Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Emergency Department Task Force

March 2015

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AHD	Acute Hospital Division
AHP	Allied Health Profession
AMU	Acute Medical Unit
AMAU	Acute Medical Assessment Unit
ANP	Advanced Nurse Practitioner
ALOS	Average Length of Stay
CCP	Clinical Care Programme
CDU	Clinical Decision Unit
CEO	Chief Executive Officer
CHO	Community Health Organisation
CIT	Community Intervention Team
CNO	Chief Nursing Officer, Department of Health
COO	Chief Operations Officer
COPD	Chronic Obstructive Pulmonary Disease
CUH	Cork University Hospital
CT	Computed Tomography
CSAR	Common Summary Assessment Report
DOSA	Day of Surgery Admission
ED	Emergency Department
G.P	General Practitioner
HCPs	Home Care Packages
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
HTA	Health Technology Assessment
IHRP	Irish Healthcare Redesign Programme
INMO	Irish Nurses and Midwives Organisation
ICT	Information and Communications Technology
IT	Information Technology
IV	Intra Venous
LTC	Long Term Care
MRI	Magnetic Resonance Imaging
NAS	National Ambulance Service
NHSS	Nursing Home Support Scheme
NSP	National Service Plan
OMNSD	Office of Midwifery & Nursing Service Development
PDD	Predicted Day of Discharge
PET	Patient Experience Time
SDU	Special Delivery Unit
Senior Clinical Decision Maker	Consultant, Specialist Registrar or experienced Registrar. May also refer to specific Nursing grades in particular context
SIPTU	Services Industrial Professional and Technical Union
SMART	Specific, Measurable, Attainable, Realistic, Timely
SVUH	St Vincent's University Hospital
UCHG	University College Hospital, Galway

Foreword

The Minister, the Department of Health and the HSE wish to thank the members of the ED Task Force for their commitment and engagement in the deliberations of the Task Force and the development of the final report. The Task Force brought considerable expertise, experience and insight to the development of actions to enable sustained solutions to ED issues at a whole system level. In particular members are to be commended for their focus on optimising the use of existing resources and capacity as well as pointing to the need for additional investment in the health system. The excellent and committed work of the secretariat that produced the document for the Task Force is appreciated.

It is recognised that while members of the Task Force contributed actively to its deliberations they have not committed their organisations, or individual members, and there is a need for further discussions relating to implementation. It is also acknowledged that for those recommendations that are resource dependent, further interaction will be required with key stakeholders regarding timeframes for implementation.

The HSE will engage in full discussions at national level with each individual representative organisation separately with the aim of reaching agreement in relation to the implemention of the actions in this report.

Background

1.0 Context

Research on overcrowding in Emergency Departments (ED) increasingly demonstrates adverse patient outcomes. Prolonged wait times in ED lead to prolonged Inpatient length of stay (Liew et al, 2003), which in turn is not simply an issue of poor resource utilisation but also adversely impacts patient mortality (Spivulis et al, 2006). Where ED overcrowding persists, not only is quality of care compromised and outcomes poorer but patient mortality is increased, (Richardson 2006, Spivulis et al 2006, Richardson and Mountain 2009). Therefore, Emergency Department crowding is not just an issue of workflow but one of patient safety.

The Emergency Department (ED) Task Force Report, 2006 was published following significant work which focused on addressing problems manifesting in Emergency Departments. It was recognised by the Task Force at that time that Hospitals were operating at close to 100% capacity while indicating that the optimum level is approximately 85%. Recent data from the OECD, Health at a Glance, 2014 also shows that Ireland is below the EU average for the number of practising doctors per 1,000 population (Ireland 2.7 against EU rate 3.4) and the number of Hospital beds per 1,000 population is also below the EU average (Ireland <4 against EU rate 5.2). The OECD report also confirms that Irish hospitals are still operating at higher levels of occupancy than other OECD countries.

The recommendations of the ED Task Force, 2006 centred on the following key domains:

- Capacity (Optimising access to existing capacity in hospitals and community)
- Capability (Patient flow and process improvement)
- Control (Accountability, oversight, measurement)

In recent years, all hospitals are required to develop full year demand and capacity plans, to underpin their response to foreseeable peaks in demand. Such plans must address escalation requirements for dealing with all surge periods and include the production of specific plans for winter months, when there is typically an increased demand for in-patient beds arising from additional unscheduled hospital attendances. A key driver for this planning process has been the Special Delivery Unit (SDU). Since 2011, they have required hospitals and community to:

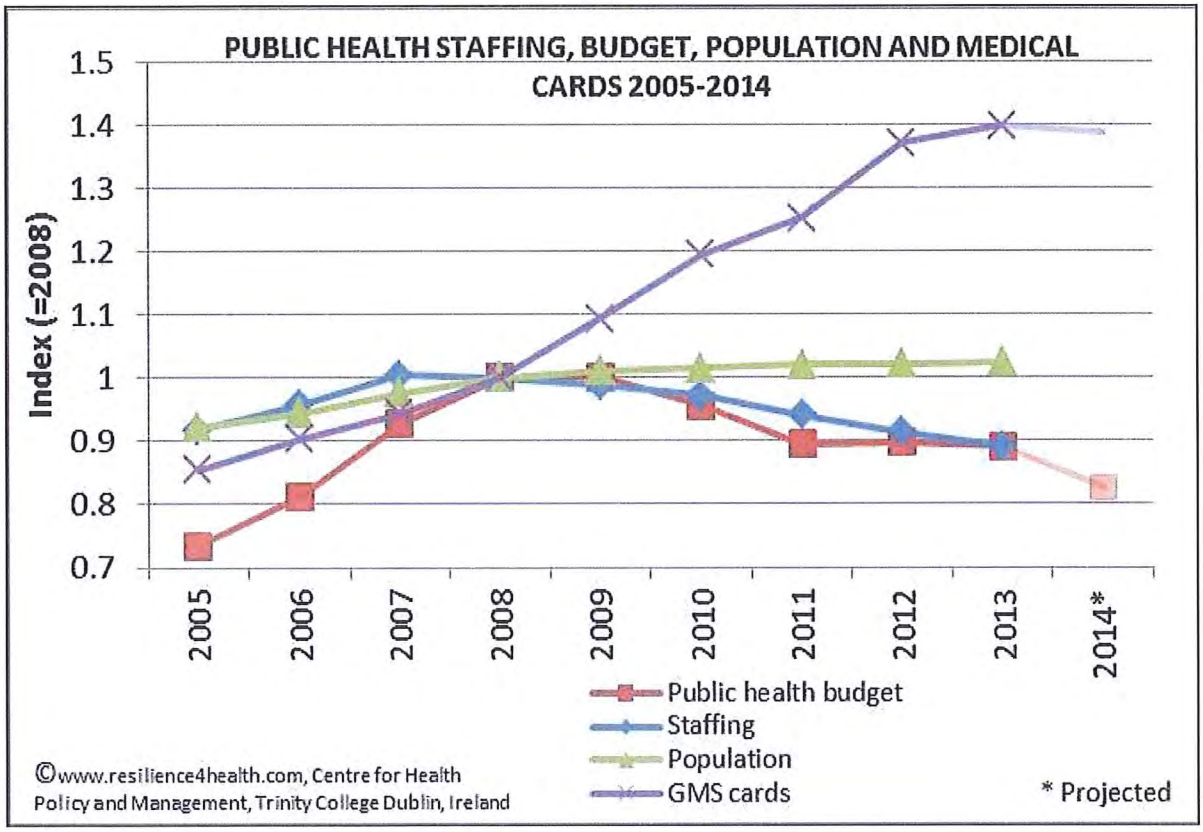
1. Proactively plan for peak periods, including public holiday periods
2. Adjust planned scheduled care activity, to allow for higher unscheduled care demands in winter months
3. Maximise the efficiency of processes that:
    a. Deflect patients from admission e.g. rapid multi-disciplinary team assessment for frail elderly
    b. Provide rapid access to senior decision makers e.g. introduce acute medical assessment units
    c. Minimise admission delays when an in-patient bed is required e.g. use 'Visual Hospital' systems that facilitate faster identification of beds about to become available
4. Engage in active discharge planning, including setting predicted dates of discharge, more frequent ward rounds and discharge from hospital earlier in the working day (home by 11 a.m.), so that beds are available at the optimal time.
5. Have clear linkages and formalised an effective working relationships with community colleagues, particularly for patients requiring off-site rehabilitation or who require home support services, whether from HSE health care professionals or contracted agencies which provide skilled nursing care, e.g. intravenous treatments, or personal care services from home help agencies.

Supported by SDU and as a result of the benefits of the Clinical Programmes, Hospitals achieved a significant and sustained reduction in the number of trolley waits during the period 2011-2013. Specifically, there was a 33% reduction in the Irish Nurses and Midwives Organisation (INMO) national trolley count in the period 2011 to 2013. The improvement over this period must be viewed against the backdrop of sustained reductions in budget and staffing level and an ageing population, specifically the following

- Sustained reduction in HSE budgets – €3.3b over the period 2008 – 2013
- Loss of 12,000 staff during this period, loss of 5000 nursing staff since 2009
- Ageing of the population (11.7% of population over 65, over 80's growing by 4% annually)

The resilience for Health Study (Centre for Health Policy and Management, TCD) illustrated these challenges very well (see table 1 below). However it also highlights significant improvements in productivity during the period 2008 -2013 with an increase of 10 % in the total discharges and 30% in day case activity

Table 1: Public Health Staffing, Budget, Population and Medical Cards 2005 - 2014



Notwithstanding the achievements over this period, it was acknowledged that unacceptable levels ofover-crowding still existed in a number of hospitals. It is also agreed that there is scope for further improvements as of length of stay, leadership and governance, internal process improvements and consistent access to community supports including residential care beds in order to achieve improved performance on a sustained basis at local and national level.

During 2014, ED performance in terms of trolley waits deteriorated and for the first time in three years, the downward trajectory was reversedin September 2014. According to INMO figures, the number of trolley waits was 6.5% worse than it was in 2013. This is a matter of serious concern to the HSE. Key contributory factors include:

- Growth in the wait time for NHSS from 4 weeks in January 2014 to 15 weeks at end of November 2014
- Growth in the total number of delayed discharges of the order of 30% during 2014 contributed by the growth in the numbers awaiting NHSS and demand for sufficient levels of home care support.
- Significant changes in management structures in hospital and community services with resulting loss of corporate experience and context to drive and oversee consistent hospital performance
- Challenges in attracting and retaining senior clinical decision makers at junior doctor and consultant levels notably in Model 3 hospitals The impact of the consultant pay cuts and protracted pay discussions also impacted on Model 4 hospitals during 2014 as evidenced by the high vacancy factor at consultant level (> 200 Posts). As a result, there has been a growing reliance on agency provision and loss of experienced staff with resulting challenges in terms of admission rates and discharge of patients. During 2014 ,medical agency costs grew by more than 50% , with residual vacancies in a number of key areas notably acute medicine , emergency medicine and anaesthesia
- Challenges in recruiting nursing staff as a result of moratorium provisions with increased reliance on agency staff. Loss of significant numbers of nursing posts due to the moratorium on recruitment and such reliance on agency has direct consequences for effective discharge planning at ward level and consistent implementation of predicted day of discharge, and effective planning of rosters at hospital ward level.
- Sustained growth in emergency admissions during 2014 of the order of 2% with 20% increase in the proportion of over 65s admitted on an emergency basis

1.1 Demographic context

The Health Service is already experiencing the impact of a rapidly increasing ageing population and will continue to do so as the trend is expected to continue over the coming years. Currently 11.7% of the general population are over 65 years of age. The over-65 population is growing by approximately 20,000 each year. The over-80 year's population, which puts the biggest pressure on health services, is growing by some 4% annually. During 2014, almost 22% of all ED attendances were aged 65 or over, and almost 12.5% were aged 75 or over. In 2014, the proportion of over 65s admitted on an emergency basis increased by 20% from 32% in January to 38% in December 2014. This trend has continued into 2015 and will also have an impact on demands for outpatient services and elective access.

Current capacity in community services is insufficient to meet growing demands associated with demographic pressures and gives rise to inappropriate levels of admission to and delayed discharges from acute hospitals. There is a real and heightened urgency required to address and alleviate issues facing the provision of services to older people across both the community and acute hospital services given that this level of population ageing is expected to continue for a number of decades.

