Office of the Chief Clinical Officer HSE

National Clinical Programmes Review and Recommendations

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

Contents

Introduction 2

Recommendations 5

1. **Relationship of National Clinical Programmes with the Office of CCO and the HSE** 5
2. **National Clinical Programmes and Sláintecare** 6
3. **Governance** 7
4. **National Clinical Programmes Core Function and Roles** 15
5. **CCO Clinical Forum** 17
6. **Programme Alignment and Consolidation** 19

Appendix 1: **Previous allocation of NCPs by Division** 25

Appendix 2: **HSE Commissioning Teams (July 2018)** 26

Appendix 3: **Quality Improvement – Role of NCPs** 28

Introduction

Clinical leadership is central to the delivery of the changes required by our healthcare system. Since their inception, the National Clinical Programmes (NCPs) have been a key transforming force in delivering change. Patients have benefited from models of care and innovations which are focused on their needs and outcomes that are important to them. The development and implementation of models of care by programmes such as the NCP for Acute Coronary Syndrome (ACS)[1] significantly improved patient outcomes through pathways of care focused on patient needs. Clinical Leadership in programmes relating to chronic disease and older people facilitated a more integrated approach to care pathways and point the way to a future for healthcare less focused on the hospital setting. Improved patient outcomes have also been clearly demonstrated through the development and implementation of national guidelines such as the National Sepsis Guideline[2] and National Early Warning Scores[3]. Building on their models of care, NCPs have also worked with National Divisions and local providers to inform service planning and develop solutions for scheduled care e.g. virtual clinics, theatre quality improvement programmes and unscheduled care e.g. Acute Surgical Assessment Units and Acute Medicine Assessment Units.

The NCPs have also played a key role in policy development and implementation e.g. Smaller Hospitals Framework[4] and more recently the Trauma System for Ireland[5]. A key tenet of these two documents is consolidation of resources and expertise in appropriate sites to ensure care is delivered safely and in the right environment.

The establishment of NCPs was the result of a fruitful partnership between the HSE and the postgraduate training bodies. Within the HSE, this partnership had a divisional representation in the form of the Clinical Strategy and Programmes Division (CSPD). CSPD now reports to the newly formed Office of the Chief Clinical Officer (CCO). The establishment of new national functions for Operations and Strategy & Planning, along with a model of commissioning, demands that the relationship between NCPs and the HSE is redefined. In addition, the role of National Clinical Advisors and Group Leads (NCAGLs), previously mapped onto Divisions which in some cases no longer exist or have been subsumed into the

[1] Heart Attack Care in Ireland: Report of the National Clinical Programme for Acute Coronary Syndrome (ACS) on standardising treatment of patients with STEMI in 2016 (HSE, May 2018)
[2] NCEC National Clinical Guideline No. 6 Sepsis Management (DOH, Nov 2014)
[3] NCEC National Clinical Guideline No. 1 National Early Warning Score, (DOH, Feb 2013)
[4] Securing the Future of Smaller Hospitals: A Framework for Development (DOH / HSE, 2013)
[5] A Trauma System for Ireland; Report of the Trauma Steering Group (DOH / HSE, 2018)

national functions of Community Operations or Acute Operations. This review also offers the opportunity to consolidate NCPs along themes that make sense to patients and delivery care organisations and which are aligned with the principal challenges of our time. NCPs can also be consolidated along specialist lines so that work can be commissioned outside the narrower confines of existing NCPs. An important principle of this review is that all NCPs should address the needs of a domain across the entire spectrum of healthcare delivery and ensure an integrated care approach to service design. As referenced above, new partnerships need to be recognised and formalised outside the relationship between the postgraduate training bodies and the HSE which underpinned the establishment of the NCPs. In particular, a strong relationship with Sláintecare[6] is essential to cultivate a common purpose and direction between NCPs and Sláintecare objectives.

The NCPs were established in 2010 (Appendix 1). Apart from the organisational changes mentioned above, there have also been a number of significant organisational changes at service delivery level. This includes the establishment of Hospital Groups and Community Health Organisations (CHOs). With the advent of Sláintecare, further changes to organisational structures, including further integration of Hospital Groups and CHOs are expected. In addition, the increasing elderly patient population and incidence of chronic diseases are placing increased demands on the health service in terms of capacity[7].

The Office of the Chief Clinical Officer (CCO) was established in April 2018 to further develop clinical leadership across the healthcare system and ensure that it is central to the design and implementation of policy. This new Office was introduced as part of an overall restructuring of the central functions of the HSE. Given these changes, the changes at service delivery level and the potential requirements of Sláintecare, the CCO commissioned a review of the NCPs. The purpose of the review is to ensure NCPs are appropriately aligned to support implementation of national healthcare policy and the development of cross service solutions to support safe, equitable access to healthcare in the appropriate setting. Looking ahead, NCPs need to be core to the development of care pathways for Sláintecare. Solutions to the challenges of modern healthcare must focus on the entire spectrum of healthcare delivery, including expansion of capability in the community and a focus on models of care that enhance prevention and support population health improvement.

[6] Oireachtas Committee on the Future Healthcare Sláintecare Report (Gov. of Ireland, 2017)
[7] Health Service Capacity Review 2018 Report. Review of Requirements in Ireland to 2031 (DoH, 2018)

An information-gathering exercise was conducted during August, September and October 2018 by an independent management consultant, Mr Paul Rafferty. He interviewed past and present NCP Clinical Leads, Programme Managers, leadership and senior management representatives from the HSE, medical training colleges, professional bodies and hospital and community health services. A NCP Review Advisory Group was charged with overseeing the Review. Members include representation from the Forum of Irish Postgraduate Medical Training Bodies, the Office of Nursing and Midwifery Services Director (ONMSD), Health and Social Care Professions (HSCP), Clinical Directors and National Clinical Advisors and Group Leads (NCAGLs).

The Review found the NCPs have provided leadership and strategic direction during a difficult period in the history of our health and social services. Sláintecare has provided, for the first time, a cross party consensus on a long-term vision for our health service. The NCPs are essential components for the transformation that is required in healthcare over the next 10 years, the anticipated lifetime of Sláintecare.

