National Clinical Programmes

Section 3

Background information on the National Clinical Programmes

Mission, Vision and Objectives

July 2011
National Clinical Programmes: Mission and Objectives

The programmes mission are to “Deliver better care through better use of resources”

Every programme has a set of objectives grouped under three headings

1. Improve Quality e.g. reduce incidence of stroke, heart failure, blindness due to diabetes, etc
2. Improve Patient Access e.g. reduce outpatient wait time, reduce time to see senior doctor in an emergency dept.
3. Reduce Cost e.g. reduce average length of stay, reduce bed utilisation.

Building on the success of the National Cancer Control Programme model, the following were identified as key success factors in achieving programme objectives:

1. Clinically led multidisciplinary team: The programmes are led by clinicians selected by their peers through their respective training colleges. Each programme has a multidisciplinary team made up of doctors, nurses (selected by the Directors of Nursing), GPs (selected by the ICGP) and allied health professionals (selected by their professional bodies), public health doctors and service planners. Where a change process is clinically led it is more likely to succeed than when clinicians engage in the change process only.

2. Structured approach from design to implementation: A structured programmatic approach was developed setting out the steps a programme needed to complete to take an improvement idea from inception through to implementation. The mantra of the programmes has been you get 5% of the marks for the solution design, 45% for its implementation and 50% of the marks for implementing the solution in a way that delivers sustained benefits.

3. Engage patients: The value of engaging patients early in any change process is well recognised. A patient reference group was established, through the HSE Advocacy function, to support the programmes. Patient review of all programme solutions is required prior to final sign off.

4. Nationalise existing best practice: The programmes are seeking to standardise care against existing Irish best practice. The National Clinical Programme Leads selected are recognised by their peers as having established good local models of care. The role of the programmes is to package these local models of care, get national input and buy-in to them and seek to standardise care nationally around them. The programmes are not seeking to re-invent the wheel.

5. Make data driven decisions: Once a programme has developed a solution it is required to provide data that demonstrates that the solution will deliver Quality, Access and Cost benefits. The National Clinical Programmes listed in the HSE National Service Plan 2011 have completed business cases with validated data.

6. Local ownership: The programmes will only succeed if there is local buy-in and leadership for the implementation of their solutions. Many of the programmes have consulted extensively to get local input into the design of their solutions. The key role in implementation is that of the local Clinical Programme Lead, which some programmes have identified already.

7. Align stakeholders: The key success of the programmes in 2010 was aligning multiple stakeholders e.g. HSE management, nursing, colleges, DOHC, patient advocates, etc to a common approach for working collaboratively to deliver on a shared vision of integrated care.
National Clinical Programmes: Vision

There are multiple programmes but they are working to a common vision. There are two aspects to this vision:

(1) **Design standardised models for the delivery of integrated clinical care**

The National Clinical Programmes will contribute to the design and implementation of a standardised and integrated patient journey. This journey can be complex and is illustrated on page four. Each of the National Clinical Programmes are contributing solutions to the key points on this patient journey. As the programmes are working together these solutions are developed in consultation with each other. This breaking down of speciality silos has been a key factor of the programmes to date. Many of the programmes have dependencies on each other.

(2) **The embedding of sustained clinical operational management of the integrated pathway**

He programmes vision is not just to implement stroke units, COPD outreach, Acute Medicine Units etc, but to implement solutions that delivers sustained benefits and continuous improvements to the patient. This can be achieved by embedding operational management at a clinical level. There are six key steps:

1. Agree the measurable Quality, Access and Cost metrics you want to achieve.
2. Ensure there is a documented standardised pathway in place, which is supported by standard clinical decision making.
3. Ensure that all parties involved in the pathway have total clarity of their roles, responsibilities and governance arrangements.
4. Ensure there is a balanced set of metrics in place to track the performance of the pathway.
5. Ensure there is an effective meeting held regularly, where those who are managing the pathway identify variance in its operational performance and log actions to be taken to improve the outcome for the patient.
6. Where the reason for the variance is unclear or the action to address variance is significant then ideally there should be some skilled local project and process improvement resource available to guide the clinicians through the change process.

If steps (1) to (4) are only implemented, there may be a risk that documentation has been agreed and implemented without full performance improvement being achieved. Therefore step (5) is essential in the continual performance improvement of the service implementation. With positive tension and clear working together by all involved the unit and pathway for the patient will be optimised.
Vision 1: Design standardised models for the delivery of integrated clinical care.

