



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

# Services For Older People

# Integration & Resource Allocation

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Building a Better Health Service

CARE COMPASSION TRUST LEARNING

# Changing landscape in Acute and Community Care

NCCA National Office of Clinical Audit

MTA Major Trauma Audit

## MAJOR TRAUMA AUDIT

NATIONAL REPORT 2017



### Community

#### 1 in 5 community dwelling older adults are living with frailty

(Approx. 118,000 older persons)



#### In a 12 month period older adults living with frailty:

**Will spend 15 days** in hospital in a 12 month period.

**Are on 6 medications.**

**Will visit their GP on 7 or more occasions** per annum.

**40% of people living with frailty live alone.**

**96% have two or more chronic conditions.**

Comprise **55% of PHN caseloads.**

### Acute Hospitals



People aged >65 and over occupy **54%** of acute hospital inpatient beds.



Almost **30%** of older people admitted to acute hospitals have dementia (and have longer stays in hospital).



People aged >65 account for **90%** of delayed discharges from acute hospitals.



People aged >75yrs spend **3 times longer in ED** than those <65.



**35%** of patients over 70 admitted to hospital show functional loss at time of discharge when compared to pre-hospital admission. This increases to 65% for 90 year olds.

### Residential Care

**Demand for Residential Care is expected to increase by 40% by 2031.**

**Demand for Home Support Services is expected to increase by 118% by 2031.**

### Falls

**1 in 3** over 65's fall annually

**60,000** older adults require medical attention a year for falls

**57%** of major trauma patients have a low fall (less than 2 metres)

The average age of a person who breaks their hip is **80 and over two-thirds are female**

# Integration – What are the Challenges?

## » **Clinical**

- Assessments (Multiple)
- Referral Pathways (Criteria)
- General & Specialist Services
- Variable Service Level Availability

## » **Funding & Budget**

- Divisional or Care Group Based

## » **Workforce**

- Unidisciplinary
- Hospital vs Community

# Map of six new health regions



70 km  
40 miles



Z-53206 OSI 030601

# Development of Community Services in Context of 6 ICOs

- Community Healthcare Networks
- 96 → 50/70k Population
- Population Based Health & Social Care Planning & Service Delivery.
- ICT based InterRai Assessment to determine care needs.
- GP & Core Multidisciplinary Teams with Supporting Services –preventative & Diagnostic.
- Specialist Services - Older People, Chronic Disease, Palliative etc.
- Support of Community, Voluntary, Families & Carers.

# Networks by numbers

**50,000**  
Average population per Network

**96**  
Networks

**9** Network learning sites in 2019

**4-6**  
Primary Care Teams per Network

**1**  
Community Healthcare Network Manager per Network



# Network Model

- Accountability for delivery of primary care services based on the assessed needs of the local population with an average of 50k
- GP Lead role to foster strong relationships with GP practices

- Enable people to work in multidisciplinary teams ensuring better co-ordinated care for people using our services

