Enhanced Community Care

Improving access for individuals within the catchment area of Tallaght Chronic Disease Hub waiting for specialist obesity care at St Columcille's Hospital Centre of Obesity Management

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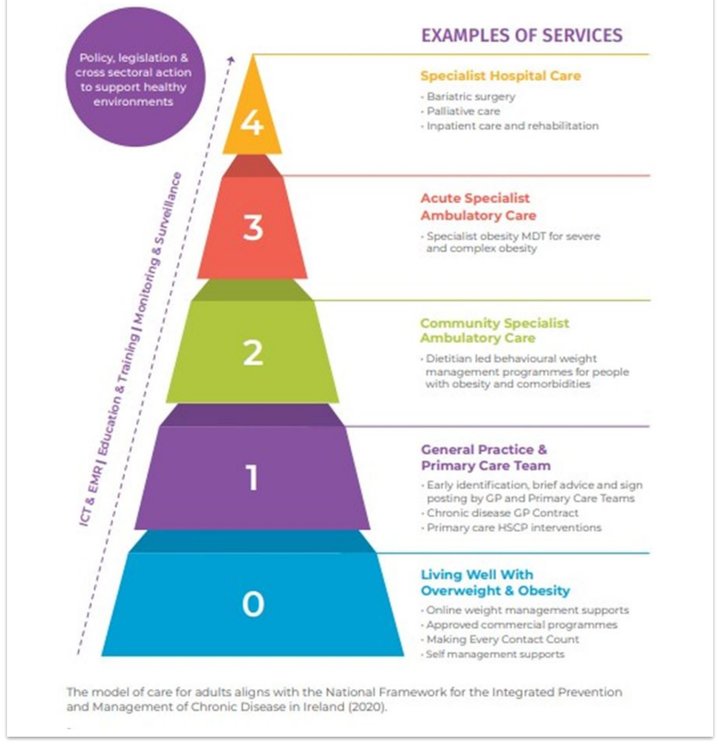
[1]HSE Obesity National Clinical Programme [2]Centre for Obesity Management, St Columcille's and St Vincent's University Hospitals [3]Community Healthcare Dublin South, Kildare and West Wicklow [4]HSE Self Management Education and Support Office

PROJECT BACKGROUND

The Model of Care for the Management of Overweight and Obesity sets out the levels of care needed for obesity prevention and treatment



- At level 2, Best Health is a dietitian-led self-management education and support (SMES) obesity management programme delivered within Chronic Disease (CD) Hubs.
- At levels 3 & 4, St Columcille's Hospital Centre for Obesity Management (SCH COM) is a multidisciplinary, hospital-based service for complex obesity, providing medical and surgical management.
- High demand for SCH COM service means that some individuals face long waiting times over 48 months.

AIMS AND OBJECTIVES

The aim of this project was to identify and offer earlier community-based obesity interventions to individuals based in Tallaght Chronic Disease Hub catchment that are waiting >48 months to access specialist care in SCH COM.

Objectives:

1. Identify individuals on the waiting list for SCH COM that are suitable for Best Health
2. Develop a process for transferring information from the hospital to community & resources to support the process
3. Understand the characteristics of individuals on the SCH COM waiting list

ACTIONS AND TASKS COMPLETED

- Project oversight was provided by a steering group that met monthly over 12 months and included all relevant stakeholders across hospital, community and national settings.
- A pathway was agreed outlining the key actions and patient flow from hospital to community
- Resources were developed to support the pathway: templates, letters to GP, information for patients
- Individuals waiting > 4 years on the SCH COM list were telephoned by the COM advanced nurse practitioner (ANP).
- A screening template was used to assess the patient against referral criteria and consent to attending Best Health.
- Best Health referrals were completed and transferred electronically to the chronic disease hub
- Patients remained on the waiting list for SCH COM while they attended Best Health.
- Patients underwent a 1:1 assessment and group enrolment with the community dietitian

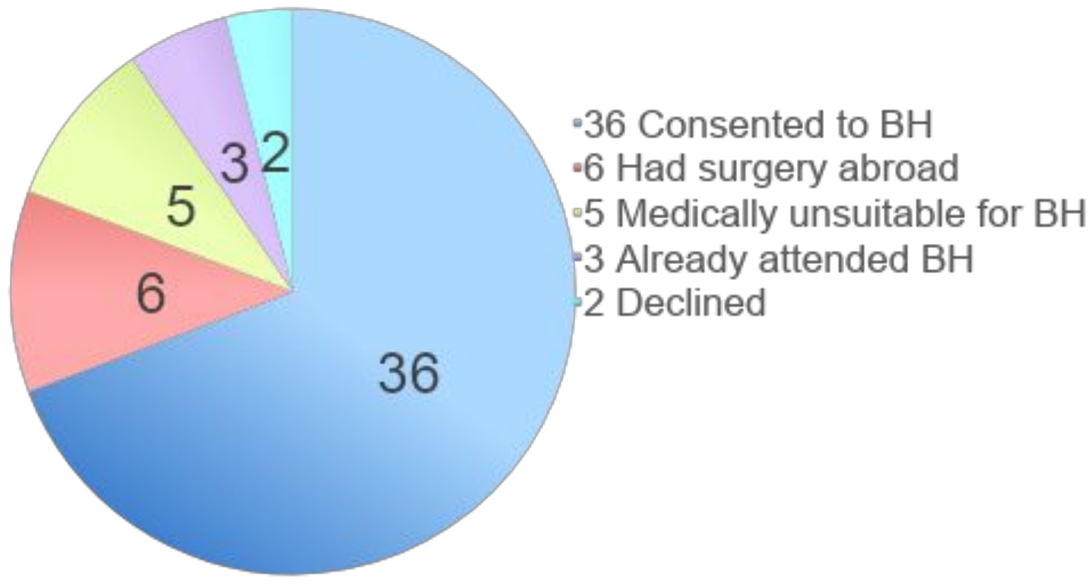
STAKEHOLDERS

A steering group was established to develop this pathway, including the following representatives:

- Dietitian Manager
- Chronic Disease Hub Manager
- GP Network Lead
- SCH Consultant
- SCH Advanced Nurse Practitioner
- Obesity National Clinical Programme
- Self Management Education and Support Lead
- Integrated Care Consultant

RESULTS

- 52 individuals form the SCH COM waiting list were contacted by the ANP.



- 69% of those contacted met the criteria and consented to Best Health. They were offered a 1:1 assessment in the CD hub.
- Six (11%) people had underwent surgery abroad. Five (10%) were medically complicated and not suitable for Best Health. Three (6%) had already attended Best Health in their community. Two (4%) declined to participate in Best Health.
- Letters were sent to the GP informing them of the process.
- Patients were assessed by the community dietitian in June 2024 and will start Best Health in September 2024.

LEARNINGS

The majority of contacted met the criteria for community care and consented to attend. Community programmes do not replace specialist care, but can provide access to multidisciplinary designed, dietitian led, self management education and support while patients are waiting. Development of integrated pathways between hospital and community settings fosters good working relationships, shared learning, improved care and efficient use of resources. Next steps are to evaluate the outcomes and effectiveness of the pathway.

ACKNOWLEDGEMENTS

To the clinical staff that worked on this project on top of their clinical caseloads. Also the stakeholders that contributed to developing the pathway and collaboration between hospital and community sites. Contact details: Karen Gaynor, Programme Manager Obesity National Clinical Programme (Karen.Gaynor@hse.ie)

Investigating staff feedback - Community Healthcare Network Implementation

Presented by: D Tyner (CHN Manager) Community Healthcare East dawn.tyner@hse.ie , K Walsh (CHN Manager) Community Healthcare East kathy.walsh1@hse.ie , F Hammond (General Manager, Primary Care CH East) fiona.hammond1@hse.ie

Introduction

- Staff engagement, communication and evaluation plays a pivotal role in any change initiative within the HSE
- To support the CHN implementation across the Wicklow CHNs in CH East, regular staff input was sought to inform the local population based priorities, challenges and opportunities afforded by the new structures.
- Evaluation of collated feedback has framed the pathway pre, during and post implementation CHN8 (Southeast Wicklow) and CHN7 (Northeast Wicklow).

Aim:

To support Community Healthcare Network implementation in CH East Networks 8 & 7 through staff engagement by capturing the lived experience of the change programme within the multidisciplinary team across a two phase review and planning process.

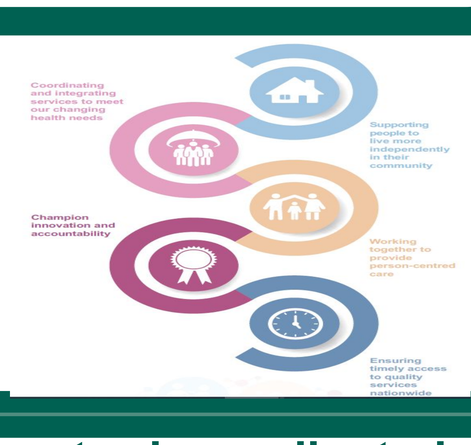
Sláintecare.

Project Objectives

- Empower CHN multidisciplinary team staff members by offering a voice in the implementation of the CHN structures
- Provide an opportunity for CHN multidisciplinary team to feedback on structures and processes implemented and to shape the shared vision and goal of the CHNs in Community Healthcare East
- Use Framework for Quality Improvement tools incorporating improvement tools and staff engagement to support local CHN implementation.

Methodology

- Staff surveys undertaken as part of CHN8 Southeast Wicklow Learning Site pre/post Go Live in September 2021
- Further role in stakeholder engagement for CHN7 Northeast Wicklow pre/post Go Live March 2022
- Online anonymous survey open to multidisciplinary team across CHN8 and CHN7 Wicklow January 2023
- Repeated survey in June 2024
- QI framework and Change Guide principles– PDSA cycles to test and refine implementation
- Lived experience team members pre/post implementation of CHN structures with focus on 5 key goals
- Results analysed and presented to teams to support development of shared vision, values, goals and plans



2023 Survey Feedback – Operational Focus

- Duplication of reporting process – Therapy Manager and Network Manager
- Competing demands on clinical time – uni versus multidisciplinary focus
- Lack of clarity re roles and responsibilities with 2 Managers
- Unclear benefit of Clinical Team Meetings
- Limited access to administration support for clinical teams

2024 Feedback – Client centred coordinated care

- Improvements in coordination of care, MDT working, complex case management and cross division engagement
- Challenge noted re lack of integrated ICT system
- Significant increase in referrals, increase in complexity of presentations, impact of recruitment pause on client care
- Enhanced collaboration with GPs, development of referral pathways
- Cross discipline timely problem solving and shared learning
- Emerging gaps identified across divisions/within Primary Care

2023 Actions

- Reduction in communications and clear reporting processes implemented
- Support for clinicians to balance competing demands
- Clear reporting matrix developed following testing of CHN dual reporting model
- CHN8 CTM project developed suite of documentation and role of Clinical Coordinator - implemented
- CHN8&7 project with Area Administration team to streamline equitable access to administration support

2024 Actions

- Focus on client journey – early identification and access to appropriated level of care
- Opportunity to advocate for areas where gaps in service identified e.g. pathway for Under 65 disability clients
- Disparate waiting times/lists across MDT – opportunity for cross discipline initiatives
- Cross service/division complex case management development
- Patient/Service user engagement forum development

Next Steps in CHN8&7 Community Healthcare East

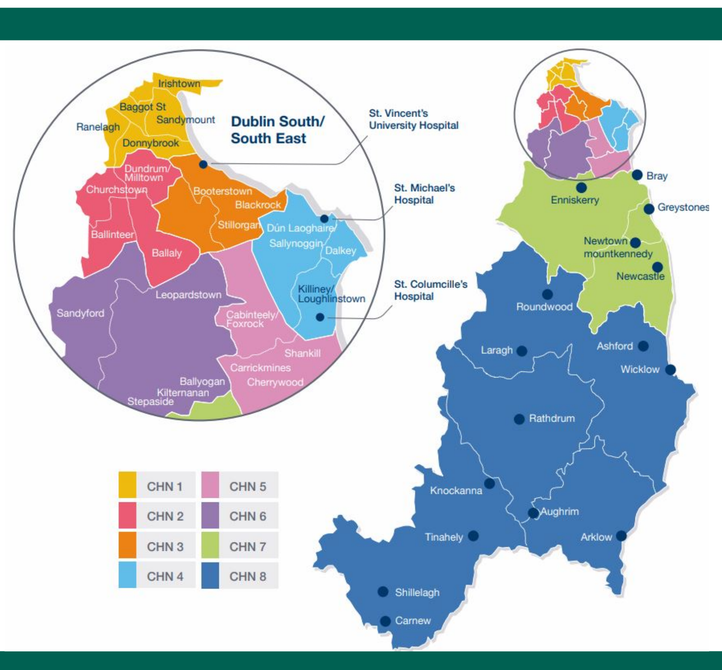
Areas Identified for 2024/2025 Focus

Recruitment and Retention:

- Supporting safe staffing ratios across disciplines to support timely access to care
- Work to translate positive impact of CHN implementation from team members to clients
- Key areas identified for recruitment – Social Work and Podiatry

Improved Efficiency and Effectiveness:

- Quality improvement initiatives focused on key ECC enablers such as ICT solutions
    - Integrated paperless referral, appointment, client tracking system
- Streamlined, equitable access to administration support to maximise clinical efficiencies
- Focus on client journey across disciplines, divisions and services within the new Regions



Integrated Healthcare: Advancing Health Service Reform Conference

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Acknowledgements: Multidisciplinary Team members CHN8 Southeast Wicklow and CHN7 Northeast Wicklow Community Healthcare East , GP Leads CHN8 and CHN7, CHN Administration Coordinators, Therapy Managers and Principals in CHN8 and CHN7, Head of Service Primary Care Community Healthcare East, General Manager Primary Care

References: Slaintecare Implementation Strategy: https://www.gov.ie/en/publication/6996b-slaintecare-implementation-strategy-and-action-plan-2021-2023/
Enhanced Community Care: https://www.hse.ie/eng/services/list/2/primarycare/enhanced-community-care/
HSE National Service Plan 2023: https://about.hse.ie/publications/national-service-plan-2023/
CH East Operational Plan 2021: https://www.hse.ie/eng/services/publications/community-healthcare-east-operational-plan-2021.pdf
HSE Change Guide: https://www.hse.ie/eng/staff/resources/changeguide/
HSE QI Toolkit: https://www.hse.ie/eng/about/who/nqpsd/qps-education/quality-improvement-toolkit.html
CHNs: https://www.hse.ie/eng/services/list/2/primarycare/community-healthcare-networks/
HSE Framework for Quality Improvement: https://www.hse.ie/eng/about/who/qid/framework-for-quality-improvement/framework-for-improving-quality-2016.pdf

REDUCING MENTAL HEALTH ADMISSIONS TO A & E

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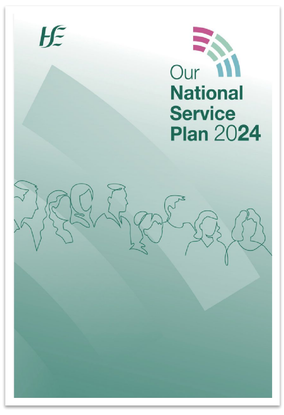
INTRODUCTION

This pilot initiative was developed by the Community Health Network (CHN) 2 & Psychiatry of Later Life (POLL) Kilkenny with a goal to improve access to mental health services and reduce acute episodes of care presenting at St Lukes, Kilkenny A&E.

Background:

- A significant percentage of people over 65 attending A&E were found to attend with acute mental health needs. Resulting in inappropriate hospital admissions.
- On a review of this cohort it was identified that a significant number were living in one geographic location in CHN2.
- POLL & CHN2 Team developed a working pathway to access this client group before A&E admission.
- A pilot initiative was developed to improve access to mental health services and reduce acute episodes of care presenting at St Lukes, Kilkenny A&E.
- This initiative is a referrals pathway from the primary care team meetings; established June 2024.



HOW DOES THE INITIATIVE RUN?

- The initiative is a referral pathway chaired by the primary care clinical coordinator at monthly clinical team meetings (CTM).
- Primary care clinicians, GP and PHNs can highlight clients at risk in the community at the CTM and the primary care clinical coordinator will facilitate the team discussion to identify if they meet a pre-set criteria for referral to POLL. This can be done in live time at the CTM.
- This supports clients to have access to the right care, right place, right time, in keeping with Sláintecare vision.

Sláintecare
Right Care. Right Place. Right Time.

- The aim is to have clients known to the appropriate service so their needs can be met before an acute episode of care is required. Good mental health is key to good physical health.

Requirements for Replication:

Governance	Staffing	Other
Primary Care – CHN Manager	CHN Manager	Monthly CTMs
POLL – POLL Psychiatrist	POLL Psychiatrist & Team	POLL attend CTM and inducted on their role and service to ensure the right people were targeted.
Referral criteria and pathway supplied by POLL	Primary Care Clinical Coordinator	
National Consent Policy for information sharing.	Network Primary Care Clinicians, GPs & PHN	

RESULTS

- New referrals accepted into POLL service via Primary Care Clinical Coordinator at CTM = 100% of referral sent.
- Information sharing between Primary Care & POLL has been established though the use of The National Consent Policy pathway and explicit consent from the individual discussed at CTM.

- At risk clients are now being flagged to POLL via Primary Care Clinical Coordinator at CTM meeting for reviews also. In 2 specific cases these have blocked an acute hospital admission.
- POLL can attend the CTM as required to flag appropriate clients to the Network Primary Care Clinicians, GPs & PHN
- Heightened awareness of mental health needs the at CTM.
- More timely and local access to POLL services is being recognised and actioned.

CONCLUSION

- We are **successfully integrating our services to offer appropriate access** in a timely and local delivery model; with the added benefit of utilising existing systems.
- We are working towards Sláintecare vision and The World Health Organisations Sustainable Development Goal 3, Good Health & Well-Being

SUSTAINABLE DEVELOPMENT GOALS

3 GOOD HEALTH AND WELL-BEING

Opportunities for Scaling & Next Steps:

- Auditing the number or referrals from the CTM & reviewing if there has been a decrease in Mental Health Admissions in A&E (Following 1 year of services)
- Rolling out to the other 2 PCT in CHN 2
- Expanding to CHN 1 & 3
- Offers a links to develop further opportunities with under 65s Mental Health Services and supporting our Primary Care Clients to access there services in a new format.

HSE HEALTH REGION & LOCATION

HSE Dublin & South East.

Thomastown Primary Care Centre,
Community Health Network 2,
Lady's Well,
Thomastown,
Co. Kilkenny.
R95 T3FW

Is there a Solution to lengthy hospital stays for Nursing Home residents? WICOP are virtually there.

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Summary:The establishment of a Virtual Ward within a Nursing Home Liaison Service marks a substantial stride in integrated care for Nursing Home residents. By integrating remote telemetry with a Virtual Ward platform, supported by a specialised Nursing Home Liaison team, the service endeavours to facilitate Early Supported Discharge for residents of Nursing Homes. An evaluation, carried out via a Simulation Laboratory and employing both quantitative and qualitative research methodologies, has offered valuable insights into its efficacy. Encouraging and positive feedback from clinicians and stakeholders regarding the Virtual Ward reinforces its value.

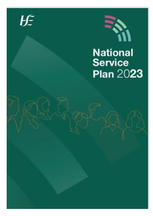
Background

HSE Strategy

- ✔ "Making a start in Integrated Care for Older Persons" (HSE, 2017) and the "Covid 19 Nursing Homes Expert Panel Report" (HSE, 2020) both outline the need for a specialist Nursing Home service provided by the HSE.
- ✔ eHealth Strategy (2013). Bringing improved population wellbeing, health service efficiencies and economic opportunity through the use of technology-enabled solutions.
- ✔ HSE National Service Plan (2023) outlines a commitment to digital technology and innovation.
- ✔ Best Practice Review of ICT Enablement of Older Persons Services (HIQA, 2021)

Research

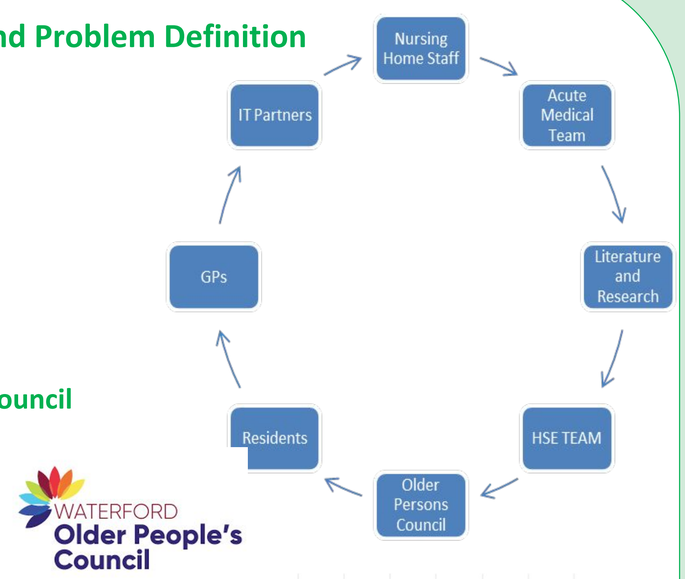
- ✔ According to Brucksch et al, (2018), Nursing Home residents are likely to be transferred to the Acute setting which is associated with adverse events and functional decline.
- ✔ Research has also shown that almost one in three admissions are potentially avoidable, especially those relating to infections or heart failure (Zuniga et al., 2022).
- ✔ Previous studies demonstrate Nursing Home staff expressing a preference for continued telemedicine post-COVID-19 (Ford et al., 2022).
- ✔ Hospital at Home is acknowledged as a cost-effective alternative to traditional hospital admissions for older individuals (Singh et al., 2022).
- ✔ Increased telemedicine usage correlates with heightened provider satisfaction indicating provider receptiveness to telemedicine's role in enhancing patient care. (Perri et al., 2020)



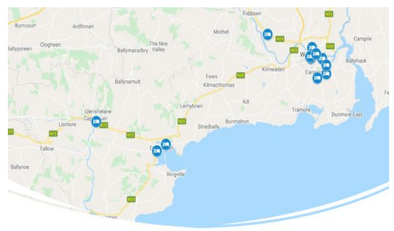
Engagement and Problem Definition

Name: Marty
Age: 84
Home: Nursing Home resident
Lifecourse: Retired farmer
Connectivity: Mobile device

- Stakeholder Engagement
- Persona Development
- Population Profiling
- PPI – Residents and Older Persons Council
- Iterative Process
- "How can we help"

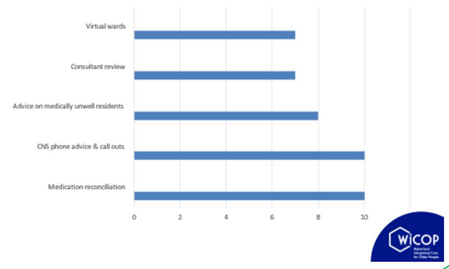


WATERFORD Older People's Council



Our Population

- Waterford County population: 130,000
- Population over 65 years old: 21,000 (16%)
- Nearly 1,000 nursing home residents

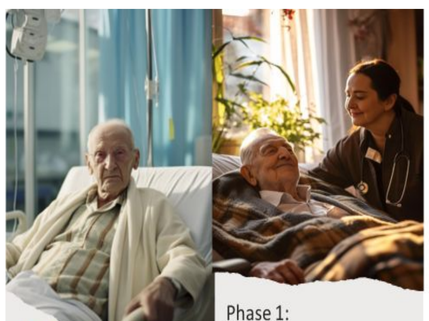


Problem Identified

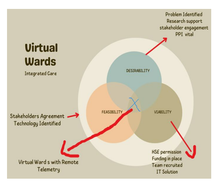
- ✔ An audit of the admissions data in University Hospital Waterford (UHW) found that the number of admissions to UHW form Waterford Nursing Homes in 2022 was 447 with an average LOS of 11.6 days (0.5-112) resulting in a total of 5,521 bed days. These appears to be higher than the research average.
- ✔ **Early Supported Discharge welcomed by hospital and Nursing Home staff and residents – Phase 1**
- ✔ Appetite for an alternative to hospital admission – **Phase 2**
- ✔ "Would be very good for dementia patients so they don't have to move setting". Older Persons Council.
- ✔ "If there was anyway I didn't have to go to the hospital, that would be my choice. Staying here would be much better". Nursing Home resident Killure Bridge Nursing Home

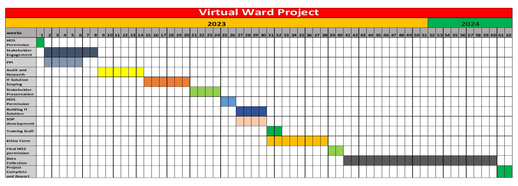
The Solution

Introducing Virtual Ward technology, alongside a dedicated Nursing Home Liaison Team, to revolutionize patient care.
By utilising bluetooth remote telemetry and a Virtual Ward platform for monitoring residents who are unwell, this innovative approach will enhance the admission avoidance and early supported discharge model of care. **Phase 1** will focus on **Early Supported Discharge** to reduce length of stay in hospital.



