Integrated Care Partnerships Northern Ireland

Leading Integration, Delivering Better Outcomes

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INTRODUCTION

17 Integrated Care Partnerships (ICPs) were established in Northern Ireland in 2013 to design and coordinate the delivery of integrated local health and social care services.

ICPs are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, allied health professionals, voluntary and community sectors, local councils and service users and carers. Clinical Priority areas are: care of frail older people, Diabetes, Stroke, Respiratory conditions, and end of life care. Northern Ireland is involved in the *SmartCare* and *Beyond Silos* European initiatives and also the *European Innovation Partnership on Active & Healthy Ageing B3 Action Group on integrated care for chronic diseases*.

AIMS AND OBJECTIVES

- **To deliver integrated and person centred care for all those within the clinical priority areas & to adopt the RICE approach:**
  - **Risk Stratification**
  - **Information Sharing**
  - **Care Planning**
  - **Evaluation**

METHODS

Risk Stratification	• Primary Care Quality & Outcomes Framework disease registers • Regional agreed data extract from Primary Care clinical system (**B3 Action Group**) • Linking data feeds across primary and secondary care (**SmartCare**) • Application of local "soft" knowledge
Information Sharing	• NI Electronic Care Record (**SmartCare**) & development of an Electronic Shared Care Summary (**Beyond Silos**) • Key Information Summary (KIS) for palliative care patients • Telemonitoring (**SmartCare, Beyond Silos, B3 Action Group**) • Project ECHO "tele-mentoring" using video conferencing technology • Electronic NI Single Assessment Tool
Care Planning	• Multidisciplinary proactive management of "at risk" patients • Collaborative person centred process to review existing Care Pathways – e.g. acute care for the elderly (**SmartCare, B3 Action Group**) • Application of Improvement Science approaches to agreeing and implementing integrated Care Pathways
Evaluation	• PDSA cycle of on-going evaluation and improvement supported by local infrastructure to promptly respond and adapt (in line with learning from **SmartCare**) • Partnership working with the Institute of Healthcare Improvement (IHI) to adopt the Triple Aim approach • System wide suite of Quantitative & Qualitative Measures including analysis of Patient Experience

Building Local Collaborative Leadership

- Coaching
- Building Improvement Science and Quality Improvement Capability
- Change Management Skills
- Organisational Development Support

IMPACT OF WORK

1. **Strong local partnerships for change**

   "At the start, I wasn't sure how this would work out, but as we got to know each other and developed relationships, things improved greatly. I feel there is respect for everyone's views and opinions round the table" – Comment from ICP member

2. **Effective advocates for system wide change**

3. **Funding achieved for a range of change projects to deliver more integrated care**

   "This is the way elderly people should be treated – in their own homes, with a dedicated team looking after them" – Service User Comment

4. **Strengthening Local Commissioning**

5. **Moving towards Population Health Systems**

CONCLUSION

http://www.transformingyourcare.hscni.net/integrated-care-partnerships #ICPchange