The Prospectus Report (2006) highlighted the requirement for almost 7,000 additional residential care places for older persons to meet expected demographic profile While the target of less than 4% of persons over 65 in residential care outlined by Prospectus has been achieved it must be borne in mind that economic downturn and subsequent high levels of unemployment were experienced during the period 2008-2014 which led to higher levels of family and carers support being available

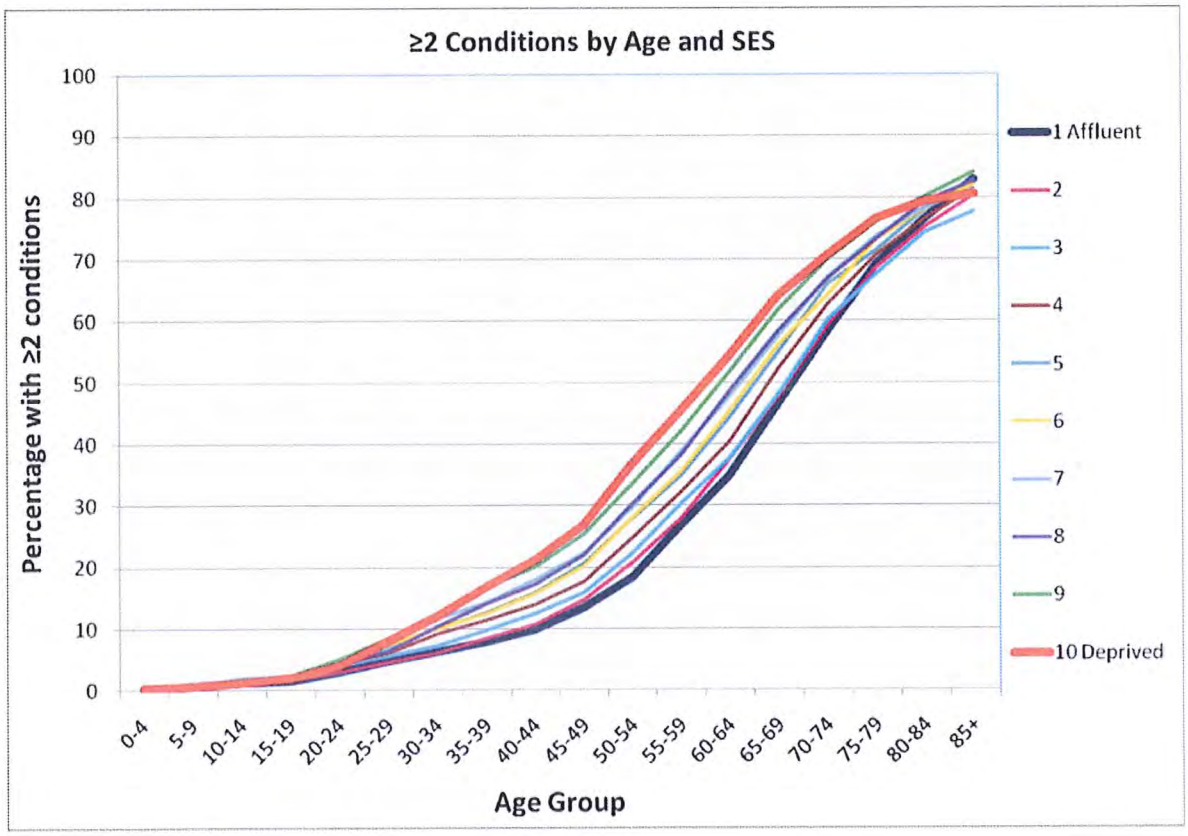
The Viability Study on the Future of Residential Care, finalised in 2012, highlights ongoing deficits in residential care at national level and in particular in the greater Dublin area with Dublin North East having one of the most significant deficits. In the short term, the challenge of meeting HIQA registration requirements in terms of physical infrastructure has resulted in a loss of long term capacity in a number of areas notably in Dublin North East which already has a deficit of long stay capacity. This has also resulted in competing demands in terms of capital cost of meeting additional requirements and replacement of existing stock. It is estimated that as a result of reduced funding and increased reliance on private provision in the past 10 years, there has been a loss of 2,000 public beds. While there has been a significant increase in private provision to support the 22,361 patients under the Fair Deal Scheme, the loss of public beds poses particular challenges in terms of placement of complex patients.

1.2 Burden of Chronic Disease

Over one third of the Irish population report having a chronic illness, including heart disease, respiratory disease, cancer, and diabetes. Over half of Irish people over 50 have 2 or more chronic diseases (see table 2 below)

The proportion of the population reporting a chronic illness increases with age. The most common acute illnesses for inpatients in Irish hospitals are circulatory disease, respiratory disease, cancer, and diseases of the digestive system. Hospital use increases with age.

Table 2: Chronic Conditions by Age and SES



The healthcare costs in Ireland are five times higher for patients with four or more conditions.

These patients have on average:

- 11 GP visits per year
- 3 OPD visits

- 3.5 admissions

Much of the burden of chronic and acute disease in our population can be reduced by lifestyle changes, lifestyle choices such as vaccination, and risk factor modification. Where disease does occur, the burden can be reduced by receiving timely, accessible, evidence based treatment and follow-up. It is estimated that there is significant potential through focus on chronic disease management to reduce the burden of chronic disease on the health service. Chronic disease pathway development within the public health services is an area which must be significantly developed to focus on delivery of care as close to the patient as possible. The role of CNS and ANP nursing services, as seen in other jurisdictions are in other areas of healthcare in Ireland have a key role to play in delivering cost effective care. Community Healthcare Organisations potentially have the ability to reduce the burden on the acute hospital system with particular emphasis on the 5% of patients with chronic disease who currently consume 40% of in-patient bed days (HSE 2008).

Introduction

2.0 Introduction

In December 2014, the Minister for Health, Mr. Leo Varadkar T.D., convened an Emergency Department Task Force to focus on the deteriorating performance in the health system manifesting in Emergency Departments. It is acknowledged that the main symptoms of sub-optimal Unscheduled Care services, which manifest as significant overcrowding and unacceptable trolley waits for patients, are not simply attributable to the functioning of an Emergency Department itself. Rather these symptoms are caused by a series of factors across the whole health system

The objectives of the Task Force are:

- To establish a communication and exchange platform between the HSE and relevant stakeholder groups, regarding on-going work and specific initiatives at whole system level to enable sustained improvements in Unscheduled Care performance.
- To inform, drive and support the HSE Acute Hospital Division's Implementation Plan for Unscheduled Care. This plan will identify specific actions to address demand capacity management, effective patient flow, integrated care pathways and discharge planning.
- To identify collaborative working arrangements between the Acute Hospitals, their Community counterparts and other relevant stakeholders, to ensure the most efficient and effective implementation of management actions, including system redesign as well as work practice and staffing profile changes where appropriate.
- To anticipate potential problems or issues and to ensure appropriate structures, processes and controls are in place to manage these before they escalate
- To inform policy development in key areas by acting as a discussion forum on policy matters between the HSE, DOH and relevant stakeholders on key issues

The Task Force is chaired jointly by the HSE, National Director of Acute Hospitals and a nominated Union Representative. At the time of publication of the report the joint Chairs were Mr. Liam Woods, HSE, National Director Acute Hospitals and Mr. Liam Doran, INMO. A core principle underpinning the work and priorities of the Task Force is that it is inappropriate for any patient to wait on a trolley after a decision to admit has been made and that there must be a whole system approach to addressing the causal factors and the agreed national hospital and community targets must reflect this principle. In this context, the elimination of long wait times was identified as an immediate priority for the Task Force. The agreed national target of 95% compliance with 6 hours Patient Experience time was re-stated; with the recognition of an interim target of no patient waiting more than 9 hours for admission set for 2015. A zero tolerance to breach of 24 hours for Patient Experience was reinforced with requirement to invoke special measures to address such events.

Membership of the group includes representation as follows:

- National Director, Acute Hospitals
- Acute Hospitals National Clinical Director
- National Director – Quality and Patient Safety
- National Director – Clinical Programmes

- HSE Social Care
- HSE Social Care – Clinical Lead
- HSE Primary Care
- HSE Emergency Medicine Programme
- HSE Acute Medicine Programme
- HSE G.P. Lead
- Special Delivery Unit
- Irish Association for Emergency Medicine
- Irish Medical Organisation
- Irish Nursing and Midwives Organisation
- Irish Hospital Consultants Association
- IMPACT
- SIPTU
- National Ambulance Service
- Deputy Director and Head of Operations, HSE AHD
- Patient Representative
- Hospital Group CEO
- Nominated Hospital Manager
- HSE, Mental Health Division
- HSE, OMNSD
- Department of Health
- Secretariat HSE Acute Hospitals Division

2.1 Critical Determinants of Improved Performance

The ED Task Force Report, 2006 identified that the key causes of delay for patients in ED are variations in the hospitals and community's capacity, capability and control processes, specifically in:

- management of available bed capacity
- the level and availability of clinical decision making
- the availability of diagnostics, senior in-house specialty assessment and other ED supports
- ED internal control processes
- community and continuing care capacity processes

The ED Task Force, 2006 key findings focused on individual hospital and system wide measures to improve performance in Emergency Departments. The findings were stratified across three areas:

- **Capacity** – Focused on ensuring that Hospitals and Community have defined the volume of capacity required to manage activity levels and the requirement to ensure that existing capacity is optimised.
- **Capability** – Appropriate systems and processes in place in hospitals and community to enable and support appropriate ED avoidance, Effective Management of Patients in ED, Senior Decision Making, Access to Diagnostics, Effective Discharge Planning, Effective management of specific patient cohorts
- **Control** – Appropriate control processes - in place across Hospitals and Community including clear lines of accountability with appropriate measurement systems in place to support decision making. The concept of operational grip has been used more recently by the SDU to elucidate the requirements in relation to control, including clinical and corporate leadership, accountability and measurement.

The SDU experience, in line with evidence from other jurisdictions mirrored the key findings from the ED Task Force in 2006. The next section sets out the high level critical determinants of improvements and the recommendations in the collective experience of the SDU and best practice:

Domain	Key Features
Leadership and Governance	• Performance is owned by local leaders, with a clearly identified Unscheduled Care Lead. • Supported by the SDU and the Clinical Care Programmes, this local ownership is a critical prerequisite to unscheduled care improvement. • It must be embedded into every local operational structure and delivered within a coherent hospital / group governance model. • Every site that has achieved sustained improvement has created a broad internal leadership coalition of managerial, nursing and medical leaders, changing the internal organisational narrative and reinforcing the moral obligation to prevent high trolley counts and reduce PET times in ED.
Process Improvement	Patient assessment Key features of 'performing' sites are: • The development of a well-functioning patient pathway which comprises: ➢ acute assessment by senior clinical decision makers, ➢ well-structured short stay facility supported by timely diagnostics and ➢ Protected streaming including ANPs, especially in high volume model 4 hospitals. • Development of frail elderly pathways underpinned by strong clinical governance and clear linkages between geriatric medicine and emergency medicine can effect reductions in length of stay • Use of rapid access assessment models for geriatric medicine and chronic disease are enabling hospital avoidance and re admission. • Geriatric teams in all sites should seek to create an immediate access elderly assessment and treatment service for elderly patients otherwise requiring ED assessment. As extensive operating hours as possible will be sought
Process Improvement	Patient pathways and processes Critical determinant of success are: • Systematised approach to patient flow where each point of the patient journey is mapped and understood • Use of demand/capacity modelling and process improvement techniques. • Standards around ALoS, driven by a navigational hub/visual hospital function, - • meaningful use of predicted date of discharge (care planning for each patient), • Specialty wards configuration and a focus on weekend discharging. • Systems and processes in relation to patient flow and processing reflective of 7 day business of hospital services to avoid the "queue" build up over weekends and out of hours, giving rise to high trolley numbers and congestion in the early days of each week. • Continuous focus on 7 day discharges with agreed daily review of predicted discharges that take account of demand capacity requirements (hospital to set daily target based on average daily admissions for that day) • 7 day working of AMAUs • planned weekend handovers of discharges (e.g. CUH, Tallaght, Kerry)
Integrated Planning	Integrated discharge planning Dependencies on stakeholders external to the hospital, particularly for complex discharge

needs must be clearly understood and managed proactively. This is especially important in efficient model three hospitals, where egress blocks have a disproportionate impact on operational efficiency. Bottlenecks at any stage of patient flow will result in queues across the system.

- Every hospital has a tolerance level for limitations on access. With specific reference to delayed discharges 10% of acute beds, in any one hospital, are considered to be an inflexion point beyond which efficiency markedly deteriorates and suboptimal care is delivered. However it is also acknowledged that even at 5-10%, it poses challenges in a system that is operating consistently at 100% occupancy
- Hospitals and their community partners must integrate their planning and understand their demand for efficient egress flows. The required resources must be delivered in a timely, efficient and continuous manner.
- The flows are predictable, with hospitals able to quantify the numbers of home care packages and transitional care beds required on a weekly basis to maintain equilibrium

Data and Information

Good use of Information and Communication Technology implemented to support front line service delivery will enhance transparency and accountability improving delivery processes and management's operational grip.

- Appropriate data systems are important for success. The system must value and exploit the potential of web-based timely, accurate, visual data systems in providing business intelligence. Organisations can then understand, plan and respond in an appropriate manner to demand and capacity profiles
- Use of SDU Standardised Unscheduled Care Assessment Tool to measure performance
- Use of standardised templates by hospitals to develop improvement plans – these can then be measured objectively to determine effectiveness
- Use of systems with proven potential to provide real time oversight and business intelligence to deliver smarter, more responsive care. TrolleyGar, the SDU Emergency Care Performance Improver web-site and the HSE Compstat are all worthy of further development.
- Use of demand and capacity spreadsheets for local use in hospitals with less developed IT systems.

2.2 Standardised Pathways

2.2.1 Integrated Care Pathways

The Patient Flow Integrated Care Pathway (ICP) seeks to ensure that people can access the care they need in a timely manner. An essential component of Patient Care ICP is that that are structures and processes in place to enable effective flow across hospital and community settings. This is a key component of providing safe and high quality healthcare.

The Integrated Care Programmes are being developed within the policy context of Future health and Healthy Ireland.

