Enhanced Community Care

Care closer to home

1st March 2023
ECC Newsletter Issue 3

COMMUNITY HEALTHCARE
CAVAN, DONEGAL, LEITRIM, MONAGHAN, SLIGO,
SAOLTA HOSPITAL GROUP & RCSI HOSPITAL GROUP

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COMMUNITY HEALTHCARE
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Introduction

Welcome to the 'new look' ECC Newsletter for CH CDLMS. This issue is focused on the **8 Community Healthcare Networks (CHNs)** in our area (pages 2-3). 96 CHNs have been implemented across the country, and are designed to deliver primary healthcare services to a local population of around 50,000 people. Each CHN operates a number of Primary Care Teams (PCTs), who work with GP practices to deliver integrated care services to their local population; this is also known as 'multidisciplinary working'. There is a map of the CHNs below with photos of our 8 CHN managers aligned to their networks.

There are a number of teams and services in place and in development who work within the CHN areas to deliver more complex care to older people and people living with chronic conditions. The ICPOP Hub teams provide care to older persons (see issue 2, 2022 for a deeper dive on ICPOP teams - link on the back page), and the CDM Hub teams providing care to people living with chronic diseases (see our November 2022 Chronic Disease Management webinar for more information on CDM Hubs and what they do - link on the back page).

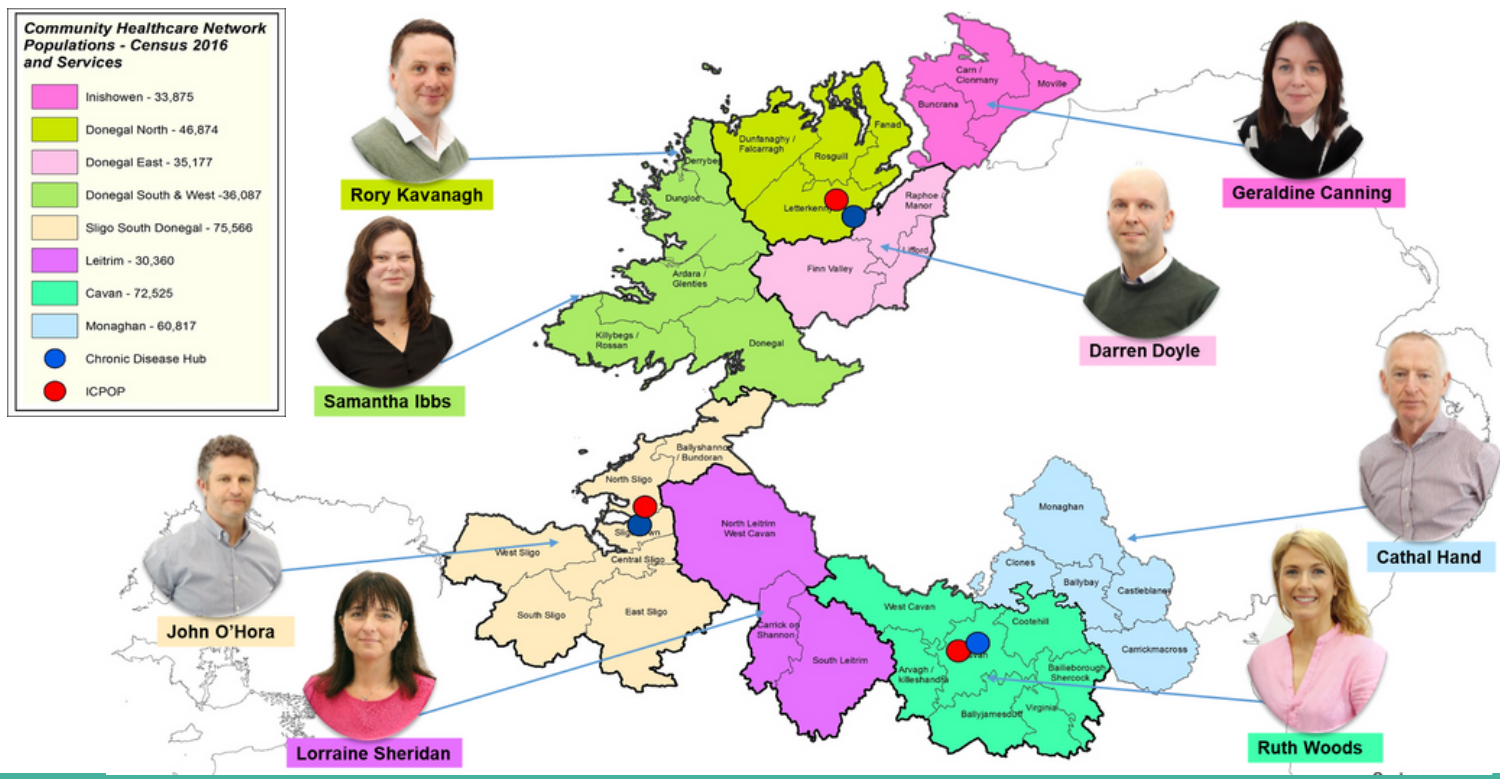
Our **Community Intervention Teams (CITs)** are featured on page 4. CITs identify people at risk of hospitalisation, and support them to reduce their hospitalisation risk. CITs also identify people at risk of long stays in hospital, and support them to leave hospital earlier, through Early Supported Discharge.

