(1) THE EXPERT PANEL’S REPORT: INFORMATION REQUIREMENTS FOR DEVELOPING A POPULATION HEALTH MODEL IN NORTHERN IRELAND
(2) DEVELOPING ALL-ISLAND SPECIALIST HEALTH NETWORKS: THE CONGENITAL HEART DISEASE NETWORK
THE EXPERT PANEL’S REPORT: INFORMATION REQUIREMENTS FOR DEVELOPING A POPULATION HEALTH MODEL IN NORTHERN IRELAND
In Northern Ireland the Health Minister’s roadmap published in October 2016 sets a clear agenda to transform the way in which we will deliver health and social care in the future.

A key feature of ‘Delivering Together’ is the commitment to embrace new models of care to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and across borders – Accountable Care System for the delivery of health and social care.
In Northern Ireland (NI) the Health Minister also published in October 2016 the Expert Panel’s recommendations to transform NI’s system to a Population Health in the future.

A key recommendation is to formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and, regionalised planning for specialist services.
As a key enabler of accountable care systems, the HSC should continue to invest in e-health to support improved self management, care at home and use of information to drive better population health outcomes.

A defined population where the new model of care can be delivered at pace, focusing on the stratified risk of that population in General Practice if this information is collated and shared.

Data and enabling technologies are vital components of a modern healthcare system. We hold large amounts of information on behalf of our patients and we need to look after this, but we also need to use it as effectively as possible to deliver improved outcomes for individual patients, for the wider population, and for society as a whole.

Provide the population with individual access to their health and care information.

The use of co-production as an approach should be mandated in accountable care systems and service redesign.
DEVELOPING ALL-ISLAND SPECIALIST HEALTH NETWORKS: THE CONGENITAL HEART DISEASE NETWORK
Very specialist services can be based anywhere on the island of Ireland.

In the face of increased specialisation and ever rising demand, it is not practical or desirable to try to deliver specialist services everywhere. However, it is true that specialist services could be delivered anywhere. Any acute hospital on the island has the potential to become a specialist centre for the total population ensuring patients have access to high quality, sustainable services.
All-island Network Delivery Models

Network Delivery Models Underway
All-island Children’s Heart Disease (CHD)
Network.
North West Cancer Centre.
All-island Congenital Heart Disease Network

- A clinical network

Cross-jurisdictional oversight group chaired by the CMOs North and South
All-island Network Board
- All-island Clinical Advisory Group
- All-island Infrastructure & Resources Group
- All-island Family Advisory Group

Surgical centre in Dublin
Cardiology centre in Belfast
Diagnostic and patient review hubs across the island
Combined staff resources and investment
Professorship and research programme
All-island Congenital Heart Disease Network

**Individual Care Plans and electronic record for all cardiac children**

- Each child and their family will have a holistic plan that will support the child and family through their care. The electronic care/patient health record will support the seamless transfer of information between centres, reduce time wasting and enable clinicians to have information instantaneously.

- To enhance the level of care provided to the patient an electronic discharge and transfer summary will be provided for each child to maximise communication with different teams in the Network to enhance the continuum of care. In particular this will streamline transfers between Belfast and Dublin and assist timely provision and handover of care.

- To support the child, family and carers information packs will be provided on-line that will explain how the service is provided, and they will also include educational material to inform the families of the diagnosis, the treatment options available and what that will mean for their child. This will also form part of the individual care plans. It will be supplementary to direct patient care and will be used as a tool to support consistency throughout the service by aligning expectations in the service for families and patients.
The Network will use telemedicine and remote monitoring to optimise patient care, reduce the burden of travel for clinicians and families and to develop a collaborative working culture across the centres. Home monitoring is in use in Northern Ireland for specific cohorts of patients, and this can be expanded across the island to support remote monitoring of patients and support provision of care closest to home. It will reduce the number of outpatient requirements and travel burden on the family. Currently this is not available in ROI.

- Create single database and shared (specialist service) electronic health record (EHR).
- ICT to support joint case conferencing (JCC) and viewing of imaging across sites (NI and ROI).
Key Points:

Network systems enable us to embrace new models of care to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and across borders.

There is potential to develop in Northern Ireland Accountable Care Systems designed for the total stratified patient population to have access to high quality, sustainable services.

The CHD Network has demonstrated the potential to design new systems and networks for the delivery of specialist health services of mutual benefit North and South. The opportunity is to formally invest, empower and build capacity in networks of existing health and social care providers to move towards models based on shared planning and delivery for specialist services.