The following sections outline the recommendations themed around the Review objectives:

1. Relationship of National Clinical Programmes with the Office of CCO and the HSE
2. National Clinical Programmes and Sláintecare
3. Governance
4. National Clinical Programmes – Core Function and Roles
5. CCO Clinical Forum
6. Programme Alignment and Consolidation.

Recommendations

1. Relationship of National Clinical Programmes[8] with the Office of CCO and the HSE

1.1 Restructuring of the HSE requires realignment of NCPs within the office of the CCO. To strengthen the concept of clinical leadership, the NCPs need to be more connected, aligned and integrated across the HSE.

1.2 The Clinical Strategy and Programme Division (CSPD) will merge with the Office of CCO to ensure that there is a single reference point for clinical leadership within the HSE.

1.3 The Clinical Strategy and Programme Division reporting to the CCO will be renamed Clinical Innovation and Design function.

1.4 All functions under the CCO, including the NCPs/Clinical Innovation and Design, the National Quality Improvement Team (previously Quality Improvement Division / QID) and Quality Assurance and Verification (QAV) functions should align with the work and priorities of the Office of the CCO. This should include input and participation in Patient Safety Programmes.

1.5 A Clinical Forum will be established within the Office of the CCO to become the focal point of two-way communication between the clinical community and corporate HSE (see Section 5).

1.6 The NCPs are required to work closely with the delivery care organisations as they are currently configured (Hospital Groups, Community Healthcare Organisations and the National Ambulance Services) as well as with any organisational structures that emerge in response to implementation of Sláintecare. This will include alignment of NCPs' programme work with the findings and recommendations of national reviews such as the Health Services Capacity Review[9].

1.7 The NCPs should work collaboratively with and be increasingly supported by wider HSE corporate functions eg. Strategy & Planning, OCIO, Health Intelligence etc. to develop and drive organisational clinical strategy and practice.

---

[8] Use of term Clinical Programmes or Programmes in this Review refers to both NCPs and ICPs unless ICPs are specifically differentiated in the text.

[9] Health Service Capacity Review 2018 Report. Review of Requirements in Ireland to 2031 (DoH, 2018)

2. National Clinical Programmes and Sláintecare

2.1 The work of the NCPs needs to respond to the principles of Sláintecare.

2.2 In line with the Sláintecare Implementation Strategy goal to provide high quality, accessible and safe care that meets the needs of the population (Goal 2), the NCPs should be the primary reference point for providing cross-service solutions in relation to:

- New models / pathways of care based on population need;
- Clinical components of community-based care expansion;
- Acute and Unscheduled Care Development;
- Models of care for Chronic Disease and Frailty ensuring that the hub of healthcare delivery lies within Primary & Community Care.

2.3 There should be close collaboration between the CCO Office and Sláintecare. The current CCO is a member of the Sláintecare Advisory Council and it is recommended that the Sláintecare Executive Director should be co-opted onto the CCO Clinical Forum. This will support two-way communication between NCPs and the DOH Sláintecare function where:

- The CCO Clinical Forum will allow for a dynamic review process;
- Clinical proposals that are raised at Sláintecare Advisory Council can be considered at the HSE CCO Clinical Forum. Similarly, ideas from Clinical Forum can be brought to Sláintecare Advisory Council.

2.3 In addition to above, it should be noted that there are a number of clinical designs already aligned to goals of Sláintecare which may be expedited and / or scaled up. To facilitate this, a number of joint workshops will be set up in early 2019. These workshops will explore clinical solutions which may have a measurable impact on Sláintecare goals in relation to chronic disease and older people within the next 12 to 18 months.

3. Governance

3.1 Chief Clinical Office: Purpose

A key function of the Chief Clinical Officer (CCO) is to ***connect, align and integrate*** clinical leadership across the HSE. The CCO will work with the Deputy Director Generals (DDGs) for Finance, Operations and Strategy & Planning in determining national priorities for HSE.