Pathway to Implementation





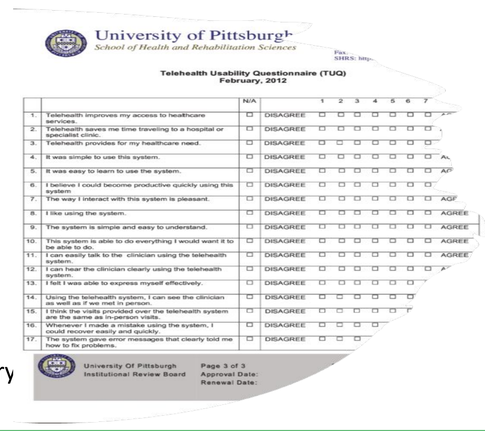
STUDY TITLE: "The feasibility of using a Virtual Ward platform in a Nursing Home Liaison Service in Waterford Older Persons Service (HSE)"

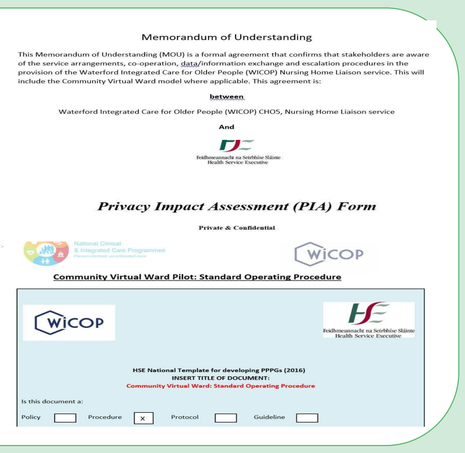
STUDY AMENDMENT STATUS: APPROVED

Dear Mr. Coen,

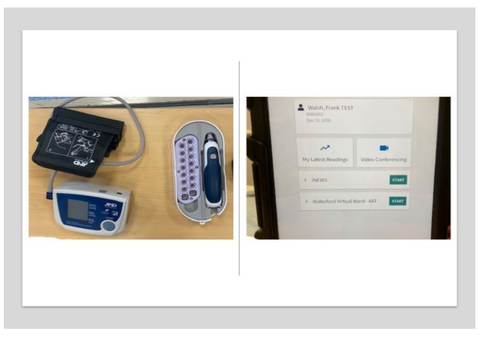
The Research Ethics Committee Chairperson, REC, HSE, South East reviewed the above study amendments to the Protocol, Consent Form and Participant Information Leaflet to include the provisions for the use of a Simulation Lab, semi-structured interviews, and debriefing sessions following simulation training.

- Continued communication with stakeholders
- Action Design Research approach
- Develop a project plan
- Ensure we have insurance and ethical approval
- Investigate an appropriate evaluation tool.
- Create a Standard Operating Procedure
- Create a Memorandum of Understanding with Nursing Homes
- Sign a Data Protection Impact Assessment
- Secure HSE Head of Service approval
- Test and evaluate the Virtual Ward in the Simulation Laboratory
- Launch Virtual Ward



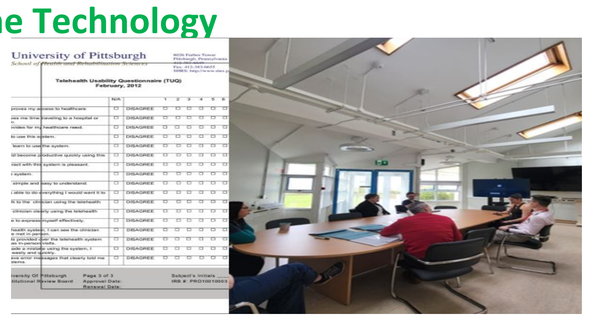


Testing the Technology



Tunstall Technology – My Kiosk, ICP Triage Manager and bluetooth remote telemetry

WICOP Simulation Lab – Nursing Home patient scenarios completed with 12 clinicians using the Virtual Ward technology prior to going LIVE

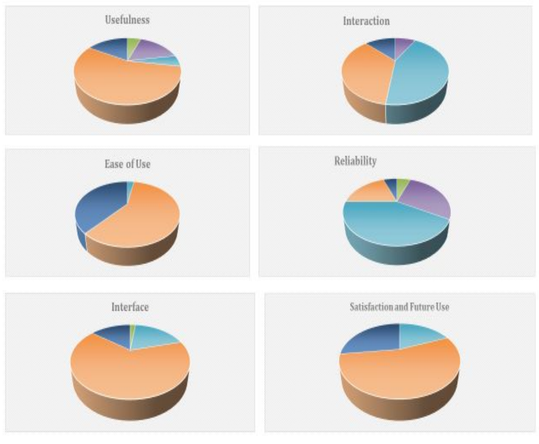


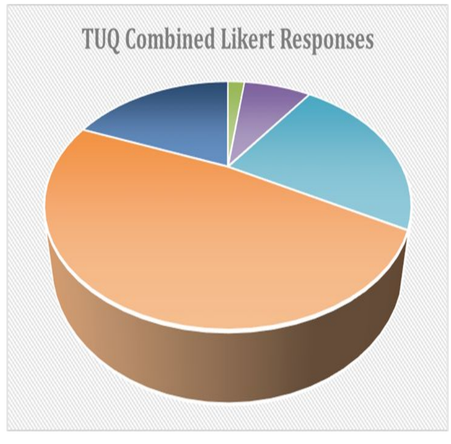
Quantitative evaluation through the *Telehealth Usability Questionnaire (TUQ) and qualitative evaluation through the debriefing sessions
*Paramento et al.,(2016)

Debriefing Quotes from Simulation Lab participants about the Virtual Ward technology

Results

TUQ Scores (N=12) – Very Positive Feedback – Across 6 Domains



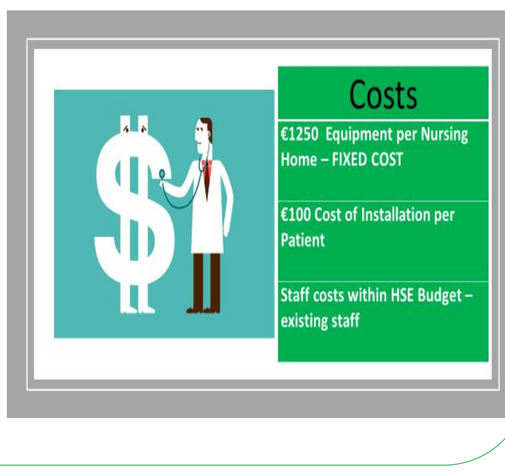


Strongly Disagree	0%
Disagree	0%
Somewhat Disagree	2%
Neutral	8%
Somewhat Agree	23%
Agree	48%
Strongly Agree	19%

Virtual Ward Scores - Median TUQ Likert Scores (1-7) Against Research Benchmark

	Virtual Ward	Hamby, 2022
Usefulness	5.8	5.5
Ease of Use	6.1	5.5
Interface	6	5.5
Interaction	5.5	5.5
Reliability	5	5.5
Satisfaction and Future Use	6.1	5.5

Excellent results

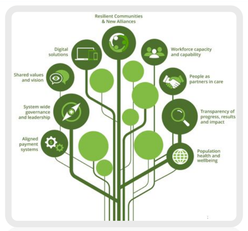


INTEGRATED CARE IN ACTION: A CASE STUDY OF COLLABORATIVE MULTIDISCIPLINARY APPROACH FOR OLDER ADULTS IN IRELAND

Marie Dooley, Clinical Nurse Specialist; Justyne O'Gara, Senior Speech and

Integrated Care Programme for Older Persons

Irish Healthcare Context



The Knowledge Tree Framework Built upon the International Foundation of Integrated Care's nine Pillars of Integrated Care.

Sláintecare is the ten-year programme to transform health and social care services in Ireland, closely aligned with the Knowledge Tree framework.

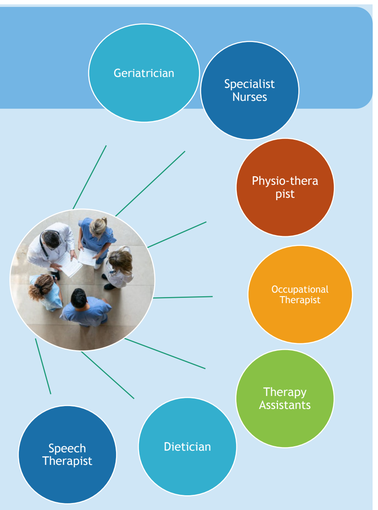
Enhanced Community Care aims to keep older persons in their homes and communities as long as possible with localised specialist community teams.

The National Integrated Care Programme for Older Persons aims to shift the delivery of care away from acute hospitals to community based, planned and coordinated care.

Introduction

Wicklow Integrated care team for older persons (ICPOP) is a specialist community team for frail and vulnerable adults over 65 providing;

- Localised
- Immediate
- Intensive multidisciplinary (MDT) care



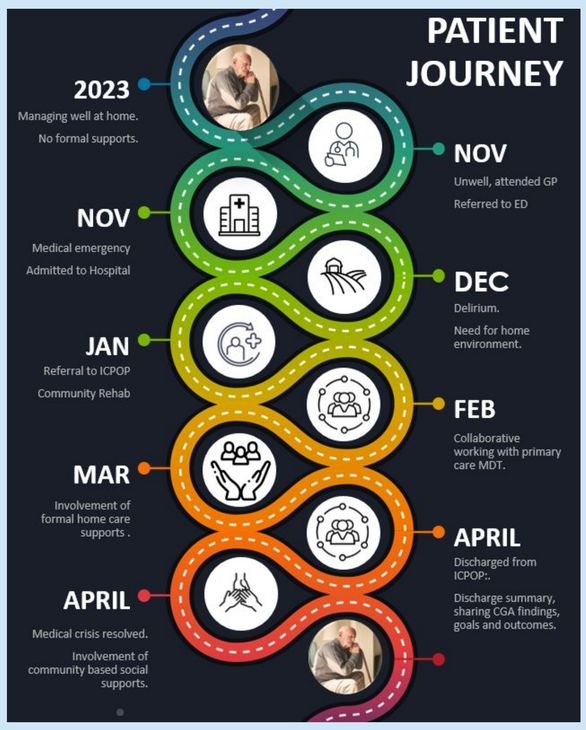
This patient's care journey highlights how health services, agencies and disciplines, once working in silos, are engaging in new ways of working, centring the client in care planning and provision.

In this instance ICPOP offered;

- ✔ Immediate & appropriate care in the home environment
- ✔ A way to expedite the client's discharge home
- ✔ Vital links with local community MDT team

However, the value of ICPOP's intervention can only be realised when there is a foundation of effective communication, trust, shared aims and visions between health and social care professionals across services.

Collaborative Integrated Care



Referred to ICPOP for early supported discharge, the patient was experiencing acute delirium, in the context of a Parkinson's related Dementia.

ICPOP takes a structured approach to assessment and goal setting:

1. Comprehensive geriatric assessment.
2. Establish issues and goals for intervention.
3. Discuss at weekly MDT meeting and establish MDT care plan.
4. Establish if known to primary care and social services.
5. MDT Assessment and Intervention
6. Liaising with stakeholders and onward referral
7. Comprehensive discharge summary report to stakeholders

Foundation of Effective Integrated Care

Effective integrated care relies on many factors of workforce capacity and capability:

Conclusion

What contributed to the effectiveness of this multidisciplinary team?

- ✔ Co-location
- ✔ Common goals
- ✔ Shared vision
- ✔ Shared values
- ✔ Existing relationships
- ✔ Trust
- ✔ AHP's embedded in community teams

What is Needed to improve?

Digital Improvement:

- Shared records
- Access to medical findings

Improved Communication

- Written discharge summary for clients

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Evaluating the role of the Diabetes Prevention Programme in the Tallaght Community Integrated Care Hub.

Peter Curley[1], Nicole Power[1], Lisa Ring[1], Lynda Parke[1], Fiona O'Shea[1], Rachel Sheane[1], Claire Ramsay[2], Gillian O'Loughlin[3]

[1] Tallaght Community Integrated Care Hub, [2] Dietitian Manager, Russell Centre, Tallaght Cross West, Dublin 24

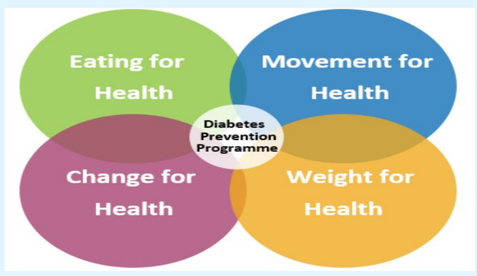
BACKROUND

The Tallaght Community Integrated Care Hub is one of 30 Hubs in the Republic of Ireland established as part of the Enhanced Community Care (ECC) programme. One of the aims of the ECC programme for Chronic Disease Management is to help prevent the development of chronic disease such as Diabetes.

These hubs aim to provide preventative, management and support services to service users through self-management education and support (SMES) programmes. Before establishing these hubs there were no pathways in place to help individuals with pre diabetes.

Since July 2022, the dietetic team have successfully delivered six 12-month Diabetes Prevention Programmes (DPP), with four still in progress. International evidence has shown that those living with pre-diabetes who follow a structured education programmes (similar to DPP) can reduce risk of developing Type 2 Diabetes Mellitus (T2DM) by approximately 60% (1, 2).

The effectiveness and demand for the programmes delivered by the hub has been evaluated.



Methodology

The DPP is for people diagnosed with pre-diabetes (HbA1c: 42-47 mmol/mol) referred into the hub by healthcare professionals (HCP's) (3). The programme supports participants to make sustainable lifestyle changes by adopting a progressive approach to diet, physical activity, weight and changes for health.

The dietitians planned to deliver this programme on a continuous basis, both online and in-person, at local health centres closer to home. The dietitian led programme delivers SMES with 14 group sessions and three 1:1 assessments over a 12 month period.

Prior to the launch of the referral pathway in November 2022 for all general practitioners (GP's) and other healthcare professionals (HCP's) a pilot group of GP's was selected for DPP referrals, beginning in April 2022.

The first programme recruitment phase then commenced; this involved a 45-60 minute 1:1 assessment with the dietitian. Suitable participants were then enrolled on the first DPP in July 2022.

To date six programmes have been completed, four are ongoing with a total of 198 participant's enrolled and 131 group sessions delivered. Data collected includes serum HbA1c, weight and body mass index (BMI) initially and upon completion of the programme. Verbal progress and survey feedback from participants is also collected throughout.

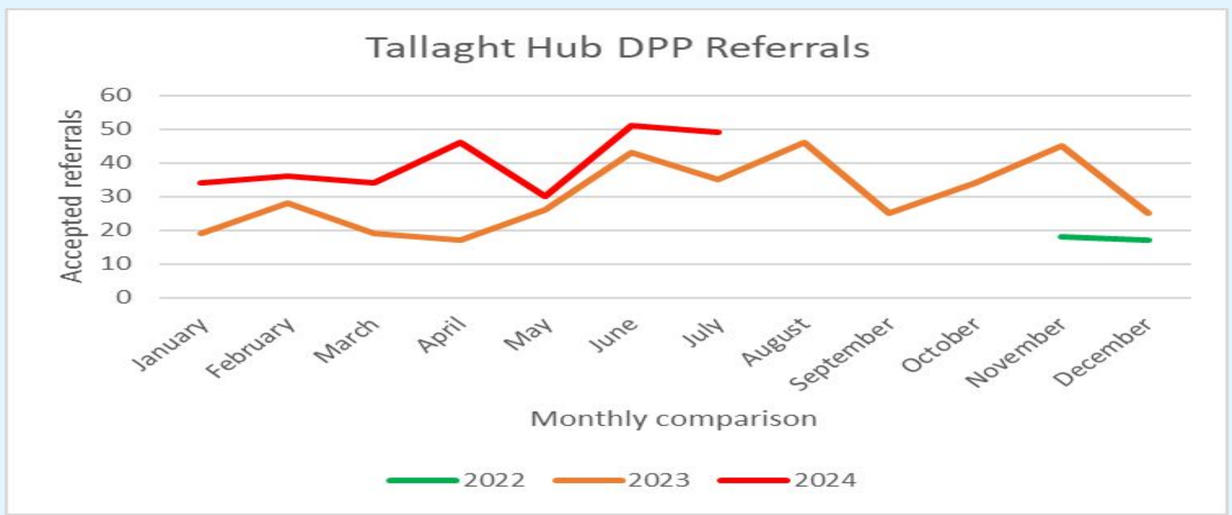
RESULTS

Statistics collected from the programmes show that of those participants with repeat HbA1c, 96% (n=74) have avoided developing T2DM, of which, 25% are below the pre-diabetes range and 60% have reduced HbA1c levels.

Data on recorded weights for participants showed of those who completed programmes 66% (n=36) achieved an average weight loss of 7.3%. However not all participants enrolled onto the programme will have weight loss goals as part of their individual plans as 28% of initial BMI's recorded were below 30kg/m^2.

Referrals for DPP have increased: 89 (2022); 362 (2023); 233 (2024 to date). Average waiting times for an initial assessment have increased from 18 weeks summer 2023 to 28 weeks in summer 2024.

96% Diabetes Prevention	66% Weight loss	18 weeks Waiting time 2023
25% Normal HbA1c	7.3% Average weight loss	28 Weeks Waiting time 2024



CONCLUSION

The programme provided by the dietetic team in the Hub demonstrates that prevention programmes can successfully prevent or delay T2DM for participants who complete them.

The programme has facilitated participants in areas such as achieving healthier eating habits, healthier weight and improvements in lifestyle related behaviours. Increased referral numbers highlight growing demand for these services.

Due to an increase in referrals, without any increase in staffing, waiting times have grown. Future research will need to assess the impact of increasing waiting times on patient outcomes and experience. Group recruitment and group delivery processes will also need to be reviewed to ensure a timely and efficient delivery of service.

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ACKNOWLEDGEMENTS

A special thanks to **Liz Kirby** (Project Manager - Diabetes Prevention Programme), operational lead **Gillian O'Loughlin**, dietitian manager **Claire Ramsey** and the excellent administration staff working at our hub, in particular **Nuala Higgins** and **Abbey Pritchard.**

SMILE 2
INTEGRATED VIRTUAL CASE MANAGEMENT OF PATIENTS WITH MULTIMORBID CHRONIC DISEASE

Supporting multi morbidity self-care through Integration, Learning & eHealth

Agatha Lawless, SMILE Project Manager agatha.lawless@hse.ie

SMILE Project Team – Dr Orlaith O Reilly[1], Margaret Curran[2], Mary Burke[2], Aideen Byrne[2], Ashleigh Farrell[2], Dr Maria O'Brien[1], Liz Murphy[1], Patricia McQuillan[1], Agatha Lawless[1] Organisations: [1] HSE [2]Caredoc

BACKGROUND

- The design of SMILE 2 is based on the integration and expansion of the established SMILE1 service provided by Caredoc since 2020.
- The project is a joint initiative between the Health Service Executive's (HSE) Enhanced Community Care (ECC) programme together with Chronic Disease Community Specialist Teams (CD CST) partnering with Caredoc.
- It is an essential element of the Integrated Model of Care for Chronic Disease.
- Participants with two or more conditions including diabetes, COPD, chronic heart failure, and heart disease use a selection of healthcare devices based on their needs, in conjunction with remote nursing support to monitor their health and wellbeing.
- The service is provided across counties Carlow, Kilkenny, Waterford South Tipperary and Wexford.

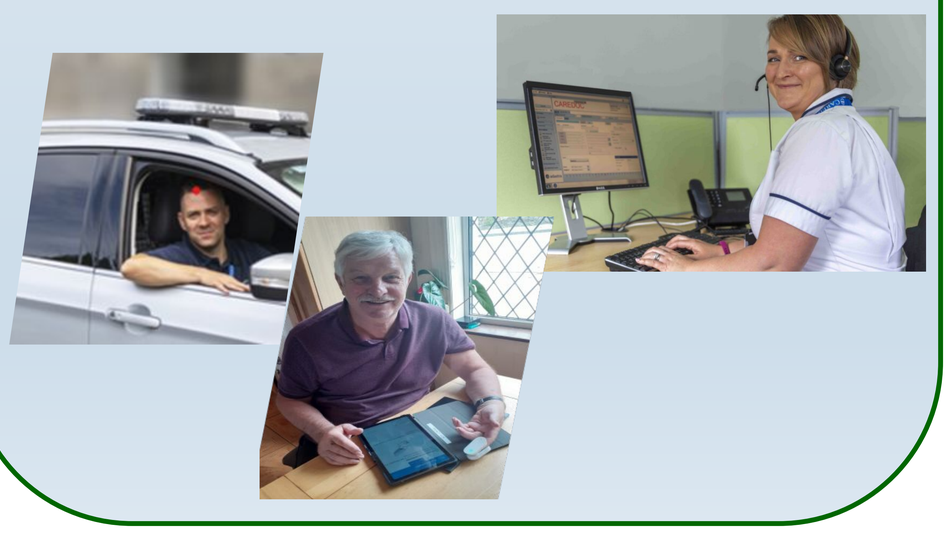
PURPOSE

The SMILE 2 service:

- Supports people to live more independently
- Allows for early intervention
- Reduces episodes of deterioration
- Reduces unscheduled visits to ED, AMAU, GPs and Out of hours doctor service

METHODOLOGY

- Patients that need more intensive case management support are identified by GPs/CD CST staff.
- The SMILE nurse provides regular telephone consultations to continually assess the patient and advise on care, which may include liaising with their GP/CD CST staff.
- The nurse is automatically alerted if vital signs from wearable devices provided to each patient are outside of normal range.
- Patients receive ongoing educational support from SMILE nurses around their chronic conditions which increases their knowledge of factors that affect their health.

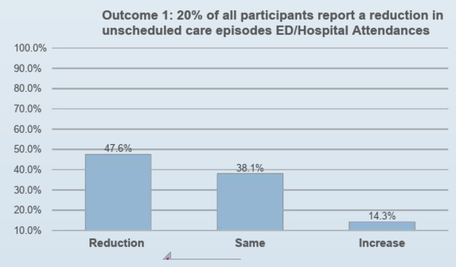


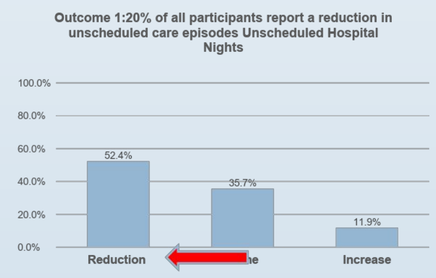
PRELIMINARY RESULTS

Data collected from patients who have been enrolled in the SMILE service for 6 months indicate the below results:

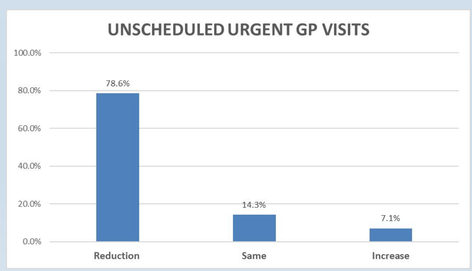
48% had a reduction in ED/Hospital visits.

52% had less nights in hospital.

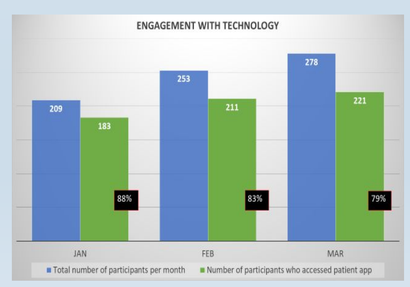




79% had a reduction in their daytime GP emergency visits



Between 79% and 88% of patients engaged with the technology in the first quarter of 2024.



PATIENT FEEDBACK

I am extremely happy to be part of this service and very grateful to everyone involved.

I don't know where I'd be today without the service. I have gained in the experience 110%, The SMILE project is my comfort blanket and the SMILE nurses are angels. May God bless them all.

I'm more aware of my blood pressure and COPD issues.

Being on the programme motivates me to do more for my health.

I feel happy knowing that someone has my back and am reassured by the triage nurses.

CONCLUSION

By using technology and nursing support for remote health monitoring and patient engagement, SMILE 2 achieves the following:

- Empowers and supports citizens in new ways to proactively self manage their health conditions.
- Enables shift of care to the community and reduces episodes of unscheduled care.
- Integrates services around the patient.
- Integration of the SMILE service with chronic disease hubs.
- Provides efficient use of resources.
- Cost effectiveness.
- Allows larger caseloads.
- Facilitates potential scaling up of the project nationally.

This project has received funding from the Government of Ireland's Sláintecare Integration Innovation Fund under Theme 7

Efficiency of App-Based Triage Systems in Cardiovascular Care: A Retrospective Study from Integrated Care Hub Bray

Capecinio, E.; Barrett, M.; Caulfield, J.; Daniel, S.; Earls, S.; Kearney, K.; Prasanth, L.

Background

Cardiovascular diseases (CVD) are a major health concern in Ireland. The cardiology service at Integrated Care Hub Bray (ICHB) implemented a virtual triage system via a secure messaging app providing a realtime MDT feedback within 24 hours and reducing wait times.

