OPTIMIZING DATA TO INTEGRATE HEALTH AND SOCIAL CARE IN DUBLIN 8

A SMART D8 PROJECT

LAUNCH WORKSHOP REPORT AND EMERGING PROJECTS

SMART D8
A Smart Dublin District

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Prepared by:

- Dylan Creane
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On behalf of the project Steering Group:

- **St James's Hospital**
  - Fiona Keogan, Director of Lean Transformation
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- **HSE**
  - Howard Johnson, Director HSE Health Intelligence Unit
  - Karen Kinsella, Community Health Network Manager
  - Christina Doyle, Chronic disease hub operational lead, Meath Campus
  - Tara Creighton, Chronic disease hub operational lead, Cherry Orchard
- **Trinity College Dublin**
  - Noel McCarthy, Professor of Population Health Medicine
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  - Darach Ó Ciardha, Assistant Professor in Primary Care and General Practitoner

CONTENTS

BACKGROUND

The national Sláintecare policy proposes changes in the delivery of care with an increased focus on delivery in the community and integration of care. Community health networks and hubs will be central to the implemention of this policy. St James's Hospital is actively engaging in the development of these integrated services and increasingly working with services and communities in its catchment area, with one of its key catchment areas being Dublin 8. Related initiatives such as the chronic disease management programme in general practice and Healthlink are further changing healthcare delivery. Many new services record substantial amounts of data on health outcomes and healthcare delivery. Moreover, these services are currently addressing how to develop their business systems, such as joining up across disciplines in the new enhanced community health network functions.

Intelligent planning and monitoring could be strongly supported with appropriate data. There are detailed data within organisations and substantial national data collections that can be provided at local population level and with interpretative input to support their use. Such data are extensively used in other countries to allow data-informed population health management. This guides service planning, delivering, changing, and monitoring. Although Ireland developed effective data guided responses to COVID-19, we lack an overall structured and integrated approach to ensure that local populations benefit in this way from data that is routinely collected from and about them.

Given the scale of investment and change in community and integrated healthcare delivery at present and in the coming years, optimisation through better use of data can offer substantial benefits through improved efficiency and effectiveness of the resulting healthcare system. The current intensity of service developments makes this gap particularly important now and motivates approaches to remedy it, and to build on learning from the national COVID-19 response.

Smart D8 has the opportunity to act as a model of how to define data needs for data-guided population health management locally, and to collaborate locally and nationally to develop information connections to support and deliver this. Commitment of the HSE and hospitals in this area to developing collaborative services and using data make it an ideal site for innovation. Our aim is to bring together local D8 health and social care services and Trinity academics, along with a wide network of national and international expertise to define priority information needs, and feasible approaches to meeting these.

OVERVIEW

Optimizing Data to Integrate Health and Social Care in Dublin 8 is a Smart D8-funded project that aims to maximise health and wellbeing in D8 by optimising use of healthcare data. It brings together local and national partners to together identify approaches to generating and jointly using data to support the delivery of integrated care responding to community needs for current and future patients.

The project was formally launched via a full-day workshop on October 10th 2022 in Dublin 8's Digital Hub. This workshop brought together 40 key stakeholders and experts from various areas, including:

- Local health service clinicians and managers across the community and hospital in Dublin 8
- Specialists in integrated care, population health management, and health intelligence
- Community representation
- Decision makers and academics including international invited speakers

The findings and experiences of a number of existing relevant projects/initiatives were presented to support a shared understanding of the healthcare data landscape in Ireland. This included a demonstration of data held by the Health Intelligence Unit applied to the Dublin 8 area. Plenary and group discussions included a mix of local, regional, national and international participants, and focused on identifying priority issues and opportunities.

The overall aim was to frame a vision for the project and propose specific initiatives that could be further developed towards improving population health management in Dublin 8. This report focuses on these proposed projects and post-workshop feedback on these.

A full list of project participants is provided in Appendix 1 (p. 22). An overview of underpinning sessions is provided in Appendix 2 (p. 24), along with details of how to obtain copies of slides presented on the day. Prior to the workshop, background material was circulated to project participants to provide information on policy, programmes, partners, and data sources including national data mapped to the Smart D8 area by the Health Intelligence Unit. This is provided in Appendix 3 (p. 25)

GENERAL FEEDBACK

Survey feedback following the workshop included participants' views of the single most important learning they took away from the workshop, which are summarised below:

- Fragmentation of data and a lack of integration between different health services in Ireland
- The importance of collaboration in order to identify barriers and realise opportunities
- The need for a shared vision
- The need for standardised pathways for managing GP-relevant problems
- The importance of access to high-quality data for strategic decision-making
- The sense that a majority of people working in healthcare, across a diverse range of roles, are seeking to improve healthcare data practices and to work collaboratively to achieve this.

OUTCOMES OF THE WORKSHOP

Four projects were identified at the Workshop, which will undergo further development and evaluation:

Project A

Mapping of Services in D8

Project B

Expanded Use of Healthlink

Project C

Clinical Pathways for Respiratory Disease

Project D

Health Data to Support Local Communities

PROJECT A

Mapping services in D8 to support referral, communication and planning

Rationale

Many referrals are based on informal and incomplete knowledge of what services are available where, and for which patients. This is inefficient and likely contributes to inequity of provision and potentially poor care. An up-to-date directory of available services to allow efficient referral was identified as potentially hugely useful to clinicians and could also be used to support planning. Maintaining it is potentially labour intensive unless a system can be identified to make it efficient to update and to search. As community services expand in the coming years this changing provision makes this ever more important.

Planned work

This project will map available and planned services in Dublin 8. It will scope options for a platform that can be updated by services as they arise, stop or change, including their referral pathways and contact details. It will identify options to support searching these including how they might be integrated in HSE Health Intelligence Unit data and maps of areas.