On pages 5-6, readers can learn about the Donegal **Frailty Intervention Team (FIT)** who work out of Letterkenny University Hospital. The FIT works exclusively with older persons, identifying people in need of intervention in the ED.
Also on page 6 we introduce the **Community Connector** role that is being piloted in Donegal North and East.

We conclude with an introduction to our Service User Engagement lead for CH CDLMS who has given us a handy guide to **Patient & Service User Engagement.** See pages 6-7 for some fantastic tips.

The **ECC Noticeboard** on page 8 contains ECC-related staffing notices, links and achievements, and a Glossary of Terms.

CH CDLMS Community Healthcare Networks and Network Managers



Community Healthcare Networks

Each locality in CH CDLMS – from Malin Head in Co Donegal to Bailieborough in Co Cavan – is aligned to one of our 8 CHNs. Each CHN provides community-based healthcare and oversight of healthcare provision for a local, average population of 50,000 people. CHN Managers are responsible for progressing the operational rollout of their CHNs, supported by a number of Primary Care Teams (PCTs), including Health and Social Care Professionals working in Speech and Language Therapy, Social Work, Occupational Therapy, Podiatry, Dietetics and Physiotherapy.

In each CHN these Primary Care-based staff have transitioned to operational line management under the CHN Manager, while their professional and clinical management remains under their Head of Discipline (HoD). Psychology staff also operate within the networks and continue to report both operationally and clinically to Principal Psychologists. A GP Lead post has also been funded for each CHN area. Where GP Leads are in post, they are well-positioned to ensure good linkage with the GPs and GP Practice Nurses providing services to the local population within the CHN.

CHN 1 (Inishowen)- original pilot site for CH CDLMS. CHN Manager: Geraldine Canning

The new Buncrana Primary Care Centre (PCC) officially opened in November 2022 and accommodates Primary Care staff including the Inishowen CHN team, other HSE Community Services, Tusla and the Buncrana Medical Centre.
The appointment of a keyworker for some service users has had significant benefits. This single point of contact for the PCT streamlines communication and care provision for service users, family members and CHN team members.

Dr. Kathy Murray is the GP Lead for the CHN in Inishowen and has been in post since July 2021. Dr Murray supports three PCTs and six GP Practices, and has been instrumental in promoting links between the Inishowen CHN and the Inishowen GPs, championing the introduction of GP eReferrals to physiotherapy services and establishing communication pathways between Primary Care and GPs.

In 2023, Inishowen CHN will:

• Recruit to vacant posts, which will support reduction of waiting lists for services.
• Continue to strengthen relationships with GPs through GP/PCT workshops.
• Establish links with Community Health Forums to ensure service users voices.
are being represented at Primary Care level.
• Work on digital solutions to streamline integrated care referral pathways and processes.
• Work with Health and Wellbeing Information officers to bridge the gap between HSE and community and voluntary groups.

CHN 2 (North Donegal). CHN Manager: Rory Kavanagh

CHN 2 is currently reviewing service accommodation needs for North Donegal and engaging with the Donegal Primary Care General Manager's office to progress this. Streamlining digitisation of referral pathways has been a key goal for the CHN; GPs are now able to make eReferrals to adult physiotherapy via Healthlink. eReferral to podiatry services will be commencing shortly. A new service initiative is planned to commence in April 2023 with the recruitment of a Senior Pelvic Health Physiotherapist.

Dr Paul Stewart commenced his GP Lead role in Donegal North in July 2022. Dr Stewart has huge expertise in planning, and knowledge around service needs and pathway development.