Five priority integrated care programmes have been identified, to be implemented on a phased basis. These are:

- Integrated Care Programme for Patient Flow
- Integrated Care Programme for Older People
- Integrated Care Programme for Chronic Disease Prevention and Management

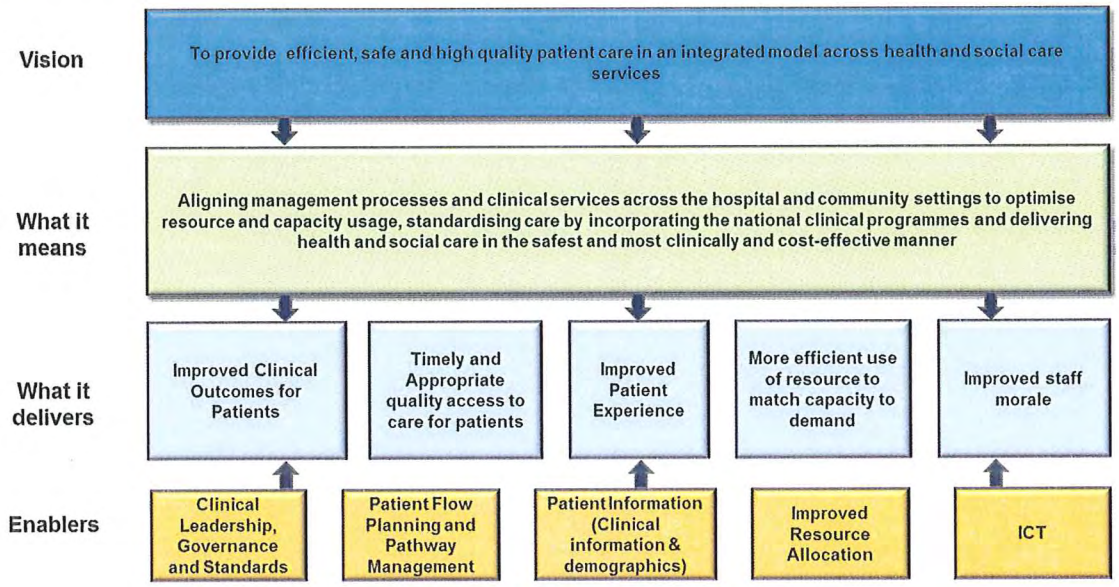
- Integrated Care Programme for Children
- Integrated Care Programme for Maternal Health

Within these ICPs, specific work streams are being identified e.g. Urgent & Emergency Care (within Patient Flow), integrated frail elderly care pathway (joint workstream older persons and patient flow)

The Integrated Care Programme for Patient Flow seeks to ensure that people can access the care they need in a timely manner. An essential component of Patient Care ICP is that there are structures and processes in place to enable effective flow across hospital and community settings. This is a key component of providing safe and high quality healthcare.

The Integrated Care Programme for Patient Flow is underpinned by proactive management of interfaces between stakeholders to reduce barriers to integration and allows for cohesive care provision across a continuum of services. The patient flow ICP is currently in the design phase with an evidence review underway and the output from a benefits realisation workshop with key stakeholders complete.

Vision and benefits:



Critical success factors – Integrated Care Programmes:

- Investment in continuing to build on a foundation of expertise in data capture analysis and management and in the information systems to enable data to be captured in an efficient way.
- Access to profound evidenced based quality improvement methodologies.
- Clear prioritisation of this work by senior figures
- Engagement of all key stakeholders
- Application of project management methodologies
- Accountability and stewardship at senior clinical and management levels

2.2.2 Frail Elderly Pathway

A particular focus is needed on frail elderly pathways, due to the potential for significant gains for both patients and hospitals. A number of initiatives have been proposed or developed in this regard:

- A recent elderly pathway initiative piloted in the ED in UCHG achieved a two day reduction in length of stay.
- Geriatric teams in all sites should seek to create an immediate access elderly assessment and treatment service for elderly patients otherwise requiring ED assessment
- The development of Rapid Access services that are underpinned by strong clinical governance and appropriate pathways between geriatric medicine and emergency medicine. A Rapid Assessment Team established in the MMUH in May 2012, as part of the implementation of the National Acute Medicine, Emergency Medicine and the Care of Older People National Clinical Programmes has resulted in 61% of frail elderly patients with reduced mobility/falls risks and concerns regarding coping at home avoiding unnecessary admission
- Community Case Management Initiative (CCMI) - targeted at meeting the needs of frail elderly people particularly those with multiple medical co-morbidities. The case management model is proposed to drive the integration of care of older people with complex needs across traditional hospital and community boundaries. Frail elderly people with complex needs are identified in a timely manner by a Case Manager, working with a Consultant Geriatrician across the hospital-community interface, and are actively managed using a variety of settings other than Emergency Departments. Such a model of care has been developed in Connolly Hospital in the Dublin area and has demonstrated a reduction in admissions from nursing homes by up to 40% .

  The objectives of the CCMI development are:

  - To provide a timely, efficient and well-co-ordinated service for older people.
  - To anticipate potential crisis situations and assist patients and their families in planning for same; this may include planning for increased home supports, planned transition to long-term care and / or continued decline in health requiring higher level health and social care supports e.g. towards end of life in the community
  - To minimise potentially avoidable acute hospital admission
  - To facilitate appropriate timely supported discharge
  - To prevent premature placement in long-term care
  - Where long-term care is required, to ensure it can be expedited from the community thereby avoiding an unnecessary acute hospital admission.
- A comprehensive integrated care programme for older people will be developed which will support service provision across hospital and community targeting those most at risk of hospital admission and ensuring that Primary Care, Social Care and Acute hospital services are delivered in an integrated way. This requires a local governance structure to ensure integrated working across four operational divisions – Primary Care, Social Care, Acute Hospital services and Mental Health. This is central to the CCMI and necessary for any measures involving frail older people.

2.3 National Oversight and Leadership

While the locus of control for change must rest with the local health system (Hospital and Community Health Organisation), this must be supported by the National system working with the SDU and the National Clinical Programmes. There is also a need for developing structures and processes that enable improvement measurement and oversight within and across the four Divisions and facilitate integrated working and care provision.

National Hospital Level

A key requirments are to:

- Support and develop systems to enable frontline delivery of services in an integrated manner with good interfaces between these systems. They must also provide key metrics in a transparent, timely, visible, understandable and relevant format, as a means of driving improved performance across the whole system. Examples include:
    - TrolleyGAR, including >9 hour Trolley Waits
    - Immediate elimination of PET times greater than 24 hours
    - Define agreed escalation points in ensuring that breaches are averted and appropriate interventions at each point
- Elimination of >9 hour PET times for patients aged 75+. Support those sites where there are validated capability issues via:
    - National workshops to share information on successful process change
    - Regional workshops on optimal patient flow
    - Seeking professional body endorsement for facilitated discharge planning and high impact practices, such as, daily rounding,
- Mandatory Operational Management training for new managers and for existing managers as appropriate. Support those sites where there are capacity issues, through:
    - Systematic and objective review of current bed numbers
    - Clearly prioritised plans for additional system capacityRecognise, reward and spread good practice.
    - Reward proven successful implementation of productive change. Ensure that any additional resource allocation, be that for service developments, education or training, takes into account improved performance. For those sites that are persistently under-performing, it is important that the performance diagnostic examines capacity, internal control and capability issues so that appropriate and targeted interventions are undertaken.

In working closely with sites, their executive teams and community partners, the SDU has used structured evidence based frameworks. The SDU analysis broadly discerns three distinct cohorts of hospital, requiring different types of responses and engagement. The operationalisation of the ED Task Force plan must recognise these cohorts so that there is appropriate targeting of action and measurement of impact.

1. Hospitals with good capability but requiring on-going support to improve clinical pathways, operational management and to maintain egress flows.
2. Well-performing Model 3 hospitals needing particular support with recruitment and patient egress.
3. Hospitals needing fundamental capacity and capability building in operational leadership and governance, in addition to a range of more comprehensive process re-design of key patient pathways. The Irish Healthcare Redesign Programme (IHRP), currently being piloted in Tallaght, will be exploited to help such sites identify the priority actions that must be progressed.

Primary Care, Social Care and Mental Health

Develop appropriate metrics to enable effective measurement of primary, social care and mental health services aimed at supporting hospital avoidance and effective integrated discharge. To include:

- Response times for primary care out of hours services to support effective admission avoidance
- Measurement of impact of Community Intervention Team (CIT) on admission avoidance and early discharge
- Measurement of wait time for approval and release of home care package funding
- Measurement of wait times for NHSS approvals
- Average number of hours per home care package

Whole System Response

- Requirement to development appropriate structures to enable effective working across primary, acute, social, mental health and community services (National Directors, AHD)

- The Irish Hospital Re-design Programme (IRHP) will require leadership and collaboration across primary, acute and social care services to ensure integrated approaches to the management of unscheduled care (National Directors, AHD)

- The role of the clinical programmes in working collaboratively to develop a shared view of what constitutes best practice. The Irish Hospital Re-design Programme (IHRP) pilot study has enabled such collaboration; the implementation of sustained change in unscheduled care demands clear and consistent messages from the professional bodies about best practice in patient flow and management (National Directors, AHD)

- Development of appropriate metrics to enable effective measurement and evaluation of integration between acute, primary, social care and mental health services(National Directors, AHD)

3.0 Priorities identified by the Emergency Department Task Force 2014/5

Many of the proposals identified in this report mirror those made in previous work and experience in this area. The ED Task Force Report, 2006, Special Delivery Unit (SDU) Unscheduled Care Strategic Plan, 2013, National Acute Medicine Report and National Emergency Medicine Programme Report have set out recommendations, guidance and processes that are evidence based and are therefore still relevant in terms of providing sustained solutions. Identified below are key areas for focus by the HSE and Department of Health that will provide a basis for resolving the ED overcrowding issue at a systemic level.

It is recognised the ED Task Force has not engaged directly with hospitals to diagnose specific local issues that may be relevant at local Hospital level however the Strategic Plan for the SDU has been informed by international evidence and also SDU's direct engagement with hospitals over a four year period in implementing improvement plans aimed at delivering sustainable change. It is important to state that the Task Force does not accept that it is appropriate for any patient to wait on a trolley after a decision to admit has been made. It is intended that the actions outlined in this report can provide sustainable solutions towards achievement of this goal, however, it is recognised that there are structural issues that will not be resolved in short term which may impede delivery of this goal.

Key issues identified by the ED Task Force 2014 are summarised below:

- **Requirement to develop sustainable solutions to the issues of delayed discharges** so that existing hospital capacity can be optimised. Specifically the wait times for Fair Deal must be 4 weeks if patient flow and egress issues are to be addressed

- The number of delayed discharges must be reduced on a continuous basis such that it does not exceed 500. The current situation whereby it is routinely in excess of 730 means that in the majority of hospitals have in excess of 15% of the beds are blocked on an ongoing basis and in a number of sites the figure is as high as 25%

- **Requirement to drive process improvements** so that hospital length of stay is reduced. There is variation in ALoS between Model 4 hospitals, in particular, even when adjustments are made for the proportion of beds blocked as a result of delayed discharge. The SDU has identified that it would be possible to free up to 60 beds in a single Model 4 hospital if length of stay was reduced in line with the National Target.

- Priorities in this regard include:

    - Application of predicted date of discharge on a pan hospital basis- immediate target for this activity is 80 %

    - Discharge from hospital – the first discharge from each ward start no later than 9.30 am on the day of discharge to align with times of maximum bed demand for newly admitted patients. A whole hospital system approach is required to achieve this including communication with families and development of appropriate waiting areas for discharged patients (e.g. discharge lounges) to ensure that there is appropriate clinical oversight of both discharged and newly admitted patients

    - 7 day discharges – The core principle is that the hospital understands its demand capacity requirements and that its discharges are appropriately aligned with its demand requirements

including at weekends so that patient flow is managed effectively. Review of SDU data suggests that hospitals discharges are not sufficient to meet the capacity requirements resulting in queuing. Accordingly hospitals need to set a daily site specific target which is based on the average number of admissions by day of the week.

- Each hospital will be required to determine with assistance of the SDU, the average admission requirement for each of the week. This will indicate the discharges required by the hospital each day. Hospitals will be expected to report against this target.

- Optimisation of Model 2 hospitals to manage unscheduled demand effectively. The recent initiatives in UL and South/South West in terms of directing patients to Model 2 hospitals needs to be replicated, having regard to the fact that there is variation in the capacity and capability of small hospitals in different hospital Groups . Therefore there is a need for tailored solutions and requirement for some targeted investment to enable bi directional flow consistently across groups. This includes the appropriate level of clinical governance including expanding roles of nursing and other professional groups.

- **Leadership and governance issues –** those hospitals that have delivered sustained improvements in Hospital performance typically have strong clinical and managerial leadership that support the consistent prioritisation of unscheduled care. This is also reflected in strong centralised operational processes and controls that enable an operational grip on the issues

- **Access to senior clinical decision making** is critical in terms of addressing admission and discharge issues. A number of hospitals have a huge reliance on agency provision at consultant and NCHD level. The issue is most acute in Model 3 hospitals however in the past year; the issues of vacancies at consultant level in Model 4 hospitals are also evident. This vacancy factor must be viewed in the context that overall numbers of practising doctors are lower than the EU average. OECD analysis highlights that Ireland has 2.7 doctors per 1,000 populations while the average is 3.4. It is recognised that consistent delivery of senior decision making requires targeted investment in additional consultant, NCHD and other professional groups (nursing & AHP). With specific reference to Model 3 hospitals there is also a need to tackle the structural challenges that militate against recruitment and retention of doctors

  - As an immediate priority, there is a requirement to tackle the structural issues that are driving continued reliance on agency in these hospitals. This will require targeted action at Hospital Group level and should consider appropriate structuring of appointments at consultant level. In relation to NCHDs there is a requirement to engage with postgraduate medical training bodies to enable appropriate rotation. The role of Advanced Nurse Practitioner should be examined in terms of fulfilling senior decision making roles within appropriate setting and agreed criteria.

  - **Delegated discharge** – The implementation of delegated discharge and agreement of appropriate criteria must be done in conjunction with the consultant representative bodies, having regard to the ongoing clinical responsibility of the consultant for their patients. The use of criteria-led, delegated discharge by senior nurses is an important component of enabling improved senior decision making. The CNM2 role is central to the implementation of delegated discharge.