Integrated Patient Journey

1. Patient information web site
2. GP/Primary Care Team
3. Chronic Disease watch
4. Pharmacy
5. Ambulatory Care Service
6. Outreach Service
7. Out patients
8. Rapid Access Clinics
9. Regional Patient Navigation Hub
10. Emergency Department
11. Acute Medical Unit (AMU) Incl. AMAU/MAU
12. Initial Assessment
13. Surgical Assessment Unit
14. Diagnostics
15. Working Diagnosis
16. Elective Surgery
17. Emergency Surgery
18. Care plan
19. Discharge management
20. AMU Short Stay Unit
21. Admission wards
22. Hospital retrieval
23. Specialist wards
24. Hospice/Palliative Care
25. Community nursing Units/Homes
26. Rehab services
27. Community Intervention Team & other home delivered services
28. Home

Hospital models

Specialist Units/Centres e.g. Stroke, Heart Failure, Epilepsy, PCI, Diabetes. In-patient Rehab

Triage and/or EWS

Clinical Prioritisation: EWS

Walk-in

Ambulance
Vision 2: The embedding of sustained clinical operational management of the integrated pathway.

6 Step Methodology

(1) Agree standards & targets
Safety, Quality, Access & Cost

(2) Agree how safe and effective service is delivered
Risk and audit assessment
Models of care
Guidelines & Standards
Pathways
Algorithms
Decision making tools e.g. Bundles
Patient information

(3) Agree who is accountable
Roles and responsibilities

(4) Establish means of measuring safety & effectiveness

(5) Define governance for agreeing action to address Safety, Quality, Access & Cost issues
Cross discipline team meeting to
• Review incidents
• Review pathway metrics
• Identify variation & risks
• Agree change action and accountability
• Track status of actions

(6) Develop change capability to implement agreed actions
Establish Programme Office
Ensure change capability and capacity
Clinical leadership

Service user involvement

Local Data sets
Regional balanced score card
National Metrics – Health Stats
Corporate balanced score card
National Clinical Programmes

While there are numerous programmes there are two distinct types of programmes:

(a) Conditions specific programmes with a single core pathway e.g. Heart Failure, Stroke, Diabetes etc
(b) Process driven programmes with multiple pathways, e.g. Emergency Medicine, Acute Medicine, Surgery, Primary Care, Rehabilitation Medicine and Radiology.

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Chronic Diseases</th>
<th>Non elective pathway</th>
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</thead>
<tbody>
<tr>
<td>Paediatrics &amp; Neonatology</td>
<td>Stroke</td>
<td>Emergency Medicine</td>
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<tr>
<td>Obstetrics and Gynaecology</td>
<td>Heart Failure</td>
<td>Acute Medicine</td>
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<tr>
<td>Other clinical services:</td>
<td>COPD</td>
<td>Care of the Elderly</td>
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<tr>
<td>Audiology</td>
<td>Asthma</td>
<td>Radiology</td>
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<tr>
<td>OPAT IV Home Therapy</td>
<td>Diabetes</td>
<td>Critical Care</td>
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<tr>
<td>Pathology</td>
<td>Dermatology</td>
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<td>Blood Transfusion</td>
<td>Rheumatology</td>
<td>Palliative Care</td>
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<tr>
<td>Acute Coronary Syndrome</td>
<td>Neurology</td>
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<tr>
<td>Mental Health</td>
<td>Epilepsy</td>
<td>Elective surgery</td>
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<tr>
<td>Safety</td>
<td>Renal</td>
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<td>HCAI</td>
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<td>Orthopaedics</td>
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<td>Medication Management</td>
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## Programme Objectives and 2011 Deliverables - *Examples*