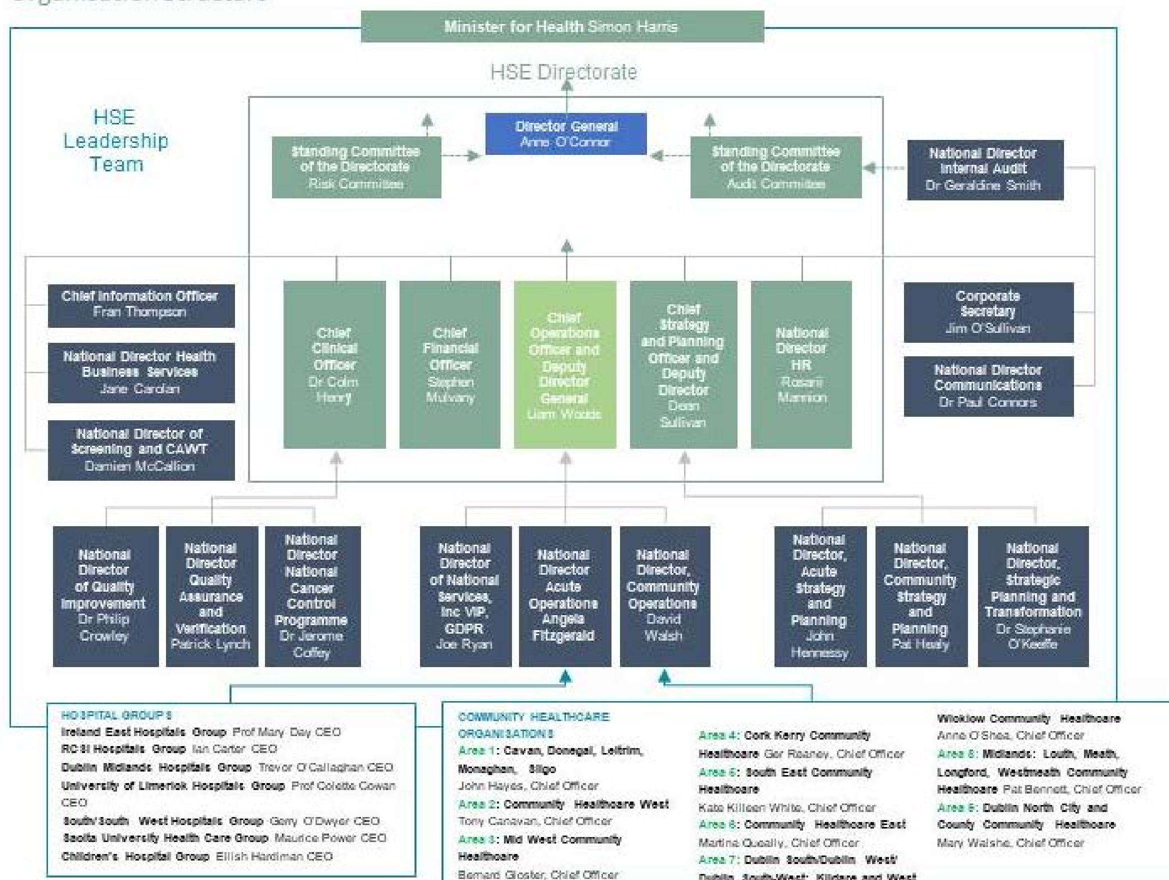

Figure 1: HSE Governance Structure (January 2019 from www.hse.ie)

3.1.1 The Office of the CCO will incorporate and be supported by a number of national functions, including Clinical Innovation & Design (previously CSPD), Office of Nursing & Midwifery Services Director (ONMSD), Corporate Office for Health & Social Care Professions (HSCP), Quality Assurance and Verification, National Quality Improvement Team (previously QID) and the National Cancer Control Programme. The work of these functions will be determined by priorities of the CCO Office and aligned to national healthcare priorities.

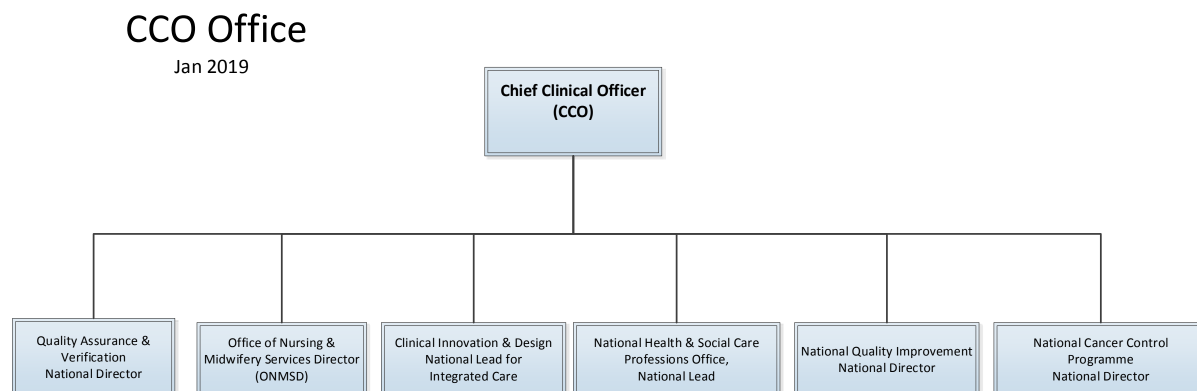

Figure 2: Office of the CCO Structure (January 2019)

3.1.2 The work of quality improvement and quality and safety will be integrated with the work of Clinical Innovation and Design to avoid duplication and ensure that there is a cohesive strategy around quality improvement and quality and safety.

3.1.3 Business management functions for the Office of the CCO are currently under review to maximise use of resources and expertise; and to support integrated working across CCO functions. This will include for example, HR and Recruitment, Communications, Finance, Budgets, Service Planning, Procurement, Service Level Agreements, Controls Assurance, Travel.

3.1.4 NCCP will maintain their current operational arrangements regarding the above.

3.1.5 The NCPs were originally established to design solutions that would deliver measurable improvement in the quality, access and cost of services working specific chronic disease areas. In more recent times a number of Integrated Care Programmes were also established. It is recommended that all NCPs should adopt an integrated care approach to their work.

3.1.6 To facilitate this and to support a robust governance structure a National Lead for Integrated Care will be appointed.

Good governance is built from the ground up i.e. from the service provided to patients. The purpose of any governance structure is to provide clarity in relation to this. Accountability, responsibility and authority are all part of governance.

The governance described below sets out how the NCPs relate to the CCO, the National Lead for Integrated Care, the Clinical Advisory Groups, NCAGLs, ONMSD and National HSCP.

