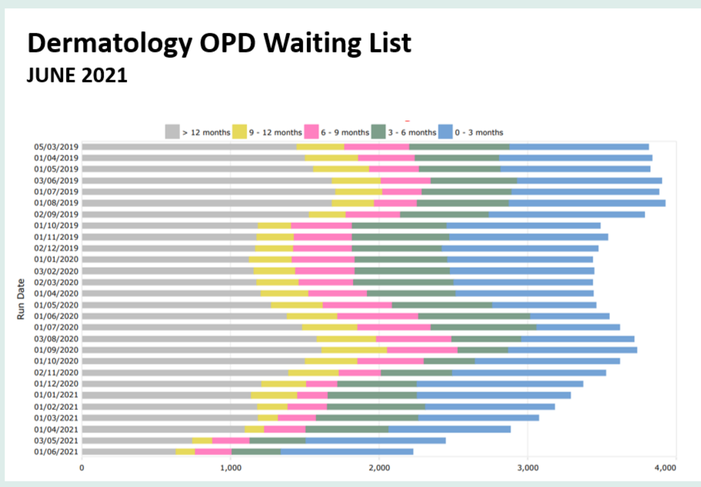


FIG 4: Dermatology Outpatient Waiting List, MMUH June 2021

40%

Reduction in waiting list
from 3736 (Sept '20) to 2,228 (June '21)
724 patients waiting >12 months
(60% reduction)

Patient Waiting times
Median

	Sep 2020	*Sep 2021*
Urgent	81 days	41 days
Soon	indefinite	4/12
Routine	indefinite	6/12

Audit of outcomes of Cataract Pre Operative Assessment in Ashgrove house.

Miss Maeve Lagan/Mr Duncan Rogers Cons Ophthalmologist,
Miss Diana Minasyan Ophthalmologist
Lucie Jones/Caroline Connolly/Sean Longwill/Una O'Mahony Optometrist,
Luana Farrell, Edel Baker @ CHO 9 Dublin North City and County

Background:

Reason for Audit: To understand and establish the reasons that patients that attended for pre-operative assessment were not listed for surgery. **Audit Period:** February 2024 **Sample Size:** 150 Charts

Outcomes:

- 106 patients listed for high volume surgery.
- 24 patients listed for non-high volume surgery
- 20 patients not listed for surgery (16 patients not listed and discharged and 4 patients not listed and referred to consultant clinics in the Mater for further investigation.

➢ Primary reason for not being listed for surgery was that the patient reported that they were happy with their visual acuity and that they were managing with their vision with no quality of life concerns. (55%)

➢ 10 of the 11 patients not listed for surgery due to no visual concerns had a VA of 6/9.5 or better in both eyes except for one outlier.

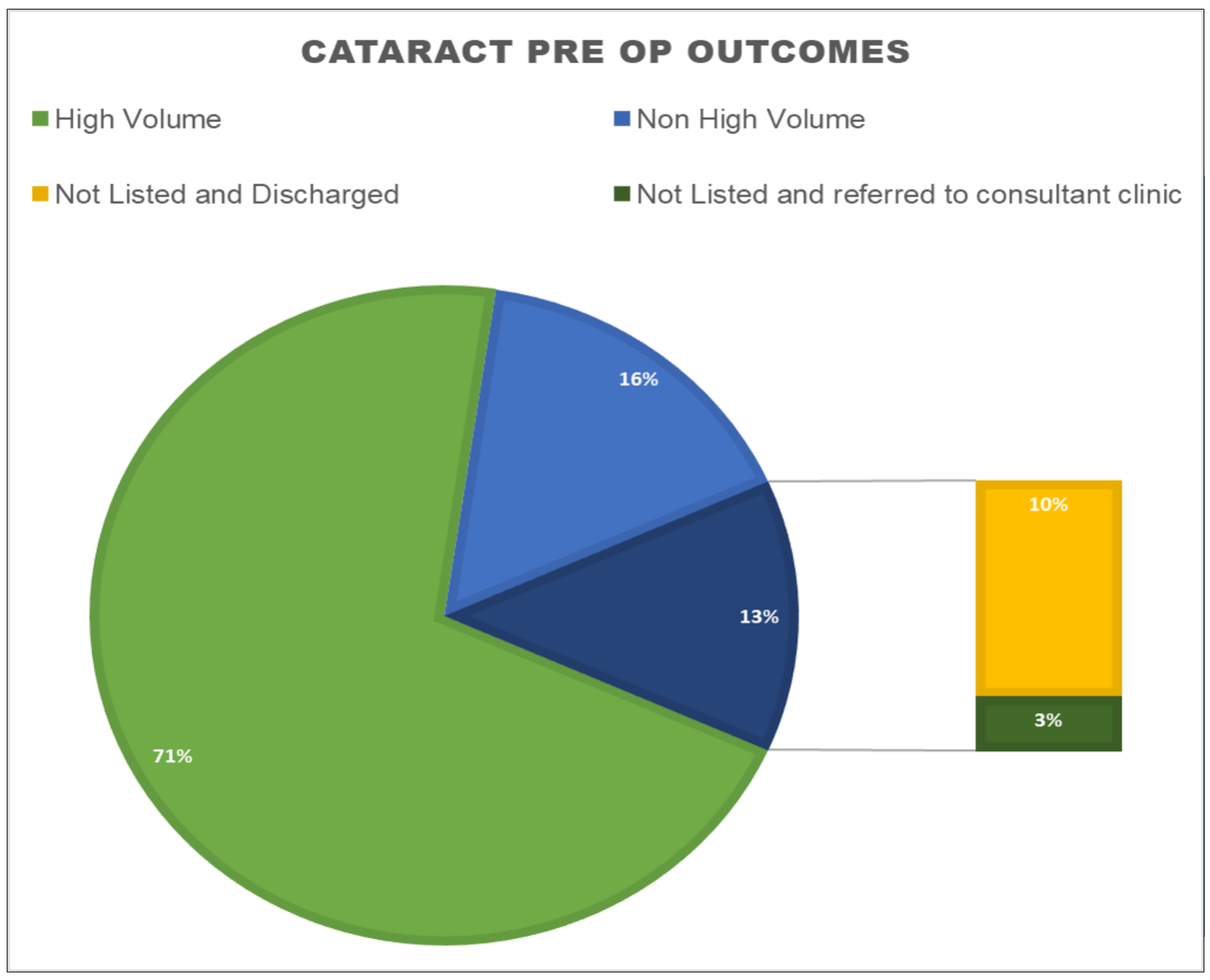
➢ 9 of 11 patients not listed for surgery due to no visual concerns were referred via Optometrists via NERIECS referral or via letter.

➢ Average wait time of patients from date of referral to pre operative assessment was 279 days

➢ B scan were required in 3 patients (2%)

➢ Immersion Biometry required in 2 patients (1.3%)

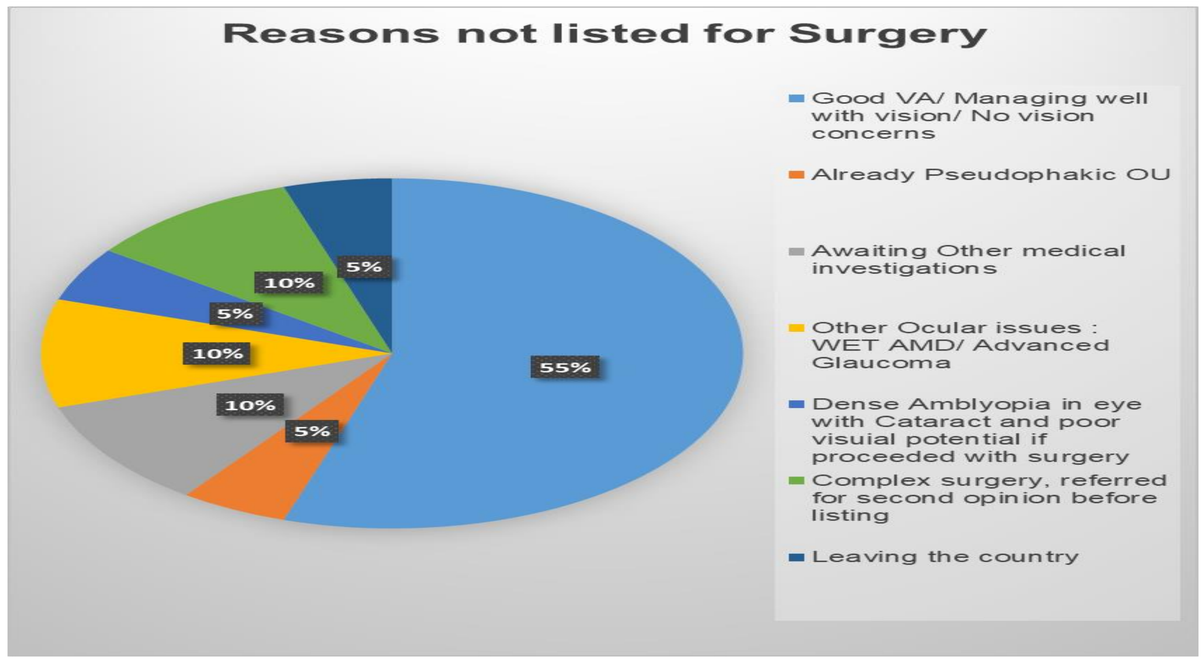
➢ Repeat biometry due to contact lens wear required in 1 patient (0.67%)



Conclusions:

Further education to Optometrists and practitioners in the NERIECS region on whether the Cataract is affecting patients quality of life prior to referral and their motivation to proceed with surgery.