Objective

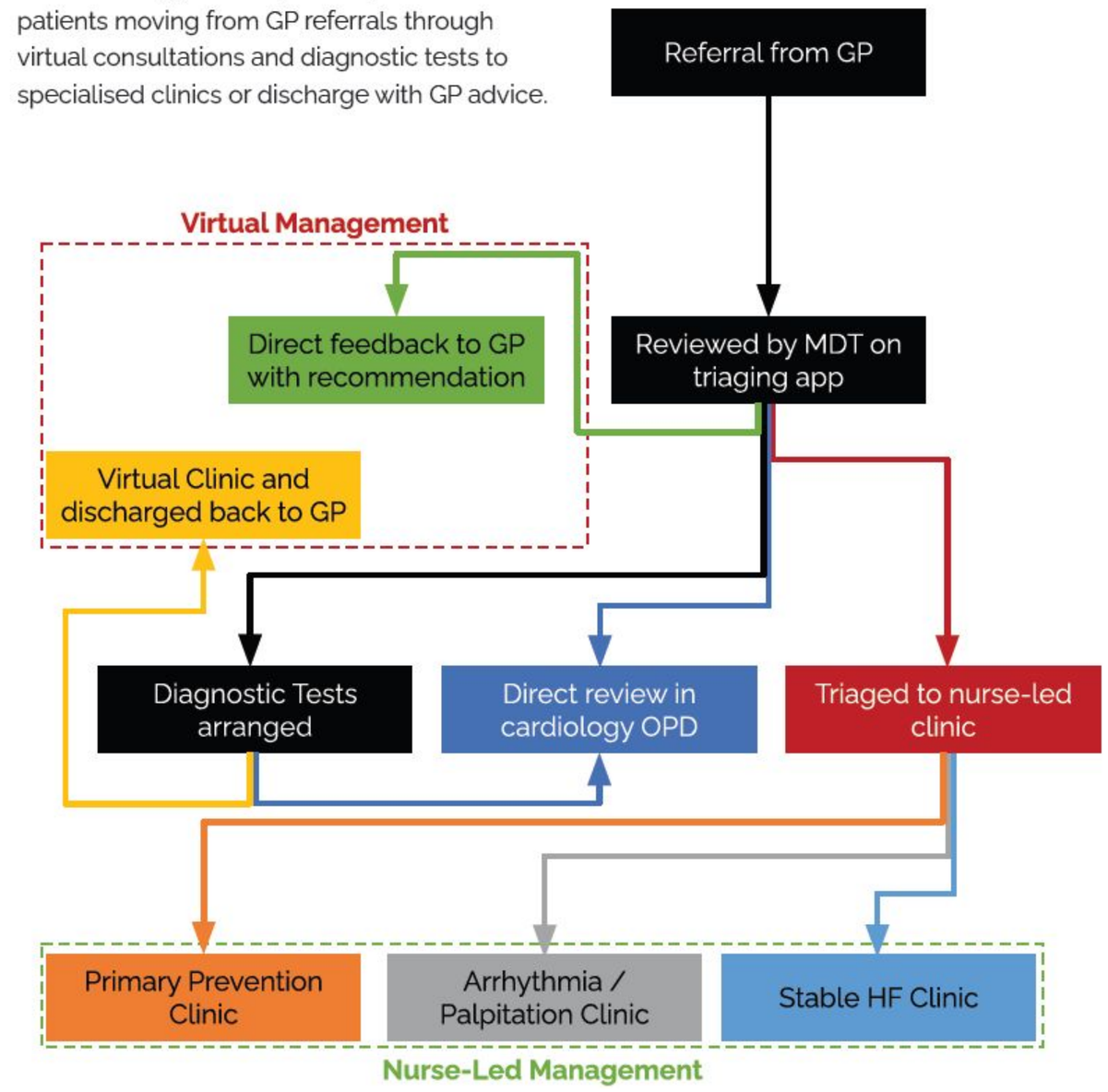
This study evaluates the efficacy of an app-based triage system in handling CVD referrals from primary care, including patients with long outpatient department (OPD) waiting times from St. Vincent's University Hospital (SVUH). The aim is to reduce delays in cardiology appointments and assess its impact on patient care pathways and service utilisation over four months.

Methods

A retrospective study of 232 patients referred between January and April 2024 from GPs and SVUH was conducted. Patients were directed to either General Cardiology or the Heart Virtual Clinic (HVC). These were managed by a specialist nursing team and a Cardiology Advanced Nurse Practitioner (cANP), respectively. Initial triage via a secure messaging app determined if patients returned to their GP with recommendations, underwent diagnostic tests, or were referred to physical or virtual cardiology clinics.

Process Map

The cardiology referral pathway shows patients moving from GP referrals through virtual consultations and diagnostic tests to specialised clinics or discharge with GP advice.

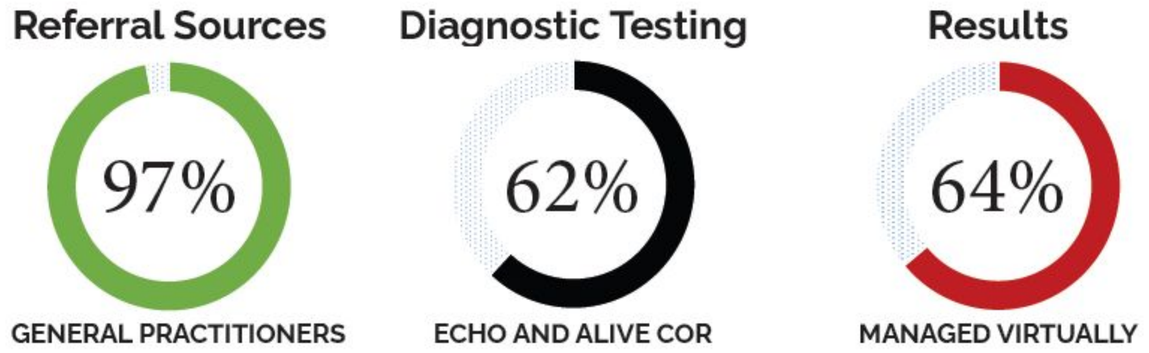


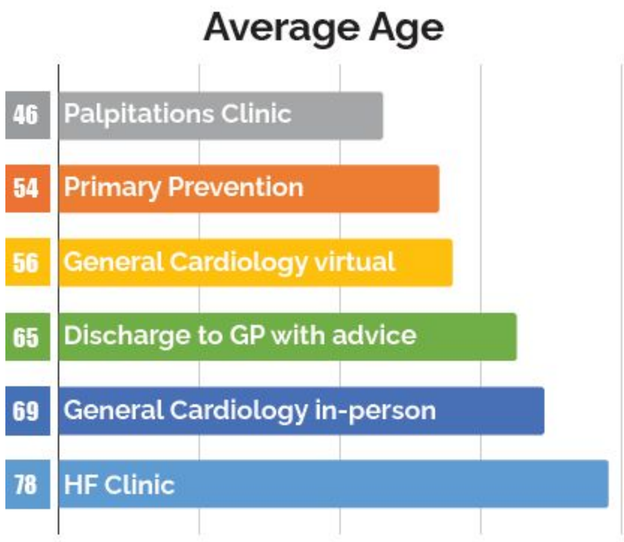
Conclusion

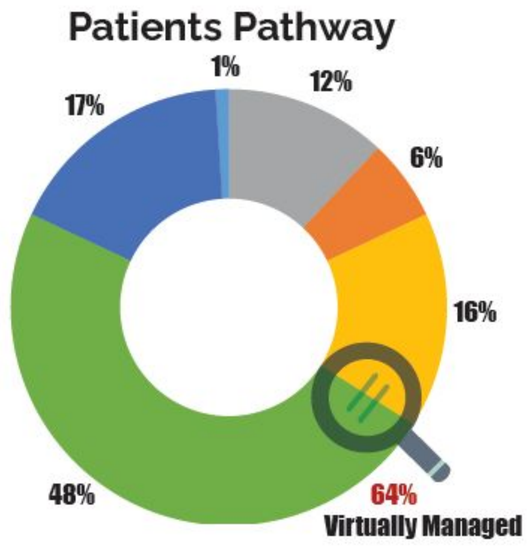
The virtual triage system effectively manages CVD referrals, reducing appointment delays that would typically burden hospitals, and improving patient care pathways.

Recommendations

- Link Healthmail with the triaging app to streamline digital referrals.
- Enhance diagnostic capabilities at ICHB to meet increased demand and improve patient care efficiency.
- Conduct further research and collaborate with other hubs to apply findings and improve virtual triage systems across multiple locations.



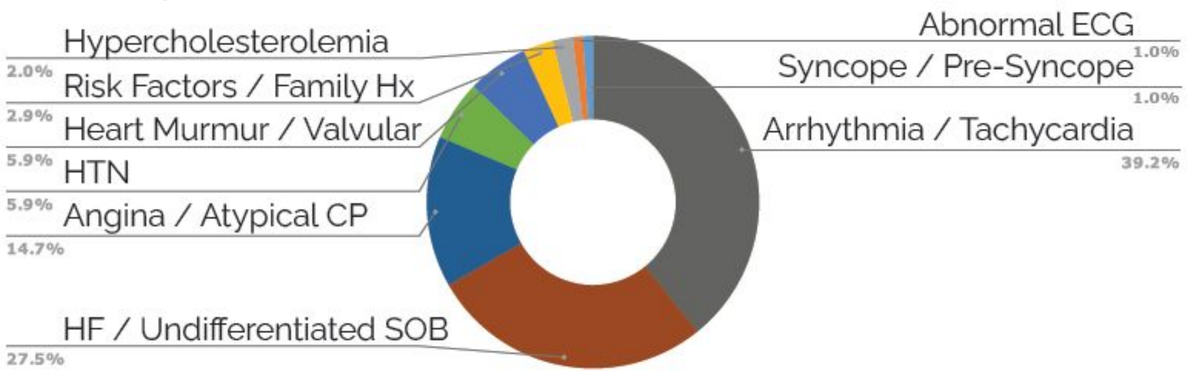




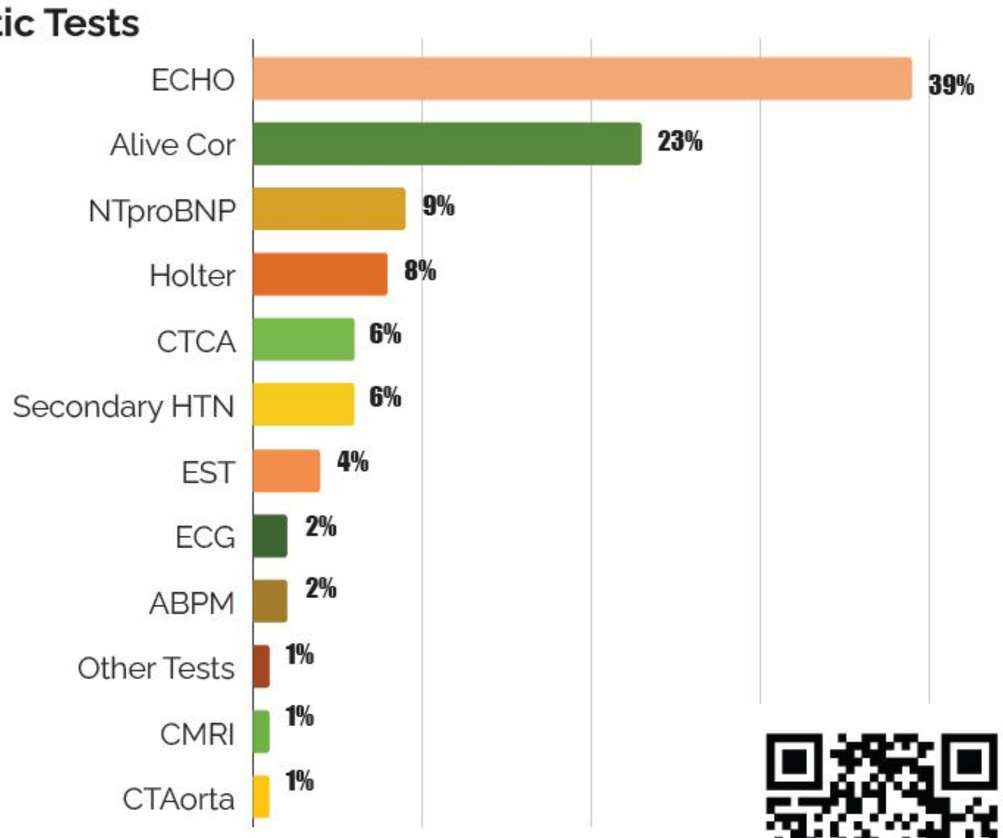
Key findings

- **64% of patients were managed virtually**, with 16% managed in the virtual clinic and 48% discharged to GPs with specific advice.
- Increased diagnostic demand at SVUH, underscoring the need for enhanced capabilities at ICHB.
- Minimised in-person visits, optimising clinical space and extending services to those not needing direct assessments.
- High satisfaction with virtual care, receiving positive feedback from patients and providers.
- Demonstrated sustainability of the virtual model in handling increased patient volumes effectively.

Category of Referral



Diagnostic Tests



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Disclosure of Interest:
No conflicts of interest to declare.

Integrated Cardiovascular Disease Team Supporting Best Practice in Lipid Management

Michelle Brennan

Integrated Cardiovascular Disease CNS, Chronic Disease Hub Waterford

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BACKGROUND

In Ireland, cardiovascular disease accounts for 32% of all deaths [1].
There has been a steady decline in cardiovascular mortality from 1985 to 2006, with 24% being attributed to cholesterol reduction[2] . Hypercholesterolemia, particularly raised low-density lipoprotein (LDL) cholesterol levels are causally linked with cardiovascular disease[3]

The European Society of Cardiology recommend the treatment of blood cholesterol to reduce atherosclerotic CV risk in adults and emphasised the importance of LDL-C lowering to prevent ASCVD (Atherosclerotic Cardiovascular Disease) [4].

A 2017 study of a snapshot of lipid levels in Ireland demonstrated that 60% of individuals had some form of lipid abnormality [5].

In Waterford, the Cardiovascular Disease Clinical Nurse Specialist (CVD CNS) for integrated care ensures that every patient contact optimises LDL-C levels to meet guideline-recommended targets.

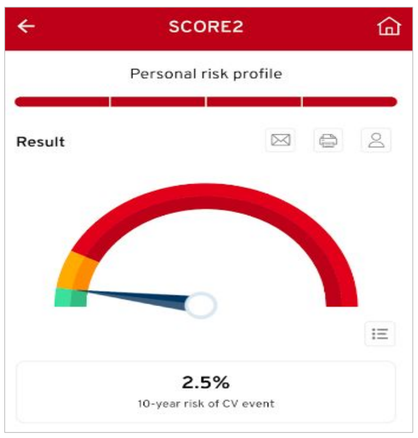
METHOD

This single-centre prospective study was conducted over a five month period. LDL-C levels of 89 patients were reviewed to determine if they met guideline target levels.

Prevention of ASCVD in a given person should relate to their total CV risk [4].

Determining CV Risk using ESC CVD RISK CALCULATORS:

- SCORE 2 (Europe) < 70yrs old
- SCORE 2 - OP (Europe) >70yrs old
- SCORE 2 – Type 2 Diabetes
- SMART Risk Score (Previous Cardiovascular Disease)



Then, Determining CV Risk Category as per below:

Very-high-risk	People with any of the following: Documented ASCVD, either clinical or unequivocal on imaging. Documented ASCVD includes previous ACS (MI or unstable angina), stable angina, coronary revascularization (PCI, CABG, and other arterial revascularization procedures), stroke and TIA, and peripheral arterial disease. Unequivocally documented ASCVD on imaging includes those findings that are known to be predictive of clinical events, such as significant plaque on coronary angiography or CT scan (multivessel coronary disease with two major epicardial arteries having >50% stenosis), or on carotid ultrasound. DM with target organ damage,[a] or at least three major risk factors, or early onset of T1DM of long duration (>20 years). Severe CKD (eGFR <30 mL/min/1.73 m^2). A calculated SCORE ≥10% for 10-year risk of fatal CVD. FH with ASCVD or with another major risk factor.
High-risk	People with: Markedly elevated single risk factors, in particular TC >8 mmol/L (>310 mg/dL), LDL-C >4.9 mmol/L (>190 mg/dL), or BP ≥180/110 mmHg. Patients with FH without other major risk factors. Patients with DM without target organ damage,[a] with DM duration ≥10 years or another additional risk factor. Moderate CKD (eGFR 30–59 mL/min/1.73 m^2). A calculated SCORE ≥5% and <10% for 10-year risk of fatal CVD.
Moderate-risk	Young patients (T1DM <35 years; T2DM <50 years) with DM duration <10 years, without other risk factors. Calculated SCORE ≥1 % and <5% for 10-year risk of fatal CVD.
Low-risk	Calculated SCORE <1% for 10-year risk of fatal CVD.

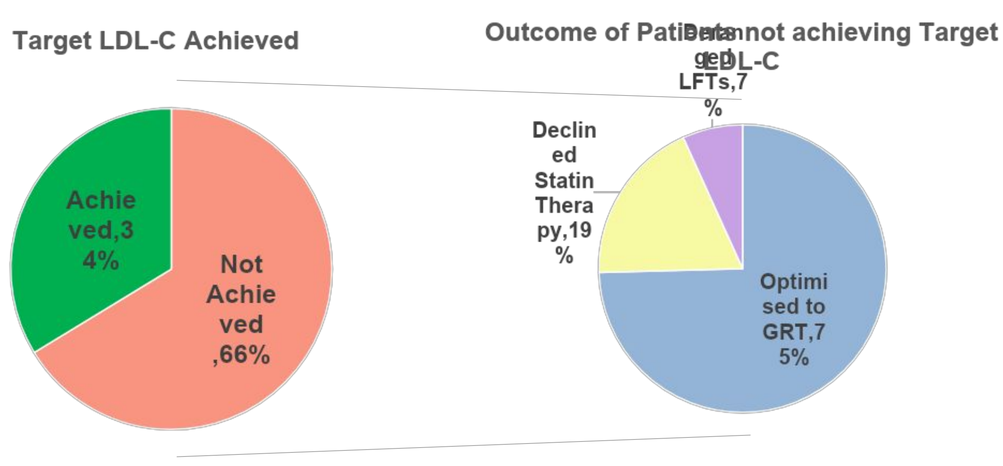
Determining Intervention strategies as a function of total cardiovascular risk and untreated low-density lipoprotein cholesterol levels:

	Total CV risk (SCORE) %	Untreated LDL-C levels <1.4 mmol/L (55 mg/dL)	1.4 to <1.8 mmol/L (55 to <70 mg/dL)	1.8 to <2.6 mmol/L (70 to <100 mg/dL)	2.6 to <3.0 mmol/L (100 to <116 mg/dL)	3.0 to <4.9 mmol/L (116 to <190 mg/dL)	≥4.9 mmol/L (≥190 mg/dL)
Primary prevention	<1, low-risk	Lifestyle advice	Lifestyle advice	Lifestyle advice	Lifestyle advice	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	I/C	I/C	I/C	I/C	IIa/A	IIa/A
	≥1 to <5, or moderate risk (see *Table 4*)	Lifestyle advice	Lifestyle advice	Lifestyle advice	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	I/C	I/C	IIa/A	IIa/A	IIa/A	IIa/A
	≥5 to <10, or high-risk (see *Table 4*)	Lifestyle advice	Lifestyle advice	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	IIa/A	IIa/A	IIa/A	I/A	I/A	I/A
	≥10, or at very-high risk due to a risk condition (see *Table 4*)	Lifestyle advice	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	IIa/B	IIa/A	I/A	I/A	I/A	I/A
Secondary prevention	Very-high-risk	Lifestyle intervention, consider adding drug if uncontrolled	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention	Lifestyle intervention and concomitant drug intervention
	Class[a]/Level[b]	IIa/A	I/A	I/A	I/A	I/A	I/A

RESULTS

- 100% (n=89) received education on lifestyle changes and the importance of medication compliance.
- 66% (n=59) had LDL-C levels not at guideline-recommended targets.

Of these 59 patients with LDL-C levels not at guideline-recommended targets:
- 74% (n=44) were optimised to guideline-recommended target levels by the CVD CNS.
- 19% (n=11) declined statin therapy despite consultation with the CVD CNS
- 7% (n=4) had deranged liver function tests, preventing the commencement of lipid therapy.



CONCLUSION

The data underscores the critical role of the CNS for Integrated Cardiovascular care in supporting general practitioners and other physicians in implementing best practices for lipid management to reduce cardiovascular atherosclerotic risk.

ACKNOWLEDGMENTS

UHW Heart Failure ANP Norma Caples, The Integrated Chronic Disease Team Service, Waterford and all service users.

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Type 1 Diabetes Structured Education in Ireland: The DAFNE Expansion

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[1]National Clinical Programme for Diabetes, Clinical Design and Innovation, HSE; [2]Self-Management Education and Support Office, Office of NCAGL for Chronic Disease, HSE; [3]School of Medicine and Centre for Diabetes, Endocrinology and Metabolism, University Hospital Galway; [4]National Director DAFNE programme, Northumbria Healthcare NHS Foundation Trust, UK

Introduction

- Dose Adjustment for Normal Eating (DAFNE) is the training programme for Type 1 diabetes recommended in national guidance from the Health Service Executive and the National Clinical Effectiveness Committee in Ireland[1].
- It is delivered over 40 hours in a 1-week or 5-week format and has both face-to-face and online delivery modes. DAFNE has been shown to improve glycaemia, quality of life, hypoglycaemia awareness and to reduce hospital admissions for diabetic ketoacidosis and severe hypoglycaemia.
- Established in Ireland since 2004, initial roll out to 6 sites was supported by the Irish DAFNE Study. Recently, its expansion has been supported by dietetic posts from the Integrated Care Programme for the Prevention and Management of Chronic Disease (ICPCD). Here we describe the work of the Diabetes National Clinical Programme to establish a national picture of DAFNE delivery in Ireland in 2023

Methods

- The Diabetes National Clinical Programme Leads contacted or met with 37 hospital-based diabetes services across all six health regions, including 21 services who were allocated ICPCD posts to support DAFNE. We gathered data on staffing, course delivery, and both opportunities and challenges to DAFNE delivery. We also engaged with DAFNE Central and ascertained centralised anonymised data (available from 2016-2022) on course delivery and trained educators in Ireland.

Results

- There are now 20 public and 2 private DAFNE Centres in Ireland, spread across 6 Health Regions (see Figure 1).
- This represents an approx. 230% increase in DAFNE availability in Ireland since 2016.
- Course delivery is supported by 71 registered DAFNE educators and 26 registered DAFNE doctors.
- Course data between 2016-2022 in Ireland shows 191 courses with 1118 graduates.
- Currently centres deliver between 2 and 10 courses per year - mainly dependent on the number of trained educators.
- Delivery is, for the most part, online or hybrid with a small number of centres delivering face-to-face courses.

Figure 2: Opportunities and challenges to DAFNE delivery in Ireland

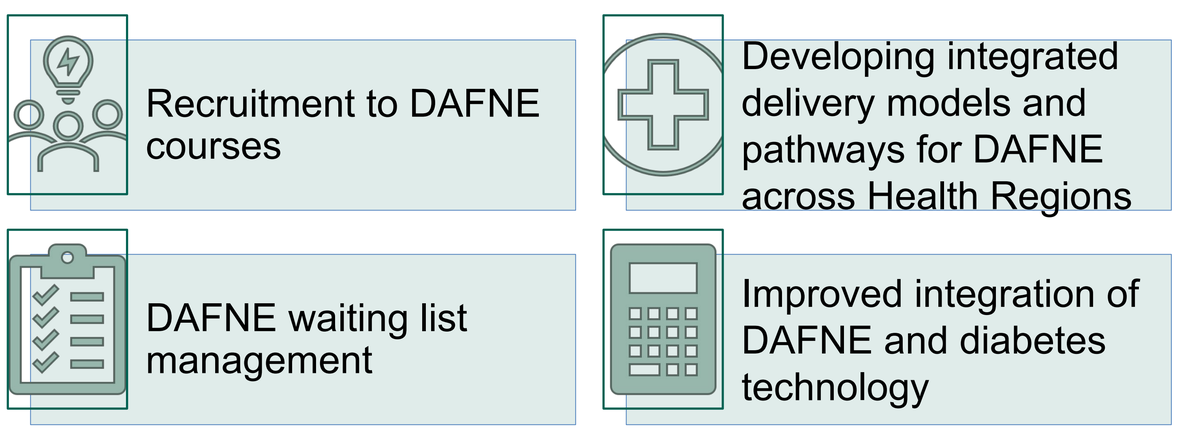
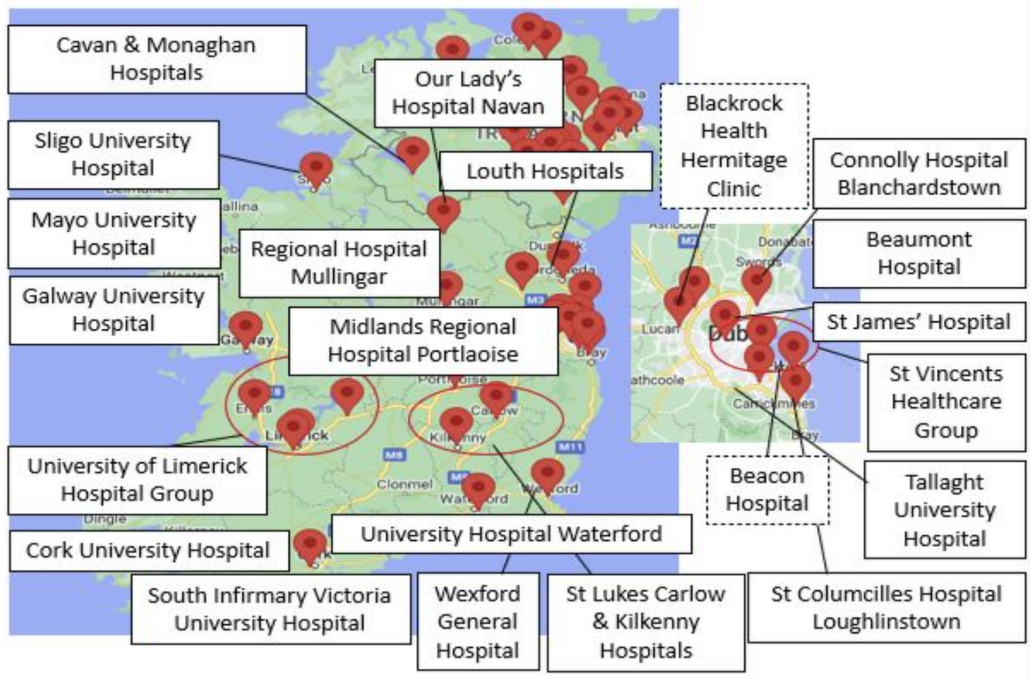


Figure 1: DAFNE centres in Ireland



- ICPCD funding was allocated for 19.5 dietetic posts, of which 12.5 (64.1%) have been filled.
- Of the 12 newer centres, 9 (75%) have used ICPCD funding to commence DAFNE, while 2 used existing staff resourcing, and 1 centre remains registered but the ICPCD posts are currently vacant.
- Opportunities and challenges for DAFNE sites are summarised in Figure 2

Conclusion

- ICPCD resourcing has increased access to DAFNE in Ireland. More publicity is needed to highlight this improvement in quality care delivery, which has been facilitated and enhanced by resourcing from ICPCD.
- In line with ECC, healthcare professionals are using telehealth, working at the top of their licence, to deliver DAFNE.
- Centres need administrative support to manage waiting lists and innovative approaches to promote recruitment. Additional support, including lunchtime webinars, from the Diabetes National Clinical Programme, Self-Management Education and Support Office, DAFNE Central and the Type 1 diabetes peer support community should be considered to enhance recruitment. At a local level, developing integrated pathways for DAFNE delivery within Health Regions, with appropriate clinical governance, should be considered.
- As diabetes technology evolves ongoing input from Irish centres to the DAFNE Collaborative will support the evolution of the DAFNE curriculum to provide up to date structured education for all individuals with Type 1 diabetes.