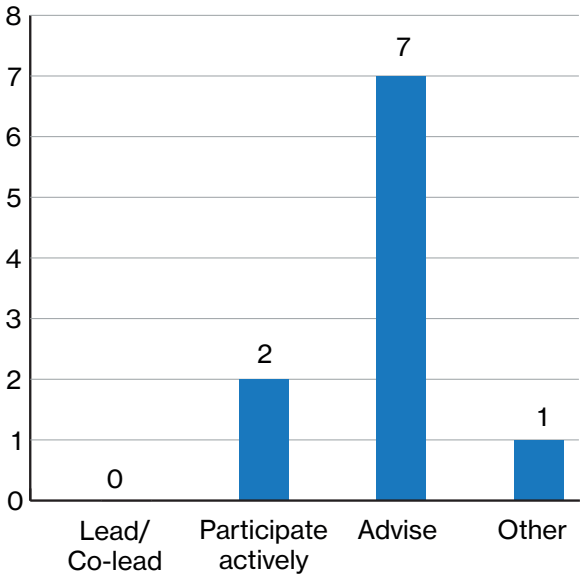
Post-Workshop Survey Feedback

Respondents' views about the potential utility and replicability of the project:

Respondents' ideas or views about the project and how best to take it forward:

Collation of the findings from the workshop
Defining key projects following stakeholder engagement and feedback from the workshop
Devising project plans and teams for these projects and leveraging funding if necessary
Suggest link in with local CHOs who should have list of podiatrists etc who provide GMS services or those that are reimbursed by HSE(Diabetic service users)
There is a lot of existing data in place that can inform this project. For example, the LAMP (Local Area Mapping Project) was conducted by SJH approx. 10 years ago and has a database of resources in the catchment area.
Steering oversight group to guide an adequately resourced and well informed project group.
A significant part of this work has been completed by the LAMP project. It would be advisable to link in there and build from that.
Add in elements of social prescribing (as per Tallaght project with Darach O Ciardha); use titles for contact, rather than names, as named individuals can turn over very quickly; incorporate the guidelines for decision-making as per Canterbury model as described by David Hambleton

43% of respondents reported their interest in active involvement in the *Mapping of Services in D8* project, with roles as shown:



Next Steps

The Workshop feedback has allowed the project team to identify people who wish to be involved in further developing the ***Mapping of Services in D8*** project. Those who have expressed an interest in further involvement (listed below) and others recommended by respondents will be contacted with a view to forming small groups to bring the project forward and discuss roles in more detail.

Name	Level of involvement
Mark Murphy	Participate actively
Orla Veale	Participate actively
Susan Smith	Advise
Declan McKeown	Advise
Berneen Laycock	Advise
Fionnuala Cooney	Advise
Lucinda Ryan	Advise
Brendan Walsh	Advise
Gerardine Sayers	Other: “as team sees fit”

PROJECT B

Expanded use of Healthlink

Rationale

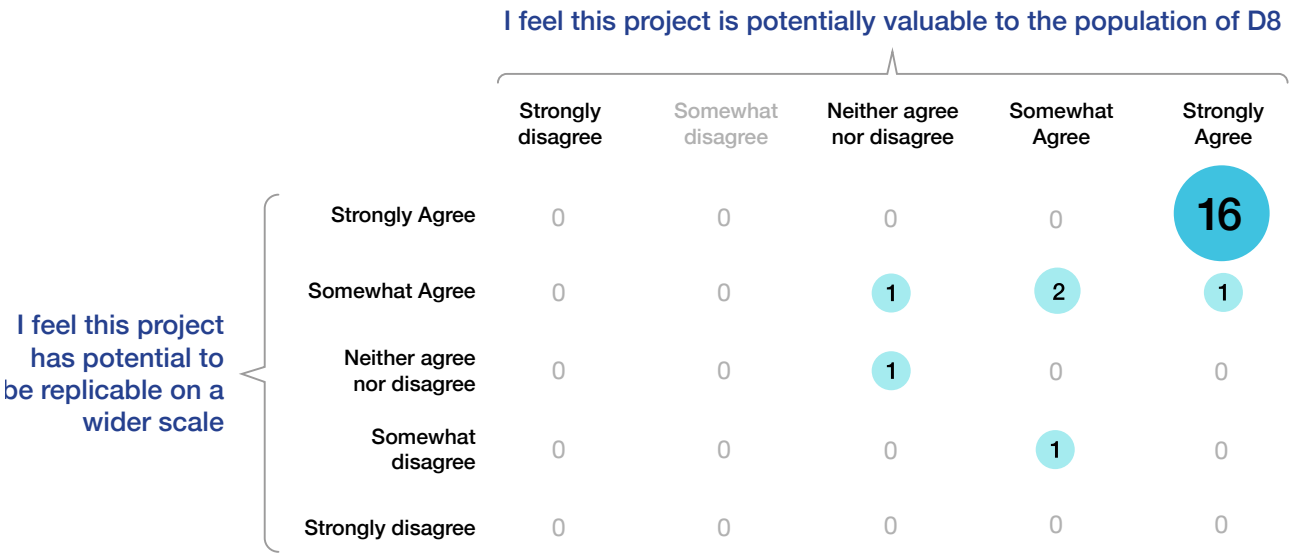
Healthlink has transformed referrals for general practice and offers an the opportunity for sharing data across the system in structured referral and feedback messages. However, few organisations can fully implement this at present. The project will explore whether access to Healthlink could be expanded to community-based services in D8, and enable structured messages to and from community services, GPs, and hospitals. This would allow these services to receive and share data, facilitating referral and generating a shared common record at each site. This will improve integration of care for individual patients and support analysis to give oversight of care provision and support planning.

Planned work

- Explore whether an existing software package may be suitable for providing Healthlink functionality to a Smart D8 service
- Map out other potential routes to access Healthlink, including learning from the experience of Primary Care Services in Wicklow
- Write up the case for expanding Healthlink's capabilities as a potential contributor to better integration between hospital and community-based care.