Re Audit in six months time to compare outcomes and wait times.



References:

14. National Institute for Health and Care Excellence . *Cataract in Adults: Management. NICE Guideline NG77.* National Institute for Health and Care Excellence; London, UK: 201

Development of a standard data set for a community healthcare network

Presented by Niamh Davis CHN Manager, North Meath & Ardee on behalf of CHN Managers Meath/Louth

Background 1

The Community Healthcare Network (CHN) model went live in CHO8 in August/September 2022. There are six CHNs in the North East. Under the CHN model staff across six disciplines report into one network manager rather than staff from each discipline reporting into a discipline specific manager. The CHN manager is responsible for KPI returns, responding to PQs and managing performance & activity. Data management processes, which developed in a unidisciplinary way need to be adapted for the CHN model.

Baseline facts and figures 2

At the time of going live (Aug 22) NMACHN referral data:

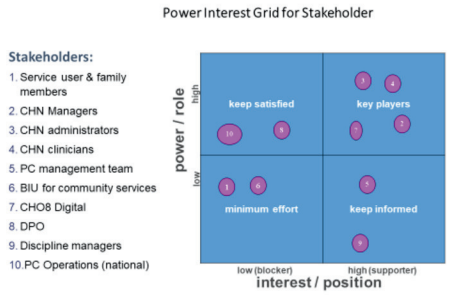
- Was stored on 19 different excel spreadsheets
- Saved in 11 different shared drives
- Across two LHOs (Meath & Louth)

- Three spreadsheets contained countywide data

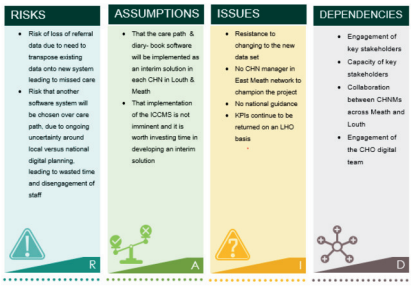
Aims & Objectives 3

1. To develop a standard data set for the CHN
2. To store network data consistently & securely in line with GDPR
3. To develop a data set that is ready to map onto diary book, care path & in time the integrated community case management system (ICCMS)
4. To have access to timely, valid, meaningful data for measuring activity and planning services

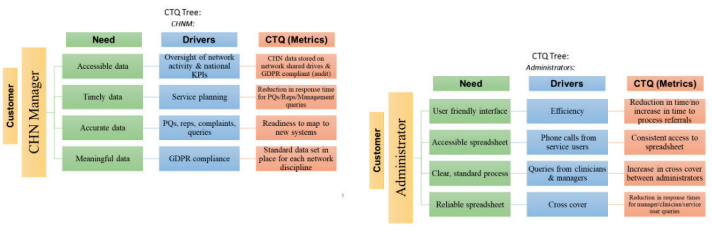
Stakeholder Mapping 4



Risk, assumptions & dependencies 5



Voice of the customer 6



Analysis 7

- 119 different data points collected across 19 spreadsheets
- Only 3 x data points commonly collected across all 19 spreadsheets (first name, surname & comment/note)
- No spreadsheet contained all data points required by care path or diary book
- Mixture of demographic data, operational data, clinical data & outcome measures collected on spreadsheets
- National KPI returns: 274 data points collected across 5 disciplines; no data point collected consistently across all 5 disciplines; no national KPI return for Social Work

Progress to date & next steps 8

- GM sponsorship for project secured
- Consultation with network staff via network management team meetings
- Questionnaire re: data management processes completed (admin)
- Mapping of existing spreadsheets Louth & Meath
- Comparative analysis of existing spreadsheets & discipline specific KPIs
- Liaison with CHO8 digital team, national community operations & BIU re: plans to roll out ICCMS
- Local working group members identified
- Commenced moving spreadsheets onto network specific drives

Next

- Working group to meet to develop standard data set: July 2024
- Pilot data set for specific disciplines: September 2024
- Roll out dataset across x 6 networks in the Louth/Meath : Jan 2025
- Roll out of diary book & care path across CHNs - TBC

North Meath & Ardee CHN, Kells Primary Care Centre 046-9251400 nthmeath.ardeechn@hse.ie

Analysing CHN Cabra demographics and service demands quantitatively and qualitatively to enhance integration and access

CHO Dublin North City and County

Alicja Downey [1] Vanessa Vieira[2]

[1] Community Healthcare Network Manager, Cabra Primary Care Centre, Navan Rd, Dublin 7

[2] CTM Support, Cabra Primary Care Centre, Navan Rd, D7

Aims and Background

This initiative aims to improve safe, timely, equitable access to healthcare services for all community dwellers in CHN Cabra particularly those in underserved areas or vulnerable populations.

The Community Healthcare Networks (CHNs) framework supports local integrated care. The implementation of CHN Cabra in June 2022 strengthened collaboration among the network, Sláintecare Healthy Communities, Social Inclusion, and voluntary organisations.

Recommendations were made in alignment with the Sláintecare Implementation Strategy and HSE Corporate Plan objectives.

Population CHO DNCC: 680,766

CHN Cabra Population is the second largest with 70,384 out of 12 Networks in CHO DNCC

Methodology

Quantitative and qualitative analysis of demographic trends were conducted

Trends in population growth, ageing, and socio-economic changes from 2016 to 2022 censuses were identified and compared to national averages

Data from the Central Statistics Office (CSO), Pobal Maps, and Health Atlas were reviewed and analysed, providing accurate demographic insights specific to CHN Cabra

Analysis of 2023 referrals received and registered in the network database

Identification of current service demand for CHN Cabra Primary Care Teams.

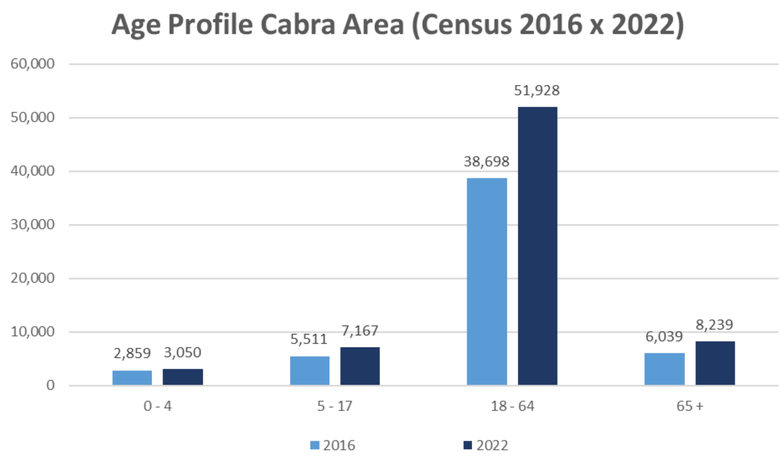
Key Learnings

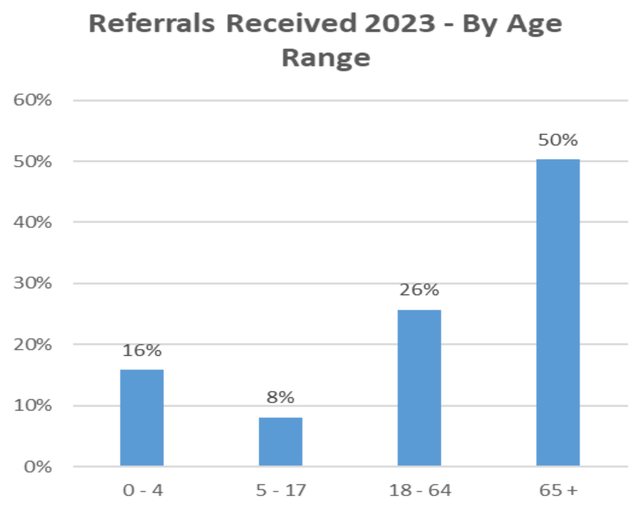
- Population in all age groups increased proportionally. The population in CHN Cabra data is higher than the national average in all age groups.
- The most significant growth in the CHN Cabra area was observed in the age group of community dwellers over 65, followed by the age group of 18 to 64, which is higher than the national in both age groups. The 18-64-year-olds consist of 73.8% of the population in CHN Cabra. The highest population growth occurred in Ashtown and Grangegorman. The least growth occurred in Cabra West. Cabra West and Inns Quay have the highest deprivation index. No increase in ‘’bad’’ or “very bad” self-report health but is higher than the national average in both categories. Deprivation increased in the most deprived areas in CHN Cabra and is higher than the national average.
- Analysis of referrals received to the network showed that there is a correlation between service demand and demographic trends in CHN Cabra. The highest rate of referrals is received for those over 65s which is 50%. From this age group, the highest number of referrals are received for those over 85. Over 65s received the highest number of MTD referrals.
- PCT -Cabra West with the lowest population growth and the highest deprivation index received 23% referrals for over 65s. The highest referral rate for this age group, 25 %, was received from Grangegorman. PCT- Ashtown the most affluent area with the highest population growth received the highest referrals number for 0-17s