DIABETES

Clinical Design & Innovation
Person-centred, co-ordinated care

Email correspondence: cathy.breen@hse.ie

References: [1] National Clinical Effectiveness Committee (2018). Adult Type 1 Diabetes Mellitus National Clinical Guideline No 17

Optimising Patient Pathways by Integrating Acute and Enhanced Community Care Diabetes Services in Carlow/Kilkenny

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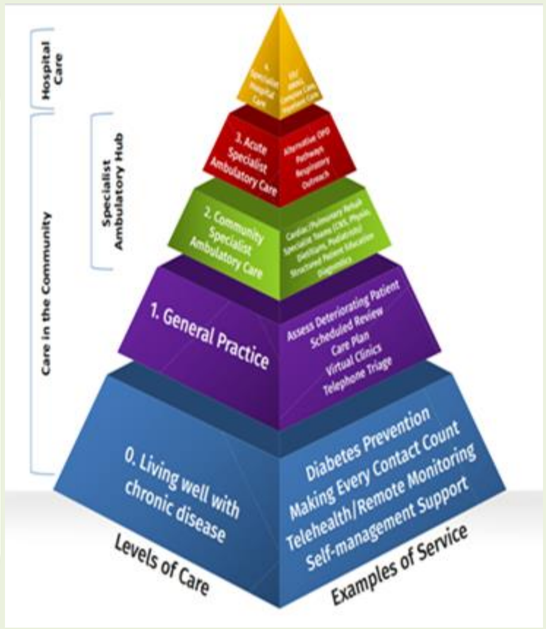
St Luke's General Hospital

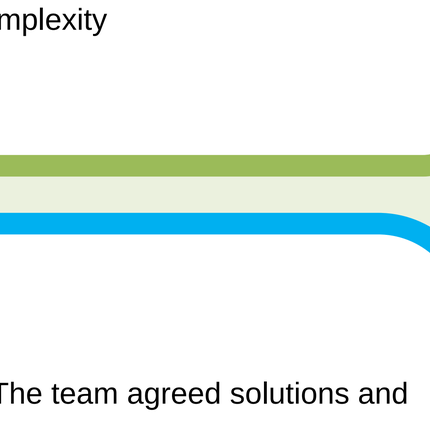
Introduction

- It is estimated that there are approximately 308,000 people in Ireland with diabetes. Type 2 diabetes accounts for approximately 90% of all cases.
- The Carlow /Kilkenny Diabetes service identified a lack of full adoption of the integrated pathway for Type 2 Diabetes in line with the new Diabetes service delivery model. The team worked together to streamline the process, integrating the hospital and community services while optimising the care of the patient with Diabetes



Engagement

- The IEHG Improvement Team engaged with multiple stakeholders from both the community and acute services
- Key stakeholders were invited to participate in a 5-day Rapid Improvement Event (RIE)
- A patient and staff survey of Diabetes care was disseminated
- Engagement with the hospital and community specialist team took place virtually and in person meetings on a weekly basis
- All stakeholders were invited to a progress report at 30-60-90 days



Aims and Objectives

- Optimise integrated patient clinical pathways to ensure patients are managed at the most appropriate level of complexity
- Improve the processes and patient flow to maximise capacity across all diabetes services
- Improve communication and education of relevant stakeholders

Methodology

The Team undertook an RIE focusing on adults with Type 2 Diabetes. An A3 problem solving tool was used to provide a structured approach. The team agreed solutions and identified 8 different work streams to deliver timely improvements

Planning
- Team Selection
- Site Readiness
- Sustainability Assessment

Current State
- Data Collection
- Surveys
- Process Mapping

Event
- 5 day RIE
- 8 workstreams agreed

Follow Up
- 30/60/90 day report outs to review progress

- Continuous Improvement Process + 90 days

Outcomes

Integrated Pathways
- Agreed criteria & integrated pathways
- Commenced discharge/transfer of patients based on new criteria

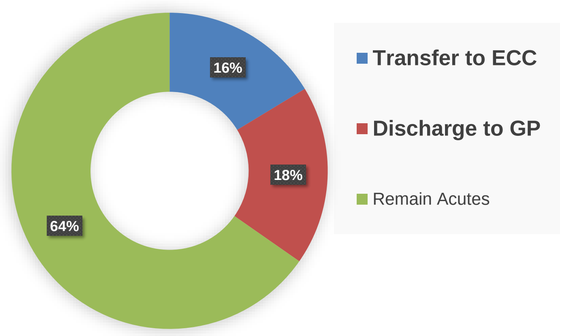
Training & Education
- Making Every Contact Count (MECC) training for all staff
- New training tools and guidelines developed for the Diabetes Team

Patient Education
- Self Management Education & Support (SMES) programmes identified and being promoted

Roles & Responsibilities
- Improved understanding of nursing roles and responsibilities & MOU agreed

Governance & Communication
- Governance structures clarified
- Communication channels improved

Progress at 60 Days



Discussion & Conclusion

Key Enablers
- Diabetes Team involvement
- Inter-professional **collaboration & teamwork**
- Continuous **engagement** with all stakeholders
- Continuous **communication, education** & awareness
- **Promote case for change** and benefits of new practice
- Senior Management **support**

Key Challenges
- Lack of ICT in the community
- Work and time constraints
- Buy in from all stakeholders
- Phlebotomy service
- Quality assurance of equipment
- Catchment areas

Next Steps
- Ensure all people with Type 2 Diabetes are on the correct pathway at consultant and nurse led clinics.
- Ensure all Diabetes related staff complete MECC training
- Implement Goal setting at all clinics
- Ensure all patients are signposted to self-management support programme

Acknowledgements: M. Ahmad, M. Dowling, G. Hanlon, L. Hennessy, M. Hayes; A. Holohan, N. Horan, E. Joyce, L. Kennedy, D. Kennedy, R. Mabbott, F. McEvoy, C. McGurk, O.O'Grady, A. Ryan, A Xavier

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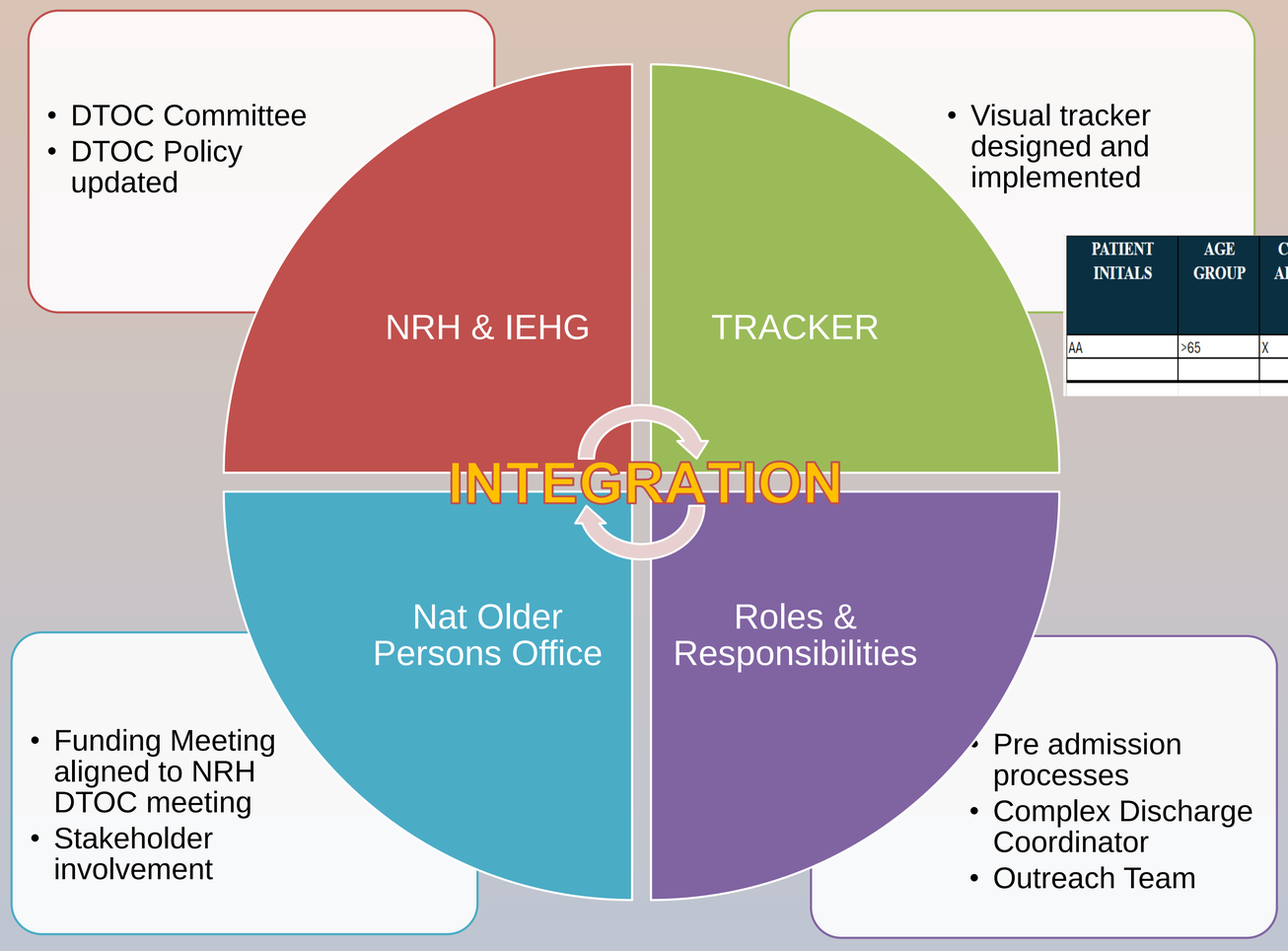
AN INTREGRATED SOLUTION TO INCREASING ACCESS TO NATIONAL SPECIALIST REHABILITATION BEDS

Claire Convery (Claire.convery@nrh.ie),Hilda Dowler (hdowler@iehg.ie),Denise Roxburgh (droxburgh@iehg.ie)

Context:

- The National Rehabilitation Hospital (NRH) delivers specialist rehabilitation services and education dedicated to returning patients to the highest level of independence possible and aims to maximize the quality of their lives. The National Delayed Transfers of Care List (DTOC) demonstrates the demand for both patients requiring access to the NRH and patients who have competed their rehabilitation within the NRH, but their discharge is delayed to their residential placements.
- One of the challenges facing the NRH is the ability to transfer/discharge patients safely once their rehabilitation period has finished. When a patient's discharge is delayed, they experience unnecessary prolonged stays in hospital (Independent Expert Review of Delayed Discharges, 2018). When a patients discharge from the NRH is delayed this then has a direct impact on patients within other sites accessing specialised rehabilitation.
- On 16th January 2024, there were 14 patients within the NRH that were listed on the National DTOC report. This equated to 2267 Bed days Lost (BDLs) by patients who no longer required rehabilitation care. Within the same period 27 patients discharges were listed on the National DTOC report awaiting access to the NRH. This equated to 1408 BDL nationally.
- One resourced bed has the capacity to facilitate rehabilitation treatment for (4-5) patients in one year assuming an anticipated length of stay of 70-90 days. There is a careful balance to be struck between maintaining the standards of service and patient centred focus, while also meeting the needs of the HSE and the wider health system by ensuring continuous patient access.

Methods :



PATIENT INITALS	AGE GROUP	CHO AREA	SPEC	ADMITTED	PDD (UPDATED EVERY TUESDAY)	DATE (UPDATED EVERY TUESDAY)	LOS	DTOC LOS	DTOC TYPE (e.g. A3/B5/D2)	REASON FOR DELAY	DISCHARGE DESTINATION	CHO UPDATE	NRH Update 08/01/2023	9/1/2024	Assigned Person	Timeframe
AA	>65	X	Spinal	1/1/2024	1/3/2024		35	20	A3	Funding	XX Lodge	xx	xx	xx	CC	

Results:

Since 16th January 2024 26 patients categorised as Delayed Transfers of Care have been discharged from the NRH. Their Length of Stay (LOS) ranged from 65 – 845 days

Improvement in Bed Days Lost (BDLs)
Extract from National DTOC List

DTOC No/BDL Total	16/01/2024	13/08/2024	BDL Variance
	2267	486	-1781
Type A: Destination Home	984	0	-984
Type B: Destination Long Term Nursing Care	913	0	-913
Type C: Rehab	0	0	-
Type D: Complex needs	78	320	+242
Type E: Housing/Homeless	292	124	-168
Type F: Legal Complexity/ADMA	0	0	-
Type G: Non-compliant	0	42	+42
Type H: COVID-19	0	0	-

*Complex needs remains a challenge

As of 15th August 2024, there are 5 patients classified as DTOC in NRH.

Extract from NRH DTOC List

NRH DTOC 16/01/2024		
DTOC Type	No. pts	DTOC LOS (Days)
A. Home	5	984
B. Long Term Nursing Care	4	913
C. Rehab	-	-
D. Complex needs	1	78
E. Housing/Homeless	4	292
F. Legal Complexity/ADMA	-	-
G. Non-compliant	-	-
H. Covid-19	-	-
Totals:	14	2267

NRH DTOC 15/08/2024		
DTOC Type	No. pts	DTOC LOS (Days)
A. Home	-	-
B. Long Term Nursing Care	-	-
C. Rehab	-	-
D. Complex needs	3	320
E. Housing/Homeless	1	124
F. Legal Complexity/ADMA	-	-
G. Non-compliant	1	42
H. Covid-19	-	-
Total:	5	486

All of these patients are being actively managed in a defined process

Challenges:

- Lack of specialist residential placements for patients with complex needs.
- Funding challenges for specialist residential placements. Limited Public funded specialised beds available country wide.
- Lack of interim step-down facilities catering for patients with complex needs, e.g. Neurogenic bowel care, NG tubes, Tracheostomy care, Behavioural support.
- Costs and lengthy timeframes for home adaptations or resolution of housing/homelessness issues.
- Shortage of suitable qualified personnel in community settings to meet complex patient needs.
- National supply of rehabilitation services/beds.

Recommendations:

- Ensure an integrated approach to patient centred care, to ensure pre and post admission process are optimised.
- Establish a central funding model to meet the needs of complex patients within their residential settings.
- Development of a National NRH outreach team (Pilot ongoing).
- Expansion of Discharge Liaison posts nationwide for earlier identification of discharge requirements. (Pilot ongoing).
- Monitor and review of new processes to ensure continuous service improvement.

Acknowledgements:

The authors wish to acknowledge the hard work and assistance from the Senior Management Team and Clinical Lead within the National Rehabilitation Hospital, National Office of the Assistant National Director of Services for Older People, IEHG Operations and CHO Regions.

SIP Funded MSK Orthopaedic Triage Initiative Post

Right Time, Right Care, Right Place

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Background

In 2011 the HSE developed the National MSK Physiotherapy Triage pathway to address long waiting lists for orthopaedic consultant services. This initiative sees patients seen by clinical specialist physiotherapists (CSPs), with advanced skills in management of MSK conditions, with recent roll out of some clinics to primary care settings. National studies have shown that these CSP clinics have been as effective as orthopaedic doctors in diagnostic accuracy, treatment choice, use of healthcare resources and patient satisfaction (2). SJH currently has 2.2 permanent WTE MSK Triage CSP posts operating these clinics. The average current waiting times for orthopaedic consultant clinics in SJH is 18 months.

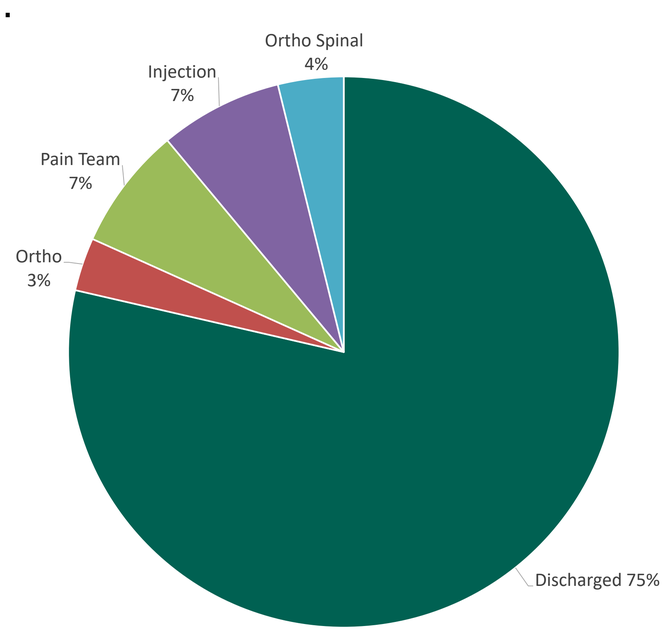
As part of an annual approach to tackling waiting lists, the Slaintecare Improvement Programme (SIP) fund has been developed by the HSE to support additional activity and enabling reform initiatives. In January 2024, SIP has funded 1 additional WTE CSP (0.6 WTE in MSK Triage and 0.4 WTE in physiotherapy) and one grade IV full time clerical officer to support these clinics and reduce the demand on orthopaedic consultant clinics.

Pathway

Appropriate patients are first triaged into MSK Triage clinics from the consultant waiting list. Currently in SJH, approximately 30-40% of referrals are triaged to these clinics. The aim is to review these patients within 3 months of referral from GP. This requires the CSP to accurately diagnose, arrange investigations and implement an appropriate management plan or onward referral. Patients that require direct consultant opinion are discussed and booked into a consultant led clinic. The SIP post operates 3 Orthopaedic MSK Triage clinics per week (2 in SJH, 1 in St Joseph's primary care clinic), and 2 days of physiotherapy in SJH outpatient department.

Results

Outcome of SIP MSK Triage Consultations



Between January and July 2024, 437 patients have been removed from consultant waiting lists. The percentage of patients waiting greater than 3 months has reduced from 43% to 3% in this time. 75% of patients were discharged with an appropriate management plan. 3% of patients required onward referral to the Orthopaedic consultant clinic. 43 patient were reviewed in a primary care setting. The DNA rate reduced from 27% to 9%. There were 19 unfilled slots

SIP MSK Triage Service Results January-July 2024	
Consultant Waiting List	437 patients removed from Orthopaedic consultant waiting list
DNA Rate	DNA rate dropped from 27% to 9%
Waiting Times	Percentage of patients seen within 3 months of referral increased from 57% to 97%
Onward referral to Consultant	3% of patient seen required onward referral to Orthopaedic consultant clinic
Discharge	75% were discharged from initial appointment
Primary Care Clinics	43 patients were seen within a primary care setting

Conclusion

- **Waiting times**: SIP funding has aided the MSK Triage service in SJH to reduce wait times for patients to receive appropriate care, whilst decreasing the demand on consultant led orthopaedic clinics

- **Clinic efficacy:** The reduction in DNA rates demonstrated could be attributed to this reduced waiting time, with the low number of unfilled slots demonstrating the value of full time clerical support to fill cancelled appointments promptly.

- **Primary Care**: Funding for this additional post has allowed the set up of a primary care clinic in St Joseph's creating close links with primary care physiotherapist colleagues and GPs for streamlined patient care, and reducing the demand on healthcare within an acute setting.

Conclusion

CSP MSK Triage posts are a proven effective, timely and cost effective use of SIP funding, demonstrating significant reductions on waiting times and consultant waitlists, as well as demand on clinic space within an acute hospital setting

Acknowledgements

Sean Higgins and team (Ortho Clerical Staff, SJH), Niamh Murphy (Operations Manager, MedEl), Yvonne Burke (Physiotherapy Manager, SJH), Stuart Garrett (Access Lead, SJH), Eimear Noonan (Network Manager, CHN2), Darryl Kelly (Physiotherapy manager Dublin South City)

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NURSE-LED SERVICE IN INTRAVITREAL INJECTIONS: INCREASING ACCESSIBILITY IN OPHTHALMIC CARE

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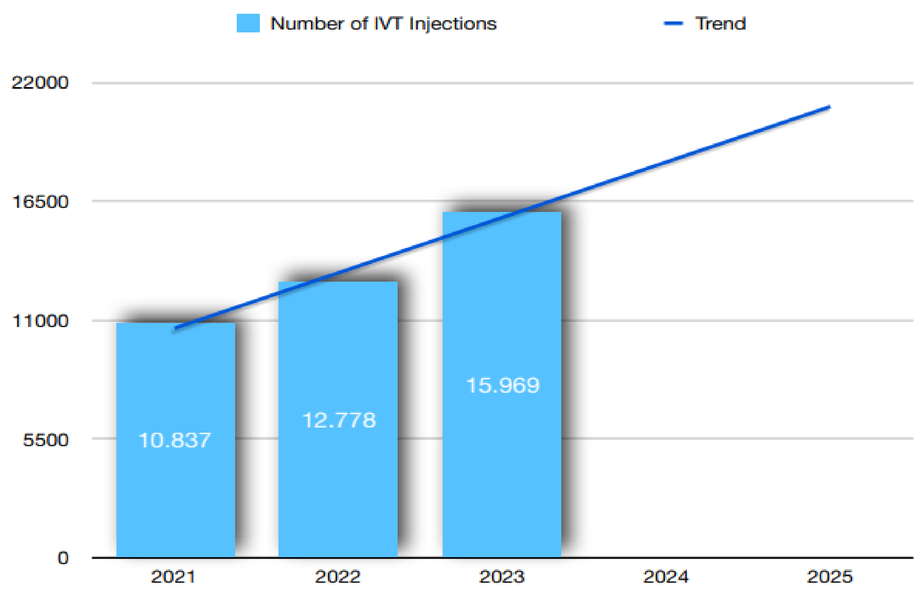
Introduction

Nursing is a key enabler to service reform (ONMSD, 2023).

The National Coalition for Vision Health in Ireland (2017) reports that as retinal conditions rise with an aging population, pressure on services and medical staff increases. Timely treatment is crucial for preserving patients' vision, quality of life, and independence.

Age-Related Macular Degeneration (AMD) is one of the leading causes of blindness in individuals over 50 years old worldwide (WHO, 2023). Patients suffering from this condition need treatment that involves injecting drugs called "Anti-Vascular Endothelial Growth Factors" into the affected eye, also called intravitreal injection. In 90% of cases, treatment can stabilise or improve vision (Fogli et al. 2018).



Aim

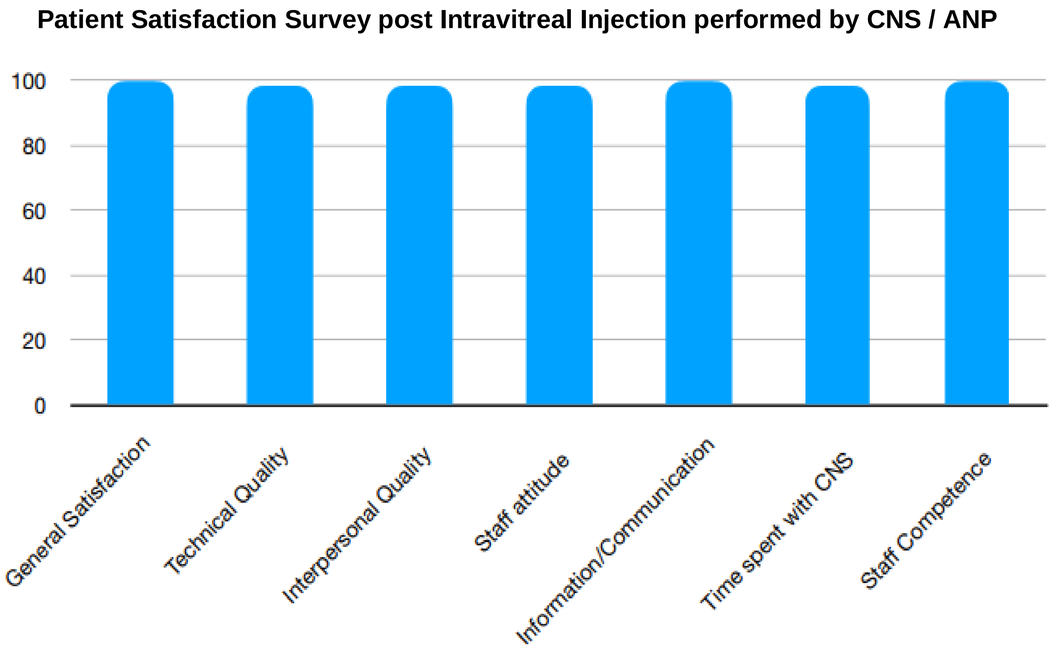
This study evaluates the efficacy and safety of intravitreal eye injections administered by trained ophthalmic nurses; a role traditionally performed by medical staffs in Ireland. Ophthalmic trained nurses delivering injections in a familiar environment enhance patient satisfaction and improve access to care.

Methods

Involves comparing injection outcomes, including infection rates, patient comfort, and procedural accuracy, with those treated by medical staff.

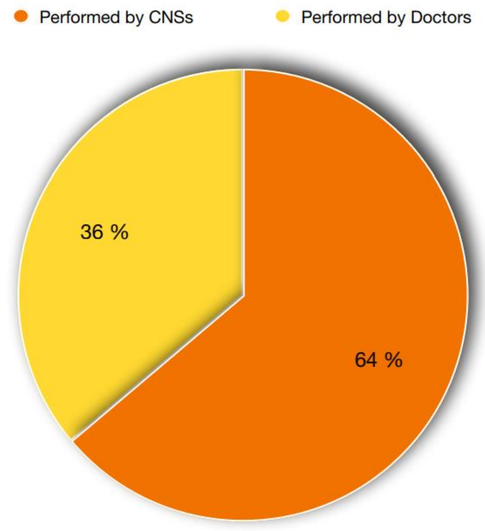
Data was collected through patient surveys and clinical assessments of 100 patients that had been injected by the ophthalmic nurse specialists (CNS) / nurse practitioner (ANP). Data was gathered over a period of one year.