  - **Cross team discharging** – cross- team discharging is already in operation in a small number of sites and has proven to be effective in enabling 7 day discharging. This needs to be extended across all hospitals within agreed criteria to ensure safe and appropriate discharge

- **Standardised care pathways**- there are a number of examples of where implementing standardised care pathways for frail elderly can enable hospital avoidance; reduce length of stay and prevent re-admission. Of particular note in this context are the Rapid Access Models and the Community Case Management Models. A key requirement is to share the learning from these initiatives and seek to mainstream as part of the overall response to unscheduled care.

- **Oversight and Measurement**- there is a requirement for effective management and control structures at hospital level that include effective demand capacity management, clear lines of accountability for bed managment and discharge policy, robust whole system escalation measures and processes

The detailed actions to address the above issues are set out in the following sections of this report.

3.1 CAPACITY - Optimising Existing Hospital and Community Capacity

The 2006 ED Task Force Report identified delayed discharges as a major structural challenge for hospitals as it militated against effective use of existing capacity. The publication of the Task Force Report in 2007 acted as an important catalyst to the introduction of the Nursing Home Support Scheme (NHSS) in an effort to provide a sustainable solution to the requirements in relation to long term care. Since 2013, due to financial constraints, the ageing population, and reduction of public nursing home beds, it has not been possible to provide adequately for the long term and continuing care requirements of the population. In 2014, we have seen an increase of 26% in the numbers of delayed discharges with between 15 -20% of available beds blocked in many hospitals.

3.1.1 Reducing Delayed Discharges

A key requirement identified by the Minister is the reduction in the wait time for NHSS to 4 weeks and to set a maximum number of 500 delayed discharges by end 2015. These requirements can only be achieved through additional investment in the Fair Deal Scheme, HCPs and short stay beds. There is also a recognised capacity deficit in terms of long term care capacity and this has been exacerbated by HIQA requirements in relation to physical infrastructure which has resulted in the loss of over 2000 public beds, notably in those areas that have historically been challenged in terms of public capacity. Prospectus, 2006 identified a capacity requirement of almost 7,000 new residential care beds by 2016 and the HSE Viability Study on the Future of Residential Care continued to highlight capacity deficits in this area.

Objective: Reduce delayed discharges to a maximum level of 500 by end 2015 in order to achieve and sustain reduction in delayed discharges to this level. it is recognised that there is need for investment in a range of areas including NHSS, Transitional Care and Home Care services, in conjunction with improvements in acute hospital processes, community service, hospital avoidance measures and with an integrated model of care, fully functional across service provision. *(This target has been set in recognition that there will always be number of discharges which are "delayed" for practical and logistical reasons and that there are recognised physical or available manpower capacity constraints that may be difficult to overcome in the short term)*

Short term actions

- Agree what is meant by a delayed discharge so that it can be appropriately measured and targeted at hospital and community level **(HSE AHD, Social Care – Immediate)**

- Set and maintain NHSS wait time of 4 weeks through the provision of adequate funding in 2015 **(HSE, Social Care – Q2 2015)**

- Enforce regulatory guidelines for submission of financial and CSAR information to NHSS **(HSE, Social Care in conjunction with AHD - Immediate)**

- Set and enforce timelines for processing of financial information by Nursing Home Section **(HSE, Social Care - Immediate)**

- Set and oversee individual Hospital targets to ensure that the total number of Delayed Discharges does not exceed 500 in 2015 and that no hospitals delayed discharges are in excess of 10% of its available beds. This should include individual Hospital weekly discharge targets for Social/Primary Care as identified by the SDU. **(HSE Social Care/Primary Care in conjunction with AHD– Immediate)**

- Set targets, by Hospital, for delivery of Home Support services to ensure minimum delay for patients in Hospitals accessing appropriate supports. It is recognised that home support is not a demand led scheme but is budget capped and must meet the requirements of those in hospital and in the community.**(HSE, Social Care – Immediate)**

- Define and implement a menu of appropriate clinical pathways using the information that is already available i.e. 27 Clinical Programmes each of which describe in detail an evidence based clinical pathway (See Appendix 1 for list). **(HSE AHD/CCP/Social Care – Q4 2015)**

- Define Community/Acute Hospital Catchment Areas for older person's services specifically **(HSE AHD/Social Care – Q2 2015)**

- Develop and implement agreed metrics to ensure that agreed targets for delayed discharges are being met consistently at national and hospital level **(HSE AHD/Social Care/Primary Care – Q2 2015)**

Medium term actions

- Develop Integrated care pathways across the acute hospitals/community interface in the context of the newly created Divisional structures **(HSE AHD/CCP – Q4 2015)**

- In conjunction with the DOH, continue to define the requirement for additional residential care capacity both in terms of long stay and short stay to support the continuum of care requirements and in particular in key locations where there is an identified shortfall in such capacity, both currently and over the coming years.

- Determine requirements in nursing and other staffing groups which will allow identified patient care needs to be met. **(HSE Social Care 2016/2017)**

- Work with the DOH and HIQA to find solutions to the current regulatory requirements so as to protect public bed capacity which is vital to support the acute hospital system. **(HSE Social Care – 2015/2016)**

- Work with the DOH to develop appropriate public long term capacity so that complex patient needs can be met consistently **(HSE Social Care – 2016)**

- Develop and establish a robust local clinical governance model with clear links to the discharging hospital and existing community services **(HSE Social Care – 2015)**

- The DOH to lead on appropriate workforce planning to ensure safe and agreed nursing staffing levels and nursing clinical governance systems are in place to accept discharged patients **(DOH/ HSE 2016)**

- Develop ring-fenced funding streams for certain patient groups **(HSE/ DOH 2016)**, specifically:
    - Older people

- Those with chronic illness
- Young people with chronic neurological conditions e.g. acquired brain injury, multiple sclerosis, motor neurone disease etc.
- Joint ownership of people that require a flexible network of care provided by Primary, Social, Acute Hospital and Mental Health Services.
- An appropriate ICT system to support all of the above.

- Develop a framework to plan proactively for the ageing population having regard to the projections for the next 6 years **(HSE AHD/ Social Care/ Primary Care – Q4 2015)**

3.1.2 Reduce Length of Stay

The optimisation of existing capacity is not dependent solely on tackling the delayed discharges issue. The work of the Surgical and Acute Medicine Programmes has highlighted the need to target length of stay to optimise the available capacity. The target for length of stay for medical patients, adjusted to exclude inpatients with over 30 days stay is 4.2 days. At this stage, the majority of model 4 hospitals are in excess of this target with the Dublin teaching hospitals operating well beyond this target in terms of medical patients.

The optimisation of existing capacity through earlier discharge requires expansion of services in the community with regard to how the ongoing care needs of patients are managed. It is accepted that CIT's, with clear governance by and linked with existing social and primary care services, can be effective in reducing length of stay and enabling hospital avoidance, There is a need to evaluate the different models of CIT to determine their effectiveness and impact on admission avoidance and early discharge with the aim of delivering seamless care across the continuum.

To enable sustained improvements in length of stay to be achieved, community services will need to be resourced in order to accept early discharge of patients. This will require additional nursing, HCA support and AHPs.

Objective: Reduce LOS in line with target set in 2015 HSE National Service Plan (Medical 5.8; Surgical 5.1, LOS All 5.0; ILOS adjusted 4.3)

Optimise Existing Hospital Capacity – Surgical Beds

Short Term Actions:

- Increase DOSA rates to national overall target of 70% in 2015 with each hospital having a target set by the National Surgical Programme. Current performance is circa 65% however there is significant variation by site. Further development of robust pre-assessment models of care through investment in CNS's in pre-assessment is critical in this regard. **(HSE AHD/Hospital Group CEO's, Immediate)**

- Increase surgical rates and reduce overnight stays – initial target set for Laparoscopic Cholecystectomy (> 60%) **(HSE AHD/ Hospital Group CEO's, Immediate)**

- % of bed utilisation by acute surgical admissions that do not have a surgical primary procedure – reduction of 5 % in 2015 **(HSE AHD/ Hospital Group CEO's, Immediate)**

- Define targets for shift of inappropriate day-case workload to outpatient settings **(HSE AHD/CCP Surgical, Immediate)**

Medium term Actions:

- Align shift of inappropriate day-case workload from Hospitals to Primary Care in the context of NSP priority for 2015 of increasing minor surgery in GP settings **(HSE AHD/Primary Care, 2015/2016)**

- Apply HIQA HTA criteria to prescribed cases to create additional day capacity within existing resources **(HSE AHD/CCP Surgical, 2015/2016)**

Optimise Existing Hospital Capacity – Medical Beds

Short term Actions:

- Exam LOS variance for core patient groups at consultant level by clinical directors and hospital management supported by appropriate data **(Hospital Groups/Hospitals - Immediate)**

- Ensure daily reviews undertaken by senior decision makers (**Hospital Groups/Hospitals - Immediate)**

- Learn from experience of implementing reconfiguration in hospital groups in terms of optimising use of available bed stock in Model 3/4 Hospitals and effecting bi-directional flow. Effective planning in terms of predictive modelling, development of capabilty within Model 4 and development of agreed patient pathways is essential if reconfiguration is to be effective **(Hospital Groups/Hospitals - Immediate)**

- Embed the operation and use of existing AMAU's to ensure consistent compliance with target of 25 % of patients being seen and discharged on the same day **(Hospital Groups/Hospitals - Immediate)**

- Ensure consistent compliance in existing AMAU's with target of 56% of patients being discharged safely within 72 hours **(Hospital Groups/Hospitals - Immediate)**

Medium term Actions:

- Extend use of outreach services (e.g. Heart Failure and COPD) to reduce inpatient stay **(HSE AHD/Primary Care/CCPs, 2015/2016).** With the Clinical Care Programmes implement and oversee agreed targets for these services in terms of reduced length of stay and re-admissions

- Determine consultant manpower and NCHD requirements for medicine and surgery to enable appropriate and timely assessment and decision making within ED **(AHD / National HR – Q4 2015, Q1 2016)**

- Extensd existing community and public health nursing services and AHP staffing to enable effective discharge to community. **(Social Care, Primary Care HSE)**

3.2 CAPABILITY - Developing internal capability and Process Improvement

3.2.1 Appropriate admission avoidance

Objective

Develop and extend additional and alternative access routes to urgent care thereby obviating the need for Emergency Department attendance. The Geriatrician led Rapid Access model developed in Smithfield and the Community Case Management Initiative Model developed in Connolly Hospital has demonstrated tangible benefits in terms of admission avoidance.

Short term Actions:

- Embed Rapid access model in Mount Carmel Hospital to support the hospitals in South Dublin subject to appropriate engagement with representative bodies **(HSE AHD/SC, Q2 2015)**

- Embed the Rapid access model in Beaumont Hospital through strengthening of geriatrician links with emergency medicine and links with Day Hospital capacity **(HSE AHD, Immediate)**

- Extend the Community Case Management Initiative to 4 AMAU sites with 7 day access **(HSE AHD, Q3 2015)**

- Set targets for extended use of CIT model as identified in 2015 NSP to enhance nursing supports to nursing homes and to support ED diversion. **(HSE Primary Care, Q2 2015)**

- Ensure that expanded CIT model optimises the benefits from appropriate linkage with home help supports and realises the targeted bed days savings **(HSE Primary Care, Q2 2015)**

- Establish national campaign aimed at promoting the use of Local Injury Units/Rapid Access Services and G.P. OOH's services for appropriate conditions. Requirement to standardise name and purpose. There is a cultural shift required to get patients in certain areas to utilise alternative services and this should be a focus of any such communication plan. **(HSE AHD/Primary Care, Immediate)**

- Review resource requirements for G.P OOH's services and CITs should the campaign result in an increased number of patients presenting at these services **(HSE AHD/Primary Care – Q4 2015)**

- Each CHO provide a **live electronic contacts register** of primary care and social care clinical and admin contacts (phone and email) to local hospitals for ease of communication. **(HSE CHOs, Immediate)**

- Make greater use of electronic communication, including references to the usage of "**healthmail**" which allows all hospitals to communicate clinical information securely to GPs**(HSE Primary Care, Immediate)**

- Commence discussions with relevant stakeholders including representative bodies to develop the expanded roles of nurses in areas of prescrbing, IV fluids and antibiotic therapy within the long terms care facilties, inclduing the potential for training and/or recruitment of Nurse Prescribers/ANPs in community to work collaboratively of GPs and Out-of Hours services, good examples of similar **nurse-led walk-in treatment centres** in UK. **(HSE Primary Care, Immediate)**

- Set specific response times for GP Out of Hours Services for particular patient cohorts and measure compliance with same. Such targets must take account of acuity of patient requirements with particular priority attaching to nursing home patients **(HSE Primary Care, Immediate)**

- Ambulance service to initiate alternative patient assessment initiative "Hear and Treat" subject to available resource **(NAS, Immediate)**

3.2.2 Effective management of patients within ED

All parties recognise that HSE are required to ensure managers and clinicians implement the recommendations from the HIQA Tallaght Report 2012 fully with particular reference to clinical governance of patients, wait time for assessment and treatment; management of patients in appropriate accommodation and supervision of patients and appropriate identification and response to deterioration in patients conditions.

In this context, it is essential that there are appropriate controls and processes in place to ensure timely and appropriate assessment and treatment of patients in ED.