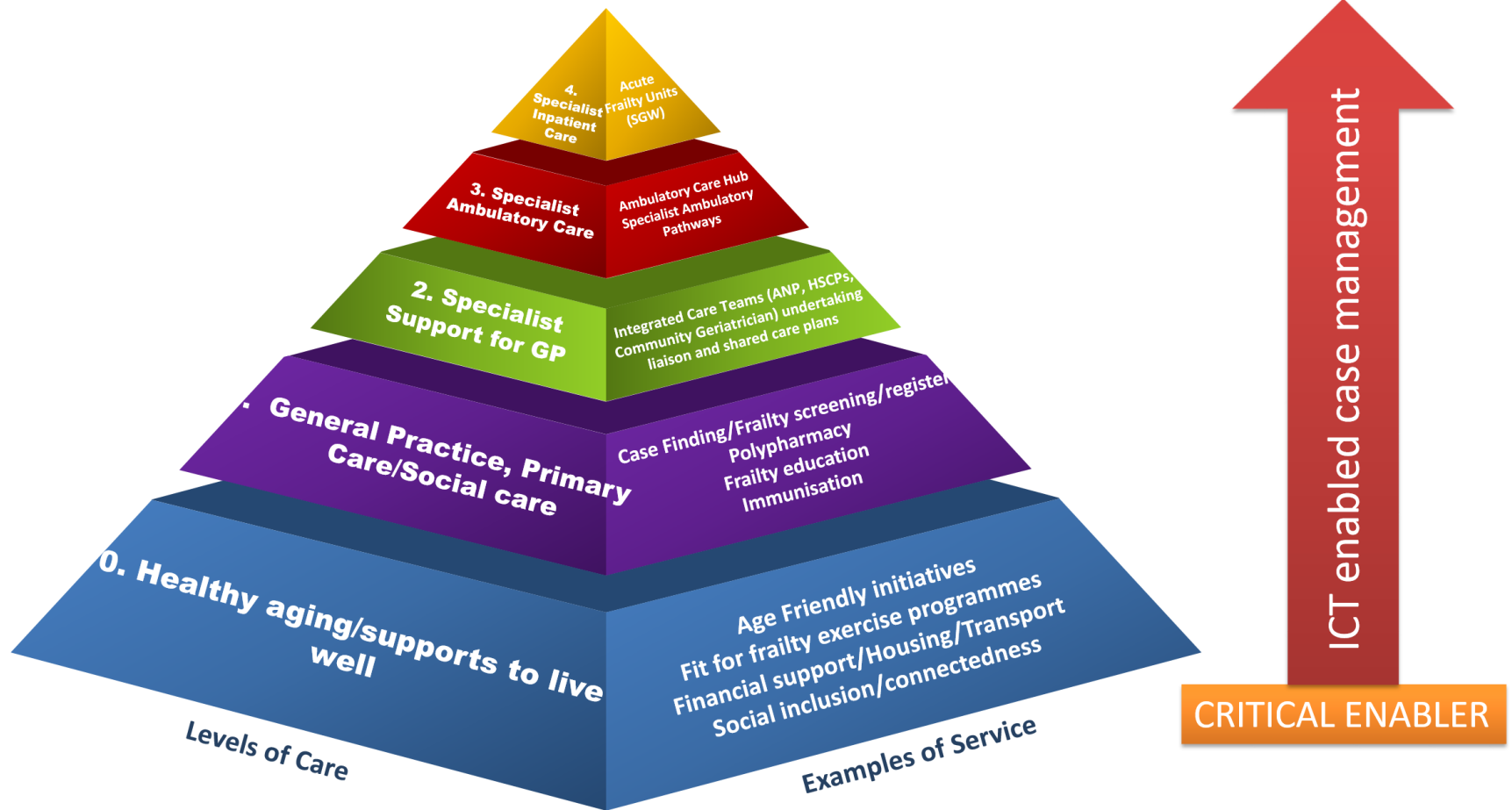
- Standardised and consistent structure to provide clear links with other community services within the Network, cross-Network services and acute services ensuring delivery of integrated care





