



'The Future Role of the Hospital in an Integrated Model of Care'

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CIT

Background

- ▶ Most solutions to the stresses on the hospital system are dependent on the hospital being examined from a population health perspective in conjunction with all other elements of the health and social care system.
- ▶ This is widely accepted internationally and why the concept of 'Integrated Care' is so deeply enmeshed in the Sláintecare report.
- ▶ Integrated Care has been the central policy driver in health policy since in Europe and Ireland (though slow to translate) for decades.

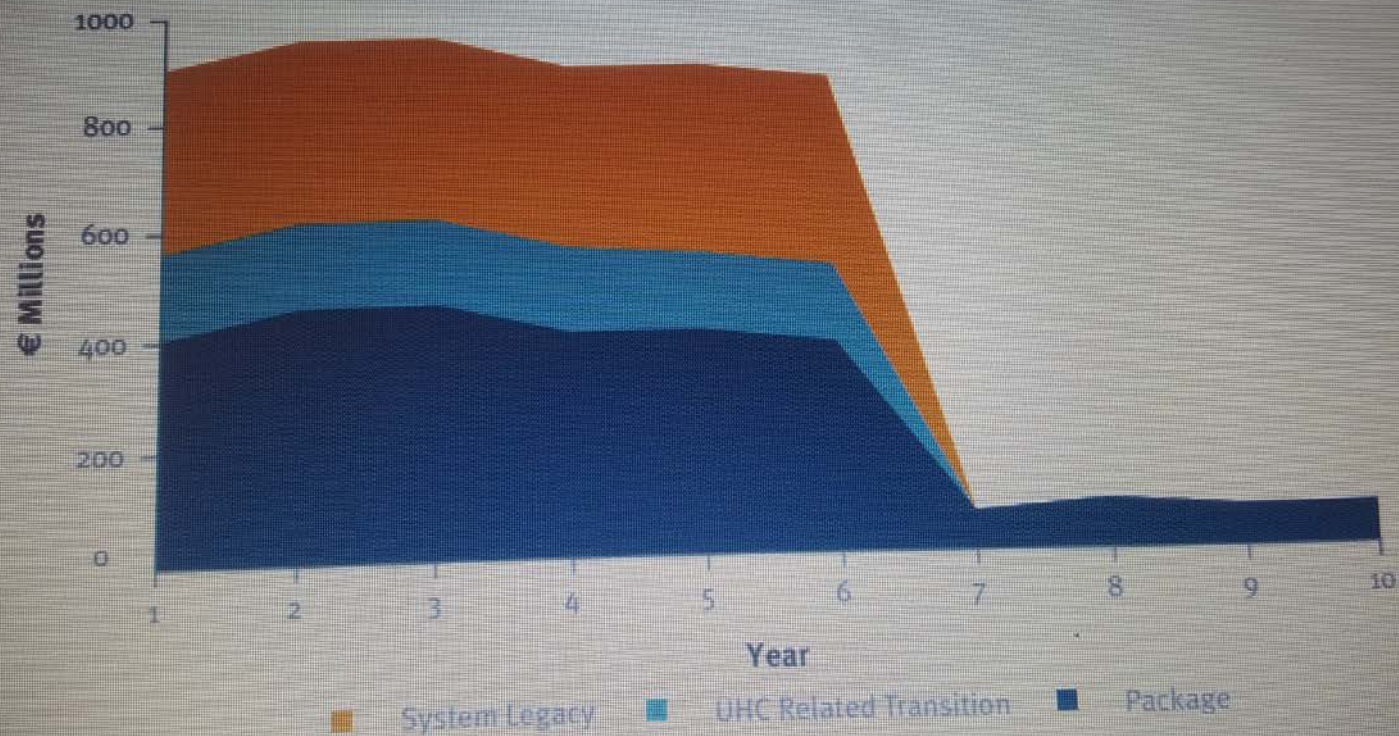
My FOCUS

- ▶ Most research on the on primary, secondary and tertiary aspects of health care and social care is valuable and insightful and add new pieces to the jig saw of possible improvements.
- ▶ However, much like 'silos' in health and social care, research often exists in isolated silos.
- ▶ But policy makers and implementers need to understand the whole system.
- ▶ My interest is to holistically look at here is to look at hospitals and other elements of the health and social care system and how each can improve the other, taking pressure off hospitals and improving the lives of patients and service users
- ▶ This can't be fully done in 25 minutes!
- ▶ But I hope to offer some ideas on the challenges and possible solutions, based in the inexorable move to Integrated Care, and by doing so reserving hospital care for those where it is the best possible fit, while offering more appropriate care solutions that are a better fit for other populations.