<table>
<thead>
<tr>
<th>Programme</th>
<th>Example objectives</th>
<th>Key Solution areas 2011</th>
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</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong></td>
<td>Integrate chronic disease management in primary care setting which should reduce hospital admission</td>
<td>• The Primary care programme is an over arching programme. All other programmes will be developing Primary care solutions which will feed into the primary care programme.</td>
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<tr>
<td><strong>Elective Surgery</strong></td>
<td>Reduce wait times for elective surgery</td>
<td>• Implementation of national targets for average length of stay (AvLos) and day case rates&lt;br&gt;• Roll out of Productive Theatre and Surgical Audit initiatives</td>
</tr>
<tr>
<td><strong>Emergency Medicine</strong></td>
<td>Improve the safety and quality of care in Emergency Departments and reduce waiting times for patients</td>
<td>• Implementation of a standardised model of care</td>
</tr>
<tr>
<td><strong>Acute Medicine</strong></td>
<td>Timely assessment of patients by appropriate senior clinician to enable early discharge and reduce average lengths of stay (AvLOS)</td>
<td>• Implementation of standardised acute medicine model and pathway&lt;br&gt;• Implementation of national Early Warning Score</td>
</tr>
<tr>
<td><strong>Obstetrics &amp; Gynaecology</strong></td>
<td>To improve choice by developing and delivering new models of maternity care</td>
<td>• Early pregnancy assessment unit (EPAU) in all maternity units&lt;br&gt;• Trained staff to national standard&lt;br&gt;• Appropriate ultrasound equipment</td>
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<tr>
<td><strong>OPD - (neurology, dermatology, rheumatology, and orthopaedics)</strong></td>
<td>Reduce waiting lists so patients will not wait longer than 3 months for a patient appointment and increase the number of new patients seen by the OPD clinic</td>
<td>• Agreed national targets for outpatient activity&lt;br&gt;• Additional clinical posts agreed and put in place</td>
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<tr>
<td>Programme</td>
<td>Example objectives</td>
<td>Key Solution areas</td>
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<tr>
<td>Stroke</td>
<td>Save a life from stroke a day</td>
<td>• 9 new stroke units established&lt;br&gt;• Standardise care provision for existing units&lt;br&gt;• 24/7 access to stroke thrombolysis nationally</td>
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<tr>
<td>Heart Failure</td>
<td>Every patient with heart failure is managed within a structured programme</td>
<td>• Hospital heart failure units in place in 15 locations by end of 2011&lt;br&gt;• Develop primary care diagnostic model</td>
</tr>
<tr>
<td>Diabetes</td>
<td>40% reduction in annual incidents of new blindness due to diabetic retinopathy by end of year 5&lt;br&gt;40% reduction in the number of lower limbs amputations due to discharges by end of year 5</td>
<td>• Rollout of National Retinopathy Screening Programme&lt;br&gt;• Rollout of National Multidisciplinary Foot Care Programme</td>
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<tr>
<td>COPD</td>
<td>To save 50 deaths a year from COPD</td>
<td>• Establish 12 COPD outreach centres</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Reduction in number deaths from epilepsy by 1/3&lt;br&gt;Rendering of 2000 patients, seizure free</td>
<td>• Establish 6 New Regional Epilepsy Centres&lt;br&gt;• Roll out of population based ambulatory nursing service</td>
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Appendix

Detailed explanation of integrated pathway
Vision 1: Design standardised models for the delivery of integrated clinical care.
Patient Pathway/Integrated Journey - Steps Explained

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>On-line Patient Information:</strong> The patient or patients’ carers can access a patient information web-site that provides information related to the management of their condition that directs them to self management information or suggested contacts for further assistance.</td>
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<td>2</td>
<td><strong>GP/Primary Care Team:</strong> The patient visits their GP/Primary Care Team who examine the patient using national assessment guidelines.</td>
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<td>3</td>
<td><strong>Chronic Disease watch:</strong> The patient may be registered on the chronic disease watch register and provided with a self management care plans and scheduled for routine monitoring by the GP/Primary Care Team. Patients’ condition and progress will be monitored through chronic disease watch against agreed national monitoring criteria. The monitoring criteria will indicate when a patient should be referred to an Acute Medical Unit* or to other services.</td>
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<td>4</td>
<td><strong>Pharmacy:</strong> At a pharmacy the patient will receive advice on treatment management, be advised on preferred drug treatments and consultation on how to manage their medication correctly.</td>
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<td>5</td>
<td><strong>Ambulatory Care Service:</strong> A patient may be referred by their GP to an ambulatory care service such as a specialist’s diabetes day care service where they can avail of ‘walk in’ consultation, assessment and care services.</td>
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<tr>
<td>6</td>
<td><strong>Outreach Programmes:</strong> The GP/Primary Care team may refer the patient to a specialty outreach programme (day care facility) based on national standards e.g. Care of the Elderly, COPD, Heart Failure.</td>
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<td>7</td>
<td><strong>Out-patients (OPD):</strong> The GP/Primary Care Team based on national GP OPD referral criteria may refer the patient to an out-patient clinic. The GP completes a national referral letter with the national referral data sets for the patient. The referral will be sent via a national electronic referral system. Referrals will be managed at a single point of entry either at a local hospital level and/or a regional patient navigation hub service level. Referrals will be opened, reviewed, prioritised, responded to and appointments scheduled per national referral management standards. Out-patient clinics will be managed in line with out-patient clinic process management guidelines. The out-patient scheduling modelling tool will be used to ensure optimum use of space and time. Individual specialties will conduct the clinical aspects of their clinics per national specialty out-patient clinical guidelines. Consultant’s out patient work-plans will be developed in line with agreed national outpatient targets. Patients will be able to access non consultant led clinics e.g. musculo-skeletal physiotherapy-led clinics or nurse-led clinics in order to speed access to assessment and post assessment care.</td>
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<tr>
<td>8</td>
<td><strong>GP Access:</strong> When a GP has assessed a patient and requires advice as to whether they should be referred into hospital they contact the Senior Doctor or Nurse in the Acute Medical Unit (AMU) for consultation via the dedicated GP liaison contact number. If the GP decides to refer the patient to the AMU, they will provide the patient with a GP referral letter which ensures the Patient has access directly to the AMU. The GP will also have a contact number for the Surgical Assessment Unit and a generic Surgical Assessment Unit referral letter will be developed shortly.</td>
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*Note: The term Acute Medical Unit is used in this explanation. Hospitals may have a variant on the Acute Medical Unit e.g. Acute Medical Assessment Unit depending on their size. See the Acute Medicine Programme Model of Care for an explanation of the difference.*
Patient Pathway Blueprint Steps Explained