Post-Workshop Survey Feedback

Respondents' views about the potential utility and replicability of the project:



Respondents' ideas or views about the project and how best to take it forward:

Identify where else the desired capabilities of sending outbound messages to GPs from services, via Healthlink already exist and explore collaboration to achieve the IT connectivity goal of Smart D8

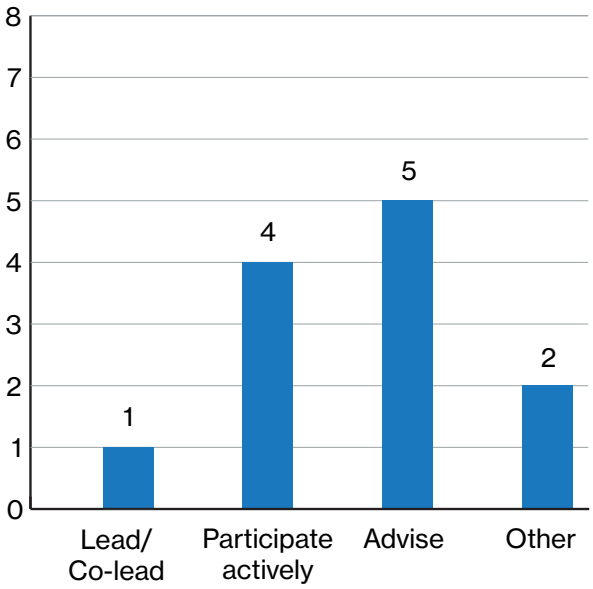
I think that it is a wonderful idea but I have no experience of such a project

Expanding the use of health link to public health departments would also be useful to aid secure communication with GPs and hospitals

As GP lead for CHN 7, I have been working on this to try to get it set up for our primary care disciplines referrals. The CHN manager in Wicklow has given helpful advice and I am waiting on a response from Healthlink to discuss next steps .

Would like to support with connection to SJH stakeholders

55% of respondents reported their interest in active involvement in the *Expanded use of Healthlink* project, with roles as shown:



Next Steps

The Workshop feedback has allowed the project team to identify people who wish to be involved in further developing the ***Expanded use of Healthlink*** project. Those who have expressed an interest in further involvement (listed below) and others recommended by respondents will be contacted with a view to forming small groups to bring the project forward and discuss roles in more detail.

Name	Level of involvement
Darach O Ciardha	**Lead / co-lead**
Eimear Mallon	Participate actively
Niamh Sneyd	Participate actively
Declan McKeown	Participate actively
Susan Smith	Advise
Fionnuala Cooney	Advise
Orla Veale	Advise
Lucinda Ryan	Advise
Brendan Walsh	Advise
Gerardine Sayers	Other: "As team sees fit"
Mark Little	Other: "Alignment with ADAPT SFI health spoke"

PROJECT C

Clinical Pathways for Respiratory Disease

Rationale

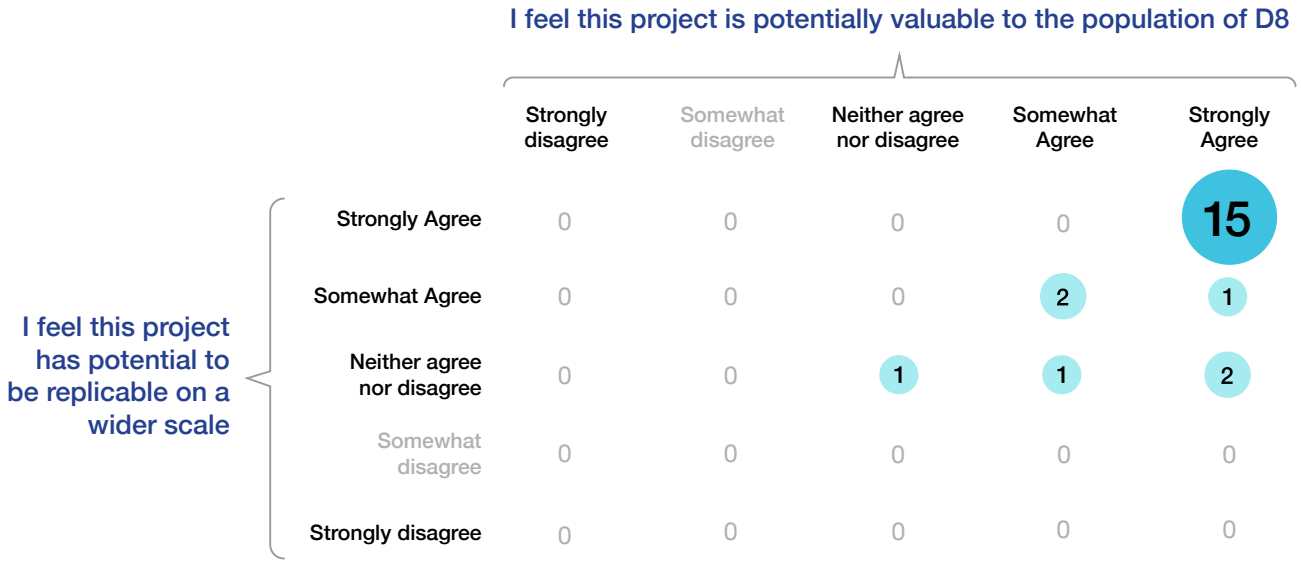
The overall aim of the project is to provide integrated care to a person with a chronic respiratory condition, in order to 'shift to the left' i.e. focus on prevention and hospital avoidance, provide optimal care management at a key contact points with the health/social care systems and to collect and share relevant data for integrated and optimal care at those points. The patient journey will be considered along a spectrum from living well with a chronic respiratory condition to emergency admission to ED. The patient is a 60-year-old man admitted as an emergency for acute exacerbation of COPD due to pneumonia. He has other chronic conditions, smokes, takes 11 prescribed medicines, and is living in poor housing. The project focus is the pathways leading to optimal control of the patient's COPD, becoming a non-smoker and improving their living conditions, in the context of existing and newly emerging structures and services such as chronic disease hubs and the GP chronic disease management programme.

Planned work

This project will map out the pathways in and out of the specialist hub, for shared optimisation of prescribed drugs, and to wider services to include smoking cessation and links to social prescribing. It will identify the data flows needed to support these pathways and identify what current or new systems can optimise this.

Post-Workshop Survey Feedback

Respondents' views about the potential utility and replicability of the project:



Respondents' ideas or views about the project and how best to take it forward:

This will need to link with the Acute Hospital pathways to be truly integrated.