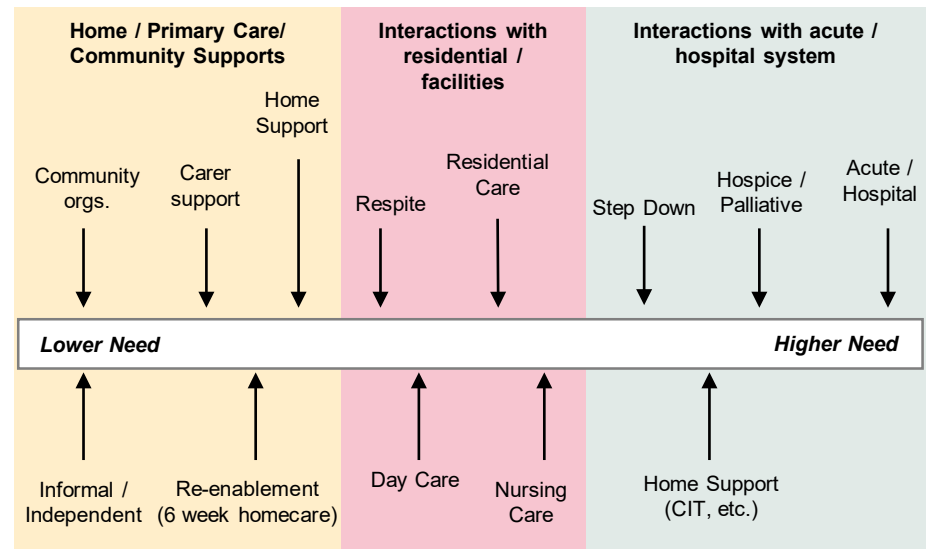
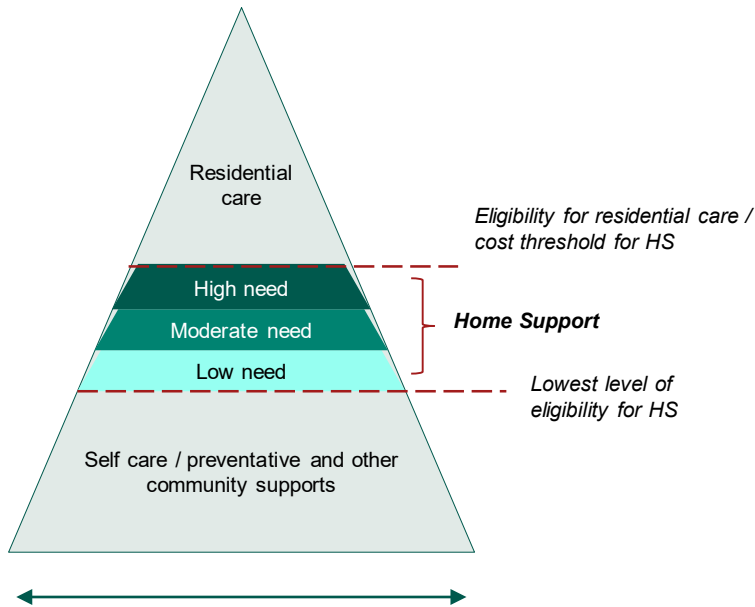
# Frail Older person living at Home

Interventions for community dwelling older person living with frailty





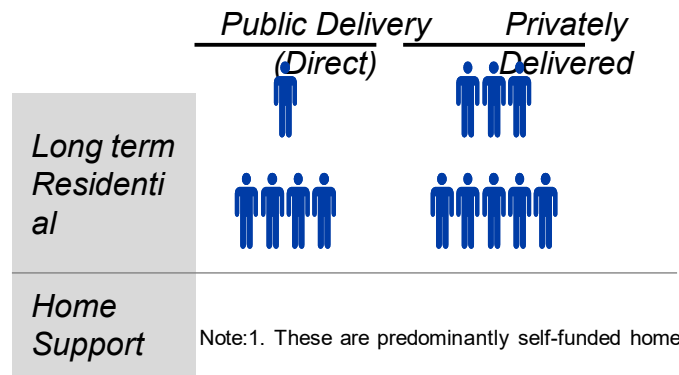
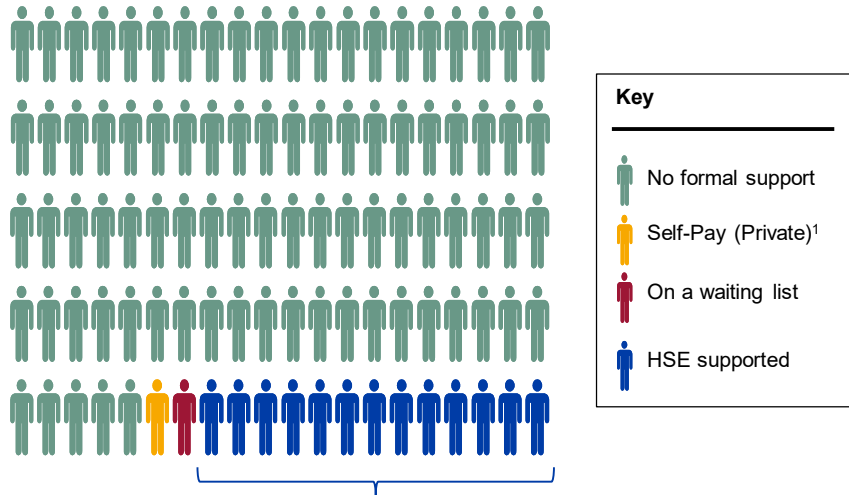
The care spectrum highlights the wide variety of care options available, from high acute hospital care to informal care, as need increases so does the acuity of the setting.