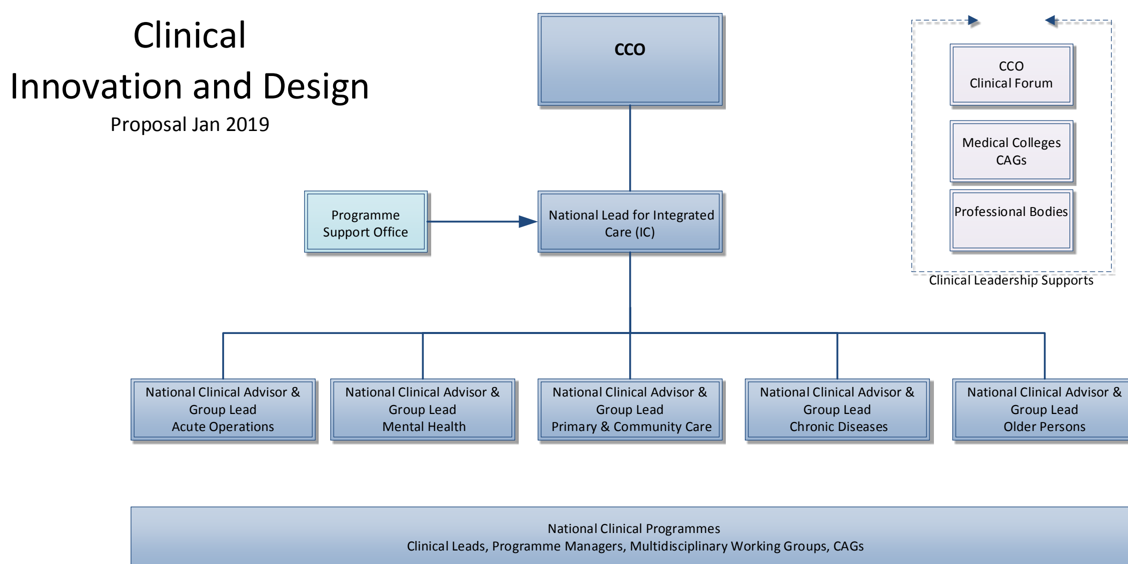

Figure 3: Proposed National Lead and NCAGL Structure

3.2 Chief Clinical Officer

In relation to clinical design and innovation, the CCO will

- Be a member of the HSE's Commissioning Oversight Group[10];
- Chair a proposed new Clinical Forum pending the appointment of a National Lead for Integrated Care;
- Represent the clinical voice at HSE Leadership Team and Directorate (Board) levels;
- Engage with the Colleges to agree ways of working with the HSE to provide clinical leadership.

3.3 National Lead for Integrated Care

This new post, reporting directly to the CCO, will oversee the work of the NCPs through the NCAGLs in line with organisational priorities. The individual will be an integral part of the Office of the CCO and be a member of the CCO Integrated (Senior) Management Team. As reflected in the title, the individual will ensure integrated care cross cuts all programmes. Additionally, the individual will be responsible for ensuring that health and wellbeing reform priorities (prevention, early detection, self-care/self-management for patients with chronic disease) are prioritised and embedded across all National Clinical Advisor programmes of work and each clinical programme.

[10] The HSE's Commissioning Oversight Group was established in July 2018 to consider the work and outputs from each of the Commissioning Teams co-led by Strategy and Planning and a senior clinician

The National Lead for Integrated Care will ensure strong links to the CCO and the functions reporting to the CCO through the CCO Clinical Forum.

The main functions of the role of National Lead for Integrated Care include:

- Chair the CCO Clinical Forum;
- Act as an interface between the Clinical Forum and the Commissioning Teams;
- Ensure direction set out by the Clinical Forum is fully responsive to HSE organisational reform priorities and is reflected in work-plans of each NCAGL and their respective programmes;
- Lead the implementation of recommendations of the NCP Review;
- Work with the NCAGLs to ensure appropriate alignment and consolidation of the NCPs (Section 6);
- Optimise management of resources to support work of NCAGLs and Clinical Leads;
- Agree resources and budget to be provided to each NCAGL;
- Advise on key design priorities nationally and locally;
- Develop links with clinical leadership at all levels of the organisation e.g. Clinical Directors, Nursing & Midwifery and HSCPs;
- Establish and maintain regular contact with colleges in their role as co-sponsors of the programmes;
- Oversee the Programme Support Office (Section 3.4);
- Ensure the work of the Clinical Innovation and Design function is effective, through its outputs and in how it works through and with others, in improving care, improving the design of care and improving patient and population health outcomes.

3.4 Programme Support Office

The Programme Support Office, previously called CSP Portfolio Management Office, will support the National Lead for Integrated Care (IC). The main function of this office is to enable the work of the NCPs through development of standard quality improvement (QI) methodologies, reporting tools and facilitating access to appropriate training and support. The emphasis on QI reflects the importance of this skill and way of thinking. The PSO will support the National Lead for IC in the allocation and management of Programme Managers and other programme staff employed and contracted by the HSE.

Planning and Performance Leads and Programme Managers will act as a central resource, to be allocated flexibly for defined pieces of work determined by the National Lead for IC.

3.5 National Clinical Advisor and Group Lead

The NCAGL role is that of internal consultant to the HSE providing clinical leadership across three core pillars of clinical excellence, strategic development and operational delivery. Through their cross cutting role in the HSE, they advise both HSE Strategy and HSE Operations and manage a group of NCPs. Their natural home as a clinical community is the Office of the CCO. Reporting to the CCO through the National Lead for IC, this arrangement enables benefits of scale and shared services such as access to research, communication and knowledge transfer.

The NCAGL role is to ensure the clinical activity within and across their group of programmes is aligned with the HSE strategic priorities and that the resources deployed are maximised to include:

- Assume direct control over a suite of programmes, supported by programme managers;
- Agree strategic direction, vision and work for programmes in their remit;
- Review the work of programmes initially and on an on-going basis to determine appropriate, scope, configuration and resource allocation;
- Agree resources and budget allocation priorities with the National Lead for IC for relevant NCPs;
- Enable a distributed, collaborative leadership approach to engaging with Hospital Groups and CHOs to ensure conditions are created to support people to implement clinical designs locally;
- Interface with HSE National Strategy & Planning and Operations;
- Advise on key clinical design priorities nationally and locally;
- Work with or identify clinical leads to support commissioning teams.

A number of workshops will be convened to further clarify the NCAGL roles and responsibilities and to determine allocation of this valuable resource across HSE functions.

NCAGLs and Clinical Leads provide a valuable resource and reference point for patient safety functions and formal links will be established between post-holders and QID and QAV.

3.5 National Clinical Leads for NCPs

- Clinical Leads will continue to be nominated in a joint recruitment process with the training colleges;
- In addition to their role of managing their programmes, the NCP Clinical Leads (CL) will have:
    - *Authority to speak on behalf of their community;*
    - *Expertise relevant to their programme;*
    - *Advise on best practice in their field;*
    - *Input into commissioning teams as required.*
- Clinical Leads will perform a spectrum of work from transactional representation to strategic design function which should be reflected in their time commitment e.g. one day per week may be sufficient where a model of care is completed and implemented ranging to a more substantial commitment for more strategic work;
    - Transactional work – PQs, advising and supporting operations on clinical matters, representing a clinical body for the HSE e.g. CAAC;
    - Strategic work involves a much greater commitment – engaging with clinicians, designing in a collaborative way, based on direction from the forum, and working with the delivery system on implementation.
- As their programme matures, Clinical Leads will employ quality improvement methodologies as they apply to transactional, systems, operations and design work.