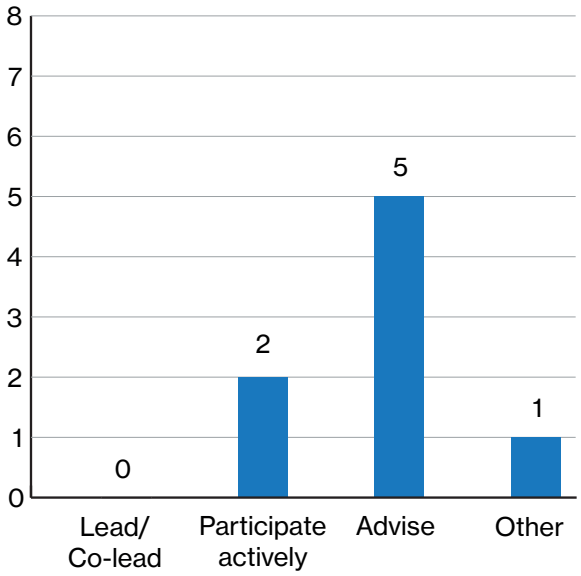
Suggest considering inclusion of a comparator non-intervention group to assist in assessing impact

The Canterbury project gives very clear clinical guidelines on the management of certain clinical conditions - and the proposed Healthlink project aims to provide a database of referrals for the range of conditions that may be encountered in General Practice. Respiratory disease is a major cause of death and DALYs in Ireland and it makes sense that this is cited as a priority for the development of decision-making guidelines. It may be that the two projects can piggy-back on one another, using the Healthlink infrastructure as a means for communicating available options to a clinician. However, I feel that it should also be expanded beyond simply General Practice. Private and community physiotherapists, for example, should also be part of a wider referral ecology as they will frequently be treating people who have respiratory decline, and the Healthlink option may not be available for them.

Important to engage the Local Integrated Care Committee

This will need to link with the Acute Hospital pathways to be truly integrated.

36% of respondents reported their interest in active involvement in the *Clinical Pathways for Respiratory Disease* project, with roles as shown:



Next Steps

The Workshop feedback has allowed the project team to identify people who wish to be involved in further developing the ***Clinical Pathways for Respiratory Disease*** project. Those who have expressed an interest in further involvement (listed below) and others recommended by respondents will be contacted with a view to forming small groups to bring the project forward and discuss roles in more detail.

Name	Level of involvement
Catherine Hayes	Participate actively
Susan Smith	Participate actively
Orla Veale	Participate actively
Declan McKeown	Advise
Fionnuala Cooney	Advise
Alison Enright	Advise
Eimear Mallon	Other: Providing a link to GPs in the area

PROJECT D

Health Data to Support Local Communities

Rationale

Community groups use available data to support their own initiatives. One such example presented at the workshop described how data on health risks (e.g. damp and mould) was used to stimulate building work in Oliver Bond House. This highlighted the potential advantage and need for having access to health data for a population such as this, to support additional advocacy and inform health policy and planning. For example, levels of disease, outcomes and healthcare attendances that might be linked to structural risk factors.

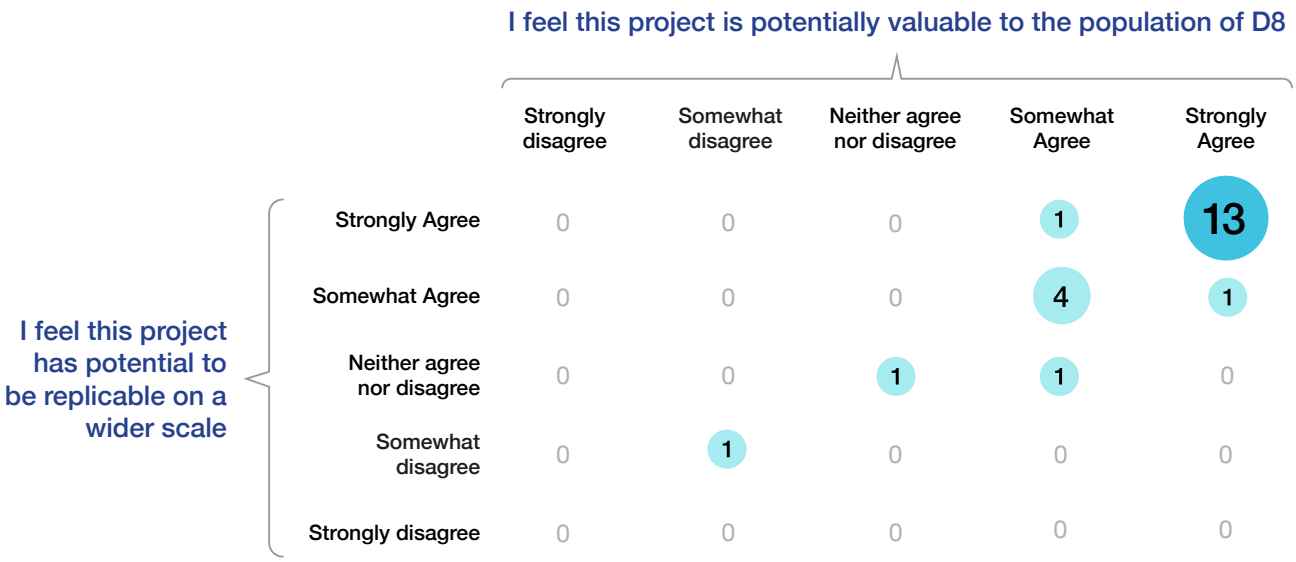
Planned work

Form a group including representative of community organisations (including Robert Emmet Community Development Programme), national expertise and holders of health data (including Health Intelligence Unit) and local healthcare providers in primary and secondary care to:

1. Scope what data could be useful and could be shared in the form of a partnership between the community and healthcare organisations
2. Seek to implement examples of this for specific purposes
3. Identify a systems approach to supporting this partnership

Post-Workshop Survey Feedback

Respondents' views about the potential utility and replicability of the project:



Respondents' ideas or views about the project and how best to take it forward:

Provision of local health profiles would be useful I feel

Limitations in trying to link aggregate health outcomes with structural risk factors as so many other co variables such as smoking/pollution in the case of respiratory outcomes - but do think that there is value in looking at ways in which people can have access to their own personal health data or biofeedback - thinking about the service user empowerment work undertaken by HSE Digital Transformation "living lab"- Martin Curley

Important to have PPI advisory group for this project Interesting to use a Participatory Action Research for this project Need to collect qualitative data in addition to quantitative data

Anonymised health data to be shared by relevant local GP practices pertaining to residents of Oliver Bond House (with appropriate permissions) with project group.