In 2023, CHN 2 (North Donegal) will focus on:

- Accommodation review for North Donegal
- Recruitment of the Clinical Coordinator role
- Recruitment of other vacant CHN positions

CHN 3 (East Donegal). CHN Manager: Darren Doyle

Newtoncunningham Primary Care Centre

CHN 3 became operational on July 1st 2022. The network has been supported by the recent opening of Newtowncunningham PCC which accommodates a range of HSE services. We have been able to relocate some services to the East Donegal area, ensuring local communities can be seen closer to home.

Dr Ciaran O'Fearraigh, GP lead for the Donegal East CHN, commenced his role in July 2022. He acts as a conduit between the CHN and GPs in the area by sharing information, promoting the CHN model and identifying and addressing needs within the network. An example of this is the successful rollout of the use of Healthlink eReferral pathways from GPs in the Donegal East CHN to the physiotherapy, adult speech and language therapy and podiatry departments.

In 2023, East Donegal CHN will focus on:

• Recruitment of a Clinical Coordinator to progress establishment of PCT meeting processes.
• Progress a single point of referral to the CHN for service users with MDT needs, and develop relationships, pathways and links with both acute and community services.

CHN 4 (South and West Donegal). CHN Manager: Samantha Ibbs

Donegal South and West CHN Team

In the past year CHN 4 have moved into their new accommodation in the PCC in Donegal. New staff grade therapists across Physiotherapy, Occupational Therapy and Speech and Language Therapy have commenced.
Three MDT days have been held, giving clinical staff a chance to engage as a team and plan for the future. We also introduced Heathlink in February for GP eReferral into Physiotherapy and we hope to echo this referral route for other HSCP services. Primary Care Referrals meetings have been commenced to assess and score MDT paediatric referrals coming in to ensure children are seen in the correct team.

Members of the CHN Leitrim /West Cavan team
Sligo, Leitrim, West Cavan (SLWC) L-R Michael Lavin, Mary Rooney, Cabrini Nolan, Deirdre Morrow.

In 2023, South and West CHN will focus on:

• Continuing to host MDT days throughout 2023
• Continuing to revive and strengthen links with Community Health Forums

CHN 5 (Sligo/South Donegal). CHN Manager: John O'Hora and CHN 6 (Leitrim/West Cavan). CHN Manager: Lorraine Sheridan

To date both CHNs in SLWC have focused on the transfer of operational responsibility for staff to the CHN Managers and the building of teams within each area. The development of PCTs will create an environment to support provision of enhanced MDT care for service users.

Members of CHN Leitrim West Cavan (L-R):
Lorraine Sheridan, Margo Beirne, Maureen Diffley,

In 2023, Leitrim/West Cavan & Sligo/South Donegal CHNs will focus on:

- Enhancing primary care services through setting up PCTs.
- Appointment of a Clinical Coordinator to the PCT in the coming months.
- Creating a central point of referral to network services.
- Fostering links and establishing pathways with our partner ECC services such as ICPOP and CDM Hubs.
- Developing relationships between Primary Care Services, Acute Hospital. Services and General Practice. The GP Lead role will be central to this.

CHN 7 (Cavan). CHN Manager: Cathal Hand and CHN 8 (Monaghan). CHN Manager: Ruth Woods

The Cavan and Monaghan CHNs have a total of 14 Adult PCTs and 2 Children's Teams. The Adult PCTs are led by the Therapy Managers (TMs), Director of Public Health Nursing (DPHNs), Assistant Directors of Public Health Nursing (ADPHNs) and Network Managers. The PCTs continue to meet monthly with a focus on clinical case discussion between team members, and the newly formed Children's Teams meet weekly to consider referrals and ongoing cases.

In 2023, Cavan and Monaghan CHNs will focus on:

• Establishment of a CHN Management Team within each Network to manage ongoing business issues and as required, clinical and operational issues escalated from the PCTs.

Community Intervention Teams

The Community Intervention Team (CIT) is a Primary Care nurse-led service providing access to short term nursing interventions including wound management, oncology care, medication administration and management, patient education and support to promote self-management of catheters and stoma care. Referrals to CITs are accepted from Hospital Consultants and ED Registrars, GPs and GP Out of Hours services, Primary Care services including PHNs and other community sources, for all clients who meet the referral criteria.