3.6 Programme Managers for NCPs

Currently there are a variety of reporting arrangements for Programme Managers. Some are employed by and report directly to the HSE and others are employed by and report directly to the medical colleges. Arrangements and structures vary in each college. In some instances it may be preferable for Programme Managers to be employed by and report directly to the HSE. It is recommended that:

- Service Level Agreements with medical colleges be reviewed to determine most suitable arrangements for NCP Programme Manager support;

- Programme Managers employed by and reporting directly to the HSE should report into the PSO;
- Programme Managers will act as a central (and flexible) resource to support specific NCPs, and/or projects for defined periods of time and as allocated by NCAGL / National Lead for IC.

3.7 Clinical Advisory Groups

NCPs are supported by Clinical Advisory Groups (CAGs), formed and coordinated by the colleges. The CAG is an important component in providing proactive clinical leadership and buy-in from the clinical community and colleges. They provide a key link to the Office of the CCO.

- In line with the Sláintecare approach and to ensure they represent the breadth and depth of the clinical community, membership of the CAGs should be revised to reflect a more multidisciplinary approach, drawing on membership and input from all relevant healthcare professions;
- Giving due regards to the HSE priorities, the function of the CAG is to ensure that the decisions and strategy of the Clinical Lead are informed by a multidisciplinary group representative of the given speciality or work-stream.

3.8 Medical Colleges, Nursing and HSCP

The Colleges are the co-founders and co-sponsors of NCPs. They play a key role in maintaining and developing links between corporate HSE and specialised clinical knowledge. They should continue to play a central role in clinical design through the Clinical Advisory Groups, nominating Clinical Leads, partnering with the HSE and providing leadership to the system.

The colleges need to continue to support cross college, cross programme and cross discipline work as they have done to date for example through work on the Acute Floor and the development of the clinical prioritisation process.

The importance of a multi/interdisciplinary approach of NCPs is recognised.

- To give effect to this each programme must have relevant Nursing and HSCP input both on the programme and through Clinical Advisory Groups. Sourcing of suitable nominees and inputs will be facilitated through the HSEs Office of Nursing and Midwifery Services Director and National HSCP Office.

4. National Clinical Programmes Core Function and Roles

The core functions of NCPs should be clearly guided by the HSE, in line with explicitly declared national policy and priorities. In the course of carrying out this review, one common theme that emerged was the importance of explicit direction in determining the work-plans and priorities of NCPs. When such priorities are clearly expressed and communicated, the work and focus of NCPs will follow. The emerging consensus that integrated care represents a new paradigm of healthcare distant from a more hospital-centric approach has guided and informed the Health Services Capacity Review[11] and Sláintecare[12] in our own healthcare system as well as those abroad.

The NCPs will continue to play an important role in policy development and implementation. They will play an increasingly important and effective role in improving population health through consideration of health and wellbeing organisational objectives. They have a significant role in quality improvement and designing cross-service solutions and care pathways to support safe, equitable access to care in the appropriate setting. This includes provision of integrated care based on a population health approach. While they do not have operational authority, engagement with clinical leadership at local and national level is an important facet of their work and complements implementation and performance management through the operational line. It is recommended that:

4.1 NCPs retain their name in recognition of the brand value that has emerged since their foundation.

4.2 Each NCP reports to a NCAGL who will direct and lead his/her respective group of NCPs in line with the agreed priorities and direction of the Clinical Forum.

4.3 There will be devolved authority and budget for defined work-plans to each NCAGL. Ultimate authority for the budget remains with the CCO.

4.4 In line with the vision of a healthcare system based around needs of patients, NCPs should ensure that the patient voice is included in their work, including co-design.

4.5 Working with the National QI Team, the NCPs will actively seek to champion service improvement, using quality improvement (QI) methodologies to inform their work. Appropriate QI training should be provided as required. (See Appendix 3).

4.6 NCPs will continue to advise and support the HSE and policy makers on appropriate configuration of services. This may come from direct requests from Hospital Groups

[11] Health Service Capacity Review 2018 Report. Review of Requirements in Ireland to 2031 (DoH, 2018)
[12] Oireachtas Committee on the Future Healthcare Sláintecare Report (Gov. of Ireland, 2017)

and CHOs or in the case of national configuration of services from HSE and DOH. This may include appropriate designation of services based on safety, capacity and capability.

4.7 Delivery care organisations may also consult the NCPs on internal service design.

4.8 The NCPs will advise their corresponding NCAGL regarding alignment of proposed consultant posts to approved Models of Care and appropriate alignment of services. The final advice to CAAC will rest with the relevant NCAGL.

4.9 Service design in response to national policy should include appropriate consultation with delivery care organisations and service users.

4.10 NCPs will make full use of the National Quality Improvement System (NQAIS) to support quality improvement throughout the system.

5. CCO Clinical Forum

5.1 Construct

The CCO Clinical Forum will act as the interface between the NCPs and the CCO, HSE and the Commissioning Teams (see appendix 2), ensuring alignment with Sláintecare and HSE policy. The Clinical Forum, which will report to the CCO through the National Lead for Integrated Care, will give explicit direction to all NCPs regarding healthcare system priorities. These priorities will determine the areas of focus of each NCP and their work plans.

During the initial phase, the Clinical Forum will be chaired by the CCO. It will be multidisciplinary in nature and include the NCAGLs and representation from the CCO functions, Lead Clinical Directors, HSE Strategy and Planning, Sláintecare and from the Forum of Irish Postgraduate Training Bodies.

Through this Forum, HSE Strategy & Planning can commission work from the NCPs based on explicit national priorities. In addition, the NCPs can submit to the Forum evidence-based and informed innovative solutions and proposals to improve patient care, introduce service efficiencies and address healthcare system priorities.