Anonymised health data to be used alongside already available data on housing conditions in Oliver Bond House to develop understanding of relationship between housing conditions and health.

Oliver Bond House to be used as a pilot due to it's size, it's current regeneration and access to the community through RECDP. Health data to be compared against national averages to contextualise findings.

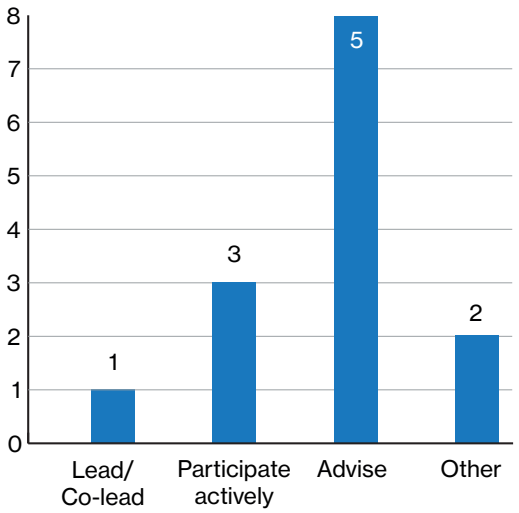
We should invite one of the architects from the county council to input into this piece. Would be a great opportunity for cross agency working

Tricky to utilise health data to support a local community.... issues around ethics, confidentiality, small population, generalizability etc. Rather, I would recommend a Health Improvement approach looking at the environment and behaviours such as built environment, public space, walkability, spaces to socialise, indoor and outdoor air quality, active transport, smoking, drinking, drug use, breastfeeding, diet and nutrition, sport participation, community cohesion etc

There are several possible strands. Some might be general approaches e.g. to using standard data packages that could help many communities if available by community selected geographies. Others may need to be more bespoke and less obviously generalisable - but are really worth trying to develop the model of community responsiveness.

I think skills such as communication, public health advocacy and risk assessment will be crucial, but also the ability to extrapolate socio-economic risk factors onto future disease patterns. This will involve integration of health providers at all levels and will enhance health professionals' concepts of the impacts of deprivation, housing, education etc. on the health of the people living in their catchment area. It may also provide a model for management of other areas of rural or urban deprivation as a form of "nested intervention" in addition to the usual care available in such areas.

64% of respondents reported their interest in active involvement in the *Health Data to Support Local Communities* project, with roles as shown:



Next Steps

The Workshop feedback has allowed the project team to identify people who wish to be involved in further developing the ***Health Data to Support Local Communities*** project. Those who have expressed an interest in further involvement (listed below) and others recommended by respondents will be contacted with a view to forming small groups to bring the project forward and discuss roles in more detail.

Name	Level of involvement
Austin Campbell	Lead / co-lead
Darach O Ciardha	Participate actively
Alison Enright	Participate actively
Berneen Laycock	Participate actively
Declan McKeown	Advise
Gerardine Sayers	Advise
Fionnuala Cooney	Advise
Brendan Walsh	Advise
Deirdre Connolly	Advise
Orla Veale	Advise
Lucinda Ryan	Advise
Catherine Hayes	Advise
Patricia Carney	Other: Advise for now but would like to participate actively if time allows.
Noel McCarthy	Other: Working with community to map data needs, links into those holding data.

FEEDBACK ON THE **HEALTH INTELLIGENCE UNIT** SESSION

One workshop session presented national datasets applied locally to seek feedback on how these might be used to support local needs assessment (Presentation: *'Supporting Local Needs Assessment using National Data'*, Appendix 2, p. 23). Survey feedback from participants showed that 86% of respondents would find access to local profiles from the national datasets held and shared by the Health Intelligence Unit useful in their work.

Respondents highlighted the following Health Intelligence Unit data/uses as important:

Wider access, applications for both research and teaching
Open data sets that could be easily accessed and integrated with existing projects.
Supply of services
Have access to this data already through HSE - very useful
Many use cases for the acute hospital team. For example, more detailed understanding of our catchment area for preventative healthcare approaches. Also will be key in preparation for new RHA structure as part of Slaintecare.
Hospital activity; human resource; mortality
demographic and social data including levels of deprivation
health related data - incidence and prevalence of different types of disease - depending on focus of research e.g. incidence/prevalence of lung cancer
We would use data to make a fact based case for resourcing of the area to meet needs of local population identified in the data.
Potential to prescribe for patients for lifestyle, pharmacological or other interventions found to be beneficial for cardiovascular conditions
Help to plan for expected requirements for certain cardiovascular conditions in healthcare settings, community or hospital
Research new interventions

Use of existing data to deliver area / cohort specific tailored health care delivery and targeted support campaigns, ideally in collaboration with local partners

HealthAtlas - useful tool for GPs for catchment areas for CHN and PC teams.