The service aims to provide enhanced acute interventions in a rapid and integrated manner to patients with an acute episode of illness appropriate for care in their home/community setting or one of our CIT clinics avoiding hospital admission/attendance or allowing for early discharge. CITs provide cares to patients aged 16 and over. On completion of CIT treatment, the patient is discharged or referred onto other care providers as appropriate, if required.
The majority of CIT referrals received to date have resulted in hospital avoidance with a small percentage receiving support for early discharge from the hospital.

CIT Donegal

The CIT service in Donegal was established under the PHN service in February 2022. Pathways have been developed for the main referral sources but will be an ongoing process as the service expands.

From February 2022 until December 2022 CIT Donegal received and accepted 3103 referrals, and carried out 9,800 patient visits and clinic appointments. The majority of the referrals received have resulted in hospital avoidance for patients with a small percentage facilitating early discharge from the hospital.

L – R Eliza Doherty CRGN, Patricia Martin CRGN, Patricia McLaughlin CNM1, Maeve O'Doherty CNM2, Michelle Bonner Clerical Officer

CIT Sligo Leitrim West Cavan (SLWC)

The SLWC CIT service was established in July 2018. This nursing service is provided by the nationally procured, preferred private provider, TCP Homecare, on behalf of the HSE, 7 days per week from 8am to 8pm.
TCP Homecare is responsible for the co-ordination of CIT services on a daily, weekly and on-going basis. The availability of CIT services in the community has meant that many now avoid unnecessary long commutes to attend for clinical management at SUH. Oncology care accounts for approximately 30% of CIT interventions and management of long-term indwelling catheters account for 48% of current activity.

Future CIT goals including the establishment of a venesection service, for service users with Hemochromatosis in the community could safely be managed by the CIT Service providing clinics in Primary Care, relieving the burden on the Acute Day Ward Services.

CIT Cavan Monaghan

The Cavan Monaghan CIT was established in September 2021. This nurse-led team is staffed by 6.5 WTE RGNs, 1.0 WTE CNM1 (under recruitment), and administrative support, under the direction of an ADPHN. The team is supported by a variety of other health professionals and services. Pathways have been developed for the main referral sources and this will be an on-going process as the service expands.

From September-December 2021 the CIT received 253 referrals, and last year (2022) 2,132 referrals were received. The CIT works in partnership with the referrer and agrees on the plan of care for the patient with the referring medical doctor. The patient stays with the CIT for a defined/short period of time (ideally < 72hrs). The Team, through its fast-tracked provision of enhanced services, also facilitates the mainstream Primary Care or the acute hospital services to arrange follow up care for the patient as required. The ultimate aim of the team is enable patients and clients to access all the care they need swiftly and with minimum inconvenience.

We are delighted to confirm that we have an Advanced Nurse Practitioner (ANP) starting for the service in May.

Donegal Frailty Intervention Team (FIT) - Letterkenny University Hospital (LUH)

Frailty is commonly seen in older adults suffering adverse events but is not a normal part of the ageing process. A person who is frail is more at risk of falling and a higher mortality rate. The good news is frailty can be managed like any other chronic disease and can be reversed where possible. The LUH Frailty Intervention Team (FIT) is an Interdisciplinary Team, consisting of a Senior Physiotherapist, a Senior Occupational Therapist, a Clinical Nurse Specialist, and a FIT Assistant, supported by a Specialty Registrar for Older Peoples Services.

FIT identify people aged 75 and over, who are frail or at risk of worsening frailty on presentation to the Emergency Department/Medical Assessment Unit (ED/MAU) using a screening tool. When frailty is identified a Comprehensive Geriatric Assessment is completed with onward referral to appropriate services either in the hospital or the community.

FIT work between 8am-5pm and work closely with the ED Doctors and Nurses, attending Physicians and the inpatient Medical, Surgical, and Orthopedic Teams.

LUH FIT (L-R): Senior Physiotherapist-Mary Kelly, Senior Occupational Therapist-Lucinda Ferry, Clinical Nurse Specialist-Anita Dolan, FIT Assistant-Sinead Black

The FIT assess older adults to recognise signs of frailty, provide a rapid comprehensive multidisciplinary assessment, provide a person-centered care pathway with a tailored treatment/management plan and refer to services based on the identified needs of the older person. We aim to avoid unnecessary hospital admissions, prevent further deterioration in functional status, provide interventions to target reversible frailty and improve patient outcomes and experience in the ED.