5.2 Purpose

The Forum will be established to promote and support effective multi-disciplinary / professional clinical engagement and leadership and to support sustainable improvements in patient and service user outcomes, safety and experience. As an outcome of the review of the National Clinical Programmes, the Forum will operate as a two-way dynamic forum between the HSE and the Programmes.

The core purpose of the Forum will be focussed on the following areas:

- Provide strategic guidance to the CCO on how NCPs can be configured and harnessed to progress and implement healthcare system priorities, as articulated by HSE leadership, national policy and Sláintecare;
- Advise CCO and Strategy and Planning on design principles and models of care that are necessary to give effect to healthcare system priorities;
- Through the NCAGLs, direct work of NCPs based on healthcare system priorities;

- Advise CCO on proposals/innovations from NCPs that can inform and address national healthcare priorities;
- Advise on engagement with patients and service users in the design and planning of services;
- Advise and inform the commissioning teams in relation to service design and innovation;
- Develop a framework for NCPs to provide guidance and a standardised approach to design, consultation and implementation;
- Agree process for commissioning and approval of work of NCPs;
- Provide guidance and direction to the work plans of NCPs aligned with priorities as decided by healthcare policy;
- Through the NCAGLs, act as an arbitrator and final point of escalation for points of difference that may arise between NCPs as they design their solutions;
- Consider and approve the initiation of all models of care and whole system redesign initiatives ahead of commencement;
- Review, both retrospectively and prospectively, and provide an integrated clinical and professional perspective on the NCPs guidance (PPGs and/or Models of Care) to ensure they are aligned with the aforementioned design principles, existing HSE and national policies and reforms e.g. Sláintecare, and other relevant MOCs;
- Approve implementation plan of each model of care following completion and make recommendation for commissioning/implementation.

6. Programme Alignment and Consolidation

The majority of the National Clinical Programmes (NCPs) were established between 2009 and 2010. One of their core purposes is clinical design, with the aim of improving quality, access and value of healthcare for patients. In 2019, there are 36 clinician led National Clinical Programmes. In addition to the original cohort of NCPs, four Integrated Care Programmes (ICPs) were set up in 2015 to enable co-ordination of care for patients across all service settings in the areas of Patient Flow, Chronic Diseases, Older Persons and Children.

Based on changes described in the introduction, some realignment and consolidation is necessary to support the principal themes of care delivery, including unscheduled care, scheduled care, waiting list management and chronic disease. Integrated Care, based on population needs should be a key component of all NCPs. It is recommended that ICPs are not separate but encapsulated in the work of each NCP. In addition, some NCPs should be aligned along specialist lines e.g. cardiology and respiratory. This will expand the capacity to respond to service needs for sub-specialties within these areas.

Some changes have taken place already:

- The Obstetrics and Gynaecology Programme has been overtaken by the establishment of the National Maternity Strategy and the establishment of the National Women and Infants Health Programme;
- The National Transport Medicine Programme has been operationalized and reports into Acute Operations through the National Ambulance Service.

For such Offices and functions, it is assumed they remain clinically led or co-led and that their relationship with advisory groups based in the various professional bodies continues. Strong linkages with the CCO need to be retained.

Clinical leadership is often referenced against a single illness or single specialties and NCPs are largely mapped in this manner. While the definitions do not always respond to the themes of healthcare delivery, a balance must be achieved between specialist representation and patient needs in terms of healthcare delivery. **It is recommended to redefine and reallocate programmes so as to provide a more equitable work distribution among the NCAGLs to deliver healthcare across a broader spectrum i.e. the title and domain of the NCAGL does not define the work of the NCP.** In doing this due regard should be given to the requirement for NCPs to include elements of health promotion and public health.

6.1 The NCAGL for Acute Operations should review NCPs

- With a view to one unscheduled care programme with a single Clinical Lead to:
    - ➢ Encompass NCPs including Acute Medicine, Emergency Medicine and elements of other NCPs such as acute surgery. The resultant Unscheduled Care Programme will support the implementation of the Acute Floor Model, based on the Urgent and Emergency Care Report[13] and supported by the Acute Floor Information System;
    - ➢ Further support the work of the Special Delivery Unit (SDU);
    - ➢ Ensure a strong focus on the development of ambulatory care.
- Develop a standardised approach to scheduled care. Sláintecare sets specific targets for scheduled care, requiring a cohesive approach to scheduled care across all relevant programmes;
- Cross-programme work is recommended and in some cases has already commenced with the development of standardised clinical prioritisation processes. This will provide a basis for future work;
- The ICP for Patient Flow will be merged into the unscheduled care programme and support the priorities above regarding scheduled care where relevant.

6.2 **NCAGL Mental Health** encompassing all mental health related programmes and continuing with advice and collaboration with relevant functions e.g. National Office of Suicide Prevention and other programmes e.g. National Women & Infants Health Programme. Inclusion of mental health well-being in the work of many clinical programmes recognises significant interdependencies in chronic illness as well as many acute conditions. The NCAGL Mental Health should review NCPs with a view to ensuring they:

- address population and service needs for mental health disorders and mental health well-being;
- include an early response/intervention approach;
- support population well-being, reducing suicide and suicidal behaviours as envisaged in the Connecting for Life Policy[14];

[13] Urgent and Emergency Care Report (unpublished, 2018)
[14] Connecting for Life: Irelands Strategy to Reduce Suicide 2015 – 2020 (DOH / HSE, 2015)

- Proactively engage with other NCPs to support positive consideration of mental health issues across the spectrum of illness, including the physical health needs of patients with severe and enduring mental illness.

6.3 **NCAGL Primary and Community care** encompassing primary care services and development of pathways, underpinned by a population health approach, to ensure services currently provided in hospital are delivered in primary and community care settings.

- The GP contract is a critical enabler for transformation of healthcare delivery. Aligned with Sláintecare and the Chronic Disease Programmes, the work of this NCAGL will be focused on harnessing the elements of the new contract to deliver benefits to patients;
- A new clinical lead for disability services will also report to this function;
- The NCP Paediatrics will merge with the ICP Children and report to the NCAGL for Primary and Community Care. The role of the current Steering Group for the ICP Children needs to be reviewed in the context of a change to one programme;
- Further develop the role of the four GP leads and relationships with the professional bodies.