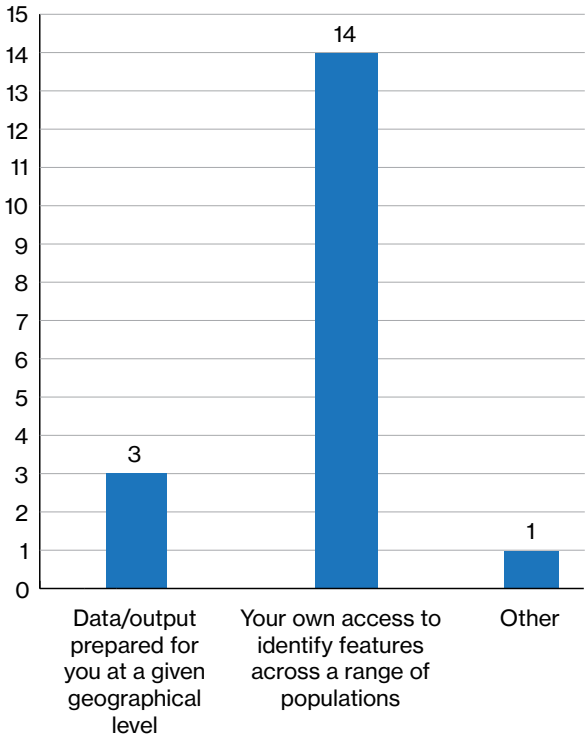
Demographics from Census 2022, when available

As one of the team working within Health Atlas, I would suggest that demographic profiles, behaviour profiles and (self-reported) morbidity profiles would be very beneficial to health professionals trying to paint a picture of their area. One project under development is to add a module to the Finder (as presented at the workshop), using HIPE data to estimate local numbers of people with a range of ambulatory conditions.

Linkage of environmental and deprivation datasets to other datasets for research purposes

Support for service providers

How respondents would want to access/use these HIU data:



GENERAL CONCLUSIONS

All four projects will be explored further. At present Lead/Co-leads have been identified for two of the four projects, namely:

Project B - Expanded Use of Healthlink

- Dr Darach Ó Ciardha (General Practitioner / Assistant Professor in Primary Care TCD)

Project D - Health Data to Support Local Communities project

- Austin Campbell (Executive Director, Robert Emmett Community Development Project)

A number of other individuals have been identified who were not present at the workshop, but who have been suggested/ recommended by attendees as potentially having an interest in specific projects.
The majority of survey respondents expressed an interest in attending a future event to develop the network and collaboration formed at this first workshop. Based on feedback, this will most likely take the form of a two-hour event that would include progress updates on specific projects and a chance for further networking.

Each project and the overall project have an open-network approach and would welcome suggestions for other contributors to any project.

For further information about the *Optimizing Data to Integrate Health and Social Care in Dublin 8* project specifically, please contact:

Dr Dylan Creane - Data Analyst/Research Assistant, Public Health and Primary Care, Trinity College Dublin

dcreane@tcd.ie

Prof Catherine Hayes - Associate Professor and Specialist in Public Health, Public Health and Primary Care, Trinity College Dublin

hayesc9@tcd.ie

Prof Noel Mc Carthy - Professor of Population Health Medicine

noel.mccarthy@tcd.ie

For broader queries relating to Smart D8, please contact:

Jack R. Lehane - Smart D8 Ecosystem Manager, Corporate Services and Transformation Department Dublin City Council

jack@smartd8.ie

APPENDIX 1

PROJECT PARTICIPANTS AND WORKSHOP ATTENDEES

*Mark Bagnell**	General Manager – PMO & Strategy, Integrated Information Service, HSE
Paula Barron	Interim General Manager Primary Care, Dublin South, Kildare & West Wicklow Community Healthcare
*Sarah Barry**	Assistant Professor of Health Services Management at the Centre for Health Policy and Management, TCD
Adam Briggs	Deputy Director of Public Health, Oxfordshire
Angela Buckley	Dublin 8 Social Prescribing Link Worker, Fatima Groups United
Dermot Burke	Spark National Fellow for Innovation and Change, HSE
Austin Campbell	Executive Director, Robert Emmett Community Development Project
Patricia Carney	Senior Research Officer, CHO 7, HSE
Deirdre Connolly	Associate Professor Occupational Therapy, TCD
Fionnuala Cooney	Director of Public Health, Area B, HSE
Dylan Creane	Clinician Analyst/Research Assistant, Public Health & Primary Care, TCD
Tara Creighton	Operational Lead for Chronic Disease Hub 2, HSE
*Caroline Daly**	Consultant Cardiologist SJH
Brenda Deering	Clinical Speciality Respiratory Physiotherapist, SJH
Adrienne Dempsey	Fatima Groups United Counselling Service Coordinator
*Christina Doyle**	Operational Lead Chronic Disease Hub 1, HSE
Alison Enright	Head of Service, Allied Health, SJH
Orla Gogarty	Director of Digital Health, St Patricks Mental Health Services
Loretto Grogan	National Clinical Information for Nursing and Midwifery, HSE
David Hambleton	Consultant Physician, Managing Director of Pathways Alliance and Leadership Consultant, Tyneside, UK
Catherine Haugh	Senior Speech and Language Therapist
Catherine Hayes	Associate Professor and Specialist in Public Health, TCD/HSE
Howard Johnson	Director, Health Intelligence Unit, HSE

Geraldine Jordan	Executive Officer, Institute of Ppulation Health, TCD
Lorraine Kennedy	Head of Service, Older Persons, CHO7, HSE
Fiona Keogan	Director of Lean Transformation, SJH
Karen Kinsella	Enhanced Community Care Network Manager CHN 1, HSE
Berneen Laycock	Operational Lead, Integrated Care Programme for Older Persons, HSE
Mark Little	ADAPT Centre PI & Professor of Nephrology, TCD
Eimear Mallon	GP-lead CHN
Noel McCarthy	Professor of Population Health Medicine, TCD
Declan McKeown	Specialist in Public Health Medicine, Health Intelligence Unit, HSE
Declan McKibben*	General Manager ADAPT
Derick Mitchell	CEO, Irish Platform for Patient Organisations, Science and Industry
Mark Murphy	GP & ICGP South City Faculty Lead
Rory Nee	Consultant Physician in Geriatric Medicine, Integrated Care Programme for Older Persons (ICPOP), SJH & Cherry Orchard Hospital
Darach O'Ciardha	General Practitioner, Assistant Professor in Primary Care, TCD
Mary O'Kelly	Interim Chief Officer CHO7, HSE
Rachel Mullen	EPR Product Manager, SJH
Lucinda Ryan	Specialist Registrar in Public Health Medicine, Area B, HSE
Gerardine Sayers*	Specialist in Public Health Medicine, Health Intelligence Unit, HSE
Kalpana Shankar	Professor of Information and Communication Studies, UCD
Susan Smith	Professor of General Practice, TCD
Niamh Sneyd	General Manager for ICT and Digital Health in CHO7, HSE
Orla Veale	Director of Programme Office, Academic Health Science Centre, SJH
Brendan Walsh*	Senior Research Officer, Social Research Division, ESRI
Teresa Wilson	Engagement & Delivery, Informatics Directorate, SJH

* Apologies received from project participants who were unable to attend the workshop.