Each nurse injector maintains a log of the patient details and number of injections administered per session. This practice is implemented to uphold competence and to monitor patients for any potential complications.



Results

- No significant differences in infection rates or complications between the groups treated by medical staffs and those treated by nurses.
- Patient satisfaction surveys indicated high levels of comfort and trust in nurse-administered injections.
- Ophthalmic trained nurses now deliver 64% of the total injections performed in the hospital.



Endophthalmitis is a bacterial or fungal infection of the inside of the eye. It is a serious complication that necessitates urgent attention to prevent permanent vision loss (Zograbyan, 2022).

In 2023, 2 cases of endophthalmitis were observed from 15,969 intravitreal injections performed.

This means the prevalence of endophthalmitis following intravitreal injections in MTC was **0.013%**. This is notably low compared to incidences reported in studies conducted at other centers.

Discussion

The nurse injectors in Macular Treatment Centre (MTC) play a crucial role in the medical retinal service. Expanding the role of ophthalmic nurses showcases a team-based approach to enhancing care capacity.

Initially, ANP has been administering IVT injections since 2017, and two CNS injectors began their work in MTC in 2020. The team has since expanded to four CNS injectors in response to the increasing patient volume, with plans for further team expansion as patient numbers continue to rise.

The nurse injectors have demonstrated an innovative approach in addressing the complex needs of patients with retinal conditions who require IVT treatment. The increasing demand from patients has placed additional pressure on service delivery and treatment timelines. However, effective management by the team and nurse injectors has successfully expanded the service's capacity, enabling more patients to receive treatment. As a result, doctors can continue assessing patients or fulfill duties in other departments where their presence is needed.

In 2023, 15,969 procedures were performed in MTC, representing an increase of approximately 25% compared to 2022 and 47% compared to 2021. The number of patients requiring intravitreal injections is steadily rising each year. Based on the observed trend since the MTC opened in 2021, it is projected that the number of IVTI cases in 2025 will reach around 22,000.

Conclusion

The study concludes that with competency-based training, nurses can safely and effectively perform intravitreal injections. Nurse-led injection services play a crucial role in preventing blindness by providing timely treatment and help reduce waiting lists.

This practice maintains high standards of patient care, optimizes medical capacity and provides a model that can be delivered in the community providing a standardized integrated team approach to safe patient care.

*For **references**, scan the QR code*

Optimising the End to End Care Pathway for Older Adults: A Multi Stakeholder informed approach

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Introduction.

As life expectancy increases, the proportion of older adults is rising in many countries. Ireland is no exception, where the older person population is expected to increase to 1.56 million by 2051.[1] Carlow/Kilkenny's population when compared nationally has a higher proportion of older persons, 24% are frail and therefore at highest risk of adverse health outcomes with associated increased healthcare utilisation and costs.[2]
In line with Sláintecare and the provision of the right service, right place, right time mantra CW/KK ICPOP Team was established to facilitate integration and collaborative delivery of older person's services, facilitating admission avoidance and optimising integrated care. However in order to develop appropriate and fit for purpose services for older persons, their perceived needs must first be explored and considered.

Aim

- To evaluate perceptions of health care services for older persons in Carlow and Kilkenny
- To identify perceived barriers and facilitators to service access
- Inform future service planning and innovation

Methodology

Qualitative Descriptive Design — To allow in-depth examination of the views and experiences of this topic from the perspective of the individual

Recruitment — Dissemination of invitation to participate using local & social media
Notifications to older person day care centres, local healthcare offices & community venues

Data Collection
- Audio-recorded
- Open-ended
- Semi-structured
- World cafe style Focus Groups
- Recordings transcribed verbatim

Analysis
- NVivo software package (version 12) was employed to organize, store and retrieve data
- Collectively analysed using reflexive thematic analysis.

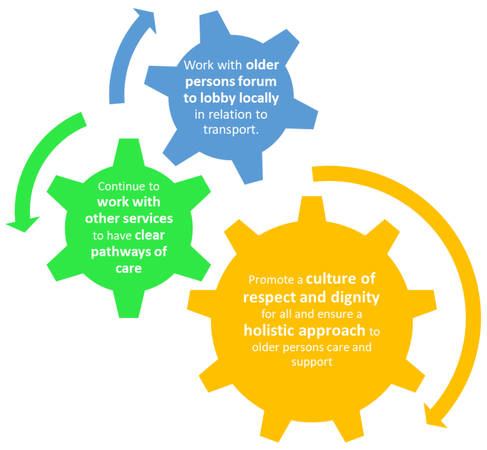
Results

Eight local world café style focus groups involving the following stakeholders were completed:
Older Adults living in the community
Older Adult Health Service users, their families and informal carers
Health care providers
Third party community service providers.

A total of 41 older persons (mean age 75) and 23 health and social care providers participated

Two main themes were identified:
1. Access to local services, continuity of care, improved transport and reliable information to support older persons to live where they wish to live.
2. Recognition of the person primarily as a person and not a condition.

Participants were invited to an event that informed them of findings and allowed further opportunity for discussion and input on findings.
Findings informed development of five one-day multi stakeholder workshops as part of Rapid Improvement Event



Conclusion

Insight into what service users and providers want from the health services accessible to older persons, informing future service innovation and planning. This underpinned development of stakeholder workshops during RIE**.**

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NURSE LED ASTHMA CLINIC : INTEGRATED APPROACH BETWEEN ACUTE RESPIRATORY SERVICES AND COMMUNITY SERVICES

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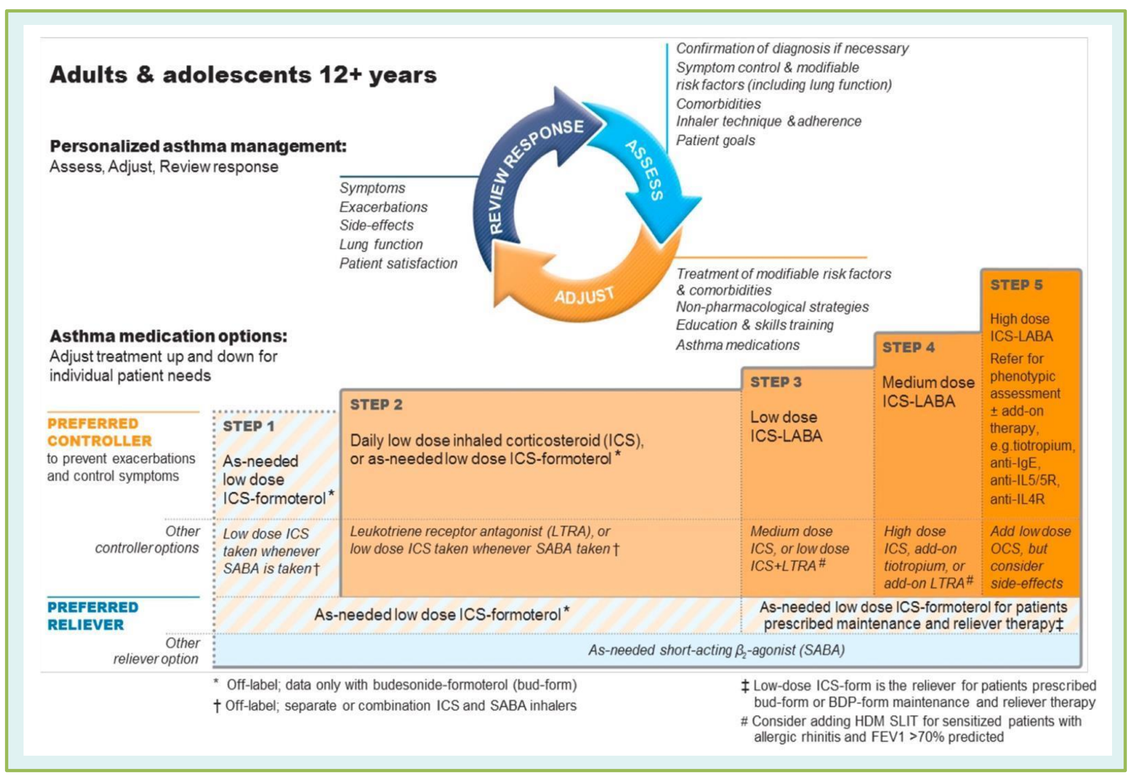
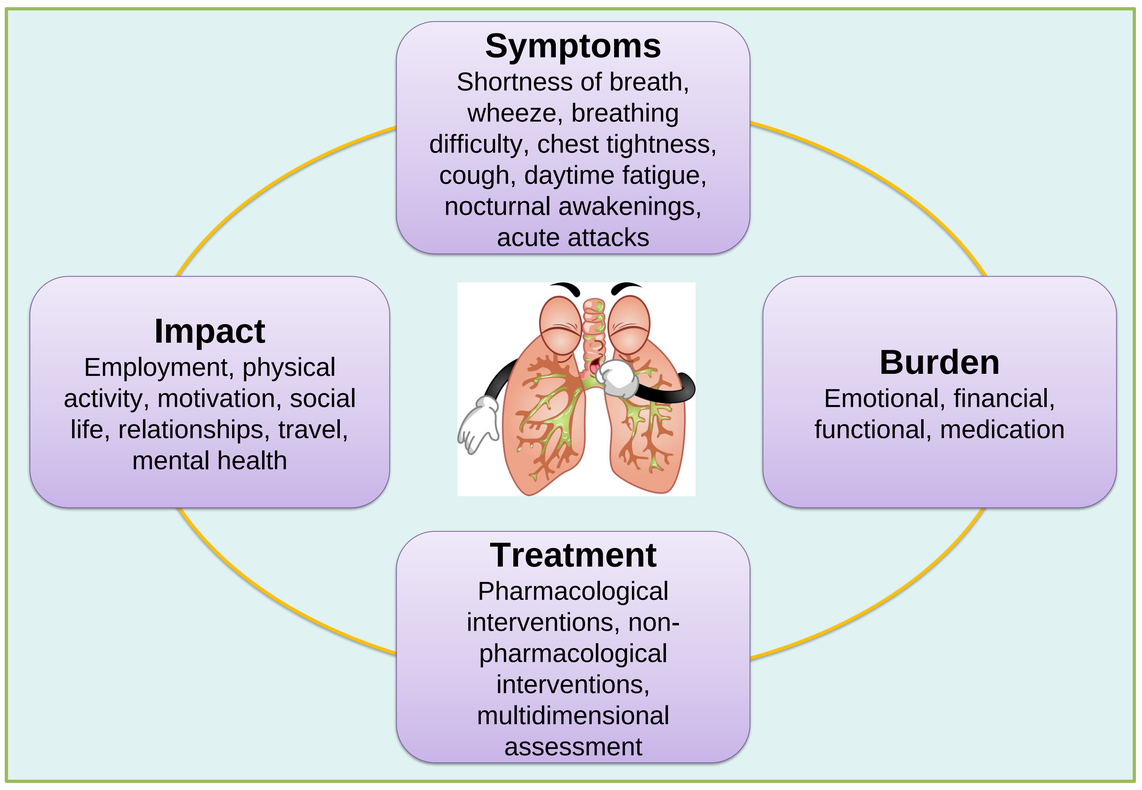
BACKGROUND:

Ireland had the second highest rate of asthma hospital discharges in Western Europe in 2016. Recurrent asthma admissions are frequent in tertiary hospitals and are commonly related to poor health literacy and medication adherence. A high percentage of patients still have inadequate asthma control, which has a negative impact on their health as well their social and economic well-being. Asthma management guidelines highlight the importance of patient education programs in improving patient understanding of disease leading to better healthcare outcomes.





METHODS:

A nurse led asthma clinic designed and set up in Respiratory Integrated Care to provide episodic care for acute exacerbation of asthma presented to Tallaght University Hospital emergency services(ED). Global Initiative for Asthma Guidelines and HSE End to End care model for asthma assisted in developing our own practice procedure.

ASTHMA CLINIC OVERVIEW:

Week 0
- Triage, diagnostics arrangements and scheduling within 48 hours

week 1-2
- Face to face appointment to review and discuss completed baseline assessment with patient. Each patient is classified for asthma control by assessing symptom history, measuring peak flow and Asthma control Test Score.

Week 4-6
- Follow up telephone call to confirm patient engagement with self-management.
- Reassess Asthma control
- Reinforced expectations and goals.

Week 6-8
- Multi-Disciplinary Team Meeting
- Review results of blood investigations, Pulmonary Function Test (PFT)
- Discuss each individual case for specialist input and optimisation of management if required.
- Refer to specialist services if needed

Week 8-10
- Face to Face or Virtual
- Clinical reassessment of progress and overall wellbeing.
- Recap of agreed goals, patient education and self-management strategies.
- Review and compare outcome measures.

Week 10-12
- Discharge back to GP with comprehensive summary if patient is symptomatically stable.

RESULTS:

- From October 2022 till March 2023, a total 71 referrals received and 64 patients attended asthma clinic.
- During 1st clinic visit only 15 patient's demonstrated good inhaler technique and adherence with their prescribed inhalers.
- After education 30 patients were compliant with peak flow monitoring.
- PFT arranged for 55 patients for diagnostic confirmation.
- Smoking cessation referral send for 10 patients.
- 36 patients successfully discharged to GP whereas 8 patients referred to severe asthma clinic for advance treatment.

CONCLUSION:

Early intervention and easy access to care may improve outcomes in asthma patients.

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LOCATION, LOCATION, LOCATION- IMPACT OF INTRODUCING A LOCAL CLINIC ON CLIENTS' WAITING TIME, TRAVEL TIME AND COST

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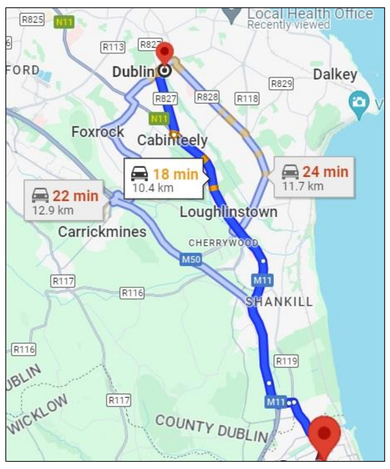
INTRODUCTION

- Comprehensive Geriatric Assessment (CGA) is the first, essential step to develop and implement a coordinated and integrated plan for older persons' care.
- The National Clinical Programme for Older People recommends that older adults identified as being frail or at risk of frailty should have a timely CGA performed (HSE 2012).
- This pilot quality improvement project relates to a recently established (June 2023) Integrated Care Programme for Older Persons (ICPOP) team.
- As our current hub lies in a different county to our clients' homes, all CGAs have been domiciliary to date.
- This project aims to investigate if running a clinic closer to clients' homes could result in earlier CGA and reduce travel time and cost.

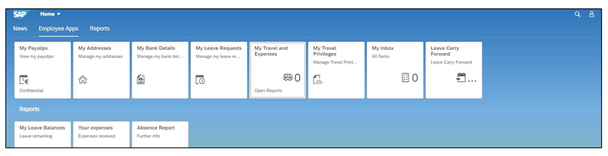
METHOD

- Three CGA-pilot clinics occurred over six weeks.
- Clients' addresses, Clinical Frailty Scale (CFS), average waiting time six weeks prior to and during the CGA-clinic period was recorded.
- Staffing was unchanged during data collection.

- Distance between office and clients' homes was calculated using Google Maps.
- Travel time was calculated on the same weekday at the same time as CGA-clinics ran.
- As clinicians tend to conduct consecutive visits, unidirectional distances only were populated.

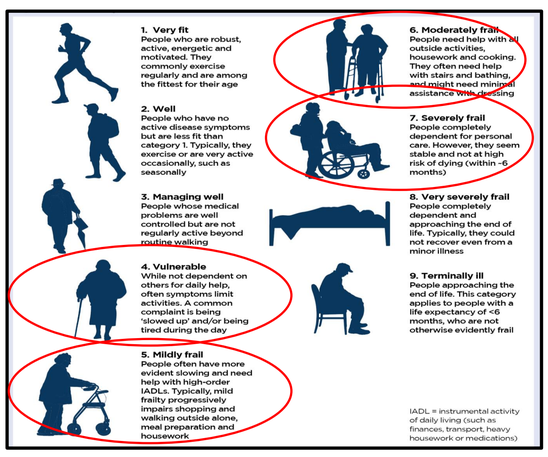


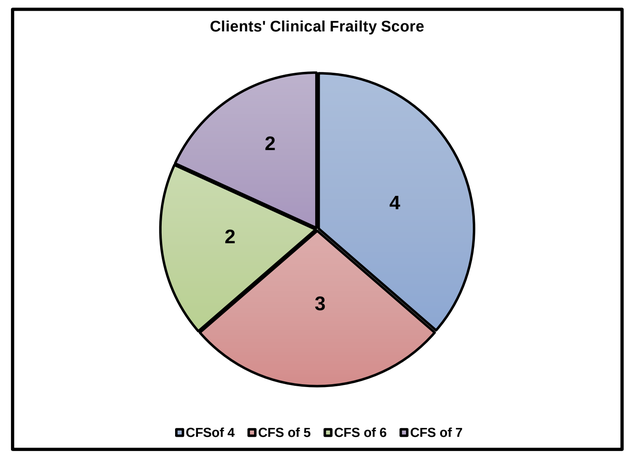
- National Integrated Staff Records and Pay Programme system was used to calculate mileage cost.



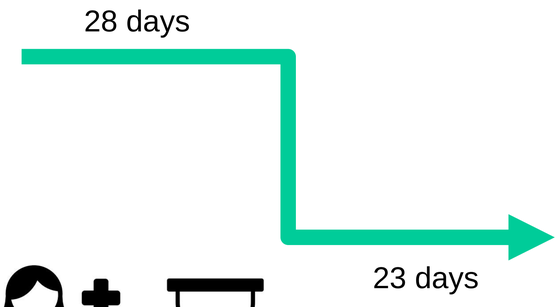
RESULTS

- Eleven clients attended clinic
- All were frail or at risk of frailty (CFS ≥4)

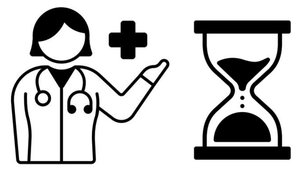




✓ Reduction in average waiting time after introducing a local clinic



✓ Clinicians saved a total of 3 hours 38 minutes



✓ 44.31 euro saved on mileage

CONCLUSION

- This pilot shows the benefits of offering in-clinic CGA closer to home in terms of reducing waiting time, optimising clinician time and reducing cost. Clients also had access to more than one clinician as a result of CGA location. Client satisfaction and numbers of clinicians seen will be included in the next steps of this ongoing project.

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Optimising integrated pathways and capacity in Benign Gynaecology outpatients to provide timely access to services

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INTRODUCTION

- The Benign Gynaecology Outpatient Departments in four Dublin hospital sites (NMH/SCH/SMH/SVUH) have multiple access points and accept referrals with no standardised referral form or criteria.
- It was identified that there was a significant Do Not Attend (DNA) rate as patients were being referred to multiple hospitals and unnecessary appointments were issued to patients due to lack of clarity around the DNA and Could Not Attend (CNA) protocols.

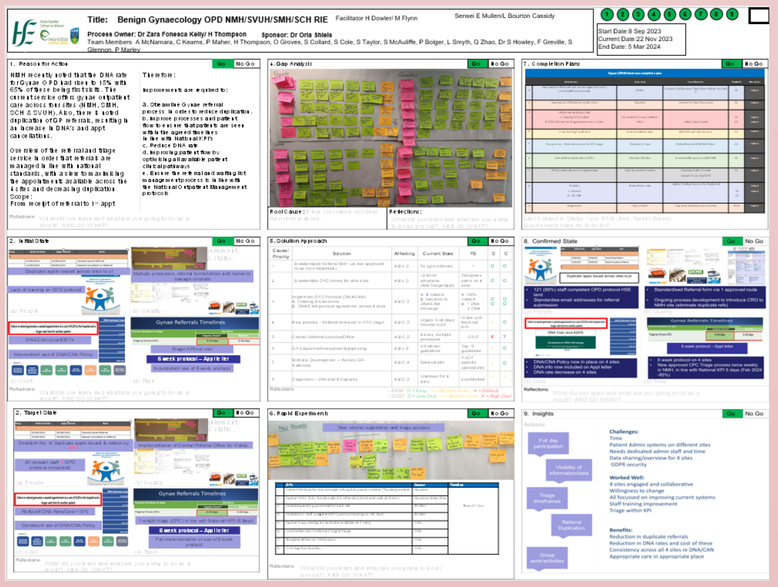
AIM

- Streamline Gynae referral process in order to reduce duplication.
- Improve processes and patient flow to ensure that patients are seen within the agreed timelines in line with National KPI's
- Reduce DNA rate
- Improving patient flow by optimising all available patient clinical pathways
- Ensure the referral and waiting list management process is in line with the National Outpatient Management protocols

METHODOLOGY

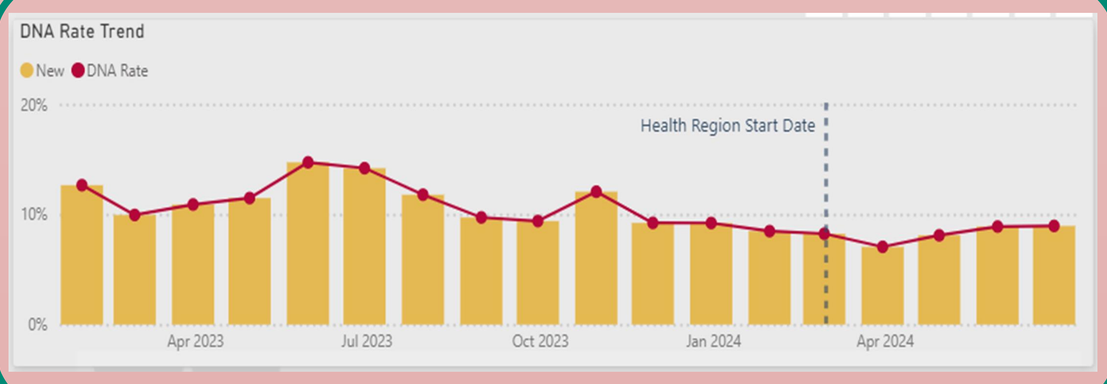
The facilitated Team undertook a Rapid Improvement Event focusing on streamlining referral processes & optimise capacity to provide timely access to Benign Gynaecology services in 4 hospital sites.
An A3 problem-solving tool was used to drive continuous improvement.
The team agreed solutions/workstreams, to deliver improvements, with updates scheduled monthly post event.

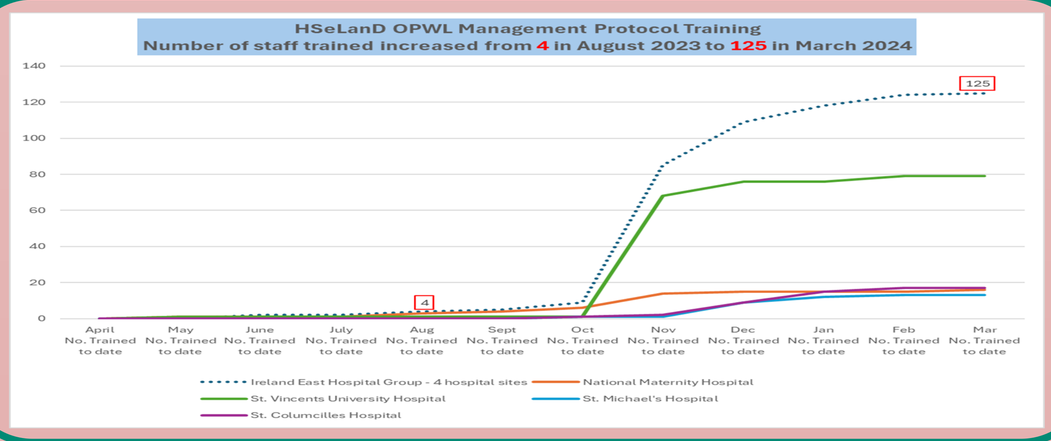
A3



OUTCOMES

- Single standard Gynaecology referral form and single route of referral submission
- Implementation of DNA/CNA protocol
- Implementation of single clinician triage process twice weekly for NMH to achieve 5 day CPC KPI
- Development of GP Clinical guidelines/education
- Agreed implementation of Central Referral Office
- 125 staff completed OPD Waiting List protocol training/education





CONCLUSION

Key Enablers

- 4 hospital sites engaged and collaborated
- Willingness to change
- All focussed on improving current systems
- Staff training improvement
- Triage within KPI

Key Challenges

- Time
- Patient Administration Systems differ across hospital sites
- Needs dedicated administration staff and time
- Data sharing/overview for 4 hospital sites
- GDPR security

Key Benefits

- Streamline Gynae referral process to reduce duplications
- Reduction in DNA rates and cost associated with DNA
- Improve the process to maximise service capacity
- Referral & waiting list management process adherence to National Outpatient Management Protocols
- Consistency across all 4 sites re DNA/CNA

Acknowledgments: Dr Z Fonesca Kelly, H Thompson, Dr O Shiels, A McNamara, C Kearns, P Maher, O Groves, S Collard, S Cole, S Taylor, S McAuliffe, P Bolger, L Smyth, Q Zhao, Dr S Howley, F Greville, S Glennon, P Marley, H Dowler, M Flynn

References: National Outpatient Waiting List Management Protocol (2022)
Outpatient DNA Strategy Version 1.0 (2023)

COAST TO COAST
INTEGRATED CHILDREN'S PRIMARY CARE
EAST TO WEST

Le Chéile Team, Multidisciplinary Team, Network 4
Community Healthcare East

represented by

Eilís Dignan, Senior Speech and Language Therapist

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Introduction

Two pilot multidisciplinary teams (MDTs) in primary care settings
Both 2-year projects (2023+2024)
Funded by Sláintecare (Pobal)

Linn Project
Galway City North and West
Network 5
Community Healthcare West

Le Chéile Project
Dublin South
Network 4
Community Healthcare East

Our goal

To support each other as we established and tested an integrated health and social care service for children and young people (0-10 years) in Galway City and in Dublin South.