Results

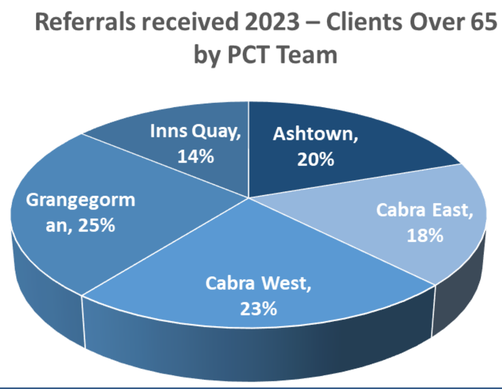
Correlation between Referrals received in 2023 by PCT and Population age, size and Deprivation Index

	Ashtown	Cabra East	Cabra West	Grangegorman	Inns Quay	TOTAL
0 - 4	160	109	116	148	52	**585**
5 - 17	86	24	83	74	32	**299**
18 - 64	153	142	217	281	153	**946**
65 +	366	326	432	464	260	**1848**
TOTAL REFERRALS RECEIVED BY PCC	**765**	**601**	**848**	**967**	**497**	**3678**
% Referrals Received By PCC	**21%**	**16%**	**23%**	**26%**	**14%**	
POPULATION SIZE	**16402**	**9656**	**9786**	**21099**	**13441**	**70384**
Average Deprivation Index	**8.9**	**3.87**	**-8.2**	**6.08**	**0.99**	





	2016	2022	% Growth	Average % Growth National
0 - 4	2,859	3,050	6.26%	5.7%
5 - 17	5,511	7,167	23.11%	1.3%
18 - 64	38,698	51,928	25.48%	6.53%
65 +	6,039	8,239	26.70%	3.0%
TOTAL	**53,107**	**70,384**	**24.55%**	



Actions

The main goal is to address the ageing population in CHN Cabra and increasing deprivation and effect on related health factors like physical health, mental health and chronic conditions.

Addressing Quality of Life indicators:

- ✓ Increase in social support
- ✓ Integration of Care
- ✓ Access to Mental Health Services and Alcohol Services
- ✓ Physical and frailty care needs

1. Prevention in over 65 years old and 50-65 y/o age group
   - Frailty detection and management
2. Sláintecare Healthy Communities initiatives implementation, collaboration with the Health and Wellbeing Department.
   - MECC
   - Walk and Talk Programme
   - Chronic Condition Management- Healthy Leaving
   - Alcohol Prevention
3. Working in partnership with ALONE services
4. Wellbeing support for over 65 y/o
5. Addressing the needs of Social Inclusion Patients Residing in CHN Cabra working with the Social Inclusion link Person.
6. Collaboration with Local Development Officer Sláintecare Healthy Communities Programme

Conclusion

- Identifying demographic trends and service needs enables early, targeted interventions for timely access to services.
- Health needs analysis is essential to address broader determinants of health
- Continuous monitoring and analysis of demographic trends and service demands provide critical insights that guide the planning and implementation of healthcare services, ensuring they are responsive to the community’s evolving needs

References: Health Atlas; Central Statistic Office Report 2016 and 2022; The Pobal HP Deprivation Index; Sláintecare Implementation Strategy & Action Plan 2021 — 2023; HSE Corporate Plan 2021-2024; NSP 2023 Health Service Executive’s one-year plan; Sláintecare Implementation Strategy & Action Plan 2021 — 2023- Progress Report; 2024 Connecting for Life DNCC Well- being a support booklet for over 65s;

100 Day Review: A Novel Approach to Access of Mental Health Care by Asylum Seekers & Refugees

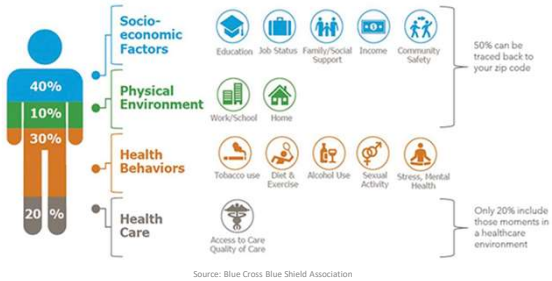
Michael Gibbons, ANP michael.gibbons@hse.ie

A mainstream approach does not guarantee equity of access or equity of outcomes for asylum seekers and refugees.

'HSE Sharing the vision - 2020' states that when there is a clear gap between "at risk groups" versus the rest of society, there is the need for policies to be adjusted and specific measures developed. In recognition of this in 2023 the HSE published *'HSE Psychosocial Response for Asylum Seekers and Refugees Seeking Protection'*.

People living in direct provision have disproportionally high rates of mental health difficulties. However, our findings from a scoping review of existing services, identified that these services were being underutilised, with several missed opportunities along the service user's journey. This higher burden of illness translated into higher involuntary admission rates and the need of more agencies to be involved in an individual or family's care.

In response, funding was secured to pilot the first specific initiative to address this cohort's needs through an '**In-Reach Early intervention Mental Health Service**'



Source: Blue Cross Blue Shield Association

A User Centric Approach - User Persona

David, 33 - Nigeria

Language: Igbo/English
Religion: Christian
Ethnicity: Igbo
Marital status: Married, no children
International Protection Status: Fire sale of assets to pay to flee home country. Paid an agent who arranged transit to UK. Came to Ireland thereafter and lodged International Protection Application (decision pending)

BACKGROUND

Professional/College educated. Worked in education - youth worker.
Not anti-establishment but advocate for better social justice.
His actions were misinterpreted by stakeholders, ultimately forcing him to flee his home country.

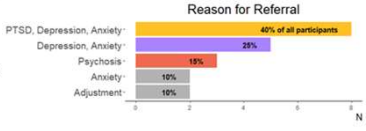
***Presenting Complaint**: Flashbacks, nightmares, low mood & anxiety.*

Barriers identified and addressed

The service has been designed with the user at its heart so that barriers and obstacles are either removed or reduced insofar as possible.

Increased access to care

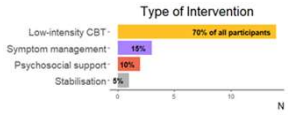
- Referrals have gone from 1 every 4-6 weeks to 1-2 per week, corresponding to at least a **300% increase in weekly referrals**.
- **Wait time have reduced** from 3 months to 0-7 days in 30% of cases, 7-14 days for 15 % & 14-28 days for 30% accessing the service.
- **Urgent referrals prioritised** and seen in less than 7 days negating the need to ask the person to present to out of hrs services for assessments.
- **Anchoring the service onsite ensures a high degree of flexibility**. If an appointment is missed or someone is unable to attend it allows for easier rebooking and rescheduling.



Sustainability and scalability

- Funding beyond the initial 3 year pilot timeline must be secured to ensure the continuation of the initiative and effective succession planning. Collaboration between HSE Social Inclusion and Mental Health Services, particularly in addressing governance and terms of employment seems to be an effective model for success.
- There is a huge appetite amongst Clinical Nurse Specialists to explore Advanced Practice but there are limited options away from the Clinical Care Programmes/Candidate Pathways. Sharing the learning from developing the project and recognising Migrant Mental Health as a Specialist field would allow other services to emulate the project

The project demonstrates that if you listen to and address the barriers and challenges faced by this "at risk" population they will embrace and utilise services.
Early intervention leads to better outcomes!!



Improvement in health outcomes

- Follow up appointments are given 1 week after initial assessment rather than it being dictated by a concrete future OPD date such as the 1st Friday of subsequent months, **allowing rapid access to care**.
- Low intensity Cognitive Behavioural Interventions, followed by symptom management and stabilisation are the most utilised resource.
- **No medication was prescribed to 45% of patients**, and of the remaining 11 individuals (55%), many had initiated their medication on referral or were already attending the service.
- When someone was admitted to hospital, due to an unforeseen relapse, the newly established service **effectively coordinated with various agencies, reducing the impact** on both the individual and those around them. This resulted in a more cohesive and coordinated response compared to what was previously typical, as reflected by testimony.

Call to action

- The success of this novel approach demonstrates the importance of innovative, culturally appropriate and responsive strategies. It is crucially important for other mental health professionals, regulatory bodies and policy makers to consider adopting similar initiatives in response to emerging needs.
- In order to sustain this project and expand future ones there is a need for policy support and funding directed towards building capacity, ensuring long-term viability and enabling broader reach.
- The challenges encountered, while admittedly breaking new ground highlights the need for stronger collaboration between all stakeholders.
- While this approach shows promising results there is still much to learn. Researchers, academics and clinicians need to continue to study this population to further refine and improve our strategies.
- The broader community has a major role to play in supporting asylum seekers and refugees. Awareness campaigns, volunteer programmes and community-based initiatives can all contribute to a more welcoming environment that supports well-being and integration.

Implications for future practice

- Sustainability & Scalability: *"The White Paper, 2021"* points to phasing out the current system and replacing it with State owned Reception and Integration Centres where people will be accommodated for no more than 4 months. The success of this approach underscores the value of embedding and anchoring services within these sites.
- Early indications show varying needs and differing circumstances of the target population which require services to be flexible and adaptive. Offering interventions in different formats (some groups, 1:1), investing in promotion and prevention, building language capabilities, utilising telehealth, mobile phone services and digital resources, such as QR codes. These are identified areas for further exploration.

Acknowledgements:

ACCESS AND INTEGRATION: A RESPIRATORY MDT CLINIC APPROACH FOR ASTHMA/COPD PATIENTS IN DUBLIN NORTH & RIC BEAUMONT HOSPITAL

Valerie Connell, Louie Fox, Lynda Haran, Megan Hyland, Susan Kavanagh, Stephen McDonnell, Lavinia McLeod, Dee Murphy, Michelle Uno, Rinu Rajan, Barry Walsh, Yvonne Walsh, Dr. Vincent Brennan

Introduction

The Respiratory Integrated Care multidisciplinary team (MDT) Clinic was set up in March 2024, consisting of a consultant, clinical nurse specialists, a physiotherapist, physiologists, candidate advanced nurse practitioner and administration staff. The weekly consultant-led clinic enables patients with asthma and COPD timely access to diagnostics and access to a specialist team on the same day. This is aligned with recommendations from the Integrated Care Programme for the Prevention and management of Chronic Disease (2024).