Big Current Challenges

- ▶ 300-600 on hospital trolleys
- ▶ Shortage of hospital beds
- ▶ Consultant-led by NCHD driven
- ▶ Public-private divide in hospital provision
- ▶ Private beds in public hospitals
- ▶ Private hospital based on insurance not need
- ▶ Increased cost of health insurance
- ▶ Approx. 45% with health insurance
- ▶ Health insurance package costing 1200 per person per year typical to offer widened choice to some private hospitals.
- ▶ Inexorable rise.
- ▶ Public hospital waiting lists
- ▶ Sláintecare Report (2017)- aims to resolve many of the above, particularly to dramatically reduce the private cost of healthcare (next slide), with reduced need for health insurance, using a hybrid general taxation and UHI model

Figure 14: Effect on households of reducing out of pocket spending and private health insurance.



Irish Hospital System Necessitating reality checks, re-balancing & Integrated Care

- ▶ Slaintecare, including its focus on many of the issues I mentioned on hospital challenges and possible solutions are being covered in a different session.
- ▶ So, I won't go in to these.
- ▶ I will focus next on the inexorable and unrealistic demands on the hospital system which cannot be handled by without a wider focus and integrated care solutions.
- ▶ I will start with patient expectations on next slide.

Expectations: Older People in Particular

- ▶ Life Expectancy: In 2012: 78 years for man and 83 for woman
- ▶ 'Life expectancy at birth has increased significantly for both men and women since the first official life table was compiled in 1926. Over the 85 year period to 2011, male life expectancy increased by 21.0 years (36.6%), while female life expectancy increased by 24.9 years (43.0%) [www.cso.ie]
- ▶ Life expectancy is rising by 1 to 1.5 years in 5 yearly inter-census periods
- ▶ In 2011 we had 532,000 people over 65 years. In 2031, we will have more than one million. There will also be an increase of 370,000 people aged 45-64, according to Census 2011 Population Projections'.
- ▶ Book: Professor Seamus O'Mahony- *The Way we die now*.
- ▶ The expectations of family members on hospitals in providing care for older people with complex needs or those with organ failure etc. v the limits of medicine and the appropriateness of over-use of therapies such as Chemotherapy, CPR, PEG feeding tubes, intubation and other difficult and invasive medical interventions, where there is low or virtually zero chance of success.
- ▶ Irish health policy historically 'two speeds', GP or hospitals.
- ▶ Expectations of hospital solutions by families have grown inexorably (O'Mahony 2017)
- ▶ The daily difficult life and death decisions which hospital doctors have to make and the conflictual situations which may occur (ibid)

Reality Checks

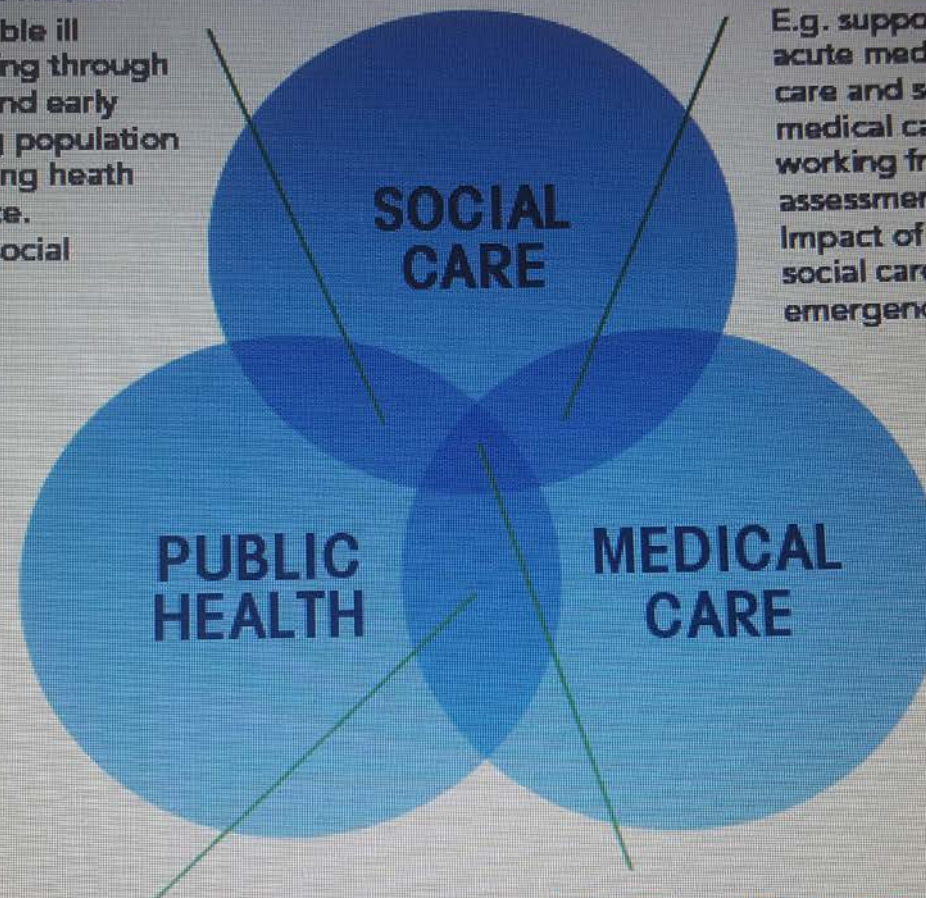
- ▶ Questioning the veracity of claims that continuous healthy living, medical screening, improved lifestyles can prevent increasing health changes correlated with getting older.
- ▶ Individuals and families expect and demand too much from hospitals and doctors. (O'Mahony 2017)
- ▶ Only a small proportion of patients are revived by CPR after cardiac arrest. Medical dramas on TV show most are!
- ▶ There are limits to hospital interventions. Expectations need a reality check.
- ▶ Solutions to hospitals in crisis have to re-balance expectations and delivery for many patient and client populations to a far greater extent in to primary and community care settings.
- ▶ But, these need to be integrated with hospital care, which is only used once enhanced primary and community care solutions are not capable of dealing with overall health and social care need.
- ▶ See next slide: elements of integrated care: Darker (2014: 27 following Goodwin & Smith 2011)
- ▶ Moving on to enhanced primary and community care to take pressure off hospitals, deliver care closer to the patient and client where they wish to be and integrating with hospital = Integrated care.