Results

What is working well for both teams?	Themes
One MDT waiting list rather than 3-4 unidisciplinary waiting lists	More efficient primary care caseload management
Co-ordinated MDT care rather than fragmented unidisciplinary care	
Quicker identification of complex needs	
Coordinated MDT drop-in clinics for parents	Service is centred around the needs of the child/young person and their family
Parents' feedback show that they feel better able to understand and support their children	
More efficient signposting to services for families	
Co-location of MDT	Staff supporting and learning from each other

Challenges common to both teams
Recruiting staff
Selecting outcome measures that reflect the qualitative and quantitative successes and achievements of the MDT
Communicating the role of the primary care MDT to colleagues and referral sources
How to coordinate care without a patient management system
Uncertainty about the future of the project after December 2024

Method

Twenty staff members from both the Galway and Dublin teams met for a discussion with two independent facilitators. They discussed their perceptions of both projects and shared their experiences of working in this integrated way.

This discussion **elicited themes** which are reported in the results.

Conclusion

The opportunity to share experiences and to share learning was very impactful.
Fostering that collaborative environment has had a very positive impact on staff experiences and service provision.
Each team now has:

A better understanding of the work of their sister project

Knowledge about what is working well on both teams and how we might further improve our services

A commitment to ongoing collaboration

Enhancing Access and Service User Experience

A Service Improvement Project for Physiotherapy Waiting Lists across CHNs in the South East

Anna Marie Lanigan, Head of Service Primary Care **Kate Weeks, CHN Manager/Service Improvement Lead**

Background

In January 2023 there were **5337** patients classified as Priority 2 referrals waiting over 52 weeks for Physiotherapy Treatment across Waterford and Wexford Community Healthcare Networks (CHNs) within CHO5. **63%** of patients had been waiting between 2 to 5 years . Demand across the Community Healthcare Networks (CHNs) was outstripping the capacity, impacting KPIs, leaving staff feeling overwhelmed and impacting on the reputation of the services. It was agreed a central targeted approach would be needed to ensure that all those on the waiting lists who still required a service would receive an appointment as soon as possible.

METHODOLOGY

Challenges	Actions Taken/Lessons Learned
Quantify Waiting lists were kept in multiple formats across the Community Healthcare Networks (CHNs).	Collating waiting lists for all the CHNs and reporting on them by CHN, length of time waiting, age and demographics enabled us to focus on reducing the number of people waiting and the length of time waiting in each CHN. All progress was measured against this baseline data.
Validate Patients Due to the length of time people had been waiting, it was unclear which of these patients still required treatment.	Validation alone enabled us to reduce the waiting lists, however during our validation calls it was clear that for those still requiring treatment it was upsetting not be offered an appointment at that point of contact. In the future we will endeavour to offer a treatment appointment at Validation in order to further enhance the patient experience.
Validate with GPs GPs were informed if there had been no contact with their patients during validation and when they had been discharged from the Waiting Lists. This was done via letters to GPs per patient by post. The GPs found this practice time consuming and wasteful.	We agreed with GPs going forward that all validation would be done electronically, once per week or month for example and we would email a list of patients for the GP to validate – this practice was also put in place when a patient was discharged from the Waiting List.
Did Not Attend (DNA) Rates DNA rates across the CHNs was having an impact on clinical time.	By utilising a central team to manage the appointments and reminder calls the DNA rate for the programme was maintained at 4%. Clinical time was not wasted reminding patients and rebooking appointments. All cancelled appointments were rebooked quickly by the team ensuring the best use of clinical time.
Appointments Demand was outstripping capacity across CHNs and additional resources were limited. Additional funding was required to support to make the greatest impact on the Waiting lists.	Funding was agreed for HSE Out of Hours clinics and interim support from Private Physiotherapy Practices to target the longest waiters. This enabled us to have the biggest impact on the longest waiters in the most affected CHN areas in the shortest time frame.
Visibility for the CHN's on Progress The teams with the CHN were unable to see any progress or light at the end of the tunnel as new referrals were being received every day .	CHN Managers,Therapists and Therapy Managers have access to comprehensive data per CHN, age profile and length or time waiting .This can inform prioritisation and decision making, thus enhancing the success and learning across the South East.

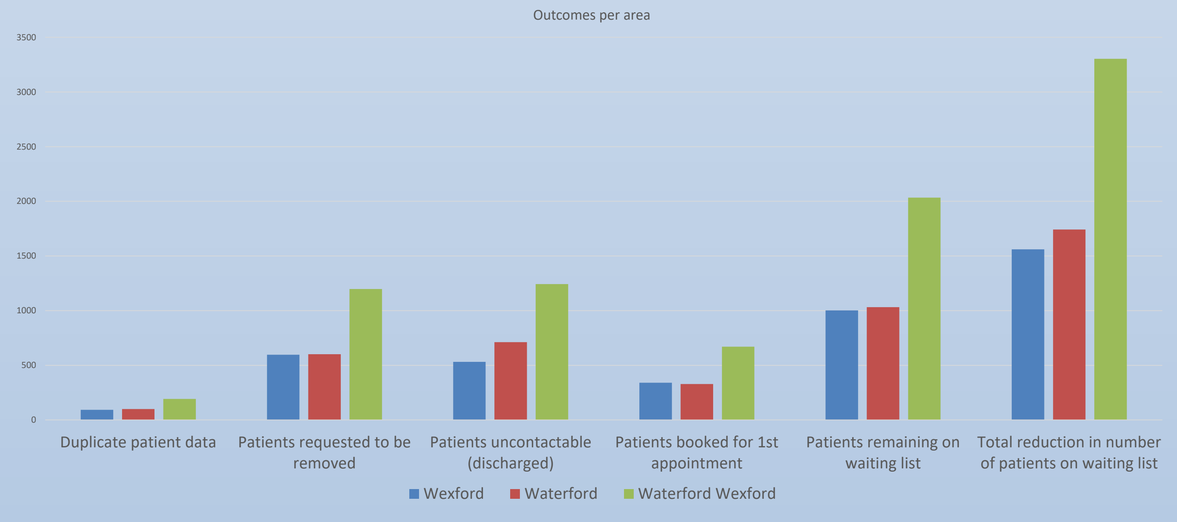
RESULTS

62% Reduction in Waiting lists >52

- Total of 3303 people removed from the Waiting List between March 23- December 2023.
- 670 people removed following referral to HSE Out of Hours Physiotherapy clinics and utilising interim private practice support.
- Therapists and CHNs have visibility of status and progress being made.

REPORTS

	Network	Original waiting list numbers	Duplicate patient data	Patients requested to be removed	Patients uncontactable (discharged)	Patients booked for 1st appointment	Patients remaining on waiting list	Total reduction in number of patients on waiting list	Total Percentage Reduction of patients on waiting List
	8	347	5	96	61	0	185	162	47%
	9	1046	49	294	199	341	164	882	84%
	10	675	21	119	165	0	370	305	45%
	11	495	18	88	106	0	283	212	43%
Wexford	Total	2,563	93	597	531	341	1002	1,561	61%
	6	1,229	43	242	349	57	538	691	56%
	7	1,545	57	359	363	272	494	1,051	68%
Waterford	Total	2774	100	601	712	329	1032	1,742	63%
Waterford Wexford	Total	5337	193	1198	1243	670	2034	3303	62%



Patient Feedback

"This is the first day in a long time that I have not had any pain, I appreciate it and want to thank you very much for the appointment."

"The Physio was very thoughtful and helpful. I am thrilled: I'll be running marathons after this"

"I am very happy, small steps. I think this will be a good start. I can walk, I can make dinner now and I can play with my kids when before I was crying in pain"

"I have had loads of treatment over the years and nothing has really worked but within 10 minutes with the Physio the pain was gone. He knew what he was talking about. I am absolutely thrilled with the treatment I got"

"The Physio I saw was so kind and nice; he was very professional; he was absolutely great"

"This is the first day I have had , in I don't know how long, that I do not have pain. I really appreciate it and thank you very much for the appointment"

"I thought the Physio was very good, he was so helpful, nice and easy to talk to . He's very nice an down to earth. I'm so impressed. Also, the place is lovely!"

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"Unlocking My Super Powers"
A Neuro-Affirmative Alternative to a Social Skills Group

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Children's Disability Network Team

BACKGROUND

Traditional Therapy

Traditional therapy approaches for neurodivergent children often frame their social abilities as deficits needing to be fixed, based on neurotypical standards

(Leadbitter et al., 2021; Sandoval-Norton & Shkedy, 2019).

Impact of Traditional Therapy

Such approaches can harm self-esteem, autonomy and mental health and can trigger sensory overload

'...fine line between supporting a child's development and attempting to change the essence of the person' (Leadbitter et al., 2021, p.3)

(Kupferstein, 2018; Dallman, Williams, & Villa, 2022)

Shift towards Neuroaffirmative Approaches

Outdated theories like Theory of Mind ignore effective information-sharing among neurodivergent individuals; new research on the Double Empathy Problem and Monotropism supports a shift to a neuro-affirmative perspective .

(Crompton et al., 2020; Morison et al., 2019)

Areas of Need

Neurodivergent individuals often face difficulties with friendships, self-acceptance, confidence and interpreting communication, making a neuro-affirmative approach that emphasizes empowerment and acceptance crucial

(Beck et al., 2020).

Summary of Key Terms

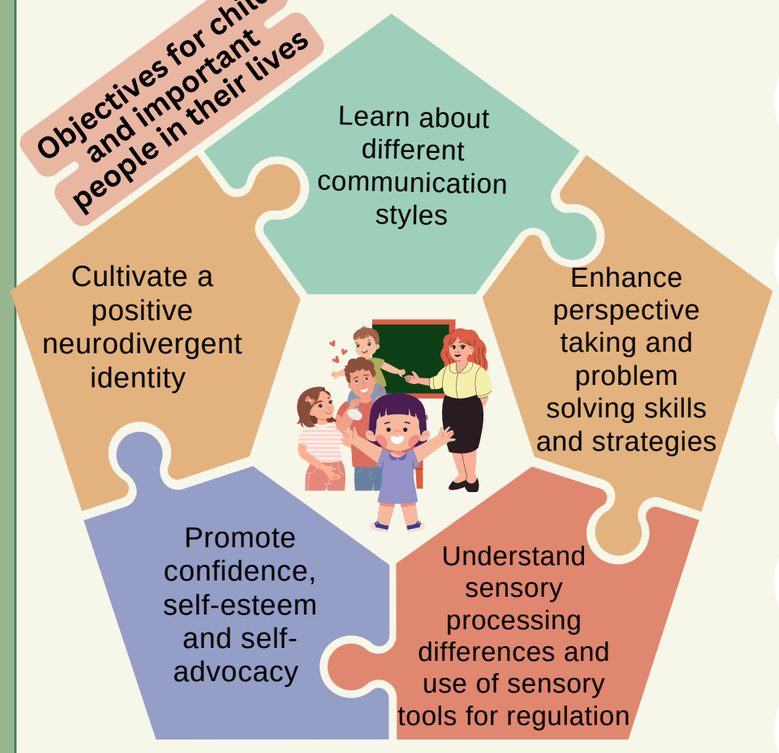
- **Neurodiversity:** A description of human society that recognises the worth of the diversity of neurologies to the health and development of the whole.
- **Neurotypical:** A person whose neurology matches closely to that of the majority of humans in a society.
- **Neurodivergent:** A person whose neurology diverges from the typical in a society (e.g. Autism, ADHD, DCD, Dyslexia, Tourettes)
- **Masking:** is the conscious or subconscious suppression of neurodivergent traits and compensation of differences in social interactions by neurodivergent people with the goal of being perceived as neurotypical. Masking can lead to mental health challenges and autistic burnout.

Need for a neuroaffirmative integrated intervention for the neurodivergent young people we work with and important adults in their lives.

Neurodiversity Affirming Group Intervention: Building awareness of neurodivergent differences, strategies to support regulation, problem solving and self-advocacy.

METHOD

Objectives for child and important people in their lives



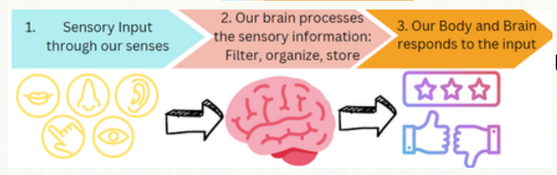
Group Process

1. **Goal identified by family/young person which included a focus on:** Friendships, self-advocacy, problem solving and understanding themselves.
2. **Parent session:** A parents only session to understand group objectives, neuroaffirmative approaches and to support skill transference.
3. **Child Sessions:** 5 group sessions for young people. Topics: neurodiversity, communication and sensory differences, friendships and self-advocacy. Pre and post measures collected.
4. **Additional Supports:** Parent letter following session with some activities for home. Areas of strength and need shared with family and keyworker on team to support additional skill building.
5. **School Information Session:** School information session offered to teachers and SNAs linked in with young person in group with a focus on skills/knowledge transference to school environment

Examples of Group Resources

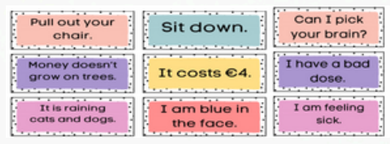
Perspective Taking Activities

Double Empathy Problem E-Book and communication differences social story



Understanding sensory processing

Matching direct and indirect phrases group game



RESULTS

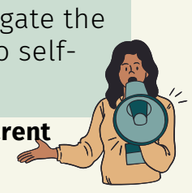
The Stirling Children's Wellbeing Scale (SCWBS) was used to measure emotional and psychological well-being in children before and after the intervention. Pre-intervention results showed that 6 out of 7 children had lower than average emotional well-being. After the intervention, 5 children completed the scale, and all showed improvement, with 4 scoring within the average range, indicating enhanced emotional and social well-being. Qualitative feedback from children, parents and teachers was positive, with reports of increased confidence, building of friendships, self-advocacy skills, knowledge of neuraffirmative strategies, and awareness of sensory and communication differences.

"He really enjoyed the group and the materials worked on have given us plenty to keep the conversation going".

Parent

"Thank you for providing us with vital tools that they can use to navigate the world and friendships and to self-advocate"

Parent



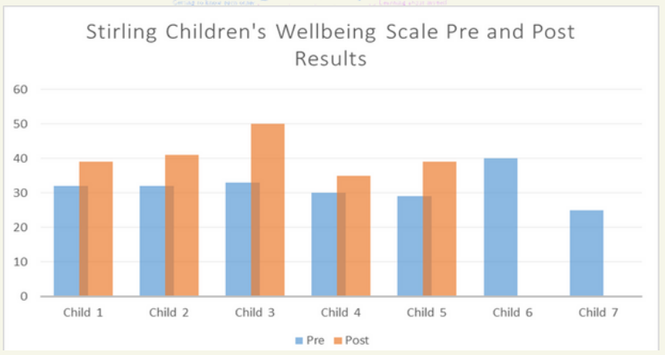
"It was a really good idea"

Parent

"Thank you ever so much for your wonderful session this afternoon. It was extremely beneficial and we learned so much from both of you".

Teacher and SNA

Summary of Feedback from Young People:



CONCLUSION

- This group shifted the focus from deficit-based intervention to an integrated strengths-based, neuro-affirmative approach which included the neurodivergent young person as well as other key stakeholders in their care (Dallman, Williams, & Villa, 2022).
- Group showed potential to enhance well-being and participation for neurodivergent young people (Toporek, Heitin, & Armstrong, 2013; Morris, 2017).
- The group provided an opportunity for young people to have access to other neurodivergent young people and sharing of interests, perspectives and experiences.
- Emphasized the importance of including neurodivergent interests to foster growth and self-advocacy (Wood, 2019).
- Highlighted the need to educate neurotypical peers, parents and school on neurodiversity to promote understanding and support neurodivergent young people to access supports required (Novak & Honan, 2019).
- Suggests further adaptation for neurodivergent individuals with higher support needs to access neuroaffirmative supports (Grove et al., 2018).
- Future tools like the F-Words Life Wheel and Goal Attainment Scale could assess broader impacts on everyday functioning (Sehajpal et al., 2023).

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Integrated Healthcare: Advancing Health Service Reform Conference

DIGITAL DELIVERY OF DIABETES PROGRAMMES IMPROVES CARE & ACCESS NATIONALLY FOR PEOPLE WITH TYPE 2 DIABETES

Dr. Karen Harrington, Orla Brady, Dr. Ciara McGowan, Margaret Humphreys

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BACKGROUND

- The Irish health service model of integrated care for people living with type 2 diabetes (2018, 2024) and the ICPCD recommends self-management education and support (SMES) as essential to quality care. A clinically effective group type 2 diabetes SMES programme (DISCOVER DIABETES – Type 2) was successfully designed, developed and evaluated in 2019-2020 to improve care access through the ICPCD hubs. It was developed for the HSE by diabetes dietitians in partnership with people living with type 2 diabetes (n=180), in line with international standards and evidence base for SMES and diabetes care.
- This group in-person programme, an empowerment and behavioural person centred community-based intervention proved resource efficient and effective, improved access being free to all and also integrated with an extensive range of HSE services and supports.
- In 2020, the COVID-19 pandemic prevented group in-person SMES programme delivery. COVID-19 also activated major diabetes care challenges including: the high risk status of this cohort, limited access to GPs and other health care professionals and increased fear and isolation.

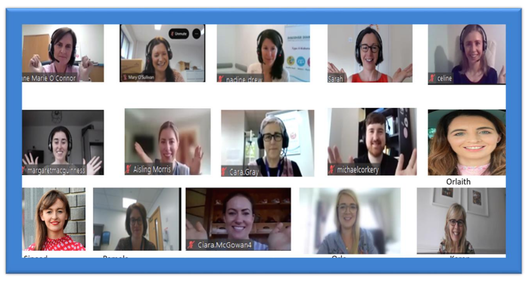
PURPOSE

The Self-Management Education team and ICPCD diabetes dietitians were challenged to respond rapidly with solutions to improve SMES access ignited by the pandemic. Having the HSE's own SMES group programme enabled pivoting to adapt and create innovative online solutions for group type 2 diabetes SMES and additional supports. Obstacles, related to IT systems, staff/client digital literacy, online pedagogy and change implementation, were efficiently and effectively resolved. .

METHODS

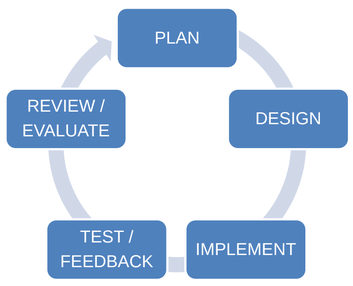
1

- **ICP Dietitians worked together online**
- Developed Online SMES Curriculum
- Attention given to learning to date, dietitian care philosophy & online pedagogy
- Stakeholder engagement: HSE Digital, ehealth Telehealth Programme, Age Action



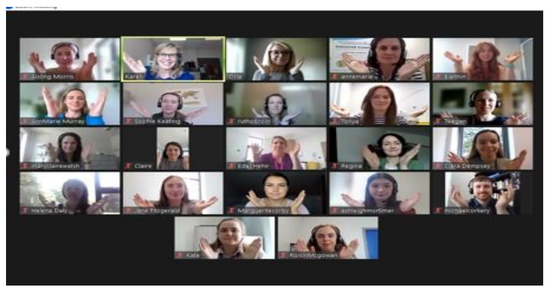
2

- **Iterative development process**
- 4 testing rounds (Nov./Dec. 2020 – May 2021)
- Client & staff feedback/evaluation
- Online service user evaluation
- **May' 21: Online programme defined**
- 1.5 hours x 6 weeks (core) & 6 month & year 1 follow-up



3

- Online SMES Package defined
- Educational Videos developed
- Telehealth support package defined
- Online educator training programme designed & developed by diabetes dietitians. New ICP dietitians trained **QISMET Accreditation achieved 2023**



*'I would just like to thank everyone involved in providing the course , it has been a huge help to me personally and has also **given me the confidence** to discuss the meds provided by doctors and consultants which I never had before'*

*'I found this course to be **very informative** especially in relation to the Health Check aspect. I previously accepted anything the doctor told me and now I feel confident to question/query. **I now understand what the numbers mean**. I have a much greater understanding of the medications'*

'*Just want to thank you again and again, **giving the patient the proactive power to change** is better than reactive healthcare'*

RESULTS

- **114 Online courses** ran Nov. 2020 – Dec. 2023. **684** online core sessions.
- Excellent engagement: more than 4 out of 5 people who registered participated.
- **1338 registered**, **1122** participated (Nov. 2020 – Dec. 2023).
- **122 educators** trained from **8 CHOs.**
- *2020-2021:* **Group sizes** (registered): 6-16, **Age** 26-81, 55% men

Online Environment & Experience

'educational, inspirational and enjoyable' ***'invaluable'***

2021 Online Implementation Service User Evaluations: 18 courses, n=85

		% agree/strongly agree
Knowledge & Skills	New Information	93%
	New Skills	92%
Confidence	Talking to HCPs	86%
	Talking to family	80%
Awareness	T2DM: serious & treatable	94%
	Personal *diabetes health results* useful	90%
Positive Experience	Made changes since	94%
	Course of benefit	93%
	Would recommend it	93%

CONCLUSION

The accredited online group type 2 diabetes SMES programme has been well received by people with diabetes. It improves access to SMES and other HSE services and supports, now offering a choice of in-person, online or blended care. Accessibility has improved - people living with type 2 diabetes and their families have participated from varied locations (at home/work, roadside e.g. trucks/taxis and abroad). This innovative solution offers a person centred co-ordinated integrated quality service to meet health needs.

Acknowledgements: People living with diabetes participating; ICP diabetes dietitian initiators of online delivery (CHEast: Celine Honohan, Sarah McEvoy, CHO 7/8: Michelle Carey, Orla Brady, CHO 9: Aoife Ward, Orlaith Burkett, CHO 5: Nadine Drew, Rita Whelan, Ann-marie Frayne); DISCOVER DIABETES – Type 2 online course development working group; Sláintecare Project 154 Dietitians: Sarah McEvoy, Clíona Twohig; Community Dietitian Managers; ICP community diabetes dietitians, chronic disease dietitians; Sláintecare Dietitians: Aoife Ward, Liz Kirby, Didi de Zwarte; HSE Digital team; Age Action; ehealth Telehealth programme; National Advisory Group for Sláintecare Project 154. Funding via Sláintecare Action Plan 2019.

References: available on request.

QISMET ACCREDITED

Sláintecare.

Rialtas na hÉireann Government of Ireland

Enhanced Community Care

NATIONAL IT SYSTEM, "HEALTH COURSE MANAGER" ENABLES BETTER ACCESS, INTEGRATION AND QUALITY CHRONIC DISEASE SERVICES

Orla Brady, John Cowhig, Aoife Ward, Dr. Karen Harrington, Margaret Humphreys

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BACKGROUND

Self-management education and support (SMES) courses are essential components of high quality chronic disease care for the 1.3 million people in Ireland who live with a chronic disease. The Enhanced Community Care (ECC) programme supports these courses for different chronic diseases. Health Course Manager (HCM) was developed by clinicians to standardise a national business process for SMES courses, streamline and maximise course access and uptake, standardise communications to service users and health care professionals, generate and report on activity metrics related to the delivery of these courses and enable the right care delivery in the right place at the right time. HCM is supported by the Enhanced Community Care programme, HSE Technology and Transformation and the Office of the National Clinical Advisor and Group Lead for Chronic Disease.

METHODOLOGY

The project involved mapping the SMES courses business model, engaging stakeholders, designing and developing the IT system, implementing evidenced base use of language, service user engagement, training staff, piloting the system and implementing in 15 chronic disease management (CDM) hubs to meet the service demands re: planning, scheduling, managing, delivering and reporting of the SMES programmes.

RESULTS

HCM ensures national standardisation of SMES courses management, organisation and generation and reporting of ECC activity metrics. HCM currently supports a variety of different SMES programmes both online and in-person. HCM is live in 15 CDM hubs and up to the start of July 2024 had supported the delivery of 981 group sessions and 8,372 service user contacts (data accurate as of 2nd July 2024). Time in motion surveys demonstrated Health Course Manager supports significant admin time saving of 1.5 days per course with automated communications to service users and health care professionals, metrics reports and filtering for planning at local and regional (and national) level. This significant time saving for course administration allows clinicians free to focus on the client care.

CONCLUSION

Health Course Manager, a clinician led collaborative development, is a live national HSE IT system that significantly improves access, delivery, reporting and integration of high quality self-management education and support courses for chronic diseases in line with the ECC programme. This learning and development will be brought forward into the National Integrated Community Case Management System further enabling us to deliver the right care at the right time and in the right place.