Objective

Requirement to ensure timely and appropriate assessment, treatment and admission or discharge from ED in line with agreed targets (all patients seen and admitted or discharged within 6 hours- 95% compliance)

Short term actions

- Implement and oversee agreed target timelines for patients to be seen within ED and by admitting teams. For ED, 3.2.1 as per EMP (3 hours to be assessesed by ED; 2 hours to be seen by admitting team; 1 hour to transfer to a bed). For admitting team/s – patient assessment should commence within 1 hour of referral. **(Group CEO's/Hospitals, Immediate)**
- Ensure appropriate level of senior clinical decision making in ED.* There is a requirement to ensure that there is a senior decision making presence in ED during peak hours with consultant availability on 8am-8pm basis, subject to resource. **(Hospitals/Group CEO's - Immediate)**
- The HSE National Service Plan 2015 provides for 4 additional Consultants in Emergency Medicine and 4 AMAU physicians. This is a first step in addressing the requirement to enable extended day provision and appropriate cover at weekends particularly in Model 3 and 4 hospitals. (**HSE AHD/Group CEO's – Immediate with appointment by Qtr. 3, 2015**)
- Determination of nurse staffing and skill mix should be made using a robust evidence based methodology, applicable to the ED and AMAU context. The Task Force on Staffing and Skill Mix in Nursing may support the development of a Framework for Nurse Staffing and Skill Mix in Emergency Nursing Care, as Phase II of its programme of work. **(DOH/AHD,CCP – Q3 2015)**
- Commence discussions with relevant stakeholders including representative bodies to optimise the existing skills amongst the wider ED & AMAU nursing resource, to enable competent nurses, working under protocol, to order, interpret and escalate diagnostic tests, such as bloods, for example. **(DOH CNO, HSE, Relevant representative bodies - Immediate)**
- Commence discussion with relevant stakeholders including representative bodies to maximise the development of ED & AMAU skills and competence to undertake advanced clinical assessment, interpretation and treatment in a standardised range of skills such as chest auscultation, palpation percussion, medicinal prescribing, ECG interpretation etc, through a combined ED & AMAU education programme, in tandem with the existing medicinal and x-ray prescribing programmes. **(DOH CNO, HSE - Immediate)**
- Each Hospital to ensure that on-call admitting Consultant is fulfilling their commitment to respond to ED activity. The recent surge in ED activity has highlighted the benefits of intensification of efforts on a pan-hospital basis to manage patient flow. In particular, the application of the following principles on a consistent basis has enabled better management of surge activity. **(HSE AHD/Group CEO's – Immediate)**

  Key requirements:

  - Daily specialist Consultant ward rounds in the acute specialties.
  - Daily handover of admitted patients to the relevant Consultant or specialty in that hospital.
  - Participation of the on call admitting team in escalation measures.
  - Availability of specialist Consultants to admit, discharge, or refer patients to fast-track clinics.

- Support and enable enhanced roles for nursing and AHP grades to facilitate patient assessment and discharge. The Task Force will bring forward specific proposals to be advanced in 2015 in conjunction with relevant stakeholders. (**HSE /CNO DOH in conjunction with Representative Bodies - Immediate)**

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* Timing of impact assessment will be determined by recruitment of Consultant staff

Medium term actions

- Determine emergency department manpower requirements by reference to robust evidence based methodology including reference to international norms and recommendations. Analysis of requirements should have regard for the proposed reconfiguration of services within Groups and the potential to leverage existing resources more effectively across the Groups. (**HSE AHD/Group CEO's - 2015**)

- Seek to increase consultant numbers in line with internationl norms to enable effective assessment and decision making within ED.

3.2.3 Rapid Access to Inpatient care

Objective

Implement targeted initiatives aimed at supporting rapid access to Consultant opinion that are underpinned by dedicated teams and supported by adequate diagnostic capability and robust clinical protocols.

Short term Actions:

- AMAU model:
  - Expansion of service to 7 day service in 4 sites in 2015 (SVUH, Mater and CUH, Tallaght with appropriate staffing supports as outlined in HSE NSP 2015. **(HSE AHD, Q4 2015)** *(Ref. Section 1.2)*
  - Evaluate the impact on ED volumes and wait times, in the 4 sites, of the AMAU 7 day service and determine requirements for expansion to other sites during 2016. **(HSE AHD/CCP, 2015)***
  - Extend G.P Direct access to AMAU within agreed criteria for AMAU referrals. As part of this process, establish appropriate communication and referral pathways and governance with GPS to enable appropriate referral and feedback. **(Hospital Groups/Hospitals – Immediate)**
  - Strengthen ED streaming to ensure optimisation of AMAU functioning and decongestion of ED Specifically, triage in ED should
    - Seek to divert all clinically appropriate Medical patients to AMAUs
    - Prioritise the selection of Elderly patients to ensure early assessment and appropriate management by AMAU physicians. **(Hospitals/CCP, 2015)**

- Development of ANP model of care for low acuity chronic illness, both in the ED and AMAU to assess, treat and discharge low acuity chronic illness, with the option for return clinics at the ED & AMAU for ongoing assessment and treatment similar to the current ED Minor Injuries model of care. **(DOH CNO, HSE, 2014/2015)**

- Access to diagnostics- Ensure full implementation of 8-8 working day, in line with the national protocol in all sites for diagnostic services, subject to review of resource requirements, and seek to optimise access for emergency services. **(Group CEOs Hospitals, Q4 2015)**

- Extend initiatives such as community case management for older persons with complex needs with other proposals such as CIT and develop agreed metrics to measure specific impact on admission and re-admission rates. **(HSE AHD/Social Care/CCP's, Immediate)**

- Examine requirement for availability of community professionals, especially Community nursing, on a seven day basis. **(HSE Primary Care/Social Care, Immediate)**

- Targeted Use of Fast track units (e.g. Clinical Decision Units and Rapid Access): to reduce the volumes and wait times in EDs, provided they are delivered and overseen by senior decision makers and underpinned by robust clinical protocols. Requirement to develop and use metrics to measure the specific impact of fast track units in terms of activity, resource utilisation wait times and length of stay. (**Group CEOs, Hospital Managers - Immediate**)

- Effective use of existing Acute Medical Assessment Units to support the reduction of ALOS and enable prompt assessment and management of specific patient cohorts. (**Hospital Groups/ Hospitals – Immediate)**

- Use of short stay (less than 5 days), high intensity capacity can result in the following benefits: **Hospital Groups/ Hospitals – Immediate)**

    - Reduced ED 'trolley' waits / prompt admission
    - 'Pull' to accommodation within appropriate ward
    - Focused condition specific protocols, rather than individualistic approach
    - Shorter average length of stay (approximately 2 day reduction)
    - Prompt effective discharge – with no adverse increased readmission

Medium Term Actions

- Evaluate the impact of the introduction of the 7 day AMAU Service on the four agreed sites for 2015 and seek to extend to other sites as appropriate **(AHD – 2016)**

- Extend AMAU model into paediatric services in Dublin by opening a Short – term Stay Observation Unit at Tallaght Hospital to drive contemporary practices in rapid access and turnaround of children being admitted across the three children's hospitals in Dublin **(AHD – 2016)**

3.2.4 Access to diagnostics

Objective

Develop rapid routine diagnostic reporting on an extended 12 hour, 7 day basis – linking diagnostic reporting capacity to ED attendance patterns and patient need over the 24 hour period.

Short term actions

- Access to diagnostics- Ensure full implementation of 8-8 working day for laboratory and radiology services in line with the national protocol in all sites for diagnostic services, and having regard to additional resource requirements. Within context of extended day, seek to optimise access for emergency serviceshaving regard to resources. It is recognised that there is a need to develop additional consultant manpower to meet additional reporting requirements.**(Group CEO/Hospital Mgr. - Immediate)**

- The prioritisation of inpatient access to diagnostics should be a core principle to effect reductions in length of stay. Requirement to implement agreed metrics to measure specific impact of extended day on wait times for diagnostics for emergency patients (**Group CEOs, Hospital Managers, Quarter 4, 2015**)

- Target 7 day radiography service initially on pilot basis using overtime. Evaluate impact on ED & AMAU performance and length of stay with emphasis on timelines for access for inpatient and emergency patients. Capital constraints need to be borne in mind. **(HSE AHD - Qtr. 2 2015)**

- In the short term, options to deliver additional diagnostic capacity may be considered particularly for outpatient workloads in order to improve overall bed utilisation and patient flow. This should be progressed in consultation with relevant stakeholders in recognition of pre-existing protocols and agreements. **(HSE AHD/Group CEO – Q2 2015)** It is vital that safeguards are in place to ensure quality assurance, shared access to results, and avoidance of test duplication should the patient require hospital attendance. Any short-term initiatives should be carefully selected and evaluated in terms of overall impact on volumes and wait times in ED and control.

Medium term actions

- Develop a plan for targeted increase in diagnostic capacity (MRI/CT) to ensure that GP and consultant access is appropriate **(HSE AHD - 2016)**

- Seek to secure the necessary additional consultant manpower to meet the additional reporting requirements associated with extended day and 7 day service. **(HSE AHD, National HR – 2016/2017)**

3.2.5 Access to senior decision making

Short term actions

- Ensure planned appointment of the 4 additional consultant posts to AMAU and 4 to ED, as provided for in the 2015 Service Plan, is targeted at addressing the requirement for consultant delivered services within ED and AMAU **(HSE AHD/Group CEO, Immediate)**

- Advertise and recruit vacant consultant posts to reduce reliance on agency provision. As part of this process, seek to appropriately structure posts within Groups to support the staffing requirements of small and medium hospitals. Engagement with training colleges is required to support appropriate rotation of junior doctors. **(HSE AHD/Group CEO, Immediate)**

- For inpatients, ensure consistent use of predicted date of discharge to support reduction in length of stay and effective use of resources; agreed by Specialty, proactively managed against treatment plan, discharge confirmed day before. **(Group CEO/Hospital Mgr, Immediate)**

- Extend use of delegated discharge and cross team discharge to address current deficits in relation to senior clinical decision-making having regard to the consultants ongoing clinical responsibility for their patients **(HSE AHD/Hospital Groups/Hospital CEOs – Immediate)**

Medium term actions

- Seek to increase the number of consultants and NCHDs in line with international norms and best practice. The targeting of these posts should be informed by robust analysis of consultant manpower requirements at hospital and group levels **(HSE AHD, National HR – 2016/2017)**

- Develop additional capacity and capability within nursing to take on senior decision making roles in relation to delegated discharge**(HSE AHD, National HR – 2016/2017)**

3.2.6 Integrated discharge planning

Objective

Ensure whole hospital systems and processes and integrated planning with community services to enable effective discharge of patients

Short term actions

- Implement across all hospitals the date of discharge for all admitted patients (within 24 hours of admission) with target of 80% compliance by end 2015 **(HSE AHD/Group CEO's - immediate)**
- Ensure that appropriate systems are in place to enable effective discharge planning in collaboration with community partners. These should be formal with regular structured engagement to address any blockages or delays. **(CHOs and Group CEOs -Immediate**)
- Weekly reporting mechanisms to be developed to identify delayed and /pr discharges and to communicate same to community partners. (CHO and Group CEOs- Immediate)
- All patients due for discharge will have a senior decision maker review to allow for discharge before 11 a.m. **(Group CEO's/Hospitals - Immediate)**
- Implement target of 40% of patients to be discharged before 11 a.m. on a day to ensure required capacity is available for admission. A whole system approach is require to achieve this including communication with families and development of appropriate waiting areas for discharged patients (e.g. discharge lounges) to ensure that there is appropriate clinical oversight of both discharged and newly admitted patients. **(Group CEO's/Hospitals – immediate)**
- Agree daily targets for discharge in line with admission profile and ensure daily review of predicted discharges on seven day basis by senior decision makers is an integral part of the discharge process with oversight by the Clinical Director. **(Group CEO's/ hospital managers - Immediate)**
- Undertake weekly systematic review of all patients with extended length of stay (>14 days) to identify issues and actions required. **(Group CEO's/Hospitals - immediate)**
- Enable delegated discharge between clinical teams within agreed parameters. **(Group CEO's/Representative Bodies/Professional bodies - Immediate)**
- Delegated authority to senior nurses to support discharge based on agreed criteria and having regard to the consultant's ongoing responsibility for the patient. **(Group CEO's/Professional bodies- Immediate)**
- Report and publish daily and weekly discharges by hospital and Group to ensure consistent application of weekend and daily ward rounds by senior decision makers **(SDU/Hospitals - Immediate)**
- Active regular review of non compliance with PDD **(SDU/Hospitals - Immediate)**
- Facilitate bi-directional flow and appropriate use of Model 2/3 Hospitals through expansion of NAS Intermediate Care service, subject to resource availability **(NAS, 2015/2016)**

3.2.7 Chronic Disease Management

Objective

Embed models for management of for chronic disease as part of core response to admission avoidance, early discharge and appropriate management of patient flow.

Short term actions

- Measure impact of existing funded chronic disease programmes to date in terms of reducing LOS Quantify reduction in length of stay for chronic diseases (e.g. COPD, Heart Failure) where speciality ambulatory care services have been developed under the clinical programmes. Maximise the national effect on length of stay reduction by filling geographical gaps in these services in the 2016 NSP **(HSE CCP's - Immediate)**

- Development of ANP model of care for low acuity chronic illness, both in the ED and AMAU to assess, treat and discharge low acuity chronic illness, with the option for return clinics at the AMAU for ongoing assessment and treatment similar to the current ED Minor Injuries model of care **(CNO DOH and HSE,– Q4 2015)**

- Implement and evaluate Service Plan 2015 requirements for Integrated Care pathways and Frail Elderly. Examine opportunity to extend the current geriatrician led model for frail elderly to community based ANPs with the aim of providing an effective model and pathway of care specific for older patients to expedite their care and treatment both inward and outward. **(HSE, Acute Hospitals Division and CCP – Q4 2015)**

Medium term actions

- Increase coverage of Clinical Nurse Specialist (CNS) and AHPs for chronic disease support to General Practice in the 2016 Service Plan (commenced in 2015)**(Primary Care – 2016)**

- Commence implementation of the chronic disease self management support strategy in 2016 NSP **(Primary Care / CCP – 2016)**

3.3.CONTROL - Leadership, Governance, Planning and Oversight

3.3.1 Leadership and Governance

The review by the HSE with SDU of hospanital performance over the period of 2011-2014 shows that those sites that have implemented and maintained improvements in performance have similar management and control characteristics. Typically they demonstrate evidence of operational grip on the key causal factors with a sound understanding of demand capacity management.