Aims & Objectives of MDT Clinic:

- Provide early access for patients to specialist respiratory care
- Provide early access to pulmonary function testing and diagnostics.
- Referral to specialist MDT members
- Reduce the hospital respiratory waiting list
- Escalate and de-escalate treatment, guided by diagnostics and assessment. Tailored interventions and treatment to reduce exacerbation rate of COPD/Asthma.
- Refer into acute services as required.
- Provide individualised COPD and Asthma education & self management plans.
- Weekly MDT meetings
- Follow up clinic reviews if required.
- Refer to community services and signpost patients to community supports as appropriate.

Methods

Data was collected from 60 patients whom attended the Respiratory MDT Clinic in St.Clare's Integrated Care Centre, Dublin North. Retrospective analysis of the data was completed. Patients were referred with a suspected/ confirmed diagnosis of chronic obstructive pulmonary disease (COPD) or asthma.

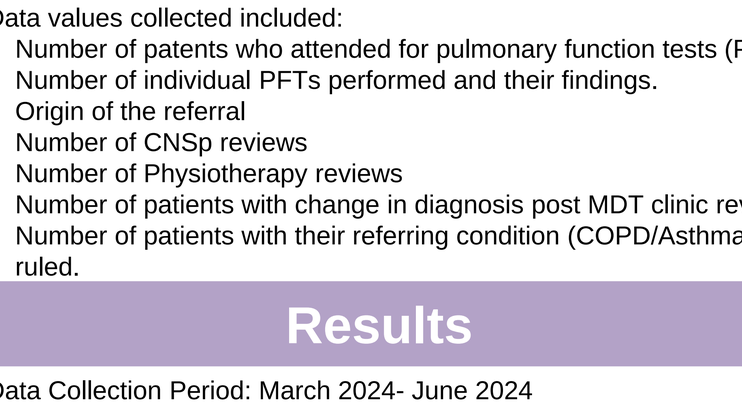
Data values collected included:

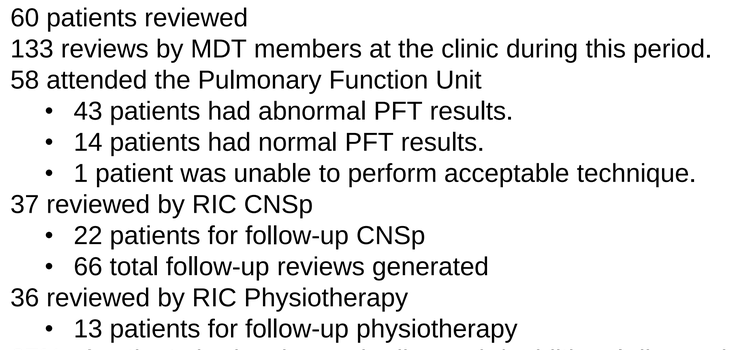
- Number of patents who attended for pulmonary function tests (PFTs)
- Number of individual PFTs performed and their findings.
- Origin of the referral
- Number of CNSp reviews
- Number of Physiotherapy reviews
- Number of patients with change in diagnosis post MDT clinic review
- Number of patients with their referring condition (COPD/Asthma) out ruled.

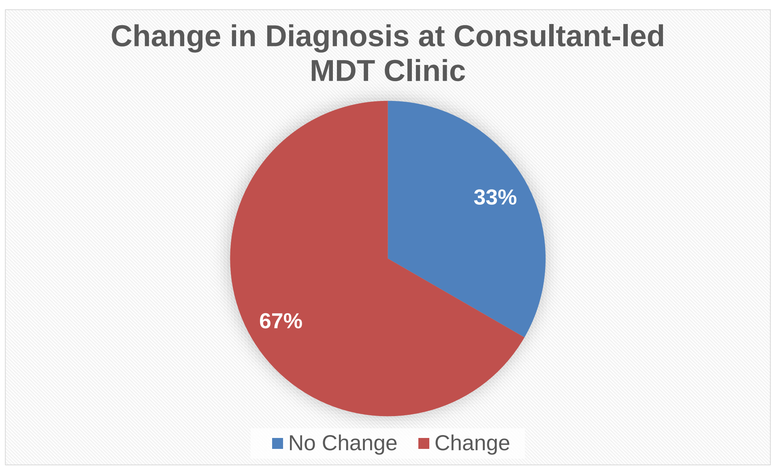
Results

Data Collection Period: March 2024- June 2024

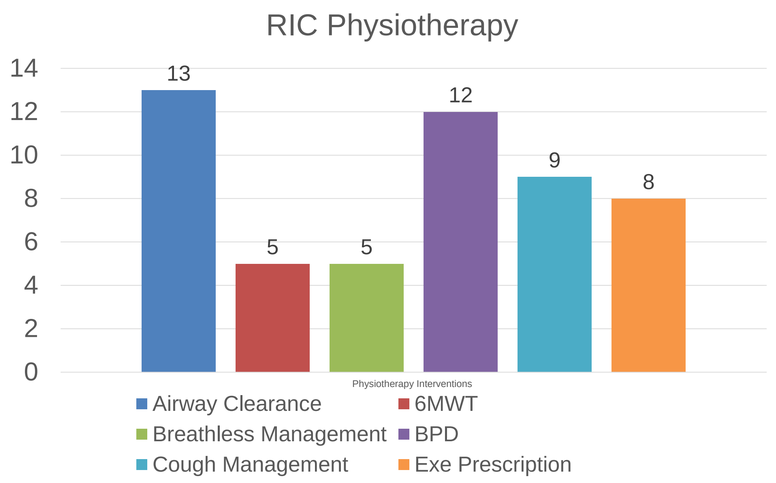
- 60 patients reviewed
- 133 reviews by MDT members at the clinic during this period.
- 58 attended the Pulmonary Function Unit
  - 43 patients had abnormal PFT results.
  - 14 patients had normal PFT results.
  - 1 patient was unable to perform acceptable technique.
- 37 reviewed by RIC CNSp
  - 22 patients for follow-up CNSp
  - 66 total follow-up reviews generated
- 36 reviewed by RIC Physiotherapy
  - 13 patients for follow-up physiotherapy
- 67% of patients had a change in diagnosis/ additional diagnosis
- 21 had their referral diagnosis or suspected diagnosis of COPD/Asthma out ruled
- 21 active smokers, 12 referred at clinic for smoking cessation
- 61 onward referrals







Physiotherapy

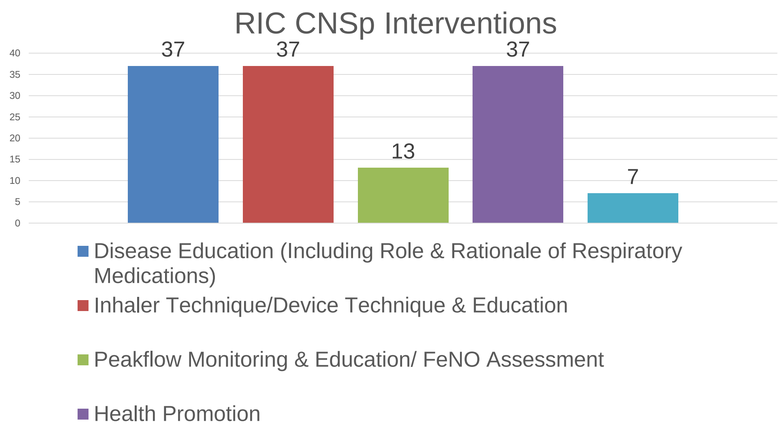


The role of physiotherapy in the management of COPD include:

- Reducing work of breathing,
- Promoting airway clearance,
- Improving mobility and promoting rehabilitation.

Breathing Pattern Disorders (BPD) are abnormal respiratory patterns specifically related to over-breathing. They range from simple upper chest breathing to, at the end of the scale, hyperventilation. BPD can, however, co-exist with diseases such as COPD or heart disease. The MDT approach ensured patients with BPD were seen at clinic and followed up for reviews. These patients had co-existing asthma /COPD or where misdiagnosed as having these.

Clinical Nurse Specialist



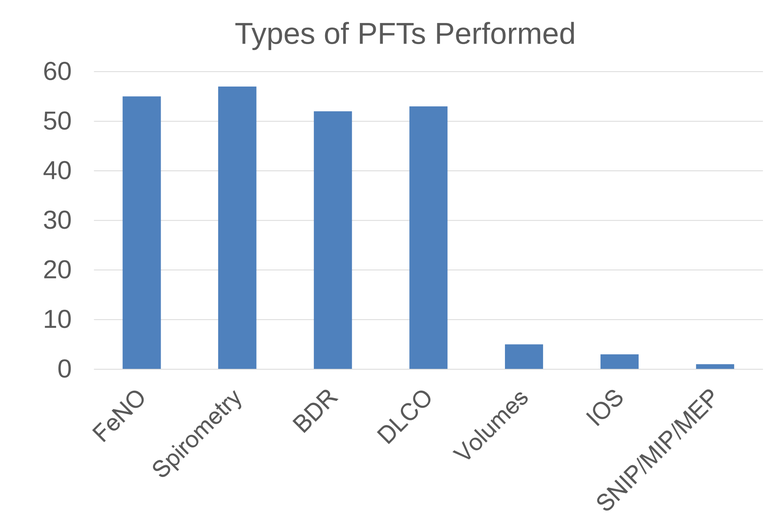
Follow up was necessary for the majority of patients seen with the aim of ensuring optimal delivery of inhaled medication,& self management education.