6.4 **NCAGL Older Persons** (replacing previous NCAGL for Social Care), encompassing all programmes as they pertain to the interests of older people. This includes amalgamation of the National Clinical Programme for Older Persons with the ICP Older Persons. The role of the current Steering Group for the ICP Older Person needs to be reviewed in the context of a change to one programme – including their role in relation to work-streams such as Dementia Care and Falls. The NCP Palliative Care, NCP Stroke and NCP Rehabilitation will report to this NCAGL.

6.5 **NCAGL Chronic Disease** (to replace Health & Wellbeing). This NCAGL will play a pivotal role in preparing our healthcare system for the increased burden of chronic disease and in advising internal and external stakeholders on Healthy Ireland clinical priorities. A whole-system approach for chronic disease requires design for all relevant conditions and specialties enabling patients and primary care practitioners to manage the great

majority of chronic disease outside a hospital setting. Underpinned by a population health approach, this individual will also be advising on supports and programmes of work required outside of healthcare settings to improve population health, reduce health inequalities and reduce the burden of chronic disease in the population. The role of the current Steering Group for the ICP Chronic Disease should be reviewed in the context of ICP for Chronic Disease supporting the NCPs that will report into the Office of the NCAGL for Chronic Diseases.

The NCAGL for Chronic Diseases should review NCPs:

- To amalgamate the current NCPs for Asthma and COPD into one Respiratory NCP under single leadership;
- To establish one Cardiology NCP to focus on cardiovascular disease along its broadest scope, including prevention and promotion and primary care and address any recommendations emerging from the DOH Review of Cardiology, currently underway;
- To examine key linkages and opportunities for alignment of programmes of work across all other NCAGL work programmes.

6.6 Criteria for reviewing and reconfiguration of NCPs

NCPs require a certain level of resources in terms of clinical leadership and programme support. While funding for these roles is largely provided through CSP, some clinical leads and clinical advisors are funded by the operational divisions. In addition, the level and source of support for NCAGLs and NCPs varies. In the context of the current budgetary constraints, these must be reviewed regularly to ensure they are used appropriately to support the objectives of the HSE. The following recommendations describe how the resource allocation to NCPs should be reviewed:

- Where a NCP is defined by a work-plan alone, once this is complete, the Clinical Forum, with recommendation from the relevant NCAGL, will consider the on-going purpose of the NCP and opt to either scale down or transfer the work and resources to a newly commissioned piece of work based on healthcare system priorities;
- Similar to the National Transport Medicine Programme mentioned earlier, once a NCP has become involved in the provision of a service, consideration should be

given to operationalizing this programme. This should include the National Rare Diseases Programme, incorporating the Rare Diseases Office and the Renal Programme, incorporating the National Renal Office;

- NCPs should be scaled up or scaled down according to the level and spectrum of work required to meet HSE objectives. This should include consideration of the clinical leadership requirements in relation to:
  - The time commitment of the clinical lead which may range from occasional clinical advice to a time commitment of between 1 to 4 (maximum) days per week;
  - The option of clinical advisors on either an ad hoc or defined time commitment e.g. a day per week / month to support transactional requirements in relation to PQs or ad hoc clinical advice;
  - The contribution to clinical leadership across the spectrum of healthcare professionals including leads and / or co-leads from other healthcare disciplines.

It must be noted that there is a fixed resource available for NCPs within which all decisions to scale up or scale down work must be contained.

6.7 New NCPs and NCPs that are currently outside the governance of CSP

There are a number of clinical programmes where the governance arrangements lie outside the Office of the CCO. These arrangements should be reviewed with a view to some programmes reporting into a NCAGL and other programmes having a dotted line reporting arrangement to the CCO / CCO Clinical Forum:

- National Women and Infants Health Programme (NWIHP) – Currently reporting to HSE Strategy & Planning. Governance to be reviewed to align with the Office of the CCO;
- Trauma Office – Governance to reflect recommendation 36 of A Trauma System for Ireland (2018)[15] i.e. report to CCO;
- Director of the National Genetics & Genomics Medicine – Report to CCO initially.

[15] A Trauma System for Ireland. Report of the Trauma Steering Group. DOH / HSE (2018)

6.8 The NSP 2019 includes the implementation of the national patient safety strategy.

This includes the establishment of new governance arrangements to oversee implementation of the patient safety strategy and to strengthen the governance of patient safety programmes.

- In line with this objective there should be one over-arching programme for Patient Safety to incorporate HCAI, Sepsis, the Deteriorating Patient, Medication Safety, Pressure Ulcers and Falls;
- All NCPs to contribute to the establishment of a national repository for policies, procedures, protocols and guidelines.

Appendix 1: Previous allocation of NCPs by Division

National Clinical Programmes by Division (CSPD 2016)

Acute Hospitals (20)	Health & Wellbeing (4)	Social Care (3)	Mental Health (5)	Primary Care (3)
Acute Coronary Syndrome	Asthma	Neurology	Assessment & Management of Patients Presenting to the ED Following Self-harm	Medicine's Management
Acute Medicine	COPD	Older People	Early Intervention for People Developing First Episode Psychosis	Ophthalmology
Anaesthesia	Diabetes	Rehab Medicine	Eating Disorders Service Spanning Child, Adolescent & Adult Mental Health Services	Palliative Care
Critical Care	Heart Failure		Dual diagnosis: Substance Misuse and Co-Morbid Mental Illness	
Cystic Fibrosis			ADHD in Children in Adults	
Dermatology				
Emergency Medicine				
Epilepsy				
Obs & Gynae				
Paeds & Neonatology				
Pathology				
Radiology				
Rare Diseases				
Renal				
Rheumatology				
Sepsis				
Surgery				
Stroke				
Transport Medicine				
Trauma & Orthopaedics				

Appendix 2: HSE Commissioning Teams (July 2018)

Commissioning Teams
Strategy & Planning – Acute, Community and Health & Wellbeing