APPENDIX 2

TITLES OF PRESENTATIONS GIVEN AT THE OCTOBER 10TH WORKSHOP

Presentation	Presented by
Building an Integrated Health and Care System using the Canterbury Model	**David Hambleton** Consultant Physician, Managing Director of Pathways Alliance and Leadership Consultant, Tyneside, UK
A Vision for Population Health Management to Support Integrated Care	**Catherine Hayes** Associate Professor and Specialist in Public Health, TCD/ HSE
Case Study: The Integrated Care Programme for Older Persons	**Rory Nee** Consultant Physician in Geriatric Medicine, Integrated Care Programme for Older Persons (ICPOP), SJH & Cherry Orchard Hospital
Current Context and anticipated future needs of Data requirements for Community Services	**Berneen Laycock** Operational Lead, Integrated Care Programme for Older Persons, HSE
Plenary including context setting, feedback, and discussion:Integrated care in England: opportunities and challenges	**Adam Briggs** Deputy Director of Public Health, Oxfordshire
Health Data Needs of Local Communities	**Austin Campbell** Executive Director, Robert Emmett Community Development Project
Supporting Local Needs Assessment using National Data	**Declan McKeown** Specialist in Public Health Medicine, Health Intelligence Unit, HSE
How can Data in General Practice support Integrated Care?	**Darach Ó Ciardha** General Practitioner, Assistant Professor in Primary Care, TCD
Plenary Discussion and Planning: Next steps	**Noel McCarthy** Professor of Population Health Medicine, TCD **Catherine Hayes** Associate Professor and Specialist in Public Health, TCD/ HSE

Presentation Slides

Redacted versions of specific presentation slides are available by request from Public Health & Primary Care, TCD: phpcadmin@tcd.ie

APPENDIX 3

BACKGROUND INFORMATION ON POLICY, PROGRAMMES, PARTNERS, AND DATA SOURCES

Policy

Sláintecare

https://www.gov.ie/en/publication/0d2d60-slaintecare-publications/

The aim of Sláintecare is healthcare transformation to achieve a universal single-tier health and social care system, where everyone has equitable access to services based on need and not ability to pay. It included defined steps toward universal healthcare provision, and also models of delivering care from the least complex provider possible, and close to the patient.

This involves both a "shift left" in care delivery and increased integration of care. Sláintecare Integration Innovation projects have piloted this with a lot of the work summarised as "Right Care, Right Place, Right Time". More recently there has been an increased focus on preventative activities targeting high risk communities and stronger links to Healthy Ireland goals. The current stage implementation action plan is at: https://www.gov.ie/en/publication/6996b-slaintecare-implementation-strategy-and-action-plan-2021-2023/. Implementation priorities include a mix of overall governance and strategy (such as six new regional health areas and a focus on permanent capacity and developing staffing for this and contractual changes for staff) alongside many pilot projects to identify ways of working with a view to rolling out approaches that work. Many targets have been missed such as increases in those fully covered for health care costs by state payments. Other areas have accelerated during COVID such as universal coverage of care costs for COVID related illness.

Sláintecare Healthy Communities

(https://www.hse.ie/eng/about/who/healthwellbeing/slaintecare-healthy-communities/)

Sláintecare Healthy Communities focuses on health determinants including smoking cessation, diet, parenting, and other individual level interventions through a standard package of interventions offered in areas identified as having social deprivation and poor health outcomes.

Healthy Ireland

https://assets.gov.ie/7555/62842eef4b13413494b13340fff9077d.pdf

The Healthy Ireland Framework 2019-2025 is the main public health strategy. It is based around four key goals: to increase the proportion of people who are healthy at all stages of life; to reduce health inequalities; to protect the public from threats to health and wellbeing; to create an environment where every individual and sector of society can play their part in achieving a healthy Ireland. The framework includes the development of outcomes to monitor impact. It acts as an umbrella for a range of existing strategies and plans across specific areas, such as the National Drug and Alcohol (http://www.drugs.ie/downloadDocs/2017/ReducingHarmSupportingRecovery2017_2025.pdf) strategy rather than being a comprehensive public health strategy. Achievements and policy ambitions vary substantially from areas of strength such as tobacco control to extremely weak interventions such as in controlling alcohol promotion and consequently consumption.

Health service structures and programmes

Organisation levels and structures in the Health Service Executive (HSE)

Region

Six regional health areas have been identified with a range of oversight activities and a core staffing across these footprints (https://www.gov.ie/en/publication/4eda4-slaintecare-regional-health-areas-rhas/). These areas control budgets and employ staff in community services in their area and the majority of hospitals, although most large hospitals are independent of the HSE. The newly emerging community care services are managed through these regional health areas.

Community Health Networks

Within Regional Health Areas Community Health Networks have been formed to deliver local primary care services across populations of approximately 50,000, together to meet the needs of the local community in collaboration with local general practices. Each has a core set of standard professional staffing across 4 – 6 primary care teams. The networks will manage specified Primary Care Team staff and will enable people to work in multidisciplinary teams ensuring better co-ordinated care across professions and with other community support services e.g. older people, disabilities, mental health and access to acute hospital services.

- Unit of service delivery that will manage Primary Care services across an average population of 50,000

- Ensure better co-ordination and integration between community and acute services
- Place an identified, accountable person as responsible for actual service delivery to the population of the Network
- GP Lead Role
- Strong relationships with local communities

The South Dublin Inner City CHN
South Dublin Inner City - Community Healthcare Networks (Network 1) has a population of 74,000 with 6 Primary Care Teams. It is largely within Dublin 8.