Social Care and Public Health:

E.g. preventing avoidable ill health or injury, including through re-ablement services and early intervention. Assessing population health needs. Monitoring health and disease surveillance. Evaluating health and social interventions.

Social Care and Medical Care:

E.g. supported discharge from acute medical care to primary care and social care. Primary medical care and social care working from a single needs assessment and care plan. Impact of primary medical and social care on reducing repeat emergency admissions.



Public Health and Medical Care:

E.g. assessing population health needs. Preventing ill health and lifestyle diseases and tackling their determinants. Monitoring health and disease surveillance. Evaluating health interventions.

Social Care, Medical Care and Public Health:

E.g. maximising the health and well being of each individual and the population as a whole. Seamless health and social care for those service users who need it.

Integrated Care Building Blocks

- ▶ Building on HSE (2011) with Healy Report on CHOs (2014), a move away from the culture of hospital care is needed.
- ▶ The Primary Care Network needs to be the focus of more health and social care delivery by bridging from Primary Care Teams of community care teams: CHOs have 90 Primary Care Networks dealing with populations of approx. 50,000 people (approx. 5 PCTs per network)
- ▶ These need to be integrated with community care, variously called 'Community Health and Social Care Networks' or 'Specialist Services' in the community or more recently titled the Community Health Network
- ▶ Relies on enhanced and most of all functioning Primary Care Teams and Community Care Teams.
- ▶ Clinical programmes and directorates are designed to fulfil the integration from PCNs to secondary hospital and tertiary hospital services and the CHO to 6 hospital groups.
- ▶ Piloting and enablers to start the process: most likely mental health, disability, diabetes, COPD?
- ▶ CHO's will 'maximize coterminosity with 6 new hospital groups' for integrated care (HSE 2014: 6)
- ▶ 'Recognize the clear relationships between primary and secondary care' (HSE 2014: 6)

Case Study of Elder Care

- ▶ 95 % of all health care is delivered at the primary care level by GPs, nurses and associated health and social care practitioners (NAGP 2013).
- ▶ The care of older people is under enormous stress now, prior to the full effect of population ageing (Jacob 2014)
- ▶ Discharge planning is very difficult to the home and community care but has improved (ibid)
- ▶ Poor Resourcing of Dementia services and poor early diagnosis, lack of memory clinics (Cahill 2013)
- ▶ Need for 'all primary and secondary care services and all allied health professionals Integrated in to an organised care pathway the would be clearly visible to the user, along with the family caregiver and other service providers' (Cahill 2013: 251)
- ▶ IT infrastructure and training + resources to follow the agreement of a Single Assessment Tool agreed InterRAI for older people (O'Neill 2013)
- ▶ Shared care plans, discharge planning and integration of health and social care however needs to happen for **all patient and client groups in clear pathways.**

Slow Progress

- ▶ Some progress in Ireland but slow.
- ▶ Falls clinics have been set up
- ▶ As have urgent care centres
- ▶ Lack of Primary Care diagnostics putting pressure on hospitals
- ▶ ICT driven single-patient records in the horizon
- ▶ Under-resourcing of primary care is problematic- putting more pressure on hospitals
- ▶ Loss of GPs newly qualified GPs abroad and rising average working age of GPs-crisis in primary care (NAGP)
- ▶ Primary Care Teams: 5 teams for each of 90 networks nationally.
- ▶ Functioning Primary Care Teams?
- ▶ One stop Shop Primary Care Centres?
- ▶ Not much progress since 2013-14
- ▶ Hopes on Sláintecare- nearly two years old