Fig 1. HCM implementation in Chronic Disease Management Hubs

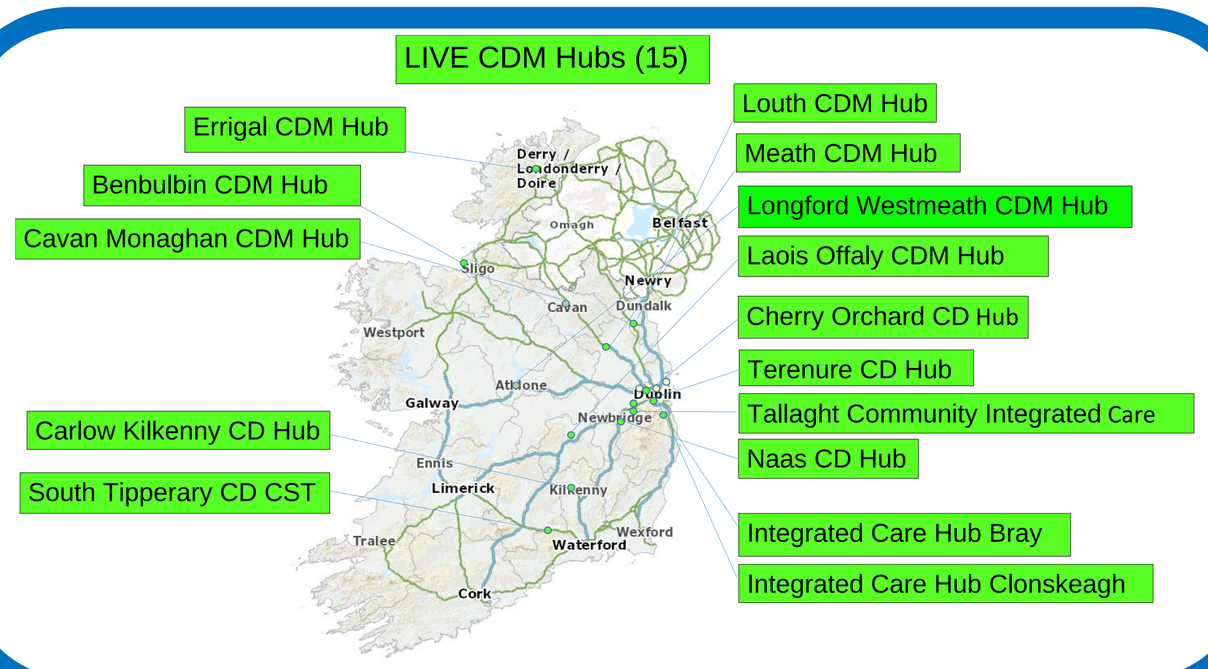


Fig 2. Training Interface Health Course Manager IT System

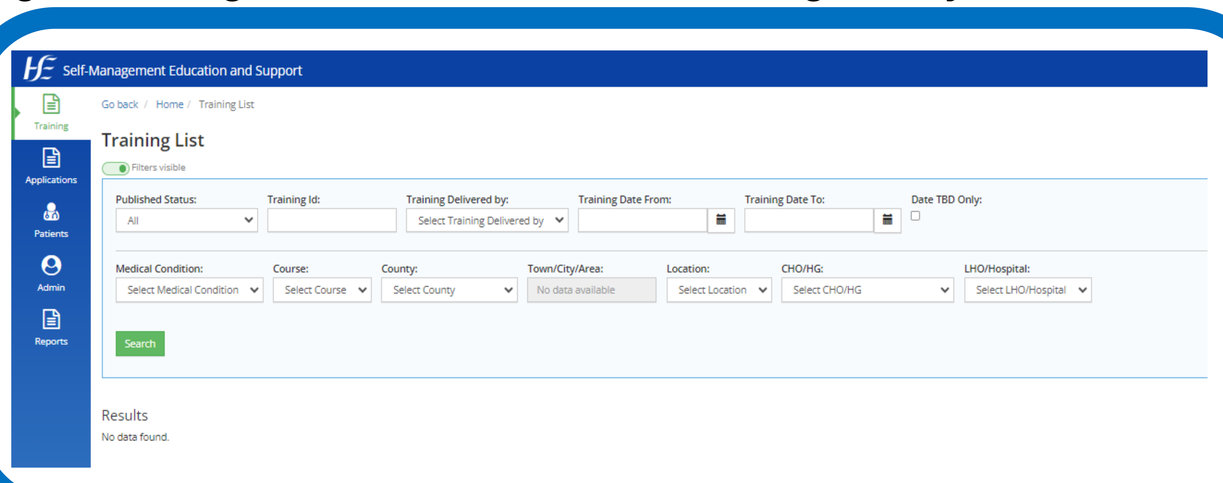


Fig 3. Examples of HSE Self-management Education and Support Programmes live on HCM

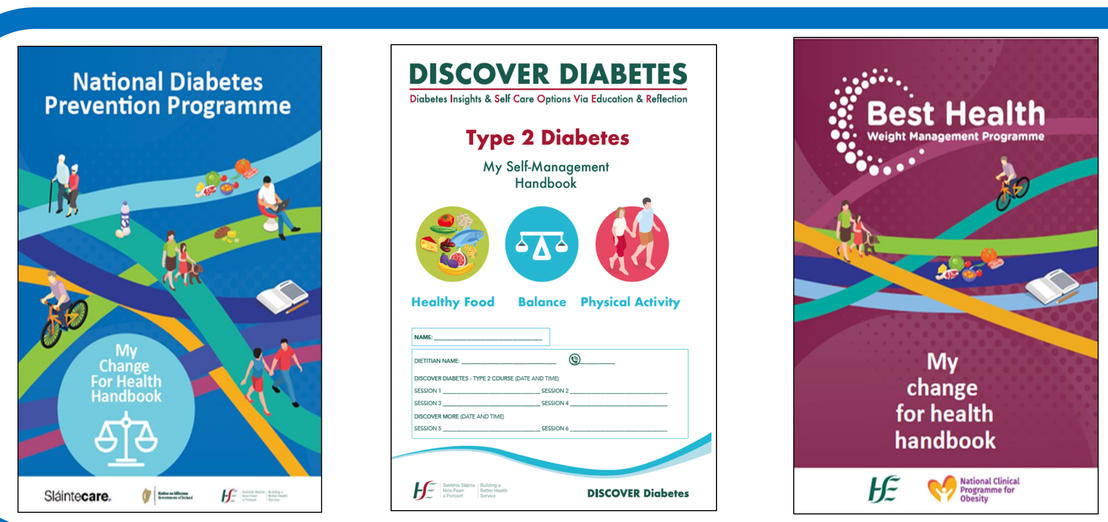


Fig 4. ECC Activity Metrics provided monthly to live CDM Hubs

ECC Activity Metrics v1.8b
Self-Management Education - Diabetes Prevention and Self-Management Education Programmes
No. of patients referred that were accepted onto the **Diabetes Self-Management Education** (DSME) Programme
No. of patients referred but not accepted onto the DSME Programme
No. of patients commencing the DSME Programme
No. of patient contacts with the DSME Programme
No. of patients referred that were accepted onto the **Diabetes Prevention Programme** (DPP)
No. of patients referred but not accepted onto the DPP
No. of patients commencing the DPP
No. of patient contacts with the DPP
No. of patients referred that were accepted onto the **Weight Management Programme**
No. of patients referred but not accepted onto the Weight Management Programme
No. of patients commencing the Weight Management Programme
No. of patient contacts with the Weight Management Programme

Fig 5. HCM User feedback

'It is a leaner way of doing things. You can easily search if a person has a referral on the system instead of searching through multiple excel sheets',' Snr ICP Diabetes Dietitian

'More efficient way of working' 'We can rely on HCM reports (metrics)', Community Dietitian Manager.

'Text reminders and emails are invaluable', Chronic Disease Dietitian

'Great that we can add in information in the public box with information on location, parking etc - very patient friendly', Chronic Disease Dietitian

'It's hard moving to another area and going back to old systems of excel and no text reminders - back to word attendance sheet etc. can really spot so many areas we could be leaner. I miss the efficiency and reliability of HCM and I have to do my groups stats myself now! Took HCM for granted in CHO X', Snr ICP Diabetes Dietitian

Acknowledgements

Ciaran Coughlan, Project Manager, HSE Technology and Transformation; Dr. Ciara McGowan, Senior Dietitian, HSE, SMES Office ; Margaret MacGuinness, Senior Dietitian, HSE; Siobhan O'Farrell, Change Manager, HSE ; HSE Community Dietitian Managers and their teams; Sláintecare Integration Fund Project ID 155 (2019); Enhanced Community Care Programme; Integrated Care Programme for Chronic Disease; Office of the National Clinical Advisor and Group Lead for Chronic Disease ; HSE Technology and Transformation.

Enhanced Community Care

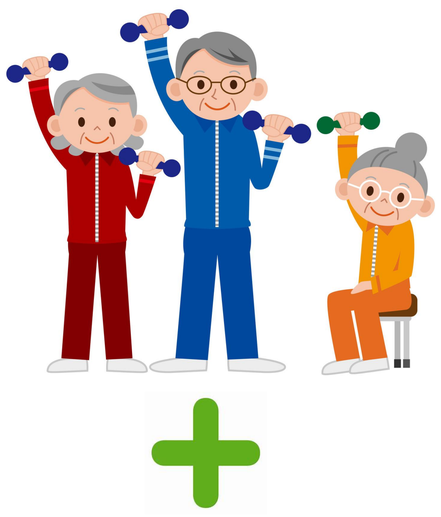
Sláintecare.

Rialtas na hÉireann
Government of Ireland

WEXICOP
Strong and Able Class

Angela Roche, Senior Physiotherapist, Wexford Integrated Care for Older People. Angela.Roche@hse.ie
Mary Renwick, Senior Physiotherapist, WEXICOP and Aideen McGuinness, Senior Dietitian, WEXICOP

Who?
Clients referred to **WEXICOP** are **moderately frail** scoring 5-6 on the Clinical Frailty Scale (CFS)
They need help with
- outside activities
- housekeeping
- personal care



What?
Almost all have **probable sarcopenia** resulting in low levels of
- muscle mass and strength
- energy levels
- function

Strong and Able Class
- We developed an **8 week conditioning class** run by a physiotherapist and dietitian.
- Exercises are based on the **Lets Get Moving programme** from the ISCP.
- These are **familiar** and correspond to client's home exercise programme to support practice and compliance.
- **Resistance is progressed** over time according individual capabilities.

- There is specialist dietetic input to improve the **quality of nutritional intake**.
- This works with strength training in improving muscle bulk and maximising outcomes.
- Classes promote the **social benefits** of group exercise and peer support.
- Run **in the hub** and in **outreach locations** to facilitate access for all.

WEXICOP Strong and Able Class
A new innovation by Wexford ICPOP Physiotherapy and Dietetics

What does the evidence say?
- **Strength training** is effective in reversing frailty and improving quality of life in frail older people (Liu et al 2011).
- Travers et al 2023 showed that a **combination of home exercises and dietary protein** significantly reduced frailty and improved self-reported health.

'can stand up better'
'more strength in arms'

''more confident''
''able to go out and meet people''

Individual Impact
Our client is 77 and living with Parkinson's disease, prostate cancer, visual impairment and heart disease.
He suffered a fall and wrist fracture, had a frailty score of 6 and low muscle mass.
After completing the class
his **grip strength improved by 32%**
and his **self-rated health improved by 30%**

Challenge in an community setting
1. **support practice** to enable people to become confident
2. **progress over time** to maintain a strength challenge
3. **optimal nutritional intake** to support muscle improvements
4. make the exercises **enjoyable**
5. improve **compliance** with home exercise

Thereby supporting long term change!

Conclusion
- **Compliance** with exercises and advice is variable and needs ongoing support.
- The class is subject to **ongoing review and improvement** as our service evolves to meet the needs of our clients in real time.

Take Home Message
*Resistance exercise works **hand in hand** with optimal nutrition*

Acknowledgements: Photos from Get up Get dressed Get moving booklet from the ISCP

THE ESTABLISHMENT OF A COGNITIVE STIMULATION THERAPY (CST) GROUP IN CARLOW/KILKENNY

Stephanie Ryan
Senior Occupational Therapist, ICPOP Carlow/Kilkenny

Introduction

This poster explores developing an integrated community based Cognitive Stimulation Therapy (CST) programme across Carlow/Kilkenny for service users of three distinct services.

What is CST?

CST is a unique therapy for Dementia. It is the only well-established non-pharmacological intervention for people living with Dementia which has shown evidence to benefit cognition and quality of life while being enjoyable, cost effective and has been adopted across the world (Spector et al, 2020).

It recommended by the NICE guidelines that those with mild-moderate dementia should be offered group CST to promote cognition, independence and well being (NICE 2018).

Who is involved?

ICPOP (HSE)

Memory Services (HSE) ⟷ Alzheimer's Society of Ireland (TSO)

How We Did It:

Working Group Established	Purpose
Members: OT Nursing Clinical Management	Staff with shared vision and values coming together to integrate our workforce capacity and capability
Terms of reference and standard operating policy agreed.	Through this integrated we can reach a larger target population and ensure sustainability.

How It Works:

- 6 participants and 2 facilitators per group → Runs over 10 weeks, one 2 hour session per week
- Themes include games, sounds, childhood, creative work, number, words etc.. → Social aspect of tea/coffee and chat incorporated each week
- Mid way check in and final feedback procedure → Everyone asked…**What next?**

What Next?

Carlow
- Local working group established to identify gaps for service users post CST
- Carlow Sports Partnership have linked with us to provide resistance exercise training as a follow on programme

Kilkenny
- Kilkenny ETB have linked with us to provide a follow on group/programme
- A participant led group has been set up to meet their needs, incorporating social and physical activities and creative arts

Future Plans
- Continue to build on the links with external agencies to provide community based groups for people with Dementia
- Look to expand referral sources in line with increased capacity through more trained facilitators, e.g. POLL

Participants To Date:

2022	2023	2024 Jan-June
0	24	24

Summary

- By integrating 3 services with shared vision and values we are reaching a wider target population
- The resources were within each service but competing demands meant no one service could commit the time/staff to run rolling groups
- Integration proved to increase the workforce capacity and capability, providing sustainable group therapy to all service users efficiently

References:

Spector, A., Woods, B., Stoner, C.R. and Orrell, M. (2020) *Making a difference 1* (Second Edition) Wimbledon: Hawker Publications.

National Institute for Health and Care Excellence (NICE), 2018. *Dementia: Assessment, management and support for people living with dementia and their carers.* (pdf) National Institute for Health and Care Excellence. Available at: https://www.nice.org.uk/guidance/ng (Accessed 10 May 2023).

DEVELOPMENT OF NURSING HOME OUTREACH SERVICE CARLOW/KILKENNY

Marie Hayden

Clinical Nurse Specialist, Nursing Home Outreach, Carlow/Kilkenny ICPOP

marie.hayden@hse.ie

Aim

"Designing and delivering integrated care for older people across local communities and hospitals is a multifaceted collaborative process between providers, users and carers. It involves changing the way health and social care is planned and delivered whilst ultimately focusing on patient experience, outcomes and quality of care."[2]

The Purpose of the Nursing Home Outreach Service as part of integrated care is to ensure delivery of the- Right care, at the right time, in the right place, to residents in Nursing Homes

Introduction

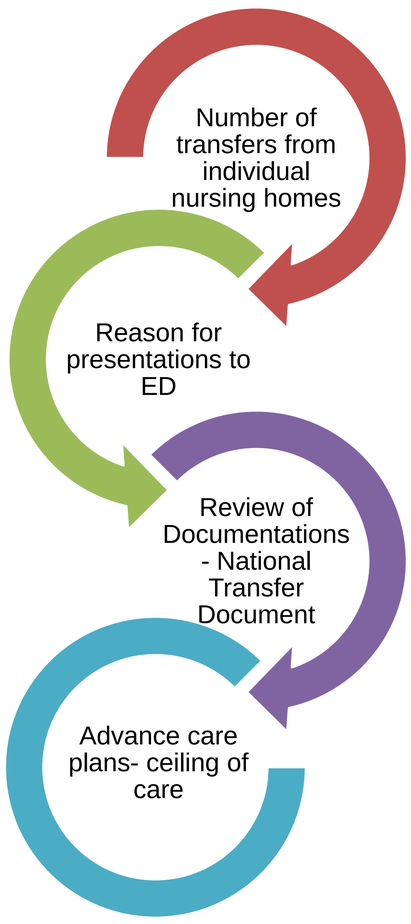
As the population ages, services such as the Nursing Home Outreach service will become increasingly important in providing comprehensive and integrated care.

The initial state, there was no Nursing Home liaison service available in Carlow/Kilkenny.

The introduction of the Nursing Home Outreach Service was as a result of recommendations from the Covid -19 Nursing Homes Expert Panel report [1], to support public and private Nursing Homes Nationally.

Currently, the number of residents presenting to St. Luke's General Hospital(SLGH). Kilkenny from the 15 Nursing Homes in Carlow/Kilkenny account for 23% of the GEMs positive attendances to the ED.

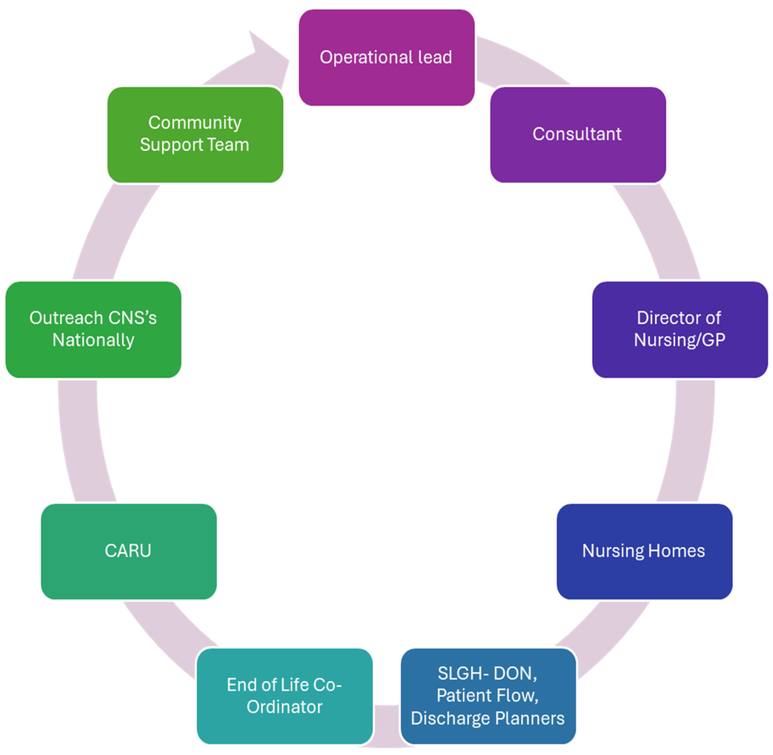
Points of focus



Methodology

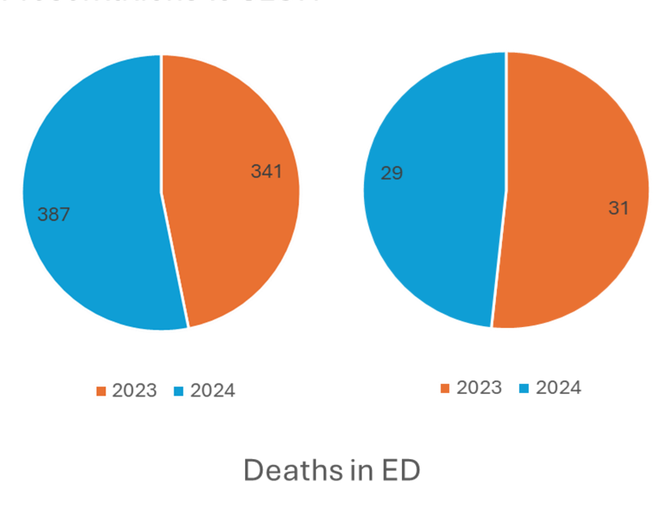
Developing a nursing home outreach service requires a structured and methodical approach to ensure its effectiveness and sustainability.

Stakeholder engagement



- Data collection: The CNS gathers data daily of presentations to SLGH, Kilkenny of residents from 15 Nursing Homes across Carlow/Kilkenny. This consists of analysing the details of the residents, number of presentations within the last four months, length of stay, reason for presentation and deaths of residents in ED/wards and Advance Care Plans accompanying residents to ED.
- Develop and Integrated Service: Define objectives- set clear measurable objectives : enhancing quality of life and reducing hospital readmissions. Completion of implementation plan, CGA development, MOUs with Nursing Homes,
- Establish governance structures: Clinical, Operational and Nursing Governance arrangements
- Implement pilot program in a limited number of nursing homes to test the service model. Use the pilot to identify any challenges and make necessary adjustments.
- Monitoring and evaluation- define KPI's such as reduction in hospital admissions, deaths in the acute from nursing homes and improvement in transfer/ACP documentation.
- Continuous improvement- Provide continuous training and professional advice for staff in nursing homes.

Data findings



Comparative data results for presentations to SLGH from NH residents in Carlow/ Kilkenny for GEMS pos aged > 65 since NH Outreach Implementation in the first six months of 2023 & 2024

Recommendations

- Service development, service requirement – ANP, CNS and access to HSCP
- Liaise with Community Support Teams establish working relations
- Continuous role out of education to NH's regarding the benefit of service
- Further engagement with stakeholders- ECC, National Older Persons Forums

Conclusion

The implementation of a Nursing Home Outreach service is a vital initiative that aims to enhance the quality of care for residents in Carlow/Kilkenny. This service offers key benefits including improved access to specialist healthcare and a reduction in hospital readmissions. By providing assessments, social support and preventative care the outreach service fostering a holistic approach.

Successful implementation requires thorough planning, adequate resources and collaboration between healthcare providers, nursing home staff and families.

Ultimately, a well- implemented nursing home outreach service can lead to better health outcome, resident satisfaction and a more efficient use of healthcare resources.

References:

1. HSE (2021) Covid-19 Nursing Homes expert Panel: examination of Measures to 2021 https://www.gov.ie/pdf/?file=https://assets.gov.ie/84889/b636c7a7-a553-47c0-88a5-235750b7625e.pdf#page=null
2. HSE (2017) Making a start in Integrated Care for Older persons: A practical guide to the local implementation of Integrated care programmes for Older persons. https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/a-practical-guide-to-the-local-implementation-of-integrated-care-programmes-for-older-persons.pdf

Carlow Kilkenny ICPOP Rapid Improvement (RIE) 2023

Philip O'Reilly – ICPOP Medical Social Worker

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CONTEXT:

Continuous service improvement is crucial in the evaluation and development of services.[1] In response to an evolving landscape of healthcare; the ICPOP multi-disciplinary team used a Lean methodology[2] and a rapid improvement event (RIE) to gain an in-depth understanding of the needs of older persons. This collaborative effort brought together colleagues from both acute and primary care setting, recognising the importance of a united approach to enhanced service developments.

ABOUT CARLOW KILKENNY ICPOP:

The Carlow Kilkenny Integrated Care Programme for Older Persons (ICPOP) was established in 2021. The service
aims to contribute to creating a comprehensive and responsive integrated care service tailored to the specific needs of older persons in Carlow Kilkenny.

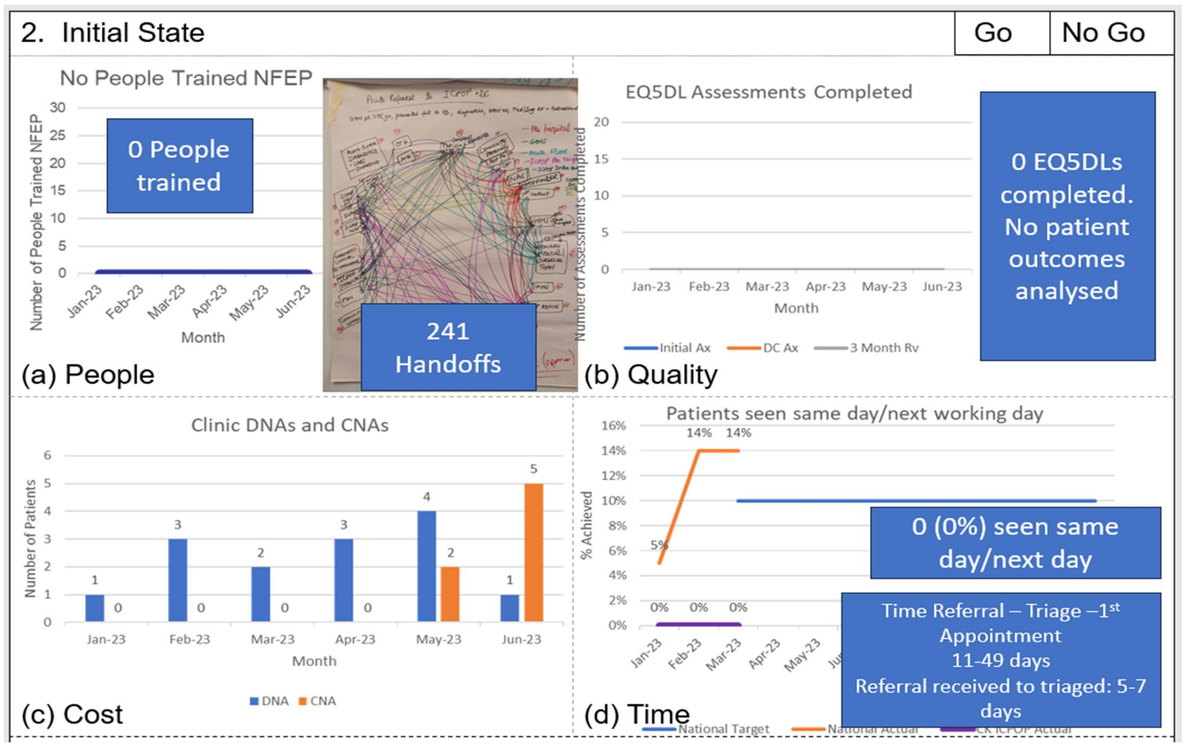
AIM:

Enhance the overall quality, efficiency and effectiveness of integrated care delivery by the HSE across Carlow & Kilkenny Older Person Services (South East Community Healthcare).

OBJECTIVES:

- Evaluate current service which was established in 2021
- Foster, enhance and promote inter-professional collaboration
- Identify opportunities for improvement
- Devise an action plan to implement sustainable changes and to provide a seamless service

CURRENT STATE:



METHODOLOGY:

The process was facilitated by the Ireland East Hospital Group Improvement Team.

All public and private social and healthcare providers working with older persons in Carlow/Kilkenny were invited to participate or provide representation.

Elements of the Lean methodology were adopted to facilitate multi stakeholder workshop style discussions over five days in Summer 2023

A current and future state was mapped and a gap analysis was completed. Solutions were identified, prioritised and implemented over a ninety day period

Progress updates were reported to all participants and stakeholders at RIE thirty, sixty and ninety days

Defined inclusion criteria, triaging and prioritization system. This facilitated more timely access for patients most in need. ICPOP team were are able to see patients identified at high risk of hospital admission in a more timely fashion, without any change in resources.