Specifically, the following requirements have been identified and timelines for achieving same within the Hospital Group construct are set out below. The role of the Group CEO working with their team and the hospital management teams will be to drive full and consistent implementation of these core requirements during 2015.

Objective

To ensure effective leadership and oversight in Hospitals to implement and maintain sustained improvements and to manage periods of surge effectively

Short term actions

- Establish clear lines of accountability within the hospital for the management of patient flow within each Hospital **(Group CEO's/Each Hospital - Immediate)**

- Establish leads for scheduled and unscheduled care in all Groups with clear reporting lines to COO for each Group **(Group CEO, Q1 2015)**

- Develop and maintain centralised bed management to ensure consistent oversight of scheduled and unscheduled workloads **(Group CEO/Each Hospital, Immediate)**

- Group and Hospital Clinical Directors to drive discharge planning and ward rounds **(Group CEO/Each Hospital, Immediate)**

- Empower and enable delegated discharge in accordance with National agreements and cross team discharge, having regard for the consultant's ongoing responsibility for their patient **(Group CEO/Each Hospital/Clinical Directors, Immediate 2015)**

- Embed and systematically review whole system escalation / de-escalation processes. patient **(Group CEO/Each Hospital/Clinical Directors, Immediate 2015)**

3.3.2 Operational Planning and Predictive Modelling

The SDU has identified measures within its Unscheduled Care Strategic Plan that reflect a number of the proposals put forward by the ED Task Force members in relation to ensuring appropriate planning and predictive modelling is in place. The actions outlined below allow for reduced variation as identified by the 2006 ED Task Force and the predictive modelling identified should allow Primary, Community and Continuing Care services to focus on matching their capacity to meet identified needs.

Objective

To ensure that there are systems and processes in place to enable appropriate planning and forecasting and to support operational effectiveness in relation to the management of unscheduled care.

Short term actions

Adjusting working practices to better match the general patterns

Rostering

- Match services with need. E.g. team on call working in EDs, weekend and out of hours service options. Solutions will require examination of additional resource requirements **(Group CEO/EMP, Immediate)**

- Develop a greater range of services in community settings on a planned basis in the evenings and at weekends subject to resource availability e.g. wound care clinics, IV services, catheterization **(HSE Primary Care, Qtr 4, 2015)**

Skill Mix

- Optimise use of the human resource, transfer of duties to other grades/ professionals in accordance with existing agreements **(Immediate, Hospitals supported by National Division)**

- Working with key stakeholders including representative bodies to expand the roles of health professionals across the heath service to ensure optimal clinical outcomes. **(Hospitals, SDU, Representative bodies - Immediate)**

Develop operational planning functions to anticipate and manage day to day supply and demand

- Develop COO capability and resources at Hospital level within existing structures to oversee and manage Scheduled and Unscheduled Care **(Group CEO's/Hospitals, Immediate)**

- Operational grip – develop capability within COO function to enable reduction in numbers and wait times within 12 hour period of escalation and recovery within 48-72 hours. **(Hospitals/SDU, Immediate)**

- Develop flexible rosters to meet demand requirements and ensure consistent access to Senior Decision makers **(Group CEO's/Hospitals/SDU/AMP, Immediate)**

- Develop appropriate (weekly, monthly and annual) elective schedules in line with assessed need, seasonal requirements and having regard to overall capacity requirements **(Hospitals/SDU, Immediate)**

- Embed and systematically review whole system escalation/de-escalation procedures and processes **(HSE AHD/Social Care/Primary Care – Immediate)**

- Ensure compliance with national frameworks and improvement plans **(Group CEO's/SDU, Immediate)**

- Undertake whole system review of existing winter planning arrangements in terms of timeliness and adequacy **(HSE AHD/Social Care/Primary Care/SDU, Immediate)**

3.3.3 Measurement

Objective

To ensure that there are effective systems and processes in place to allow for routine measurement of performance at local Hospital/CHO and national level and to enable review and audit of performance

Short term actions

- Reinforce system wide definitions that apply to all Hospitals and Emergency Departments - **(SDU with Clinical Care Programmes, Immediate)**

- Implement appropriate IT systems to support both ED (EDIS) the AMAU IT systems to measure agreed variables consistently across hospitals - **(SDU with Clinical Care Programmes, Immediate)**

- Report on agreed targets to be applied for 2015 as follows:

    - Weekly Targets for number of discharges required to maintain flow to be established. **Acute Hospitals Division to set targets with individual Hospitals; HSE Social Care/Primary Care Divisions to determine capacity to deliver (consistently in order to meet target of 500 Delayed Discharges, Immediate)**

    - 95% compliance with 6 hour target for all patients to be seen and discharged or admitted from ED & AMAU **(HSE NSP 2015)**

    - 100% compliance with 6 hour target for all patients to be seen and discharged or admitted from ED & AMAU

The Minister, in recognition of the immediate pressures on the Hospital system, has identified an interim target for 2015 as follows:

- No more than 70 patients on any day waiting in ED for admission greater than 9 hours

The Task Force has identified that the following targets should immediately be applicable:

- Zero tolerance of anyone waiting over 24 hours for admission – reportable event to National Hospital Director
- Over 75s – eliminate 9 hour breaches (100% compliance) – regarded as a reportable event to National Hospital Director **(Group CEO's/Hospitals/SDU, Immediate)**

Social Care

- NHSS waiting times to be maintained at 4 weeks (currently 11 weeks). If further funding is provided to support the scheme.
- When funding is approved to provide home supports, it is targeted that the service will be available in the person's home, within a 72 hour period.
- Specific metrics to be agreed on a hospital by hospital basis as a target for transitional care.
- Target times for processing NHSS applications will be agreed and monitored
- Target Times for processing , approval and release of funding for Home Care Packages will be agreed

(Social Care - immediate)

Primary Care – Immediate

- Target response time will be set for Out of Hours Services and will be monitored as part of the Performance Framework
- Metrics will be agreed between Acute Hospital Division and Primary Care to determine the impact of CITS in terms of admission avoidance and re-admission

(Primary Care – immediate)

3.3.4 Oversight

Objective

To ensure effective oversight is in place at all levels to drive and maintain consistent hospital performance

Short term actions

- Implement appropriate formal monitoring and oversight structures at National, Group/CHO and Hospital/Community levels that enable the following:
  - Daily review within and between Hospital/Community level with Hospital Group COO/CHO Care Lead(s)
  - Weekly oversight with relevant National Division and Group/CHO to review performance and effect appropriate interventions
  - HSE Performance Accountability Framework between National Directors and Director General and also National Divisions and Group CEO/CHO to include formal regular review of hospital performance and Delayed Discharges.
  - Appropriate escalation framework to enable prompt intervention by the National Division's with the delivery system through the CHO and Hospital Group's.

  (HSE National Divisions/Group CEO's/CHO's/Hospitals, Immediate)

4. Enabling consistent improvement across all Hospitals

The framework and actions set out in this report are designed to enable consistent improvement in all Hospitals. It is recognised, however, that a small number of Hospitals have persistent challenges. In some cases there are structural issues such as inadequate long term residential capacity or difficulties in attracting and retaining medical manpower and nursing staff.

Objective

To enable consistent improvement across all Hospitals and to support those Hospitals with persistent challenges in terms of hospital performance

Short term actions

In the short term these Hospitals, working with the SDU and community partners, must prioritise the escalation responses that are known to assist with patient flow. Each of the actions recommended meets the SMART criteria, which can be applied by local management.

- Implementation of agreed target response times within ED as follows:
    - 3 hours for assessment/diagnosis within ED
    - 2 hours for admitting team to review and determine outcome
    - 1 hour for discharge from ED
- Implement agreed target that a senior clinical decision maker would see each patient within one hour of arrival in AMAU
- Daily Senior Decision Maker Review of predicted discharges, which can be a board-round review
    - (A senior decision maker in the context is a Consultant or a Registrar with delegated authority to discharge)
- 80% of patients to have a meaningful Predicted Date of Discharge, used to drive discharge planning, by end 2015
- Introduce structured Demand and Capacity levelling across the 7 day working week
    - Each hospital to be able to indicate the number of discharges (average and 85th percentile) required each day of the week to meet typical admission patterns for a given day
    - Each general medical/surgical ward to have first bed occupied by an unscheduled-care patient admission by 09.30hrs, 7 days a week
- Number of discharges each day to be reviewed on a monthly basis through review of HIPE data

Following the immediate emergency response, each hospital must then focus on sustainable, medium to long term developments that will militate against future high trolley counts. Sites will require support from the Group CEO's and SDU to create a tailored, realistic plan that takes account of the range of particular factors that impact upon their individual performance. Due consideration must be taken of such factors as:

- Recent changes in leadership teams
- Prior interventions, including HIQA service reviews
- Projects currently in progress e.g. IHRP, LEAN projects
- Internal resources including ICT and performance reporting capacity

(AHD, Group CEOs, SDU – Immediate)

Medium term actions

There is a requirement to develop medium term strategies to address structural challenges in terms of capacity and manpower.

Specifically there is a requirement for

- Development of additional consultant and NCHD manpower in line with international norms and recommendations **(AHD – 2016/2017)**
- Requirement for medium term investment to develop the required residential care capacity to meet assessed needs. This will be a mix of public and private provision and therefore will also require an assessment of pricing and contractual arrangements with private providers to ensure their effectiveness in meeting assessed needs. This will be enabled once the report on the review of NHSS is published by the DOH. **(Social Care – 2016/2017)**
- Hospital Groups to drive reconfiguration of services and structuring of posts to attract and retain consultant and NCHDs **(AHD, Hospital Groups – 2015/2016)**

4.1 Service Improvement and Re-design

Irish Hospital Redesign Program

In a number of jurisdictions, whole system re-design programmes have been undertaken to enable and support sustainable improvement in Hospitals. Clinical re-design programmes aim to improve efficiency of patient flow through hospitals, as well as improving quality, patient satisfaction and service delivery within budget, by redesigning the business processes that underpin clinical care. In Ireland the first clinical re-design programme was started in 2014 and it is intended to extend the programme to other sites. The selection of Hospitals will be informed by the requirement for significant improvement, however, the Hospital's readiness in terms of leadership and governance is also important in terms of driving such programmes.

Actions

- The Solution Design phase for Tallaght completed in April 2015.
- Implementation phase Tallaght 10-12 weeks - Implementation phase for solutions identified as high impact but relatively easy to implement.
- Extend the program in 2015 to 4/5 additional hospitals.
- Secure continued engagement and leadership from the Colleges in defining best practice and addressing work practice issues

Developing an Improvement Function and model

It is envisaged that IHRP will sit within an overall framework of service improvement and re-design that will seek to bring together the expertise from the Clinical Care Programmes, SDU and will also draw on the work of International leaders with expertise, experience and practical application of improving whole system patient flow in healthcare. This improvement programme and approach will include building executive, middle management and clinical leadership, engagement, knowledge and skills in improving patient flow and the application of operations management science and related programme methodologies to optimise patient flow in healthcare.

4.2 Sharing Learning

The SDU has played an important role in supporting and enabling performance improvement. As part of its analysis it focuses on improver sites and seeks to mainstream good practice. In this context it is proposed to hold a workshop for HSE management and clinical professionals which will include presentations from Hospitals on their experience of what works in achieving and sustaining positive hospital performance. The Clinical Programmes and colleges will also be afforded the opportunity to present the evidence base for delivering effective unscheduled care. The first workshop will be held in Q2 2015. A series of further workshops will be hosted by hospital groups during 2015.

The shared learning network and Performance Improvement Academy which comprises key stakeholders from RCPI and RCSI and UCD and SDU and clinical programmes will deliver a series of master class modules this year in relation to Leadership for change, operational management, demand and capacity planning and management, systems thinking, performance improvement methodologies and change management. IHRP should deliver this with specialist expertise and partners and not the SDU alone as described in the document.

4.3 Patient Engagement and Feedback

There is a requirement to actively pursue Independent Patients and Family's / Carers views/ opinions of their Hospital experience through an identified formal platform. It is recognised that Patient Involvement is a key element of the Irish Hospital Redesign Programme.

The principles that underline Patient Centred care are:

- Respect for their unique needs preferences and value
- Involvement in policy
- Access and support
- Information that is accurate, relevant and comprehensive

The commitment to patient engagement/involvement in the Hospital Re-engineering Programme is a major milestone. The closer the enterprise can connect, listen and learn from its users i.e. Patients and/or those close to them means that the system can offer better service value, opportunities for improvement in patient centred care and contribute to overall Patient Safety .

Short Term Actions

- Initiate active end user surveillance in the main areas that are being targeted to reduce the surges on the ED need; to include:
    - Within the ED
    - During inpatient admission
    - At time of discharge
    - Out of hours doctors on call in community,
    - Treatment in residential or community services
    - Readmissions from home and nursing homes
- Use of smart technologies to provide patient experience results in real time, which empowers management to alter activities to meet corporate patient centred objectives ultimately at all levels of

patient contact. Utilising such real time feedback is a powerful tool for individual patient feedback at many levels.