Sláintecare- Integrated Care

- ▶ The largest section of this report is on Integrated Care
- ▶ Where are we at now with some main recommendations:
- ▶ “The alignment of health and social care delivery structures with common defined geographical catchment areas makes sense. It provides a coherent and enabling platform for improved clinical integration and for collective responsibility for health outcomes and value for money. Potentially, greater alignment could remove some of the barriers between hospital and community services, between physical and mental health and between health and social care.”
- ▶ “In rolling out the implementation of the reforms outlined in the SláinteCare Report, I am keen to consider the views of health and social care professionals and of the Irish public, and to receive their guidance on how best to progress this fundamental recommendation of the SláinteCare Report.” (Minister Harris 29-3-18)

International Case Studies: Northumberland Model

'Integrated care 'hubs' are being developed to deliver urgent primary care (booked GP appointments and walk-in services) over extended hours seven days a week. There are also locality-based integrated complex care teams to proactively manage those patients with the most complex needs in the community and provide a rapid response when a patient's condition deteriorates. These teams will deliver planned care with locality-based, integrated teams of community nursing, mental health and home care staff, working together with medical leadership from GPs and / or consultants. Also provided is timely specialist advice for both planned and urgent care, via local clinics and home visits, as well as cost-effective diagnostics close to home. Clinicians are employees of the trust, rather than of specific hospitals. This has enabled the Trust to create job plans involving roles in multiple sites and instilling the expectation that clinical staff may be needed to travel and spread their time across several locations if patient needs are to be best served (Naylor et al. 2015). Northumbria's hospitals will continue to operate as part of larger regional clinical networks. NHS Northumberland also plans to deliver an integrated patient record which is shared across all organisations to enhance communication' (NHS 2016:12)

Sweden: The Esther Project

- ▶ 'a redesigned intake and transfer process across the continuum of care
- ▶ open-access scheduling
- ▶ team-based telephone consultation
- ▶ integrated documentation and communication processes
- ▶ and an explicit strategy to educate patients in self-management skills.
- ▶ The 'Esther Project' proved inspirational for the team, which was pushed to focus specifically on the patient and her needs. Mats Bojestig, the chief of the Department of Medicine at Höglandet Hospital and one of the developers of the project, said this: "It is very important that we called this work 'Esther'. It helped us focus on the patient and her needs. We can each imagine our own 'Esther.' And we can ask ourselves in our work, what is best for Esther?" (NHS Confed 2015)

Esther Project

- ▶ 'The initiative led to significant improvements towards seamless patient care, by overcoming fragmentation between providers of primary, hospital, home and social care. This resulted in impressive improvements over a three-to five-year period, including:
- ▶ an overall reduction in hospital admissions by over 20 per cent (9,300 to 7,300) and a redeployment of resources to the community
- ▶ a reduction in hospital days for heart failure by 30 per cent (from 3,500 days per year to 2,500)
- ▶ a reduction by more than 30 days of wait times for referral appointments with specialists, such as neurologists.
- ▶ This is an exemplary case of how leadership and a new working culture has led to health system transformation, with significant benefits for patients, while at the same time allowing improvements in efficiency. The success of the project led several other county councils across Sweden to work in a similar way'

(NHS Confed 2015)

Challenges for Ireland

- ▶ Under-resourcing of primary care, fragmented social care client group delivery
- ▶ More support for home care
- ▶ GP under-resourcing and breakdown of trust with govt is a huge stumbling block
- ▶ Demystifying and making Integrated Care a commonly understood paradigm
- ▶ Short term dedicated costs for long term gains competing with increased exchequer health costs, unplanned or as a result of demographic pressures.
- ▶ The need for the books borrowing for investment in Primary Care Centres, possibly using Special Purpose Vehicles with a majority public stake.
- ▶ Exciting use of technology for working with patients must respect the needs of patients to have an active and fulfilled life in the community rather than apps that focus on keeping them indoors counting steps and monitoring calorific intake.
- ▶ Single patient identifiers within an ICT driven complete health and social care records for clients.
- ▶ Breaking from the 'silo culture'.
- ▶ Universal health care model which covers elder care. Home care is far too expensive.
- ▶ Moving away from 'ad hoc' budgeting in health resourcing nationally.
- ▶ Robust auditing.
- ▶ Individualised care budgets
- ▶ Public health improvements.

Notes

- ▶ Notes on Figure 14 chart 10
- ▶ “The effect on households of reducing out of pocket spending and reducing their reliance on private health insurance all other things being equal, is shown in Chart 10 below. In the funding model proposed, more of the costs are borne by the system rather than through direct expenditure by household, and hence are funded by the whole population” (Slaintecare 2017: 126)