**Patient Navigation Hub:** The GP can contact a regional patient navigation hub where a case manager can advise the GP on hospital and community bed availability within a region. In addition the case manager can advise on alternative pathways e.g. availability of rapid access clinics, accessing the Community Intervention Team or other care in the home services. The Navigation Hub will have visibility of all acute and community beds available and can direct the GP / patient to the best service for their need at that time. However the GP ultimately decides on which service to refer the patient to. The navigation hub technology can support the tracking, not just of bed stock but also GP out of hours service, availability of community intervention teams, ambulance availability etc. The navigation hub could be located with the Ambulance Service to aid co-ordination and communication between mobile patient services.

**Ambulance Access:** The ambulance service will take patients to the appropriate hospital Emergency Department (ED) either at the direction of the patients GP or based on assessment of the patient using the national early warning score (EWS) and with reference to hospital access protocols.

**Emergency Department:** Patients who arrive in an emergency department (ED) will be managed by the national ED management guidelines and model of care. These guidelines will assist in enabling the patient to experience standardised care in a safe environment and for the ED to deliver a service in line with the national ED standards of care. ED clinical service delivery is underpinned by the ED audit system and governance. Following triage in an ED a patient can be directed to the Acute Medical Unit (AMU).

**Acute Medical Unit:** When the patient arrives in the Acute Medical Unit (AMU) either directly with a GP (incl. GP out of hours) referral letter or indirectly via the Emergency Department (ED) they will be assessed by a nurse using the national early warning score (EWS). The purpose of the EWS is to ensure that deterioration in a patient’s condition can is detected and addressed as early as possible. The EWS is also used by the ED, Surgical Assessment Unit and the ambulance service to track patient deterioration and trigger proactive clinical action.

**Initial Assessment:** The AMU will have a senior doctor continuously present to ensure that patients are seen within 1 hour of their arrival in the AMU. The clinical staff of each AMU will have available to them a standard set of chronic disease decision tools such as algorithms, bundles and patient information to ensure that early, safe and standardised care can be provided to the patient. Acute Medicine consultants will work alongside their ED, Surgical and specialist colleagues to ensure patients will receive quality care. Specialist Nurses will review the patient need for education in self management e.g. diabetes.

**Diagnostics:** Patients in an AMU and Surgical Assessment Unit will receive same day diagnostics, meaning that both their tests and results will be available on the same day.

**Specialist Care Units:** A patient may be referred directly to a Chronic Disease/Rehab Specialist Unit/Centre by a GP or be taken to the unit following triage in the ED or assessment in the AMU. Examples of chronic disease units include Diabetes Unit, Cardiac/ Heart Failure Unit, Stroke Unit, Epilepsy Centre or PCI Centre. These units/centres will be managed in line with their national chronic disease model of care.