Summary of Actions

Action	Owner	Timeline	Action	Owner	Timeline
3.1 CAPACITY - Optimising Existing Hospital and Community Capacity					
3.1.1 Reducing Delayed Discharges					
Agree what is meant by a delayed discharge so that it can be appropriately measured and targeted at hospital and community level	**HSE, Social Care**	**Immediate**	Set and maintain NHSS wait time of 4 weeks through the provision of adequate funding in 2015	**HSE, Social Care**	**Q2 2015**
Enforce regulatory guidelines for submission of financial and CSAR information to NHSS	**HSE, Social Care in conjunction with AHD**	**Immediate**	Set and enforce timelines for processing of financial information by Nursing Home Section	**HSE, Social Care**	**Immediate**
Set and oversee individual Hospital targets to ensure that the total number of Delayed Discharges does not exceed 500 in 2015 and that no hospitals delayed discharges are in excess of 10% of its available beds. This should include individual Hospital weekly discharge targets for Social/Primary Care as identified by the SDU.	**HSE Social Care/Primary Care in conjunction with AHD**	**Immediate**	Set targets, by Hospital, for delivery of Home Support services to ensure minimum delay for patients in Hospitals accessing appropriate supports. It is recognised that home support is not a demand led scheme but is budget capped and must meet the requirements of those in hospital and in the community	**HSE, Social Care**	**Immediate**
Define and implement a menu of appropriate clinical pathways using the information that is already available i.e. 27 Clinical Programmes each of which describe in detail an evidence based clinical pathway	**HSE AHD/CCP/Social Care**	**Q4 2015**	Define Community/Acute Hospital Catchment Areas for older person's services specifically	**HSE AHD & Social Care& DOH**	**Q2 2015**
Develop and implement agreed metrics to ensure that agreed targets for delayed discharges are being met consistently at national and hospital level	**HSE AHD/Social Care/Primary Care**	**Q2 2015**	Develop Integrated care pathways across the acute hospitals/community interface in the context of the newly created Divisional structures	**HSE AHD/CCP**	**Q4 2015**

In conjunction with the DOH, continue to define the requirement for additional residential care capacity both in terms of long stay and short stay to support the continuum of care requirements and in particular in key locations where there is an identified shortfall in such capacity, both currently and over the coming years. Identify the nursing and other staffing requirements which will allow identified patient care needs to be met.	**HSE Social Care DOH**	**2016/2017**	Work with DOH and HIQA to find solutions to the current regulatory challenges so as to protect public bed capacity which is vital to support the acute hospital system	**HSE Social Care**	**2015/2016**
Work with DOH to develop appropriate public long term capacity so that complex patient needs can be met consistently	**HSE Social Care**	**2015**	Develop and establish a robust local clinical governance model with clear links to the discharging hospital and existing community services	**HSE Social Care**	**2015**
DOH to lead on appropriate workforce planning to ensure safe and agreed nursing staffing levels and nursing clinical governance systems are in place to accept discharged patients	**DOH/HSE**	**2016**	Develop ring-fenced funding streams for certain patient groups	**HSE/DOH**	**2016**
Develop a framework to plan proactively for the ageing population having regard to the projections for the next 6 years	**HSE AHD/ Social Care/ Primary Care**	**Q4, 2015**			
3.1.2 Reduce Length of Stay					
Increase DOSA rates to national overall target of 70% in 2015 with each hospital having a target set by the National Surgical Programme. Current performance is	**HSE AHD/Hospital**	**Immediate**	Increase surgical rates and reduce overnight stays – initial target set for Laparoscopic	**HSE AHD/ Hospital Group**	**Immediate**

circa 65% however there is significant variation by site. Further development of robust pre-assessment models of care through investment in CNS's in pre-assessment is critical in this regard.	**Group CEO's**		Cholecystectomy (> 60%)	**CEO's**	
% of bed utilisation by acute surgical admissions that do not have a surgical primary procedure – reduction of 5 % in 2015	**HSE AHD/ Hospital Group CEO's**	**Immediate**	Define targets for shift of inappropriate day-case workload to outpatient settings	**HSE AHD/CCP Surgical**	**Immediate**
Align shift of inappropriate day-case workload from Hospitals to Primary Care in the context of NSP priority for 2015 of increasing minor surgery in GP settings	**HSE AHD/Primary Care**	**2015/2016**	Apply HIQA HTA criteria to prescribed cases to create additional day capacity within existing resources	**HSE AHD/CCP Surgical**	**2015/2016**
Examine LOS variance for core patient groups at consultant level by clinical directors and hospital management supported by appropriate data	**Hospital Groups/Hospitals**	**Immediate**	Ensure daily reviews undertaken by senior decision makers	**Hospital Groups/Hospitals**	**Immediate**
Learn from experience of implementing reconfiguration in hospital groups in terms of optimising use of available bed stock in Model 3/4 Hospitals and effecting bi-directional flow. Effective planning in terms of predictive modelling, development of capabilty within Model 4 and development of agreed patient pathways is essential if reconfiguration is to be effective	**Hospital Groups/ Hospitals**	**Immediate**	Embed the operation and use of existing AMAU's to ensure consistent compliance with target of 25% of patients being seen and discharged on the same day.	**Hospital Groups/ Hospitals**	**Immediate**
Ensure consistent compliance in existing AMAU's with target of 56% of patients being discharged safely within 72 hours	**Hospital Groups/ Hospitals**	**Immediate**	Extend use of outreach services (e.g. Heart Failure and COPD) to reduce inpatient stay	**HSE AHD/Primary Care/CCP's**	**2015/2016**

Determine consultant manpower and NCHD requirements for medicine and surgery to enable appropriate and timely assessment and decision making within ED	**AHD / National HR**	**Q4 2015, Q1 2016**	Extend existing community nursing and AHP staffing requirements to enable efffective discharge of patients to the community	**Social Care / Primary Care**	**2016**
3.2 CAPABILITY - Developing internal capability and Process Improvement					
3.2.1 Appropriate admission avoidance					
Embed Rapid access model in Mount Carmel Hospital to support the hospitals in South Dublin subject to appropriate engagement with representative bodies.	**HSE AHD/ Social Care**	**Q2 2015**	Embed the Rapid access model in Beaumont Hospital through strengthening of geriatrician links with emergency medicine and links with Day Hospital capacity	**HSE AHD**	**Immediate**
Extend the Community Case Management Initiative to 4 AMAU sites with 7 day access	**HSE AHD**	**Q3 2015**	Set targets for extended use of public CIT model as identified in 2015 NSP Plan to enhance nursing supports to nursing homes and to support ED diversion.	**HSE Primary Care**	**Q2 2015**
Ensure that expanded CIT model optimises the benefits from appropriate linkage with home help supports and realises the targeted bed days savings	**HSE Primary Care**	**Q2, 2015**	Ambulance service to initiate alternative patient assessment initiative "Hear and Treat" subject to available resource	**NAS**	**Immediate**
Set specific response times for GP Out of Hours Services for particular patient cohorts and measure compliance with same. Such targets must take account of acuity of patient requirements with particular priority attaching to nursing home patients	**HSE Primary Care**	**Immediate**	Establish national campaign aimed at promoting the use of Local Injury Units/Rapid Access Services and G.P. OOH's services for appropriate conditions. Requirement to standardise name and purpose. There is a cultural shift required to get patients in certain areas to utilise alternative services and this should be a focus of any such communication plan	**HSE AHD/Primary Care**	**Immediate**

Review resource requirements for G.P OOH's services and CITs should the campaign result in an increased number of patients presenting at these services	**HSE AHD/Primary Care**	**Immediate**	Each CHO provide a **live electronic contacts register** of primary care and social care clinical and admin contacts (phone and email) to local hospitals for ease of communication	**HSE CHO's**	**Immediate**
Make greater use of electronic communication, including references to the usage of "**healthmail**" which allows all hospitals to communicate clinical information securely to GPs	**HSE Primary Care**	**Immediate**	Commence discussions with relevant stakeholders including representative bodies to develop the expanded roles of nurses in areas of prescrbing, IV fluids and antibiotic therapy within the long terms care facilties, inclduing the potential for training and/or recruitment of Nurse Prescribers/ANPs in community to work collaboratively of GPs and Out-of Hours services, good examples of similar **nurse-led walk-in treatment centres** in UK.	**HSE Primary Care**	**Immediate**
3.2.2 Effective management of patients within ED					
Implement and oversee agreed target timelines for patients to be seen within ED and by admitting teams. For ED, 3.2.1 as per EMP. For admitting team/s – patient assessment should commence within 1 hour of referral.	**Group CEO's/Hospitals**	**Immediate**	Ensure appropriate level of senior clinical decision making in ED.[†] There is a requirement to ensure that there is a senior decision making presence in ED during peak hours with consultant availability on 8am-8pm basis, subject to resource.	**Hospitals/Group CEO's - Immediate**	**Immediate**
The HSE National Service Plan 2015 provides for 4 additional Consultants in Emergency Medicine and 4 AMAU physicians. This is a first step in addressing the requirement to enable extended day provision	**HSE AHD/Group CEO's**	**Immediate with appointment by Qtr. 3,**	Determination of nurse staffing and skill mix should be made using a robust evidence based methodology, applicable to the ED andAMAU context.	**DOH/AHD,CCP**	**Q3, 2015**

[†] Timing of impact assessment will be determined by recruitment of Consultant staff

particularly in Model 3 and 4 hospitals.		**2015)**	The Taskforce on Staffing and Skill Mix in Nursing to develop a Framework for Nurse Staffing and Skill Mix in Emergency Nursing Care, as Phase II of its programme of work.		
Commence discussions with relevant stakeholders including representative bodies to optimise the existing skills amongst the wider ED & AMAU nursing resource, to enable competent nurses, working under protocol, to order, interpret and escalate diagnostic tests, such as bloods, for example	**DOH CNO, HSE, Relevant representative bodies**	**Immediate**	Commence discussion with relevant stakeholders including representative bodies to maximise the development of ED & AMAU skills and competence to undertake advanced clinical assessment, interpretation and treatment in a standardised range of skills such as chest auscultation, palpation percussion, medicinal prescribing, ECG interpretation etc, through a combined ED & AMAU education programme, in tandem with the existing medicinal and x-ray prescribing programmes	**DOH CNO, HSE**	**Immediate**
Each Hospital to ensure that on-call admitting Consultant is fulfilling their commitment to respond to ED activity. The recent surge in ED activity has highlighted the benefits of intensification of efforts on a pan-hospital basis to manage patient flow. In particular, the application of the following principles on a consistent basis has enabled better management of surge activity. Key requirements: ○ Daily specialist Consultant ward rounds in the acute specialties. ○ Daily handover of admitted patients to the relevant Consultant or specialty in that hospital. ○ Participation of the on call admitting team in	**HSE AHD/Group CEO's**	**Immediate**	Support and enable enhanced roles for nursing and AHP grades to facilitate patient assessment and discharge. Proposals to be advanced in 2015 in conjunction with relevant stakeholders.	**HSE /CNO DOH in conjunction with Representative Bodies**	**Immediate**

escalation measures. ○ Availability of specialist Consultants to admit, discharge, or refer patients to fast-track clinics.					
Determine emergency department manpower requirements by reference to robust evidence based methodology for all Hospital Groups having regard for the proposed reconfiguration of services within Groups and the potential to leverage existing resources more effectively across the Groups.	**HSE AHD/Group CEO's**	**2015**			
3.2.3 Rapid Access to Inpatient care					
AMAU Model: Expansion of service to 7 day service in 4 sites (SVUH, Mater and CUH, Tallaght) initially in 2015 with supports as outlined in HSE NSP 2015. *(Ref. Section 1.2)*	**HSE AHD**	**Q4 2015**	AMAU Model: Evaluate the impact on ED volumes and wait times and determine requirements for expansion to other sites during 2016. *	**HSE AHD**	**CCP, 2015**
Strengthen ED streaming to ensure optimisation of AMAU functioning and decongestion of ED Specifically, triage in ED should ▪ Seek to divert all clinically appropriate Medical patients to AMAUs ▪ Prioritise the selection of Elderly patients to ensure early assessment and appropriate management by AMAU physicians. ▪ Extend AMAU model into paediatric services in Dublin by opening a Short – term Stay	**Hospitals/CCP**	**2015**	Development of ANP model of care for low acuity chronic illness, both in the ED and AMAU to assess, treat and discharge low acuity chronic illness, with the option for return clinics at the ED & AMAU for ongoing assessment and treatment similar to the current ED Minor Injuries model of care	**DOH CNO, HSE**	**2014/2015**

Observation Unit at Tallaght Hospital to drive contemporary practices in rapid access and turnaround of children being admitted across the three children's hospitals in Dublin					
Extend G.P Direct access to AMAU within agreed criteria for AMAU referrals. As part of this process, establish appropriate communication, referral and governance pathways with GPs to enable appropriate referral and feedback.	**Hospital Groups/ Hospitals**	**Immediate**	Access to diagnostics- Ensure full implementation of 8-8 working day, in line with the national protocol in all sites for diagnostic services, subject to review of resource requirements, and seek to optimise access for emergency services	**Group CEOs Hospitals**	**Q4 2015**
Extend initiatives such as community case management for older persons with complex needs with other proposals such as case management for CIT and develop agreed metrics to measure specific impact on admission and re-admission rates	**HSE AHD/Social Care/CCP's**	**Immediate**	Examine requirement for availability of community professionals, especially Community nursing, on a seven day basis.	**HSE Social Care /Primary Care**	**Immediate**
Targeted Use of Fast track units (e.g. Clinical Decision Units and Rapid Access): to reduce the volumes and wait times in EDs, provided they are delivered and overseen by senior decision makers and underpinned by robust clinical protocols. Requirement to develop and use metrics to measure the specific impact of fast track units in terms of activity, resource utilisation wait times and length of stay.	**Hospitals/ Group CEO's**	**Immediate**	Effective use of existing Acute Medical Assessment Units to support the reduction of ALOS and enable prompt assessment and management of specific patient cohorts.	**Hospital Groups/ Hospitals**	**Immediate**
Use of short stay (less than 5 days), high intensity capacity can result in the following benefits: • Reduced ED 'trolley' waits / prompt admission • 'Pull' to accommodation within appropriate	**Hospital Groups/ Hospitals**	**Immediate**			

ward • Focused condition specific protocols, rather than individualistic approach • Shorter average length of stay (approximately 2 day reduction) Prompt effective discharge – with no adverse increased readmission					
3.2.4 Access to diagnostics					
Access to diagnostics- Ensure full implementation of 8-8 working day for laboratory and radiology services in line with the national protocol in all sites for diagnostic services, and having regard to additional resource requirements. Within context of extended day, seek to optimise access for emergency serviceshaving regard to resources. It is recognised that there is a need to develop additional consultant manpower to meet additional reporting requirements	**Group CEO/ Hospital Mgr**	**Immediate**	Target 7 day radiography service initially on pilot basis using overtime. Evaluate impact on ED and AMAU performance and length of stay with emphasis on timelines for access for inpatient and emergency patients. Capital constraints need to be borne in mind.	**HSE AHD**	**Qtr. 2 2015**
In the short term, the options for developing additional diagnostic capacity may be considered particularly for outpatient workloads in order to improve overall bed utilisation and patient flow. This should be progressed in consultation with relevant stakeholders in recognition of pre-existing protocols and agreements.	**HSE AHD/Group CEO**	**Q2 2015**	Develop a plan for targeted increase in diagnostic capacity (MRI/CT) to ensure that GP and consultant access is appropriate **(-)**	**HSE AHD**	**2016**

