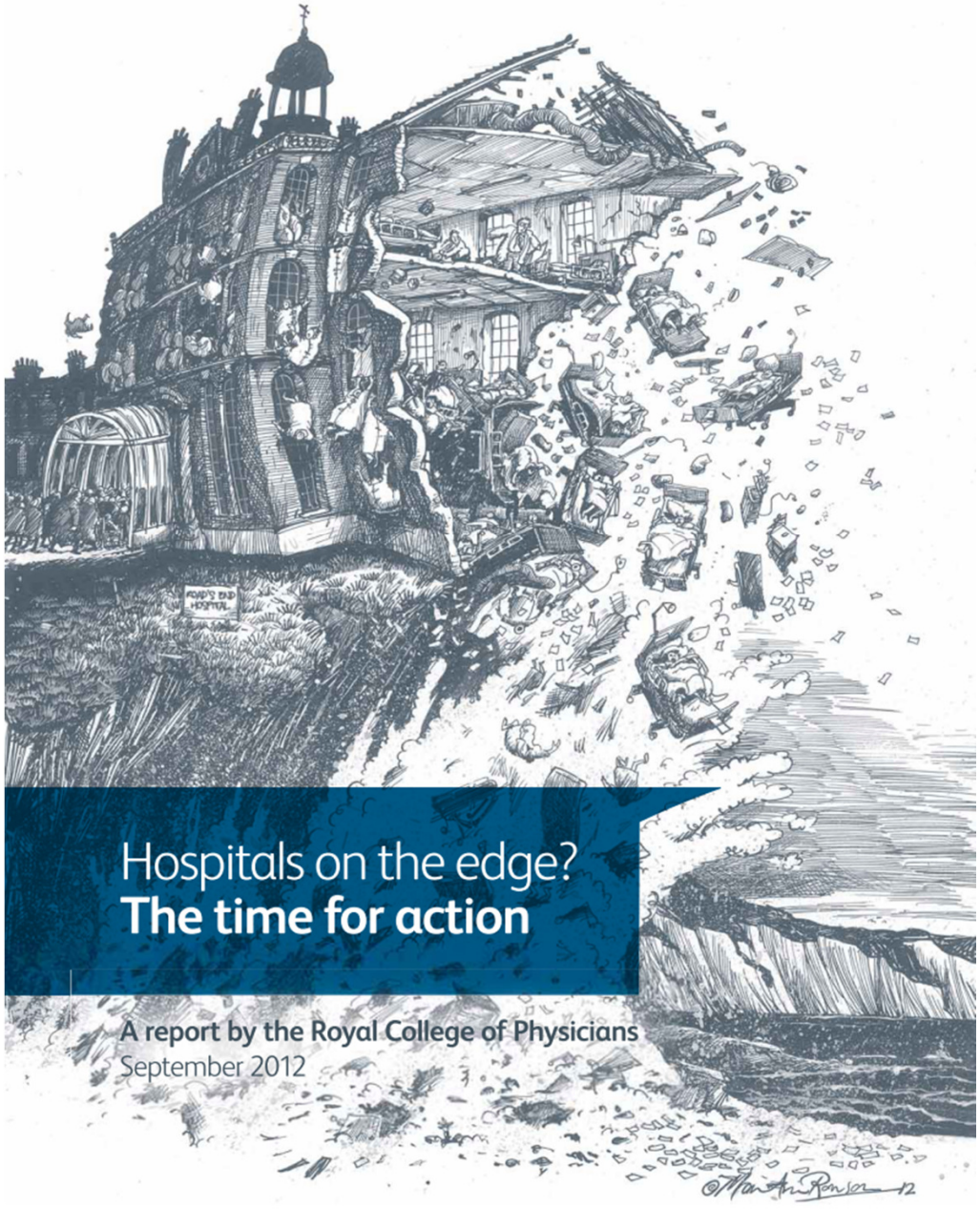
CCPs arose from HSE/RCPI/RCSI collaboration 2010