**Surgical Assessment Unit:** GPs/Primary Care Teams, AMU staff and ED staff can refer a patient to a Surgical Assessment Unit. The assessment unit will determine a patient’s best pathway based on national surgical assessment guidelines. Similar to the AMU, the GP will also have a contact number for the Surgical Assessment Unit and a generic surgical assessment referral letter.
### Patient Pathway Blueprint Steps Explained

<table>
<thead>
<tr>
<th><strong>Surgery:</strong> Both elective and emergency surgery will be conducted in theatres that meet the national theatre management guidelines, apply the national surgical checklist and whose management processes have been continuously improved using the productive theatre methodology. Elective surgery is managed according to each national surgical specialty clinical guideline and is underpinned by the national surgical audit system and governance.</th>
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<tbody>
<tr>
<td><strong>Elective Surgery:</strong> is delivered per national elective surgery targets. These targets cover: average length of stay, day of surgery admission and day surgery targets.</td>
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<tr>
<td><strong>Critical Care:</strong> At any point in the journey the patient's condition may deteriorate and the patient may become critically ill requiring critical care support. Following safe transfer, patients are treated and managed in appropriate Critical Care Units of adequate quality and safety. A critical care audit system and governance is used to monitor the clinical performance of critical care units.</td>
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<tr>
<td><strong>Hospital Transfer &amp; Retrieval:</strong> If a patient needs to be transferred to another hospital to avail of specialist or more intensive care, a transfer &amp; retrieval service managed by the ambulance service will ensure the patient is taken in a safe and timely manner to the appropriate hospital. Once the patient’s condition or procedures are completed they will be transferred back to the originating hospital if not already discharged. This bi-directional flow of patients is key to managing bed capacity.</td>
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<tr>
<td><strong>Hospital Network:</strong> Regions may have a number of hospitals of different sizes. Hospitals may differ in terms of the range and level of clinical services. Each of these hospitals will need to work effectively together to provide both safe and standardised care to patients and their families. Specifically the following key services will need to be aligned in a network to ensure best use of resources and best patient care e.g. Acute Medicine, Surgery, Critical Care, Emergency Medicine, Care of the Elderly and Ambulance Service Groups. Decisions in relation to the resourcing of each individual service can not be made in isolation. Decisions need to be made jointly and linked to an aligned network of hospital models. This alignment process should also take account of capacity surges.</td>
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## Patient Pathway Blueprint Steps Explained

**Admission:** Patients may be kept in for observation and further diagnostics and treatment in a short stay unit or alternatively admitted to specialist wards.

**Discharge Management:** Once a patient’s care plan within the AMUs is agreed, the patient will either be discharged per the national discharge guidelines or admitted. Senior clinicians will conduct 7 days a week early morning ward/board rounds to discharge patients. Discharge lounges will be used were appropriate to free bed capacity. Discharged patients should be provided with a discharge care plan which combines self management guidance and where appropriate is developed in consultation with the patients Primary Care Team staff. More detailed information will be available on the patient information web site. It is important that there is integrated discharge planning between the case manager and primary care team to ensure continuity of care.

**Rapid Access Clinics:** will be available to both GPs and to patients discharged from Acute Medical Units. These Rapid Access Clinics will have 'ring fenced' clinic slots which can be accessed at short notice based on agreed national criteria.

**Community Intervention Team:** The Community Intervention Team (CIT) may be called upon to assist patients at home post their discharge. CIT generally look after patients for a maximum of 72 hours and then hand over the patient care to the patient’s Primary Care team. Care in the home services such as Home IV treatment will be available to assist patients to manage their condition in the comfort of their home rather than in hospital thus reducing the average length of stay (Avlos) and further admissions. (IV in the community might be undertaken in model 1 hospitals or Primary Care Centres).

**Rehabilitation:** Patients requiring physical rehab care will be managed either in existing Rehabilitation Centres e.g. National Rehabilitation Centre in line with the national rehabilitation model of care, which will ensure their early discharge and better transition from rehabilitation to home care. The standardisation of model 2 hospitals will include the enhancement of rehabilitation services in these hospitals.

**Community Nursing Units/Homes:** A patient may be referred to a community nursing unit/home by a GP or discharged from hospital to a unit/home. Out-reach services will be designed to deliver care in these settings in order to minimise patients having to access hospital services.

**Palliative Care:** Should the patient require Palliative Care they and their families will receive guidance and advice based on national palliative care guidelines and algorithms. Patients will receive palliative care support at the appropriate location e.g. in the home, in a hospice or in a hospital.