Community Strategy & Planning

Primary Care Commissioning Team	**Older People Commissioning Team**

• Chair & Executive Lead
• Commissioning Teams (x 3)
  - Primary Care – Co Chair & Clinical Lead
  - Chronic Disease- Co Chair & Clinical Lead
  - Social Inclusion- Co Chair & Clinical Lead
• Operations Lead
• Finance
	• Chair & Executive Lead
	• Commissioning Teams (x 2)
	  - Older People– Co Chair & Clinical Lead
	  - Palliative Care– Co Chair & Clinical Lead
	• Operations Lead
	• Finance

Mental Health Commissioning Team • Chair & Executive Lead • Co-Chair & Clinical Lead • Operations Lead • Finance	**Disability Commissioning Team** • Chair & Executive Lead • Co-Chair & Clinical Lead • Operations Lead • Finance Business Partner
***The intention is also to involve leads from other key corporate areas including- Quality & Patient Safety, HR, Estates and IT who will participate as required** *** Provision is also made for meeting with providers organisations i.e. CHOs**	

Acute Strategy & Planning

Medical Services/ Unscheduled care	**Surgical Services/ Scheduled care**

• Executive Lead
• Clinical Lead
• Operations Lead
• Finance
  - Commissioning Teams – 4
	• Executive Lead
	• Clinical Lead
	• Operations Lead
	• Finance
	  - Commissioning Teams – 3

Women & Children's Services
• Executive Lead
• Clinical Lead
• Finance
  - Commissioning Teams – 2
	Specialist / Tertiary Services
	• Executive Lead
	• Clinical Lead
	• Executive / Operations Lead NAS
	• Finance
	  - Commissioning Teams – 4

***The intention is also to involve leads from other key corporate areas including- Quality & Patient Safety, HR, Estates and IT who will participate as required** *** Provision is also made for meetings with provider organisations i.e. Hospital Groups**	

Health & Wellbeing

Health & Wellbeing Commissioning team Executive Lead, Clinical Lead, Operations Lead and Finance supporting work programmes - Healthy Ireland; - Alcohol Programme; - Healthy Childhood Programme; - Healthy eating and active Living Programme; - Sexual Health and crisis Pregnancy Programme; - Tobacco Free Ireland Programme.
The intention is also to involve leads from other key corporate areas including- Quality & Patient Safety, HR, Estates and IT who will participate as required** ***Provision is also made for meetings with provider organisations as required

Appendix 3: Quality Improvement – Role of NCPs

Clinical leadership at a national level is key to healthcare improvement. But not all improvement is dependent on there being a national programme of change. Hospital groups, CHOs and individual service teams are delivering improvement and the growth of the quality improvement movement and the use of quality improvement methods are also driving improvement in service delivery. At a national level, there is a constant need for the multidisciplinary championing of improvement across organisational boundaries and the provision of advice on the standards improvers should aspire to.

One of the aims of the NCPs is to champion quality improvement at a national level in their area of clinical service and, in collaboration with others, across the patient's integrated pathway. Quality is defined by the Institute of Medicine (IOM) as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". The Institute of Healthcare Improvement (IHI) identified six domains of healthcare quality. It is the National Quality Improvement Teams aim to champion improvement across these domains. They are:

1. **Safety**: Initiatives to avoid harm to patients from the care that is intended to help them.
2. **Effectiveness**: Initiatives to reduce the variation in patient outcomes
3. **Patient-centred:** Initiatives to promote care that is respectful of what is important to patients and ensures that patient values guide clinical design.
4. **Timely**: Initiatives to reduce waits and sometimes harmful delays in accessing care.
5. **Efficient**: Initiatives that reduce waste, including waste of equipment, supplies, and staff energy.
6. **Equity**: Initiatives that ensures care is provided based on need rather than gender, ethnicity, geographic location, and socioeconomic status.

The NCPs will actively seek to champion quality improvement by:

1. Proactively **seeking out examples of local or regional innovations** in the delivery of care that have delivered proven measurable quality benefits and sponsoring and promoting the adoption of these standards and ways of working at a national level.
2. Organising regional and national **quality improvement knowledge sharing networking events** at which multidisciplinary teams can and learn from each other and from international experience.
3. Leading national **collaboratives** to tackle shared challenges whether it relates to patient flow, safety, patient experience, staff resilience etc. A collaborative does not start with a solution but seeks to draw on the collective wisdom of teams from multiple sites. National collaboratives are a better approach for designing and promoting the adoption of guidelines than merely issuing an approved set of guidelines to the system via e-mail or the web.
4. Promoting and facilitating **Quality Improvement Skills training** for teams providing the same service but working in different geographic areas. Teams learn as much from each other as they do from the QI training when this approach is taken. Because they provide the same service, they coach each other, and outcome is the sharing of best practices and better collegiate networking.
5. **Influencing the design of clinical education and training** at under graduate, post graduate and on-going professional development level is a successful strategy for National Clinical Programmes seeking to standardise and innovate health care delivery. The programmes have been successful in promoting training in areas such as the management of Frail Elderly patients. Also, the programmes have led the way in up-skilling nurses and Health and Social Care professionals. Advanced Nurse Practitioner roles and the roll out of physiotherapy-led clinics have reduced pressure on senior clinical decision makers and improved patient access and flow.

6. Establishing and promoting **shared learning and networking through social media**. The National Quality improvement Teams should seek to use social media channels to acknowledge and socialise best practices and to communicated and promote shared learning and network events.

All NCPs should complete QI and implementation science awareness training, including practical skills in topics such as:

- Effective teams and physiological safety
- Co-design and patient centredness
- Measurement for improvement
- Analysing patient flow including demand, activity and capacity analysis
- Change management and communication
- Managing human factors and influencing
- Staff engagement and facilitation
- Sláintecare goals and strategic actions explained
- HSE and DoH management process and organisation structures
- Implementation science and planning
- Lessons learnt from examples of successful service design implementation
- National Quality Improvement Teams governance and management processes
- Commissioning and the national service planning process.