Of the 37 patients reviewed by the CNSp Service at the Clinic, 22 required follow-up RIC CNSp which led to 66 follow-up CNSp reviews.

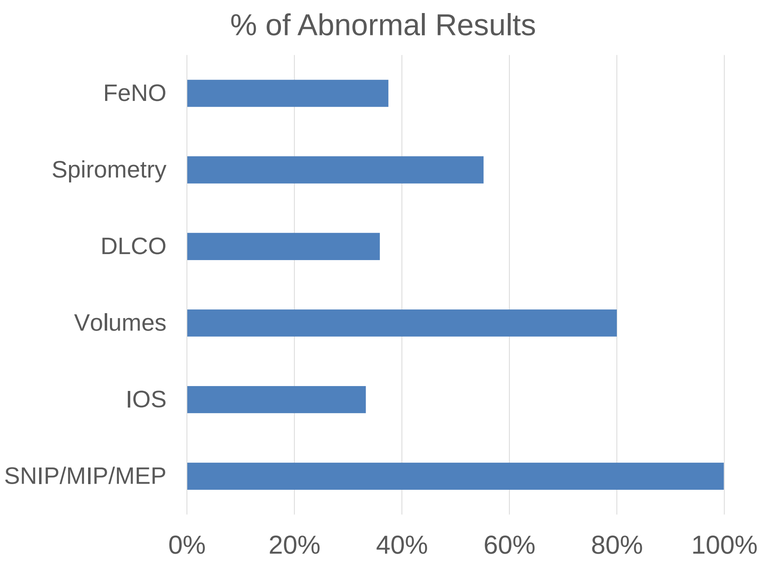
Physiologist

Of the 60 patients reviewed, 58 had a variety of Pulmonary Function Tests performed.

Providing advanced Pulmonary Function Testing additional to Spirometry is paramount to obtaining the correct Respiratory diagnosis and providing the correct treatment plan. Spirometry testing indicates airway obstruction however this alone is not always enough to classify the cause of the obstruction.



The following shows the percent of abnormal results found for each type of PFT performed:



Conclusions

- The set-up of a weekly respiratory consultant-led MDT clinic in integrated care has enabled the integration of hospital and community referrals. This has ensured patients get access to early diagnosis and specialised respiratory team input, close to their home.
- A MDT clinic provided a holistic approach to patient care and ensured further specialist follow up was facilitated. It enabled patients to be assessed by multiple disciplines with tailored interventions, education and treatment. This empowered patients to self- manage their respiratory condition.
- Providing care on the same day reduced the number of visits to the Integrated Care Centre for patients, and the associated burden of same.
- Providing advanced pulmonary function tests in addition to spirometry improves the quality of diagnostics, aids the quality of aftercare in treatment plans and avoids patients re-referral to the hospitals Pulmonary Function Lab.

Limitations & Future Considerations:

- Data collection limited to the first 3 months of clinic (new clinic).
- GP referral pathway opened in the last month of data collection only, therefore, initial referrals were from the Beaumont Hospital respiratory consultant waiting list.
- Additional breathing tests were required to achieve a definitive diagnosis for some patients.
- BPD can co-exist with COPD& Asthma.
- The quality of PFT results are dependent on patient technique.

Acknowledgements

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Barbara McCann, ADPHN, Integrated Care Dublin North.
Louise Clarke, Chief Respiratory Physiologist, Beaumont Hospital.

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NIMIS Project Connecting Respiratory Diagnostic Services in Connolly Hospital and the Dublin Northwest Integrated Care Centre

- Louise Brien[1,2], Dr. Abirami Subramaniam[1,2], Gary Monk[3], Aisling McGowan[1,2]
- [1] Connolly Hospital Blanchardstown, Dublin 15, Ireland; [2] Dublin North West Integrated Care Centre CHO9, Dublin, Ireland; [3]National NIMIS team, Ireland

Background

Pulmonary function testing (PFT) once limited to acute hospital settings is now available in the community as part of the integrated care programme for chronic disease management.

The National Integrated Medical Imaging System (NIMIS) enables the acquisition, storage, retrieval, and sharing of images and test reports.

The aim of this project was to connect diagnostic services in Connolly Hospital with the Dublin Northwest Integrated Care Hub in order to improve remote access capabilities and operational efficiency.

Methods

Over a period of 11 months, Respiratory Physiologists worked with the NIMIS team, local and national IT, and the PFT equipment supplier to extend NIMIS to the community setting.

Step 1: Service and resource planning including engagement with NIMIS, IT and PFT supplier
Step 2: Delivery and installation of PFT systems and NIMIS review stations
Step 3: Connection of NIMIS stations to HSE network and NIMIS VLan
Step 4: Trial of image storage, retrieval and reporting

Results

A uniform diagnostic pathway was established allowing PFT images and reports to be viewed in both sites. This facilitates faster diagnosis, better coordination of care, and improved outcomes with equal benefits for community patients, staff and referring physicians.

Healthcare professionals enjoy streamlined workflows processed via NIMIS and accessed both in the community and acute settings.

This workflow is shown below;

Order
- Physician adds test order to NIMIS

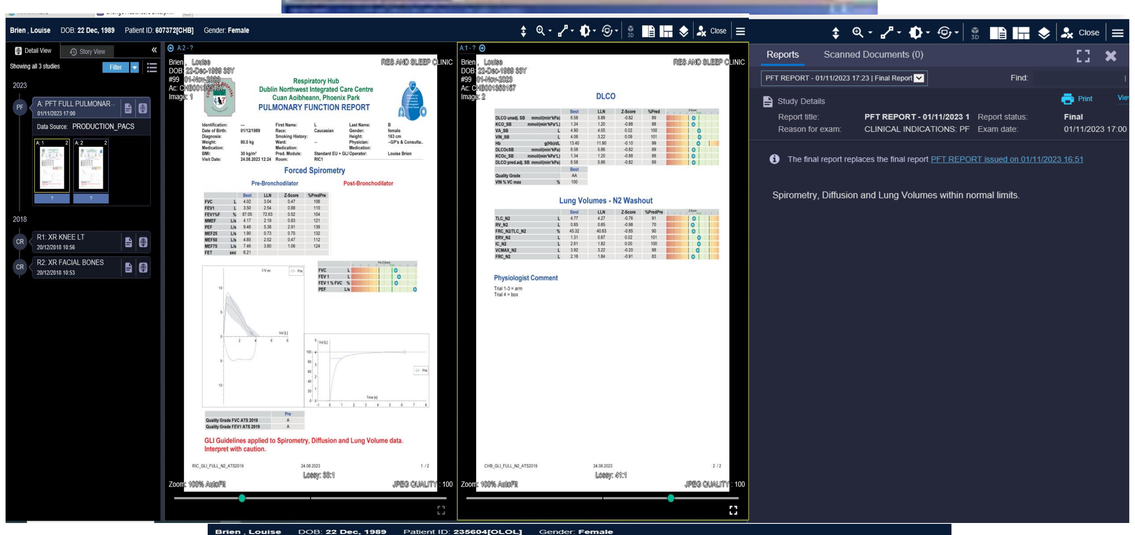
Vet
- Order is immediately available for Physiologist to vet

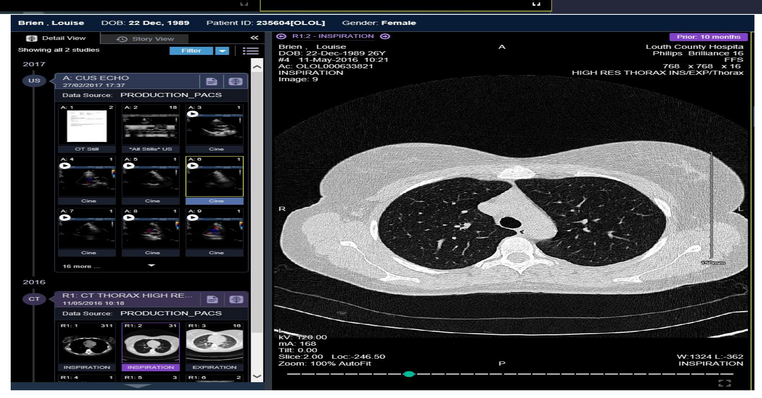
Schedule
- Test is scheduled with date, time and location visible to both sites

Test
- Patient and order details sent to PFT system for patient testing

Interpret
- PFT image is sent to NIMIS for review and interpretation by both Physiologists and Consultants

Report
- Report is generated and becomes available for viewing by healthcare professionals in both sites as well as by GPs via Healthlink





Conclusion

The successful implementation of NIMIS in the Community Integrated Care Hub and Connolly Hospital promotes the use of NIMIS in other hub settings which will revolutionise the way physiology services are delivered, improving patient care in both community and acute settings.

Breathe Easy, Beat Strong: A unified approach to Cardiopulmonary Disorders

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BACKGROUND

Patients with COPD and/or Heart Failure wait for extended periods of time before they see a specialist and obtain diagnostic testing. This affects their clinical outcome resulting in increased disease severity, risk of exacerbations and hospital admissions.