Chronic disease management and associated hubs

The Integrated Care Programme for Chronic Disease (ICPCD) focuses on improving the standard of care for Cardiovascular Disease, Type 2 Diabetes, COPD and Asthma. HSE funded staff and funded general practice activities support this management. These conditions affect over one million people in Ireland. This investment aims to re-orientate delivery towards General Practice, Primary and Community based Services. Chronic disease hubs generally cover 3 CHNs. City Lodge Hub based in Dublin South city (Population base 150,000) is linked to three CHNs including South Dublin Inner City. There is a Ten-step Guide for the implementation of integrated care for the prevention and management of chronic disease in Ireland aiming to provide end to end care to individuals living with chronic disease and multi-morbidity in the community tailored to their local needs. Staffing includes individuals with contracts across hospitals and community services and part time HSE contracts for GP leads to work in and with the Hubs alongside staff fully employed in the Hubs. The GP based activity of the chronic disease management programme includes case finding, structured treatment, and prevention activities for the conditions covered. Starting with those over 70 it is gradually extending down to younger age groups with the treatment component covering all adults and case finding and prevention those aged 45 and over. GPs have contracts that specify activities and data recording requirements in substantial detail. (https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/chronic-disease-management-programme/).

The National Integrated Care Programme for Older People (ICPOP)

https://www.icpop.org/

ICPOP aims to transition from an acute, episodic care to longitudinal, coordinated and integrated care models for older people, with a focus on those with complex needs and frailty. Although the Irish population is relatively young with 14.8% aged 65 and over compared to 20.8% across the European Union and 1.7% aged 85 compared to 2.9% (Eurostat 2021) this is changing quickly. The population growth estimate (CSO) from 2012 to 2021 among those over 65 was 35% compared to 15.7% among those over 65 in the European Union, and 9.1%

overall population growth in Ireland. Staff are employed across community and hospitals including individuals contracted across both. The planning framework for ICPOP (https://www.icpop.org/integrated-care-framework) identifies governance structures, population needs assessment, mapping existing resources and planning care pathways as the first 4 steps in a 10 step process, and monitoring and evaluation as the tenth. The framework thus depends on the availability and use of locally relevant data to and data integration.

References further reading:

- *National Framework for the Integration Prevention and Management of Chronic Disease in Ireland 2020-2025:* https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/documents/national-framework-integrated-care.pdf
- *National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020-2025 – A 10-step guide to support local implementation:* https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/documents/national-framework-integrated-care.pdf
- *Integrated Model of Care for the Prevention and Management of Chronic Disease Implementation Guide:* https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/documents/chronic-disease-service-model-implementation-resource-pack.pdf

St James's Hospital

St James's Hospital is Ireland's largest acute academic teaching hospital and is based in Dublin's south inner city. The hospital purpose is the delivery of health treatment, care and diagnosis as well as health promotion and preventative services at local, regional and national levels. The hospital is a "voluntary hospital" with direct funding from the Department of Health. This is within the Irish healthcare hospital system comprised of a mix of voluntary, HSE managed and private hospitals.

Other partners and institutions in this project

Health Intelligence Unit

The HSE National Health Intelligence Unit provides information to the health service aimed at supporting planning and operational activities. The HSE National Health Intelligence Unit generates this information by accessing data, both health specific and non-health specific, and analysing it to gain insights for the area/topic in question. These insights are then used by the planning or operation functions within the health service to help ensure decisions promote an optimised service.

HealthPathways

https://healthpathwaysglobal.org/contact

HealthPathways began in Canterbury, New Zealand, in 2008, as a collaboration between Streamliners and the Canterbury District Health Board (CDHB). The Canterbury

Initiative, with a goal of addressing the challenges of health care in Canterbury aimed to drive system wide change by encouraging and facilitating the development of relationships between community, primary and secondary care providers and develop pathways that support clinicians and patients through their healthcare journey. Community HealthPathways was born and since then has produced over 600 clinical pathways. Local Canterbury clinicians now use HealthPathways to make over 2,000 better informed decisions with their patients daily. HealthPathways has been a key enabler in Canterbury's collaborative and integrated health system, which has been recognised in a report by acclaimed British health authority, The King's Fund (August 2017). Health systems across New Zealand, Australia, and the United Kingdom have adopted and adapted the learnings from Canterbury. The HealthPathways methodology and toolset is now used by nearly 50 health systems caring for 30 million people. Streamliners provides a shared platform and services to all health systems implementing HealthPathways. St James's Hospital is exploring HealthPathways approaches with partners.

Public Health and Primary Care, School of Medicine, Trinity College Dublin

Trinity has a joint discipline of public health and primary care across three sites: the Institute of Population Health, the Centre for Health Policy and Management, and the Trinity Centre for Global Health. The discipline has a strong interest in health care planning, contributed substantially to the emergence of the Sláintecare policy and areas of research in improving the data guided healthcare planning and monitoring.

The Irish Platform for Patient Organisations, Science and Industry (IPPOSI)

https://www.ipposi.ie/

IPPOSI is a patient-led organisation that works with patients, government, industry, science and academia to put patients at the heart of health innovation. For more than 10 years IPPOSI has been the primary contact and conduit for patients interested in engaging more actively in the R&D process. IPPOSI is also recognised as a key influencer contributing towards the overall development of Health Research Policy in Ireland.

Robert Emmet Community Development Project

htpps://recdp.ie

Robert Emmet Community Development Project (CDP) is based in Dublin's South West Inner City. The CDP was founded in 2003 to work with local individuals living in the area, voluntary groups and other stakeholders to support conditions for the creation of a thriving community, where everyone, regardless of their background can reach their full potential. The regeneration of Oliver Bond House is a significant infrastructure project with real potential to improve the welfare of residents of Oliver Bond House. Ensuring that the community voice is heard is central to the design of the improved complex.

F2 Fatima Centre

https://www.familyresource.ie/details.php?ID=128#

F2 Fatima Family Resource Centre is located in Rialto, D8. The Family Resource Centre (FRC) programme is Ireland's largest National Family and Community-based support programme, core funded by Tusla – The Child and Family Agency. The principal objective of the FRC programme is to combat disadvantage and to ensure that all children and families have equal rights to participate in society. The programme involves local communities in addressing the issues they face and creates meaningful partnerships for social change between voluntary and statutory agencies. FRCs work from community development principles working through a voluntary Board of Directors.