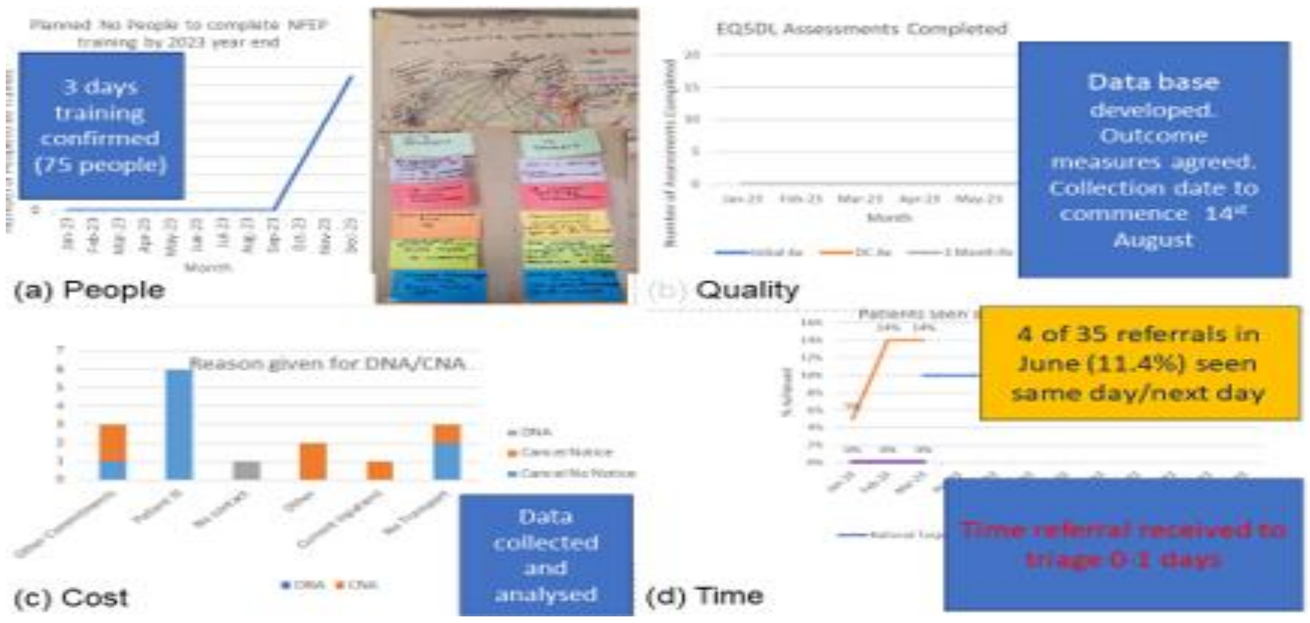
Development, evaluation and re-evaluation of defined metrics to measure impact of service interaction on older persons' quality of life and function.

Priority areas for development and changes in practice

The development and provision of education modules on older person's service and frailty education for health and social care providers.

Development of a service directory for older persons and establish clear integration pathways across acute and community services.

RESULTS:



Conclusion:

This Integrated Care Older Persons RIE has proven to be a transformative journey, successfully achieving all objectives through collaborative efforts. The impact is evident with a sustained increased referral rate of 26% over a 5 month period. This demonstrates the success of our streamlined processes which ultimately improved outcomes for Older Persons and services.

References

1 James E. Hill, Anne-Marie Stephani, Paul Sapple, and Andrew J.Clegg *"The effectiveness* of continuous quality

2. Gupta S., Sharma M., Sunder M.V. (2016). Lean services: A systematic review. International Journal of Productivity and Performance Management, 65(8), 1025–1056

Grúpa Ospidéal Oirthear na hÉireann
Ireland East HOSPITAL GROUP
UCD DUBLIN

CARLOW KILKENNY ICPOP
INTEGRATED CARE PROGRAMME FOR OLDER PERSONS

PULMONARY REHABILITATION "FAST-TRACK" SERVICE IN CHO6

Ní Chléirigh, M., Franciosi A., Gopika U., Kelly S., Krishnamoorthy M.

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Clinical Lead: Alessandro Franciosi, Respiratory Consultant, St. Vincent's University Hospital

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Introduction

A review of our Pulmonary Rehabilitation (PR) waiting lists in CHO6 highlighted significant waiting times, with the longest patient waiting 132 weeks (in April 2023). There were PR Programmes (PRP) running across two different sites and patients could only be prioritised if there happened to be a class running in their area. Our waiting lists did not meet the national target times as per the PR guidelines for enrolment. Additionally we were not addressing the priority patient: the guidelines for PR priority patient is that they are offered an appointment within 1 month of hospital discharge to enable them to regain respiratory functionality and the skills and confidence needed to manage their condition in the community. Our PR team increased with the addition of two full time physiotherapists in 2023 which allowed for the growth and expansion of the service with a keen focus on increasing access to the service. To ensure timely access to the programmes for those with the greatest need, the development of specific criteria for priority patients and the introduction of rolling PRPs has allowed for the commencement of our Fast-Track Service in CHO6.

Methods

Collect and analyse waiting list data for pulmonary rehabilitation (Apr 2023 - 2024).

Establish how long patients are waiting, the most sought after venues and who the main referring sources are.

↓

Devise a set of criteria for the priority patient based on national guidelines:

- Patients who had a recent exacerbation of COPD +/- requiring hospital admission

- Must meet all other established PR inclusion and exclusion criteria

↓

Link with key stakeholders / referrers

Explain the new role out of our Fast-Track Service in locations Bray and Arklow and how to refer into the service to access it in a timely manner.

↓

Trial a priority Fast-Track Service starting with a target wait time to enrollment of 6 weeks and reducing this to 4 weeks as capacity allows.

Additionally establish a rolling PRP in 2 sites to tackle long waiting times: Bray and Arklow.

↓

Ongoing evaluation and monthly metrics.

Aim to reduce routine PR waiting times to 6 months from referral.

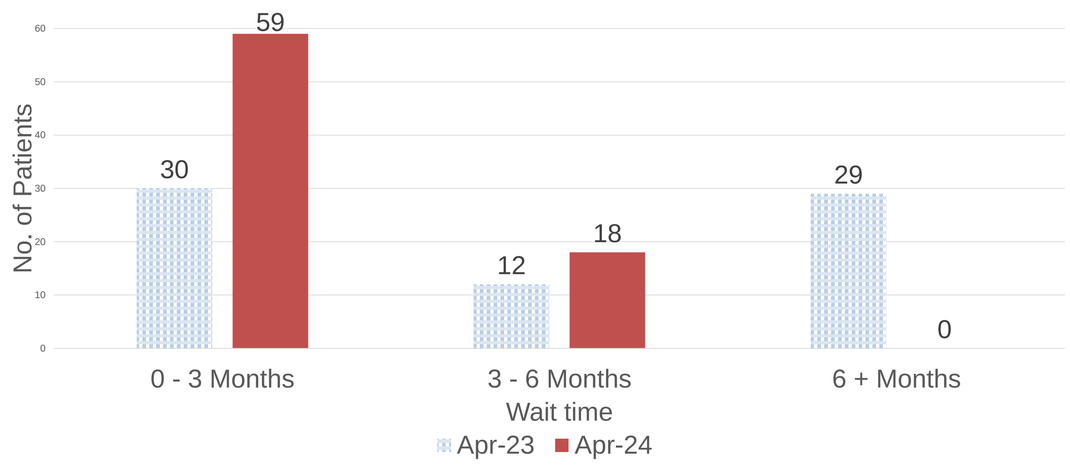
Results

Data was collected from April 2023 – April 2024. In this time, the Fast-Track Service was offered to 40 patients. Thirty-two patients were assessed within the target of 1 month post hospital discharge. The remaining eight Fast-Track patients were seen within 5-9 weeks of their hospital discharge. At time of contact, they were not available for sooner appointments – for reasons including further exacerbation, delayed return to pre-morbid status, or ongoing medical appointments (figure 1).

Figure 1: Fast-Track Wait Time

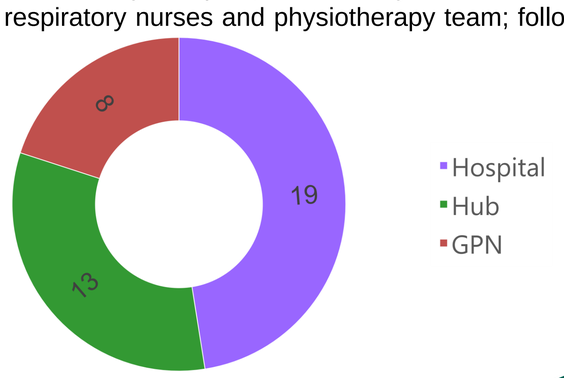
In April 2023 there were 71 patients waiting for PR: 30 waiting 0-3 months, 12 waiting 3-6 months and 29 waiting over 6 months, with the longest waiting 132 weeks. Within 1 year, this routine waiting list reduced significantly to < 6 months, with the majority of patients (N = 59) waiting in the 0-3 months and 18 patients waiting 3-6 months (figure 2).

Figure 2: Pulmonary Rehabilitation Referral to Assessment Wait Time



The most common source of referrals for the Fast-Track Service was from the hospitals (N=19), predominantly St. Vincent's University Hospital; followed by Hub staff which included the respiratory consultant, respiratory nurses and physiotherapy team; followed by the GP Network (N=8).

Figure 3: Referral Source



Conclusion

This service review brought about positive change in terms of access to our service for those patients most in need of it, and in terms of how we deliver the programme. We have broadened the sites we are using to deliver PRP in CHO6 and now with a mix of rolling and block programmes we can better cater for priority patients: in the past year we have had PRP running in Arklow, Bray, Rathdrum, Shankill and Wicklow town. The Fast-Track Service for those recently discharged from hospital onto the PRP close to their home has been successfully established in CHO6. Waiting times for priority patients is in line with the national guidelines, where they are offered a PRP within 1 month of hospital discharge. While our waiting time for routine PRP has significantly reduced down to 6 months, the goal of 3 months waiting time for routine PRP is a target we will continue to strive for. We plan to arrange an information evening with GPs in our region to further integrate our service in the community.

Disclosure: No conflict of interest to declare

Waiting List Initiative for Adults with Type 2 Diabetes Accessing Self-Management Education & Support

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DISCOVER DIABETES
Diabetes Insights & Self Care Options Via Education & Reflection

Type 2 Diabetes

BACKGROUND

- Self-management education and support (SMES) programmes are recognised as a core component of care for people living with type 2 diabetes. The DISCOVER DIABETES – Type 2 programme is an accredited SMES programme which is aligned with the national Slaintecare programme goals of right care, right place, right time. DISCOVER DIABETES – Type 2 has been shown to empower people with the knowledge, confidence and skills needed to self-manage their diabetes. Timely access to care is recommended.
- In March 2020, in-person DISCOVER DIABETES – Type 2 programmes were paused due to Covid-19 pandemic restrictions. In Waterford, in-person DISCOVER DIABETES – Type 2 programmes remained paused between March 2020 and November 2022.
- During this period, seventy five percent of people on the waiting list expressed a preference for attending an in-person, rather than online, DISCOVER DIABETES – Type 2 programme.
- This resulted in significant increases in waiting list numbers and waiting times.

AIMS & OBJECTIVES

AIM: • To develop and action a waiting list initiative

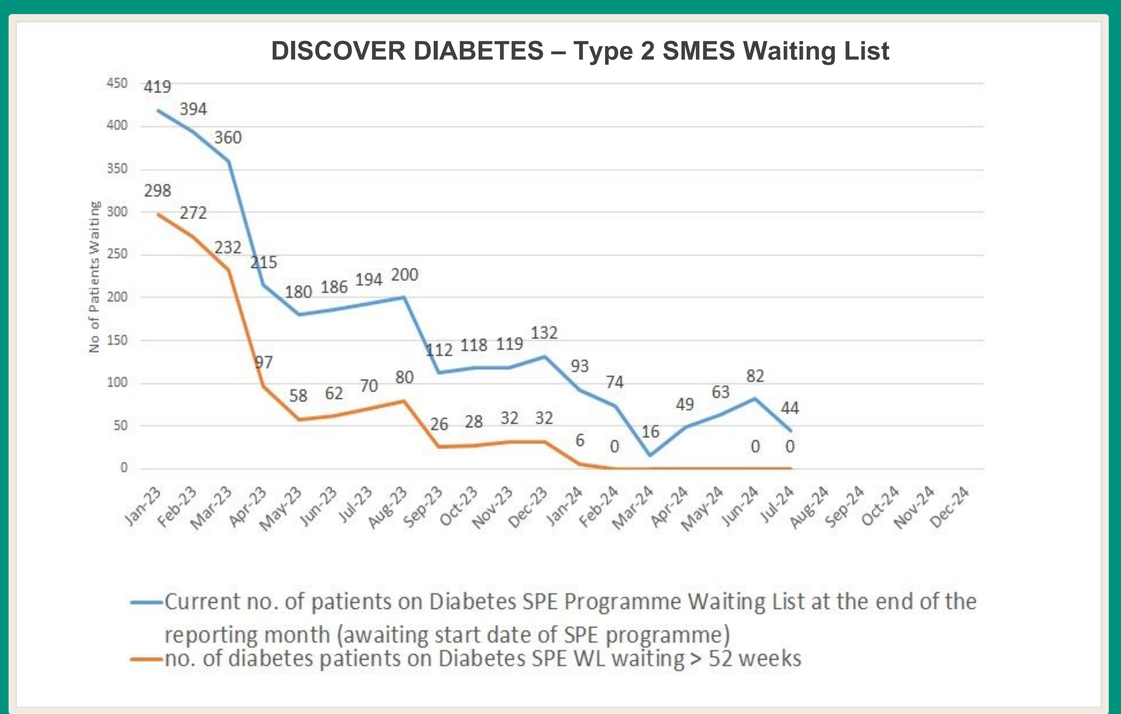
OBJECTIVES: • To reduce total waiting list numbers
• To reduce waiting times from referral to invitation to a DISCOVER DIABETES – Type 2 programme
• To maintain a quality service that meets the needs of those participating in the DISCOVER DIABETES – Type 2 programmes

METHODS

- The waiting list initiative was developed, in collaboration with the Dietitian Manager CHO 5, the Waterford Integrated Specialist Healthcare (WISH) HUB Operational Lead and Administration Support.
- The waiting list initiative targeted:
  - Administrative waiting list validation
  - Significant additional DISCOVER DIABETES – Type 2 programme delivery
- All on the waiting list were invited to confirm their interest in attending upcoming DISCOVER DIABETES – Type 2 programmes. This work was supported by the WISH Administration Support.
- Sixteen in-person DISCOVER DIABETES – Type 2 programmes (sixty four sessions) were delivered across Waterford city and county, between January 2023 and February 2024.
- The sixteen programmes sought to meet the expressed preferences and needs of the people waiting.
- Morning, afternoon and evening in-person programmes were delivered. Family and support persons were invited to take part.
- The sixteen programmes were delivered by one senior dietitian.

RESULTS

- Results reflect the waiting list initiative completed between January 2023 and February 2024.
- The waiting list initiative resulted in:
  - **82%** reduction in total waiting list numbers: **419** (Jan 2023) to **74** (Feb 2024)
  - **100%** reduction in waiting times > 52 weeks: **71%** (Jan 2023) to **0%** (Feb 2024)
- In February 2024, the longest waiting time for a DISCOVER DIABETES – Type 2 programme was reduced to **< 3 months**.
- Qualitative evaluation of the DISCOVER DIABETES – Type 2 programmes delivered, indicated high levels of satisfaction amongst participants.



"I have learned more in the last 4 weeks than I ever knew in the 30 years I have diabetes"

"Incredibly helpful and informative and gave me all the knowledge I need to better understand and manage my diabetes"

"The group was great for bouncing ideas and learning from each other"

"I loved the group and the peer participation"

CONCLUSIONS

- Timely access to self-management support programmes, such as DISCOVER DIABETES – Type 2, is vital. These programmes are a key component of diabetes care, empowering people living with type 2 diabetes to live healthily, to take an active role in their own care and to improve their quality of life.
- The waiting list initiative, which took place between January 2023 and February 2024, successfully resulted in a significant reduction in waiting list numbers and waiting times for people living with type 2 diabetes in Waterford.
- This has resulted in the WISH HUB being able to offer more timely access to care.
- High levels of participant satisfaction were maintained throughout the period of the initiative.

Acknowledgements:
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WISH HUB
Waterford Integrated Specialist Healthcare HUB

Integrated Care Programme for the Prevention and Management of Chronic Disease

Impact of a Nurse-Led Virtual Palpitation Clinic - Bridging the Access Gap in Integrated Care using AliveCor Monitoring in the Community Setting

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Background

Palpitations are a common and often distressing symptom that leads to frequent GP and emergency department visits. They can indicate a range of underlying conditions, from benign arrhythmias to serious cardiac issues. To improve patient care and reduce the burden on tertiary cardiology services, the Integrated Care Hub, Bray, introduced a CNS-led Palpitation Clinic utilising the AliveCor Kardia Mobile monitoring device. This initiative allows rapid, non-invasive assessment and continuous monitoring of patients in a community setting, facilitating timely interventions and reducing unnecessary referrals to tertiary care.

Introduction

This study aims to evaluate both the patient experience and clinical outcomes associated with AliveCor monitoring within the Palpitation Clinic. The study focuses on how the device influences patients' ability to manage palpitations, reduces their anxiety, aids in identifying the underlying causes of symptoms, and fosters confidence in its use. Additionally, clinical outcomes were tracked, including referrals to electrophysiology and medical intervention. The insights gained from this study will help assess the effectiveness of the AliveCor device in enhancing patient care and streamlining the management of palpitations in community setting.

Methods

A 7-question survey using a 5-point Likert scale (1 = Strongly Agree, 5 = Strongly Disagree) was administered to patients after completing AliveCor monitoring at the Palpitation Clinic. Of 196 surveyed, 125 (64%) responded. The survey assessed patient experience and clinical outcomes were also evaluated including the need for further tests, medication management, or follow-up plans.

Palpitation Clinic Workflow

Referral Source
- GP or Consultant (via Healthlink or direct email)

Vritual Triage
- Review symptoms and assess suitability for AliveCor
- If unsuitable, consider other diagnostic tests or discharge back to the referrer with recommendations

Virtual Consultation
- Confirm need for AliveCor
- Assess patient's ability and willingness to use the device and app effectively

Clinic Appointment
- Review ECG, vitals, and medical history
- Assess other factors causing palpitations
- Provide brief lifestyle interventions (e.g., smoking, diet, exercise)
- Set up AliveCor and educate patient on use and emergency procedures

Virtual Follow-up
- Monitor for up to 6 weeks, with possible extension

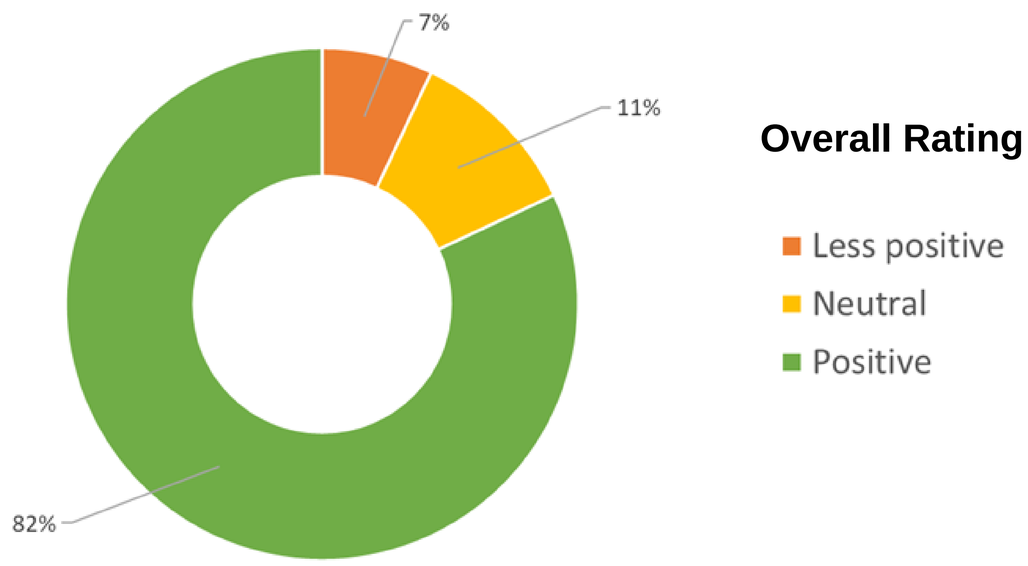
Outcome
- Determine need for further intervention
- Collect device and discharge patient

Conclusion

This study found a positive overall rating of 82% (±4.06% margin of error at a 95% confidence level) from 125 respondents out of 196 surveyed (64% response rate) on the use of the Kardia Mobile device for palpitations. Additionally, 82% of the palpitations monitored were benign and did not require further intervention. Traditionally, all these patients would have been referred to the hospital for diagnostic testing, highlighting the effectiveness of the Kardia Mobile device and the current management approach at the Palpitations Clinic in reducing unnecessary referrals.

Disclosure

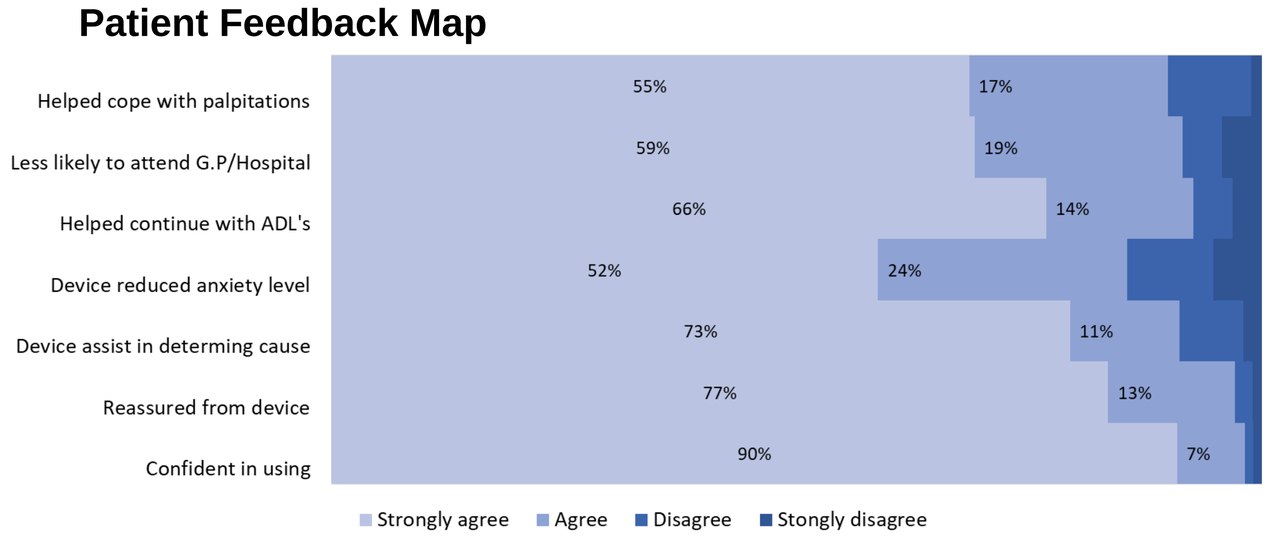
The authors have no financial interest in the Kardia Mobile device. This study was conducted independently to evaluate its effectiveness in managing palpitations.



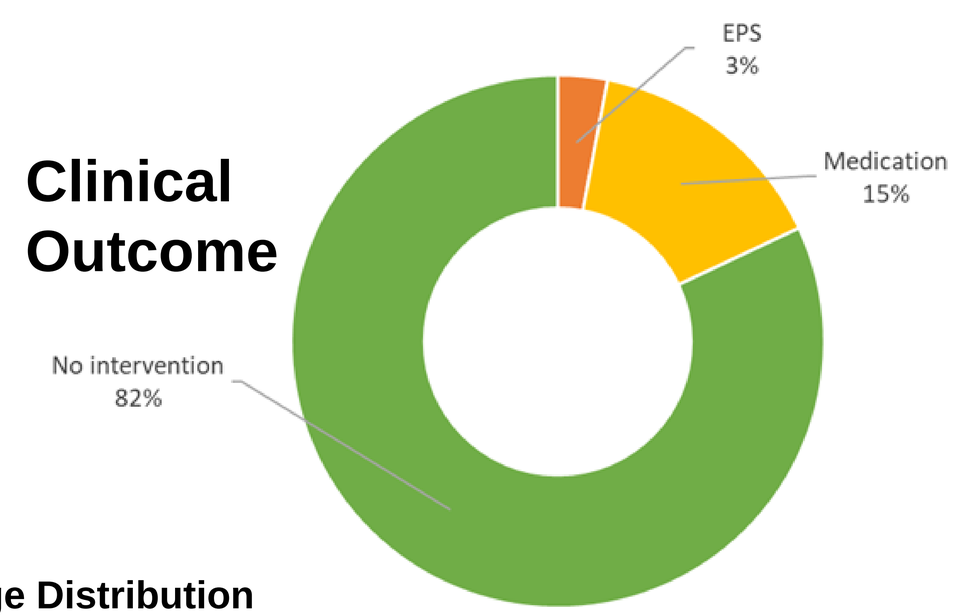
Survey Summary and Insights

- **Overall Rating:** Approximately 8 out of 10 respondents reported a very favourable patient experience.
- 8 out of 10 patients indicated they would be less inclined to visit a GP or hospital due to the device, supporting the aim of reducing unnecessary medical visits.
- 9 out of 10 patients felt confident in using the device.
- 9 out of 10 patients felt reassured by the device.
- The device's reassurance likely contributed to 7 to 8 out of 10 patients experiencing reduced anxiety levels and improved ability to cope with palpitations.

Patient Feedback Map



Clinical Outcome



Age Distribution

Most patients at the Palpitations Clinic are aged 45-64, with fewer in the 18-24 and 75-84 age groups. Females outnumber males across all ages, indicating that middle-aged women are the most common patients.