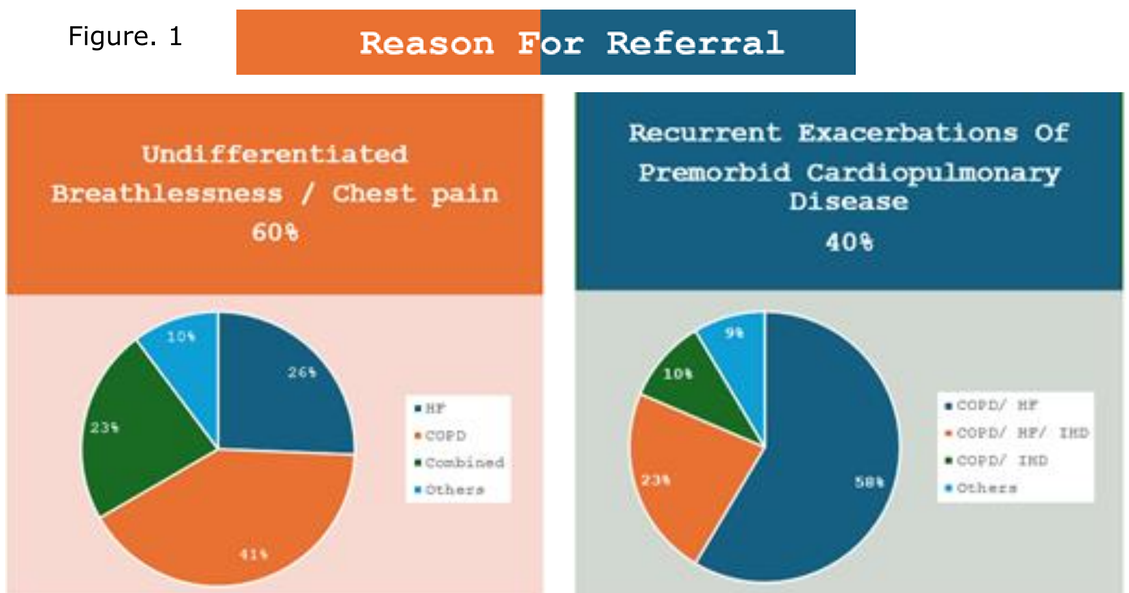
Physicians treating comorbid cardiorespiratory disorders face several diagnostic and therapeutic challenges. These include shared risk factors, similar demographics, symptoms, pathophysiology, complex interpretation of diagnostics and frequent pharmacological interactions. Addressing these issues requires interdisciplinary collaboration for effective diagnosis and therapeutic interventions. Establishing effective teamwork and care pathways is therefore crucial for improving patient outcomes. Our solution involved implementing an integrated care model for the assessment and management of comorbid Cardiovascular disease and COPD in a community based setting.

In line with Sláintecare's aim, the Dublin North West integrated care team pioneered a combined model of care for evaluation and treatment of patients with concomitant cardiopulmonary diseases.

METHODOLGY

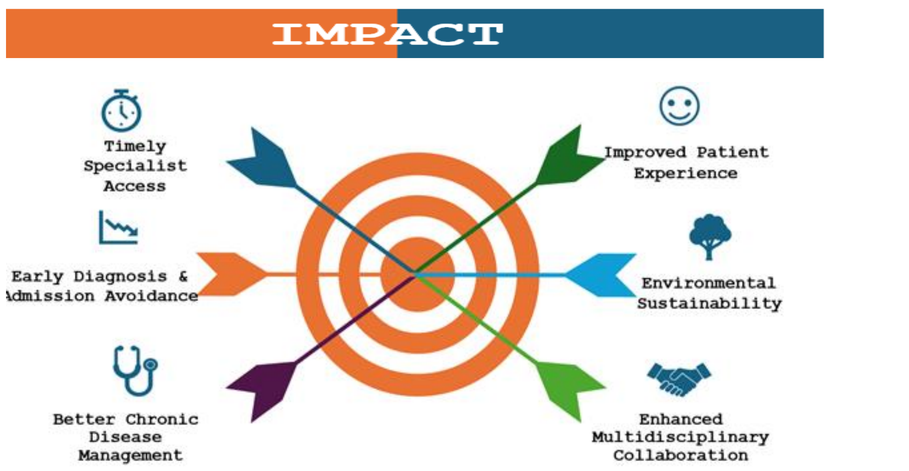
- A retrospective review was conducted on 52 patients (over 10 clinics) who attended the joint Cardiorespiratory Clinic between April 2023 and May 2024.
- Reason for referral was documented with the final diagnosis and outcome documented (see Figure 1.)
- Waiting times for both services were compared before and after establishment of the joint clinic.
- Financial cost savings were analysed and operational costs, patient visit costs and overall cost savings were calculated.
- Carbon footprint was assessed as potential greenhouse gas emissions associated with reductions in time travel to and from the clinic.

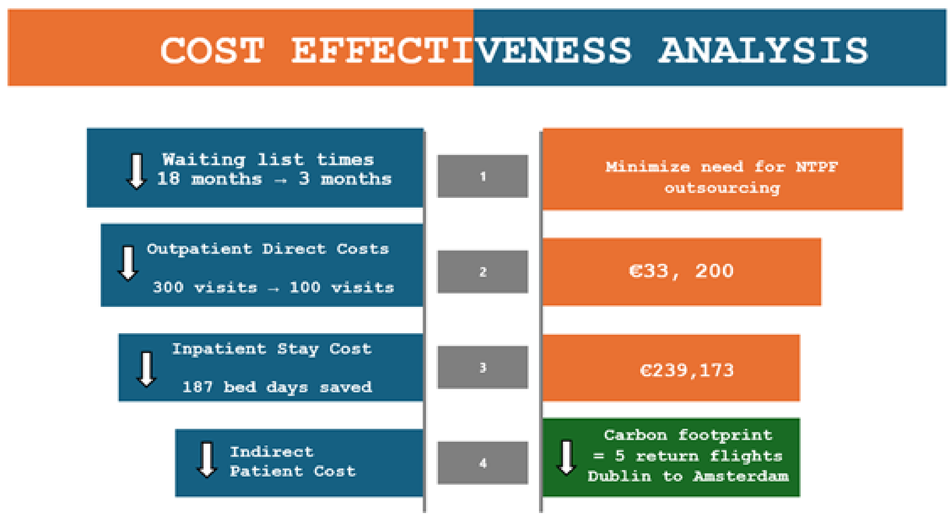
Figure. 1



RESULTS

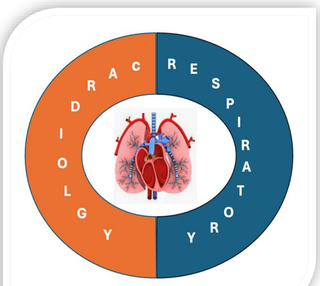
- Reduction in Out-Patient Department (OPD) wait times from 18 months to 3 months.
- OPD appointments reduced by 200, resulting in savings of €33,200.
- Reductions in Emergency Department presentations and Hospital admissions (187 Bed days) resulting in savings of approximately €239,173.
- Patient travel time reduced with a resultant carbon footprint reduction of 906.085 Kg CO2e/Km (equivalent to 5 return flights from Dublin to Amsterdam).





FUTURE STEPS

- Development of a combined cardiopulmonary rehabilitation program for patients with coexisting heart failure and COPD.
- Establishment of an Oxygen Assessment Clinic for both ambulatory and long-term oxygen therapy.
- Integration with the Palliative Care Team for symptom management and advanced care planning.
- Local-level pilot expansion.
- Blueprint design for the Clinic.
- Development of a patient experience questionnaire.



CONCLUSION

Physicians treating comorbid cardiorespiratory disorders face several diagnostic and therapeutic challenges. Addressing these issues requires interdisciplinary collaboration for effective diagnosis and therapeutic interventions. Establishing effective teamwork and joint care pathways is therefore crucial for improving patient outcomes. Our solution involved implementing an integrated care model for managing those with co-morbid CVD and COPD in a community based setting. Our clinic has proven to be service user friendly, financially effective and has advantages of environmental sustainability. Such clinics can also be rolled out at a national level.

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TAKE THE FUSS OUT OF FUSSY EATING: A MONTHLY WEBINAR FOR PARENTS

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Background

- Fussy eating (also known as picky eating or faddy eating) is a general term used to characterise an unwillingness to eat familiar foods or to try new foods. Fussy eating most commonly begins in early toddlerhood (12 to 24 months) and can be seen as being a normal stage of development.
- Many studies have shown that the majority of children will outgrow fussy eating without needing medical intervention.
- Despite this, fussy eating has been shown to cause significant parental anxiety and have a negative impact on family mealtimes. This anxiety may prompt the use of coercive feeding practices of pressure to eat or using rewards as incentives to eat. These strategies are not conducive to food acceptance and may prolong or worsen the picky eating behaviour.
- Dietitians are appropriately qualified to deliver education to parents on the management of fussy eating. Dietetic interventions have traditionally been delivered in a one to one setting or via in-person groups.
- The Health Service Executive has committed to increasing digital transformation to meet the needs of service users, with increased use of telehealth being a key area for expansion.
- This project aimed to assess the feasibility and acceptability of delivering first- line advice for the management of fussy eating via a webinar delivered by dietitians.