Our main aims are:

- Early identification and assessment of people over 75 for frailty, creating a Frailty Friendly Front Door.
- Early assessment and mobilisation of older adults who are frail in ED and MAU.
- To Identify frailty markers earlier in order to enable an integrated health promotion and preventative approach, across acute and community services.
- To aim for admission avoidance for patients who present to the ED over 75 years old were appropriate.
- Improve patient flow through the ED and MAU-Appropriate and early discharge planning, with follow up by the most suitable available community services and their geographical area.
- To commence early therapy input and assessment to decrease length of stay.
- Continued research to support best practice within our service.
- To increase awareness of delirium and delirium assessment within the ED setting.
- Education and advice to patients and families/caregivers to maximize patients' functional potential and discharge.
- To educate the staff on Frailty Syndromes.

Services we refer to are:

- Inpatient OT, Physio, Speech and Language Therapy (SLT), Dietitian, ANP Older Peoples services, Social Work, Respiratory, Diabetic service, Palliative, Cardiac.
- Integrated Care Team for Older Person (ICTOP)
- Community OT, Physio, SLT, Dietitian.
- Early supported discharge - Public Health Nurse and Community Intervention Team.
- Signposting to Social prescribing, Dementia Services, Alone.

FIT complete assessments on:

- A person's transfers and mobility.
- Ability to carry out Activities of Daily living (Personal and Instrumental).
- Cognition and Delirium assessments.

FIT also carry out reviews of:

- Home Environment and Social Supports
- Mood
- Medication
- Continence

Who can be referred?

- People over-75 with a
- Recent Decline in Mobility.
- A Recent Fall.
- Increase in care needs.
- Decline in Cognitive Ability.

Community Connector - Piloting in North and East and Donegal areas

A core element of the Older Persons/Chronic Disease Service Model is supporting people to live well in their own homes and communities. Ireland has a very rich and diverse community and voluntary sector that provides a variety of supports that address healthy ageing under key domains such as Exercise, Social Connectedness and Nutrition. For many older people, health and social care services sign post them to relevant supports and this is sufficient as an enrolment strategy. However, others need an added level of support in accessing services due to a variety of factors such as poor social supports, motivation, complex care needs, co-morbidities and practical obstacles.

YOU'RE NOT ALONE

As a consequence, this cohort are more vulnerable to crisis resulting in hospitalisation and/or premature admission to residential care, despite the rich mix of local resources (statutory and non-statutory) that could provide a buffer against crisis.

The new role of Community Connector piloting in Donegal under ECC will act as a resource to ensure that all local statutory and non-statutory resources are fully accessed by the older person with complex care needs as appropriate. The Community Connector role will be managed in partnership between H&WB, Older Persons Services and Alone. Members of the ICTOP team will identify potential suitable patients for referrals to the Community Connector and once the patient provides consent they will be added to the caseload of the Community Connector. A Wellbeing Plan is commenced and will be co-produced by the MDT, the patient, and the Community Connector. The areas of focus within the plan should include exercise/physical activity, nutrition, social connections, and mental health. Once accepted onto the caseload,, service will be provided for a period of up to 6 weeks.

Patient & Service User Engagement

What is Patient Engagement?

Patient Engagement is a term used to describe the way in which healthcare staff work together with patients and their personal support network to actively involve them in decisions made about their own health and healthcare; healthcare service design; and healthcare policy. It means patient's needs, preferences, beliefs, experiences and expertise are heard and acted upon and that all participating have influence on the decisions being made. (Patient Engagement Roadmap, HSE 2022)

Where should Patient Engagement happen?

- Patient point of service contact / use (Individual level)
- Healthcare design, delivery and evaluation (service level)
- Healthcare policy making (EMT level)

Caroline Bradshaw
Service User Engagement Officer CH CDLMS

Why is Patient Engagement important?

• Patient and public partnership involvement in healthcare delivery is an ethical right.
• Patient and public partnership builds trust between the patient and the healthcare services, it enhances communication and transparency.
• Patient and public partnership leads to improvements in health outcomes.
• Having patients at the center of decision making will help ensure our services are meeting the needs of users and are delivered through our HSE values: Care, Compassion, Trust and Learning.
• More job satisfaction better Staff retention.

Who could be a Patient Engagement Rep? Someone who:

• Has recent experience of accessing healthcare (in the last 3 years).
• Has a lived experience of healthcare.
• Has the ability to see beyond personal experience and use personal experience constructively.
• Feels that engagement is valuable.
• Has previous experience of engagement could be beneficial.
• Is a member of a larger patient org./support group whose input we need.
• Who has a good self-care and support network.