The prioritisation of inpatients access to diagnostics should be a core principle to effect reductions in length of stay. Requirement to implement agreed metrics to measure specific impact of extended day on wait times for diagnostics for emergency patients	**Group CEOs, Hospital Managers**	**Q 4, 2015**	Seek to secure the necessary additional consultant manpower to meet the additional reporting requirements associated with extended day and 7 day service.	**HSE AHD, National HR**	**2016/2017**
3.2.5 Access Senior Decision Making					
Ensure planned appointment of 4 additional consultant workforce to AMAU and 4 to ED, as provided for in the 2015 Service Plan, is targeted to address the requirement for consultant delivered services within ED and AMAU	**HSE AHD/Group CEO**	**Immediate**	For inpatients, ensure consistent of predicted date of discharge to support reduction in length of stay and effective use of resources; agreed by Specialty, proactively managed against treatment plan, discharge confirmed day before	**Group CEO/Hospital Mgr**	**Immediate**
Advertise and recruit vacant consultant posts to reduce reliance on agency provision. As part of this process, seek to structure posts within Groups to support the staffing requirements of small and medium hospitals. Engagement with training colleges required.	**AHD/Group CEO's**	**Immediate**	Extend use of delegated discharge and cross team discharge to address current deficits in relation to senior clinical decision-making having regard to the consultants ongoing clinical responsibility for their patients	**Group CEO/Hospital Mgr**	**Immediate**
Seek to increase the number of consultants and NCHDs in line with international norms and best practice. The targeting of these posts should be informed by robust analysis of consultant manpower requirements at hospital and group levels	**HSE AHD, National HR**	**2016/2017**	Develop additional capacity and capability within nursing to take on senior decision making roles in relation to delegated discharge	**HSE AHD, National HR**	**2016/2017**
3.2.6 Integrated Discharge Planning					

Implement across all hospitals the predicted date of discharge for all admitted patients (within 24 hours of admission) with target of 80% compliance by end 2015	**HSE AHD/Group CEO's**	**Immediate**	All patients due for discharge will have a Consultant review to allow for discharge before 11 am	**Group CEO's/ Hospitals**	**Immediate**
Implement target of 40% (check agreed target) of patients to be discharged before 11 a.m. on a day to ensure required capacity is available for admission. A whole system approach is require to achieve this including communication with families and development of appropriate waiting areas for discharged patients (e.g. discharge lounges) to ensure that there is appropriate clinical oversight of both discharged and newly admitted patients.	**Group CEO's/Hospitals**	**Immediate**	Ensure 7 day ward rounds by senior decision makers are an integral part of the discharge process and task Clinical Director with oversight of compliance with this requirement.	**Group CEO's/Unions/ Professional bodies**	**Immediate**
Undertake weekly systematic review of all patients with extended length of stay (>14 days) to identify issues and actions required.	**Group CEO's/Hospitals**	**Immediate**	Enable delegated discharge between clinical teams within agreed parameters.	**Group CEO's/Unions/ Professional bodies**	**Immediate**
Delegated authority to senior nurses to support discharge based on agreed criteria and having regard to the consultant's ongoing responsibility for the patient.	**Group CEO's/ANO/Professional bodies/Unions**	**Immediate**	Report and publish daily and weekly discharges by hospital and Group to ensure consistent application of weekend and daily ward rounds by senior decision makers	**SDU/Hospitals**	**Immediate**
Active regular review of non compliance with PDD	**SDU/Hospitals**	**Immediate**	Ensure that appropriate systems are in place to enable effective discharge planning in collaboration with community partners. These should be formal with regular structured engagement to address any blockages or delays.	**CHO'S/Group CEO's**	**Immediate**

Weekly reporting mechanisms to be developed to identify and/or discharges and to communicate same to community partners	**CHO/Group CEO's**	**Immediate**	Facilitate bi-directional flow and appropriate use of Model 2/3 Hospitals through expansion of NAS Intermediate Care service, subject to resource availability	**NAS**	**2015/2016**
3.2.7 Chronic Disease Management					
Measure impact of existing funded chronic disease programmes to date in terms of reducing LOS Quantify reduction in length of stay for chronic diseases (e.g. COPD, Heart Failure) where speciality ambulatory care services have been developed under the clinical programmes. Maximise the national effect on length of stay reduction by filling geographical gaps in these services in the 2016 NSP	**HSE CCP's**	**Immediate**	Implement and evaluate Service Plan 2015 requirements for Integrated Care pathways and Frail Elderly. Examine opportunity to develop community based ANPs which can provide an effective model and pathway of care specific for older patients to expedite their care and treatment both inward and outward. This would extend the current proposal on geriatrician led services to include ANP delivered services in collaboration.	**HSE, Acute Hospitals Division and CCP**	**Q4 2015**
Development of ANP model of care for low acuity chronic illness, both in the ED and AMAU to assess, treat and discharge low acuity chronic illness, with the option for return clinics at the ED & AMAU for ongoing assessment and treatment similar to the current ED Minor Injuries model of care	**CNO DOH and HSE**	**Q4 2015**	Increase coverage of Clinical Nurse Specialist (CNS) and AHPs for chronic disease support to General Practice in the 2016 Service Plan (commenced in 2015)	**Primary Care**	**2016**
Commence implementation of the chronic disease self management support strategy in 2016 NSP	**Primary Care / CCP**	**2016**			
3.3. CONTROL - Leadership, Governance, Planning and Oversight					

3.3.1 Leadership and Governance					
Establish clear lines of accountability within the hospital for the management of patient flow within each Hospital	**Group CEO's/Each Hospital**	**Immediate**	Establish leads for scheduled and unscheduled care in all Groups with clear reporting lines to COO for each Group	**Group CEO**	**Q2 2015**
Develop and maintain centralised bed management to ensure consistent oversight of scheduled and unscheduled workloads	**Group CEO/Each Hospital**	**Immediate**	Group and Hospital Clinical Directors to drive discharge planning and ward rounds	**Group CEO/Each Hospital**	**Immediate**
Empower and enable delegated discharge in accordance with National agreements and cross team discharge, having regard for the consultant's ongoing responsibility for their patient	**Group CEO/Each Hospital/Clinical Directors**	**Immediate**	Embed and systematiccally review whole system escalation / de-escalation processes	**Group CEOs and CHOs**	**Immediate**
3.3.2 Operational Planning and Predictive Modelling					
Match services with need. E.g. team on call working in EDs and out of hours service options. Solutions may be subject to resource.	**Group CEO/EMP**	**Immediate**	Develop a greater range of services in community settings on a planned basis in the evenings and at weekends subject to resource availability e.g. wound care clinics, IV services, catheterization	**HSE Primary Care**	**Q4 2015**
Optimise use of the human resource, transfer of duties to other grades/ professionals, e.g. delegated discharging in accordance with the HRA	**Hospitals supported by National Division**	**Immediate**	Operational grip – develop capability within COO function to enable reduction in numbers and wait times within 12 hour period of escalation and recovery within 48-72 hours and to manage balance between scheduled and unscheduled care.	**Hospitals**	**Immediate**
Develop flexible rosters to meet demand requirements and ensure consistent access to Senior Decision makers	**Group CEO's/Hospitals / SDU**	**Immediate**	Develop appropriate (weekly, monthly and annual) elective schedules in line with assessed need, seasonal requirements and having regard to	**Hospitals/SDU**	**Immediate**

			overall capacity requirements		
Ensure compliance with national frameworks and improvement plans	**Group CEO's/SDU**	**Immediate**	Undertake whole system of existing winter planning arrangements in terms of timeliness and adequacy	**Group CEO's/SDU / Social Care / Primary Care**	**Immediate**
Working with key stakeholders including representative bodies to expand the roles of health professionals across the heath service to ensure optimal clinical outcomes.	**Hospitals, SDU, Representative bodies**	**Immediate**	Develop COO capability and resources at Hospital level within existing structures to oversee and manage Scheduled and Unscheduled Care	**Group CEO's/Hospitals**	**Immediate**
Embed and systematically review whole system escalation/de-escalation procedures and processes	**HSE AHD/Social Care/Primary Care**	**Immediate**			
3.3.3 Measurement					
Reinforce system wide definitions that apply to all Hospitals and Emergency Departments	**SDU with CCP**	**Immediate**	Implement appropriate IT systems to support both ED (EDIS) the AMAU IT systems to measure agreed variables consistently across hospitals	**SDU with CCP**	**Immediate**
Weekly Targets for number of discharges from Hospitals required maintain flow to be established.	**Acute Hospitals Division to set targets with individual Hospitals; HSE Social Care/Primary Care Divisions**	**Immediate**	Zero tolerance of anyone waiting over 24 hours for admission – reportable event to National Hospital Director Over 75s – eliminate 9 hour breaches (100% compliance) – regarded as a reportable event to National Hospital Director	**Group CEO's/Hospitals/SDU**	**Immediate**
• NHSS waiting times to be maintained at 4 weeks (currently 11 weeks). If further funding is	**Social Care**	**Immediate**	• Target response time will be set for Out of Hours Services and will be monitored as part	**Primary Care**	**Immediate**

provided to support the scheme. • When funding is approved to provide home supports, it is targeted that the service will be available in the person's home, within a 72 hour period. • Specific metrics to be agreed on a hospital by hospital basis as a target for transitional care. • Target times for processing NHSS applications will be agreed and monitored • Target Times for processing , approval and release of funding for Home Care Packages will be agreed			of the Performance Framework • Metrics will be agreed between Acute Hospital Division and Primary Care to determine the impact of CITS in terms of admission avoidance and re-admission		
3.3.4 Oversight					
Implement appropriate formal monitoring and oversight structures at National, Group/CHO and Hospital/Community levels that enable the following: ○ Daily review within and between Hospital/Community level with Hospital Group COO/CHO Care Lead(s) ○ Weekly oversight with relevant National Division and Group/CHO to review performance and effect appropriate interventions ○ HSE Performance Accountability Framework between National Directors and Director General and also National Divisions and Group CEO/CHO to include formal regular review of ED performance and Delayed Discharges. ○ Appropriate escalation framework to enable	**National Divisions/Group CEO's/CHO's/Hospitals**	**Immediate**			

prompt intervention by the National Division's with the delivery system through the CHO and Hospital Group's.					
4. Enabling consistent improvement across all Hospitals					
In the short term these Hospitals, working with the SDU and community partners, must prioritise the escalation responses that are known to assist with patient flow. Each of the actions recommended meets the SMART criteria, which can be applied by local management.	**AHD, Group CEOs, SDU – Immediate**	**Immediate**	Development of additional consultant and NCHD manpower in line with international norms and recommendations	**AHD**	**2016/2017**
Requirement for medium term investment to develop the required residential care capacity to meet assessed needs. This will be a mix of public and private provision and therefore will also require an assessment of pricing and contractual arrangements with private providers to ensure their effectiveness in meeting assessed needs. This will be enabled once the report on the review of NHSS is published by the DOH.	**Social Care**	**2016/2017**	Hospital Groups to drive reconfiguration of services and structuring of posts to attract and retain consultant and NCHDs	**AHD, Hospital Groups**	**2015/2016**
4.1 Service Improvement and Re-design					
Irish Hospital Redesign Program • The Solution Design phase for Tallaght completed in April 2015. • Implementation phase Tallaght 10-12 weeks - Implementation phase for solutions identified as high impact but relatively easy to implement. • Extend the program in 2015 to 4/5 additional	**HSE AHD/SDU**	**2015**			

hospitals. • Secure continued engagement and leadership from the Colleges in defining best practice and addressing work practice issues					
4.2 Sharing Learning					
workshop for HSE management and clinical professionals which will include presentations from Hospitals on their experience of what works in achieving and sustaining positive hospital performance	**HSE AHD**	**Q2 2015**			
4.3 Patient Engagement and Feedback					
• Initiate active end user surveillance in the main areas that are being targeted to reduce the surges on the ED need; to include: • Within the ED • During inpatient admission • At time of discharge • Out of hours doctors on call in community, • Treatment in residential or community services • Readmissions from home and nursing homes	**HSE AHD/Group CEO's**	**2015**			

• Use of smart technologies to provide patient experience results in real time, which empowers management to alter activities to meet corporate patient centred objectives ultimately at all levels of patient contact. Utilising such real time feedback is a powerful tool for individual patient feedback at many levels.					

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