Methods

- A video of two dietitians discussing the topic in an informal way was recorded. The webinar was called ‘Take the Fuss out of Fussy Eating’.
- The content covered the following areas: introduction and definition of fussy eating: causes and development of fussy eating: identifying when to worry: handling mealtime challenges: encouraging acceptance of new foods: avoiding counterproductive techniques: challenges outside the home: nutritional concerns and supplements: managing parental stress and expectations: conclusion and resources.
- Thirteen webinars were held over the first year, at various times of day and evening. Webinars were held once monthly, with the exception of April 2024, when two webinars were held.
- Participants signed up to the webinar using the platform Eventbrite, and the webinar was delivered using the Zoom webinar platform.
- Automated reminder emails were sent two days before the webinar, two hours before the webinar and 10 minutes before the webinar.
- A health promotion and improvement officer opened each webinar session. They welcomed the audience and informed them about current health promotion offerings in the region before playing the pre-recorded main video content.
- The webinar did not include a facility for individual questions from viewers.

Results

Webinar Registration and Attendance:

- 3334 people registered to attend the webinar over the course of 12 months. Registration numbers for the webinar series steadily increased over the first year of implementation, from 23 for the first webinar in July 2023 to 480 in June 2024. Registration for the webinar increased dramatically after a 1 week paid advertisement on Facebook and Instagram in March (Figure 1).
- Sixteen percent of those who registered identified that they were as either a “health care professional” or a “healthcare professional and a parent”. The remaining 84% were parents.
- A total of 963 people attended the webinar over the course of the 12 months. The average attendance rate each month (attendees as a percentage of signups) was 34% (range 12.8-56.9%) (Figure 1). Viewer retention (as measured by the number of viewers still online at the end of the webinar) averaged 95%.

Participant Feedback:

- 84% reported that they would recommend the webinar series to other parents or caregivers facing similar challenges with fussy eating. Most (70%) reported that they felt more reassured about fussy eating.
- Seventy-three percent indicated that that they would change their parenting practises to manage fussy eating after watching the webinar.

Results cont.

Thematic Analysis of Feedback:
Thematic analysis of the open question which asked participants to share the main message they took from the webinar revealed 5 main themes.

1. Reducing pressure and stress at mealtimes A significant theme that was identified from the responses was the emphasis on reducing pressure and stress during mealtimes. Many parents highlighted the importance of not forcing children to eat, creating a relaxed atmosphere, and avoiding negative feedback.
2. Continued exposure to new foods Another prominent main message that participants took was around the importance of repeated exposure foods without applying pressure.
3. Reassurance and patience Reassurance was also a key take home message for participants. Many expressed that they were comforted by knowing that fussy eating is often a normal phase.
4. Positive mealtime environment many participants took on the message about creating a positive mealtime environment. The webinar included information about practices like family-style meals, role modelling, and making mealtimes enjoyable rather than a battleground.
5. Practical strategies and tips Some participants took away messages about practical strategies, such as involving children in food preparation, using games to make mealtime fun, and offering a variety of foods without making a fuss

Figure 1: Numbers registered and attendees per month for first year of webinar.

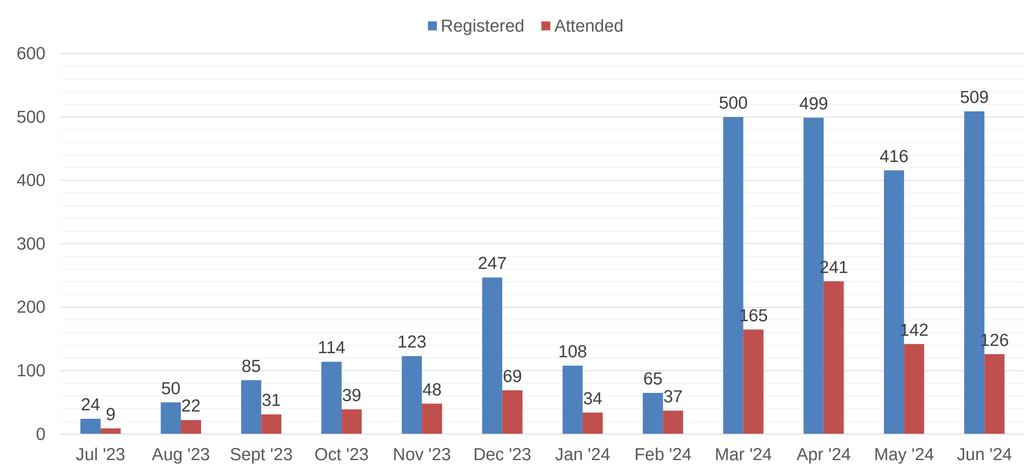
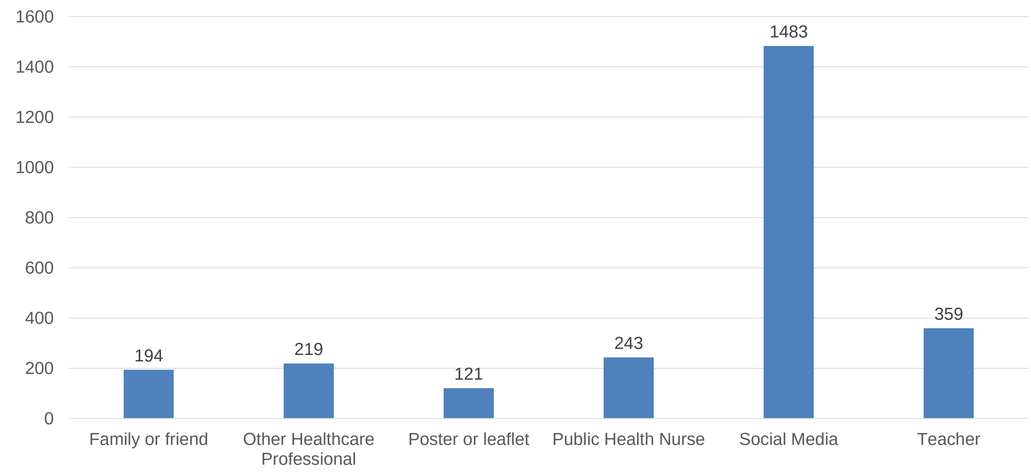


Figure 2: Source of information about the webinar for registrants.



Conclusion

This impactful yet lean digital solution to support parents with fussy eaters is the first of its kind in Ireland. Providing a live webinar encourages attendance and allows signposting to other relevant services. The methodology for this project is readily transferable to other areas of healthcare where first line information sharing is required.

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Experience of a Waitlist Validation Initiative in a CDNT

Eve Wardick Social Care Worker **& Kate Rabbitte** Senior Psychologist, **Finglas CDNT.**

Since the transition to PDS, the Finglas CDNT waitlist waiting time was at **5 years**. There was an urgent need:

1) to validate children to ensure they meet criteria for the CDNT.
2) to understand the needs of children on the waitlist in order to inform waitlist initiatives.

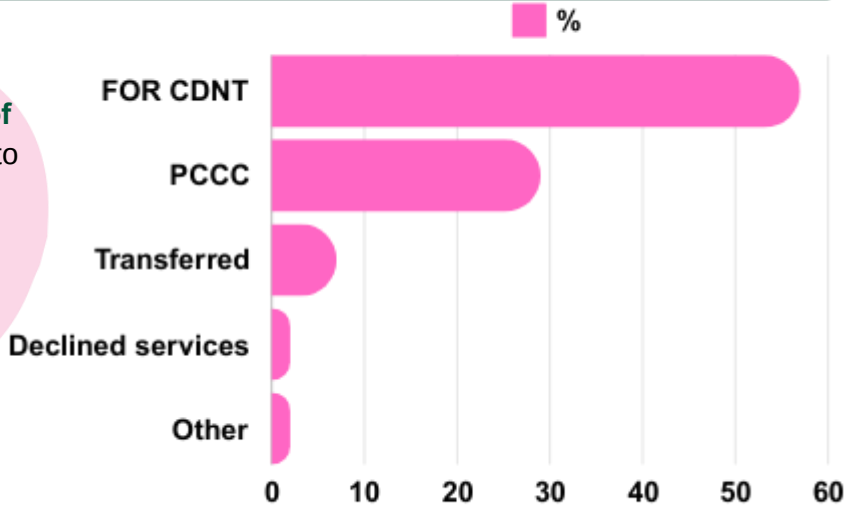
Methodology:

A **database** was developed with all families on the **waitlist referred from 2017 to 2023**.
A process was established:

- Development of an information gathering tool to complete validation calls.
- Development of a script to support staff to communicate effectively with families.
- 1 staff member allocated lead over the initiative
- Allocation of waitlist calls to team members.
- Development of letters to support families who were not contactable by phone, did not engage and to support discharges when necessary.
- Development of local resolution forum with PCCC and CAMHS to ensure full implementation of National Access. Policy (NAP) and Joint Working Protocol
- Monthly case discussion meetings to support decision making and highlight priority cases.
- Weekly tracking of data base and check in meetings with administration staff regarding follow ups.
- Auditing of active, waitlist, transferred and discharged files and databases.
- Each family was called by a member of the team, and information gathered about their current needs and strengths. Letters were sent to support families who were not contactable by phone or did not engage. Discussions were held in relation to decision making about appropriate services for the children (CDNT, Primary Care or CAMHS) and to highlight priority cases.

Results:

332 children on the waitlist were validated. **57% of these were for our CDNT**. 29% were transferred to Primary Care, 7% were transferred to another CDNT due to change of address, 1% were transferred to CAMHS, 2% of families declined services and 2% of families did not engage / were uncontactable.