In a recent survey, over 90 percent of respondents said that patient engagement was important or very important to their service.

Consider skills that may be required and how to close communication gaps to ensure learning within the committee or group. It is important to think about what training and support might be required.

• Have you discussed what is expected from Patient Engagement representative, time, skills etc.?
• What would success look like?

Considerations before inviting a Patient Engagement Rep to attend your group

• What is the main objective of your project for Patient Engagement and at what stage is it at planning/implementation/evaluation?
• Have you a staff member who has an interest in Patient Engagement and has some expertise and time to undertake meaningful patient engagement guided by national guidelines and PSUE supports?
• Think about how to identify and invite people to be Patient Engagement representative. Can you ask healthcare team to identify someone? Could Patient Engagement be an item on all agendas?
• How many patient representatives are you looking for? It is recommended to have more than one patient rep as part of a group or committee.

ECC STAFFING ANNOUNCEMENTS

NEW GM FOR PRIMARY CARE DONEGAL

We would like to congratulate Maura Gillen on her new role as General Manager for Primary Care, Donegal. Maura was previously the CHN Manager for the Inishowen network, one of 9 CHN pilot sites nationally. Maura commenced her new GM role in early 2023.

NEW NETWORK MANAGER FOR INISHOWEN

Geraldine Canning has taken up the role of CHN Manager in Inishowen (January 2023). We wish Geraldine the best in her new role and look forward to working with Geraldine and team

NEW ASSISTANT STAFF OFFICER FOR ECC PROGRAMME OFFICE

Edel Gallagher took up the role of the Assistant Staff Officer role in the ECC Programme Office and commenced in December 2022. We are delighted to be working with Edel who has joined us from the Chief Officer's office.

GP LEADS FOR CH CDLMS NETWORKS

CH CDLMS now has GP leads in post in 6 of our 8 Community Healthcare Networks with the remaining 2 posts under recruitment. We would like to formally welcome the following GP leads to their new and exciting roles which they have taken on in addition to their GP practice responsibilities:

Dr Kathy Murray, CHN 1 (Inishowen)
Dr Paul Stewart, CHN 2 (Donegal North)
Dr Ciaran O'Fearraigh, CHN 3 (Donegal East)
Under recruitment, CHN 4 (Donegal South and West)
Dr Conor Mitchell, CHN 5 (Sligo/South Donegal)
Under recruitment, CHN 6 (Leitrim West Cavan)
Dr Rukshan Goonewardena, CHN 7 (Cavan)
Dr Vincent Brett, CHN 8 (Monaghan)

ECC STAFF ACHIEVEMENTS

Massive congratulations to Niamh McLaughlin (pictured below), Physiotherapist with CHN 2 North Donegal.

Niamh not only won Player of the Year 2022 (the first Donegal female footballer to win this award) but was also named on the 2022 TG4 Ladies Football All-Star team. Maith Thu Niamh!

GLOSSARY OF TERMS

ANP	Advanced Nursing Practitioner
ADPHN	Assistant Director of Public Health Nursing
CDM	Chronic Disease Management
CDMH	Chronic Disease Management Hub
CGH	Cavan General Hospital
CD	Community Diagnostics
CHN	Community Healthcare Network
CHNM	Community Healthcare Network Manager
CNM	Clinical Nurse Manager
CIT	Community Intervention Team
CST	Community Specialist Team
DPHN	Director of Public Health Nursing
ECC	Enhanced Community Care
ED	Emergency Department
EMT	Executive Management Team
FIT	Frailty Intervention Team
GM	General Manager
GP	General Practitioner (doctor providing primary healthcare services in the community.
GP Lead	A GP in the GP Lead role liaises between the CHN area and the other GPs providing services in the CHN area.
HoD	Head of Discipline
HSCP	Health and Social Care Professional
Hub	The Hub is the physical location for the CSTs. There is a CDM Hub and an ICPOP Hub in each area (Donegal, SLWC and Cavan Monaghan)
LUH	Letterkenny University Hospital
MAU	Medical Assessment Unit
MDT	Multi-Disciplinary Team
PCC	Primary Care Centre
PCT	Primary Care Team
PHN	Public Health Nurse/Nursing
RGN	Registered General Nurse
SLWC	Sligo Leitrim / West Cavan
SUH	Sligo University Hospital
TM	Therapy Manager
WTE	Whole Time Equivalent

ECC INFORMATION LINKS (click image to follow)

CH CDLMS YouTube Channel

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