- Community care can generally be stratified with the majority of people supported informally or by community supports, then as need increases people are cared in their homes or else finally in residential facilities.
- Efforts to improve care outcomes and improve value for money have focussed on an increased focus on care delivered in service users homes, supporting them to be as independent as possible, while serving a larger population with a lower cost per person.
- A range of supports across the care spectrum support the return or stay in the lowest level of complexity of care

# The majority of Ireland's older population are supported by informal supports in their own community – these informal supports are becoming challenged and need ongoing strategic support

Ireland's Over 65 population as 100 people

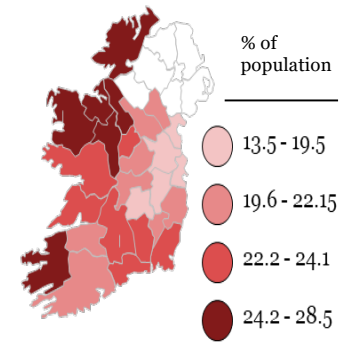


Note:1. These are predominantly self-funded home support services

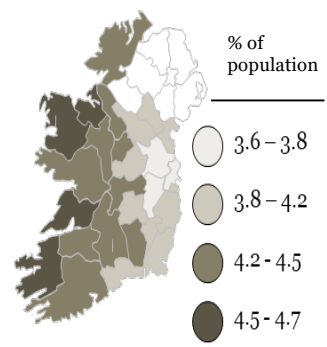
## The role and challenge for informal care

- The majority of over 65's receive no formal support from the HSE in relation to Home Support or Residential Care. Many of this cohort do not need care, but in some cases where it is required, it can be delivered by family or relatives.
- Of the 13% delivered by the HSE, 4% is Nursing Home Care (or Fair Deal) and 9% is Home Support, both of which are delivered by the HSE and also through the Private market through tender or pricing arrangements.
- Changing social dynamics in Ireland are putting informal care structures under pressure in rural and western areas. Drivers include urbanisation, female labour participation and the ageing of informal carers themselves.
- Supporting community networks that enable the 85% of over 65s who receive no formal support is a critical part of optimal policy in this area in the future.

Rate of elderly dependency by county (%)



Rate of unpaid carers by county (%)



## There are multiple factors that will have a significant impact on the community and social care configuration for Home Support Services

Driving Factor		Home support
<b>Demographic factors</b>	Ireland's ageing demographic is growing at a rapid rate. This means that Ireland's health and social care infrastructure which is already greatly strained, will have to deal with high volume growth levels in future.	H
<b>Capacity constraints in other settings</b>	Growing waiting lists with strongest demand growth concentrated in specific areas.	M
<b>Cost inflation</b>	Staff costs increasing driven by close to full employment levels, increasing wage rates, geographic dispersion of service users and reimbursement requirements for travel time.	H
<b>Regulation</b>	Regulatory impact can drive up cost for both direct and private providers e.g. training, quality, monitoring and standards.	H
<b>Change to eligibility/entitlement</b>	A statutory obligation to care may cause unintended demand increases as levels of service converge with the highest current regional levels; demand may also be induced by availability and codified standard assessment processes	H
<b>Decline in community supports</b>	The ageing of existing informal carers (e.g. 85 year old parent cared for by 65 year old) may strain the social care model in communities. Urbanisation and increased female labour participation also strain this model.	H
<b>Capacity constraints in other settings</b>	Capacity constraints in acute hospitals as well as GP shortages (particularly in rural areas) may have a knock on effect on the levels of support provided.	M
<b>User Choice</b>	The introduction of decision making legislation incl. deprivation of liberty will mean that user choice becomes an important issue going forward, which may push up levels of Home Support.	M