Conclusion:

- The 6 children identified with urgent needs were prioritised and opened immediately.
- Waitlist interventions developed to meet identified needs. These included Hanen / Early Bird / emotional regulation groups / toileting groups / sleep groups etc.
- Universal strategies were provided to families as needed.
- Targeted communication to families for specific needs identified.
- Increased and targeted communication has reduced complaints to the service.
- The waiting list was reduced by 40%.

Through the Waitlist Validation process which incorporated application of National Access Policy and Joint Working Protocol the waiting list reduced by 40%.

Outcomes from a 'proof of concept' Specialist Lymphoedema Clinic in Primary Care

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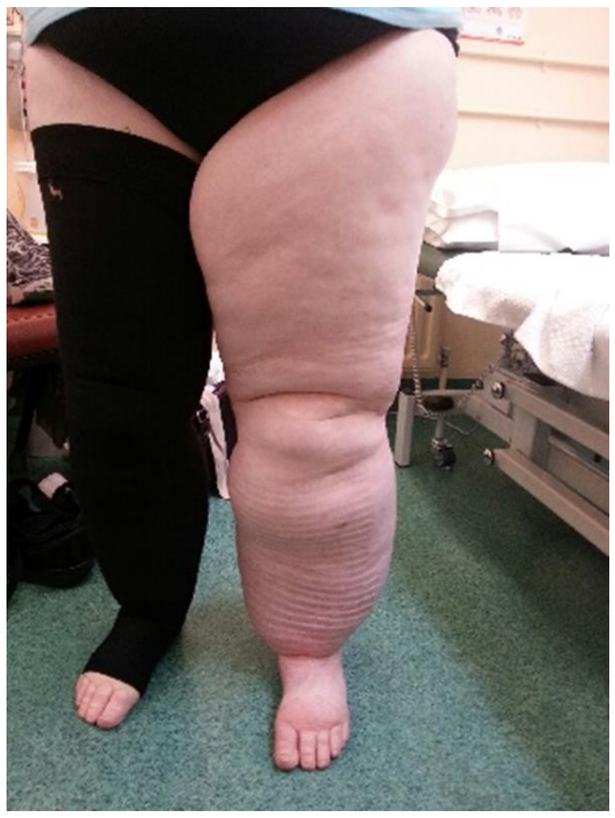
Introduction

Lymphoedema is a chronic, progressive disease affecting an estimated 20,000 people in Ireland. Lymphoedema can have severe impact on QoL including;

- heaviness, achiness, and loss of function.
- increased risk of cellulitis, with a risk of sepsis.
- psychosocial symptoms burden patients with impaired body image, altered social roles
- can affect return to work.



In 2018 the Model of Care (MOC) for lymphoedema and lipoedema was approved providing for a hub and spoke design with Specialist Lymphoedema Clinics (SLC) in primary care.
In 2019 funding was approved for the first proof of concept SLC in one county in Ireland. The SLC is staffed by a senior physiotherapist and a TVN supported by a HCA. The clinic opened in May 2021 and the outcomes from the first year are presented.

Methods

A Minimum Data Set was used to capture demographics and disease information and also outcome measures including;.

- QoL, using the validated LYMPHQoL tool
- Baseline data; GP visits, PHN visits, cellulitis and associated hospitalisations from the year prior to starting treatment.
- HSE patient satisfaction survey

Data was collected on assessment, 6 months and 12 months,
137 patients completed the 12 month review.

Results QoL

The LYMQOL quality of life measure was used which is specifically for lymphoedema and can also be used for lipoedema. The questionnaire covers 4 areas: symptoms, body image, function and mood and is scored 0-5, 0 the least impact and 5 the highest.
All areas in the QoL had improved with symptom reduction having the biggest impact.

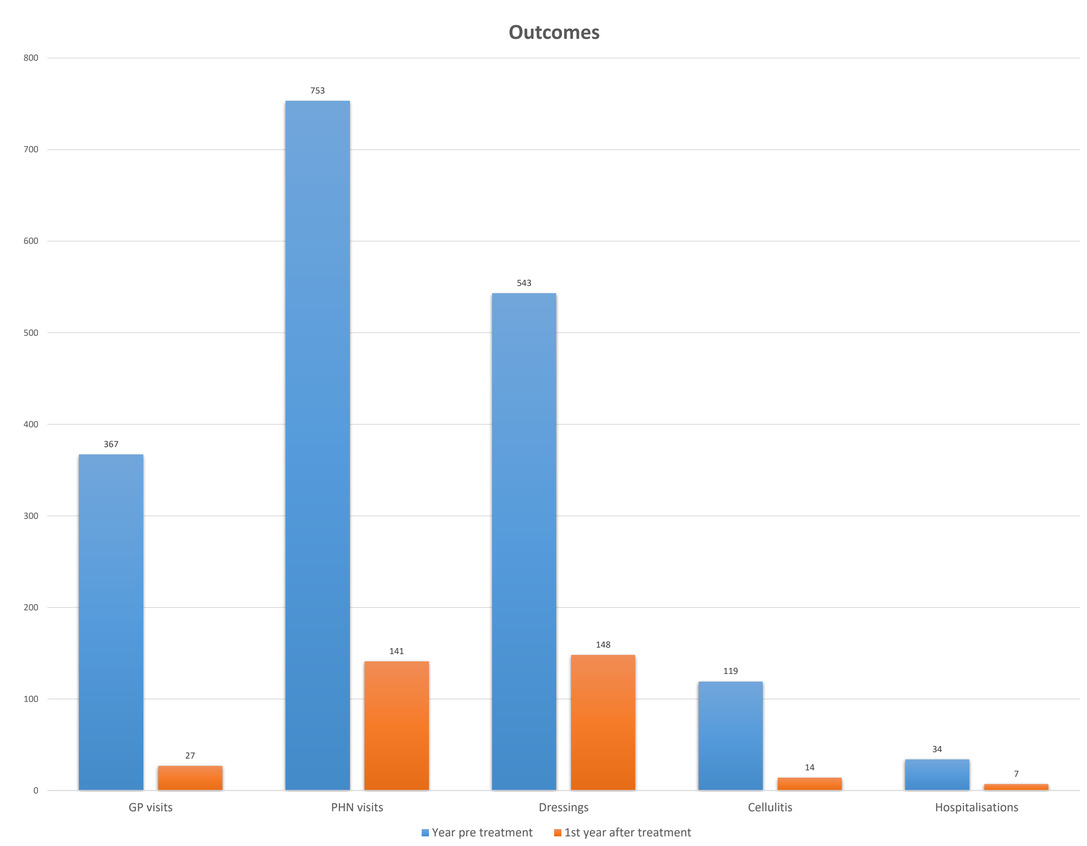
Area	Pre treatment	12 months
Symptoms	2.57	2.10
Body Image	2.6	2.36
Function	2.52	2.08
Mood	2.46	2.12

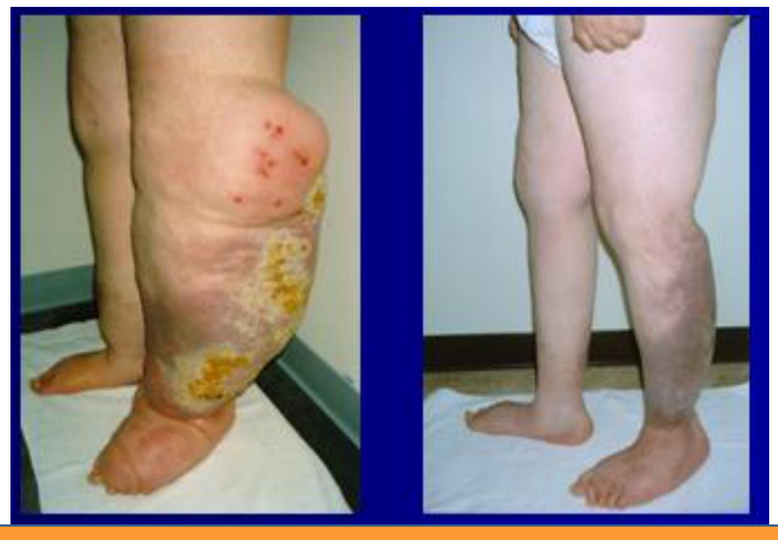
Patient satisfaction was 89% excellent

Results after 1 year following treatment

137 patients were reviewed after 1 year.

- **93% reduction in GP visits,**
- **81% reduction in Public Health Nurse visits,**
- **88% reduction in cellulitis and**
- **80% reduction in associated hospital admissions.**





Cost savings

Total cost of the clinic for 1 year was €181,905,
estimated cost savings were €361,868

	Costs 1 year pre treatment €	Costs 1st year after treatment €	Cost Savings €
Episodes of cellulitis not requiring hospitalisation (€150)	12,750	1050	11,700
Episodes of cellulitis requiring hospitalisation (€11,319)	384,846	79,233	305,613
GP Visits (€48)	17,616	1,296	16,320
PHN visits (€30)	22,590	4,230	18,360
Dressings (€25)	13,575	3,700	9,875
Total	**451,377**	**89509**	**361,868**

Conclusion

Dedicated lymphoedema services are essential to improve patient outcomes, prevent detrimental side effects and provide value for money for the health service. The SLC are self funding with potential estimated cost savings of €179,963 annually.
The one-year findings strongly support the roll-out of SLCs in primary care to all regional health areas; improving access to services, patient QOL and efficiencies for the health service..

Delighted to have such a fantastic resource on my doorstep