Royal College of Physicians

Setting higher standards



Hospitals on the edge?
The time for action

A report by the Royal College of Physicians

September 2012

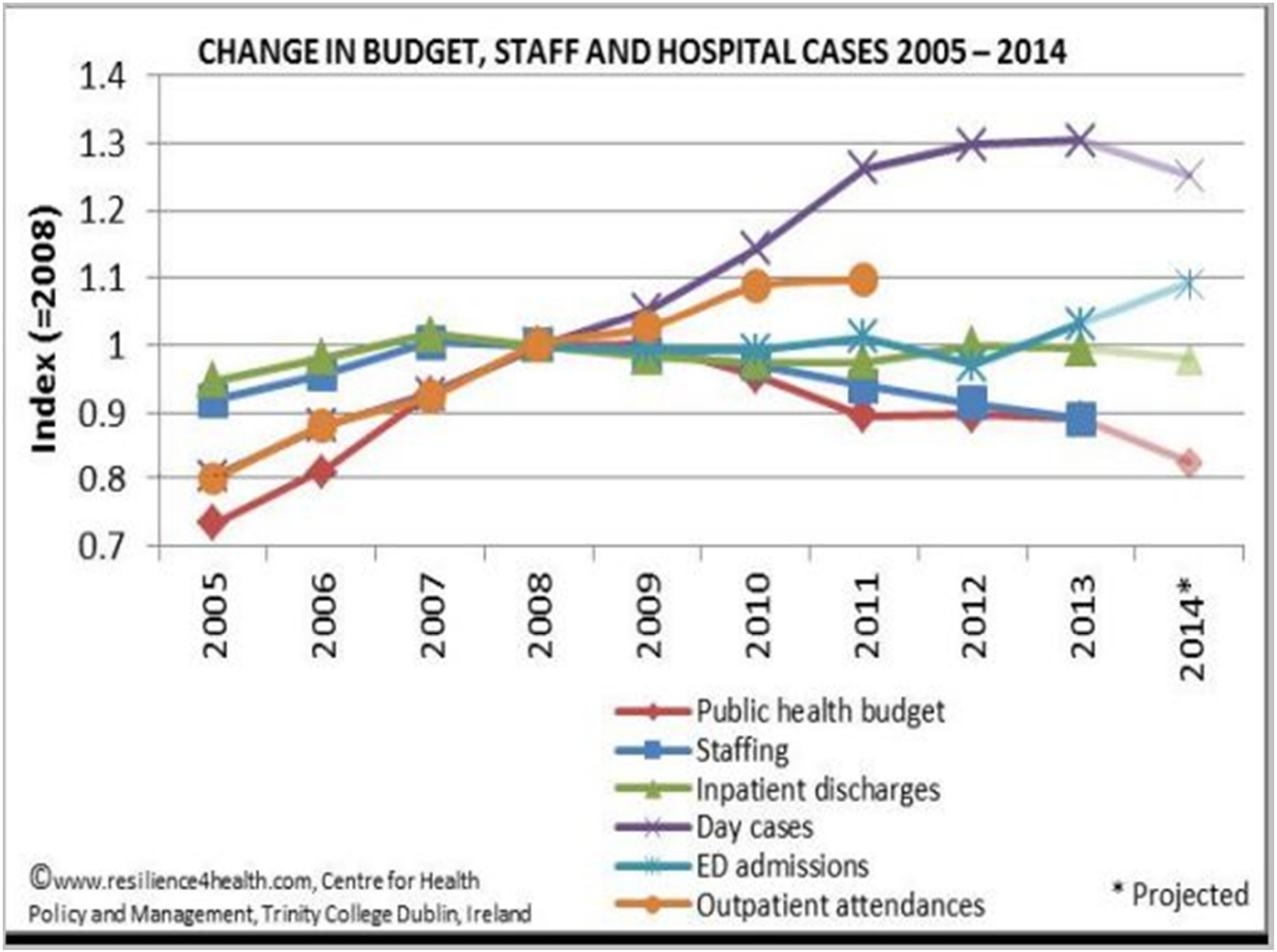
THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY

Chaired by Robert Francis QC

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

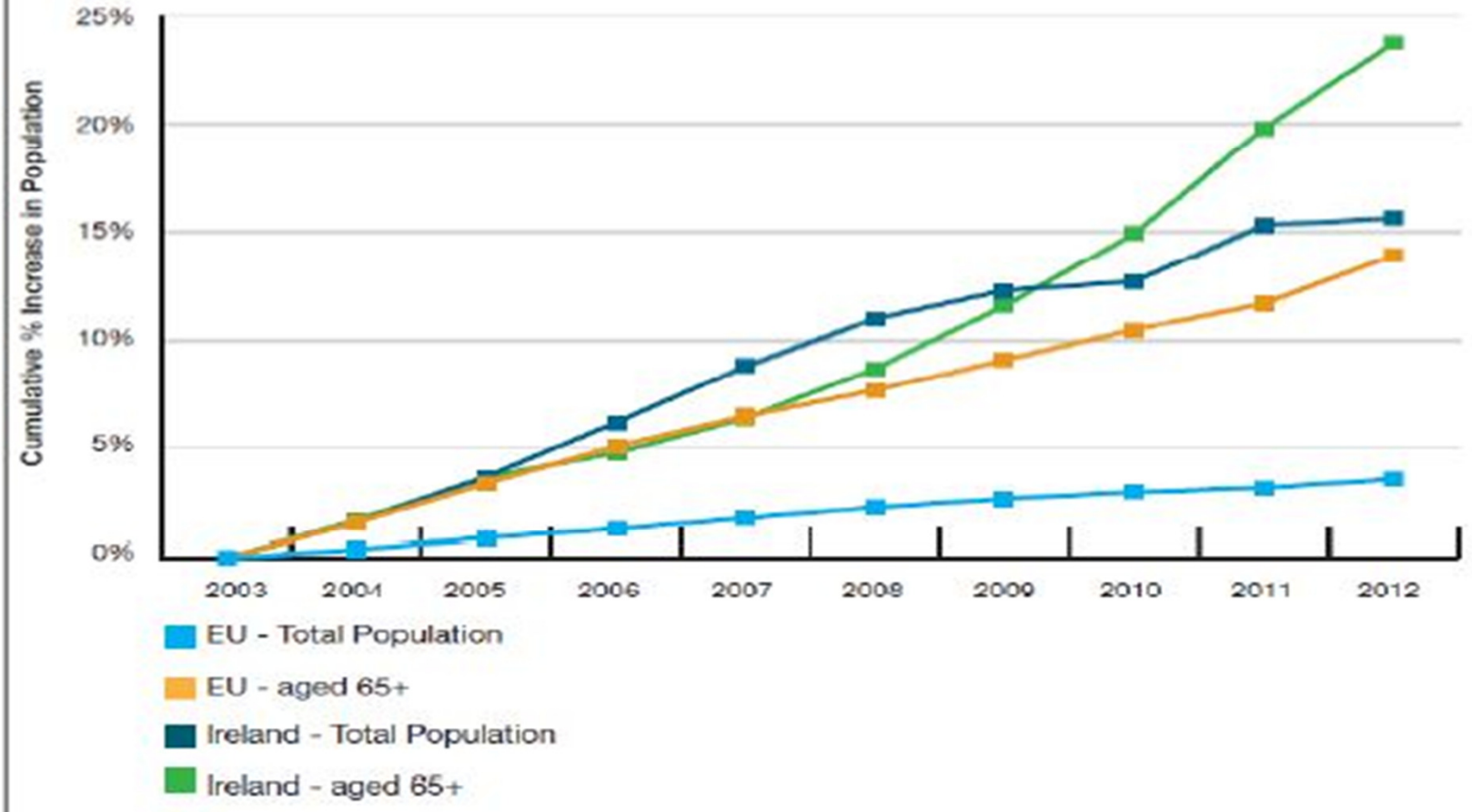
Executive summary

HC 947


CHANGE IN BUDGET, STAFF AND HOSPITAL CASES 2005 – 2014
Index (=2008)
1.4
1.3
1.2
1.1
1
0.9
0.8
0.7
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014*
Public health budget
Staffing
Inpatient discharges
Day cases
ED admissions
Outpatient attendances
* Projected
©www.resilience4health.com, Centre for Health Policy and Management, Trinity College Dublin, Ireland

2.1. Demographics and professionalism

Figure 2.1.1. Cumulative percentage increase in population, all ages and aged 65+. Ireland and EU, 2003 to 2012



Source: DH Key Trends 2013

Opportunities

- New Minister
- New Secretary General
- New HSE Directorate Structure (5)
- New National Clinical Leads (5)
- New Presidents RCPI and RCSI
- New Hospital Groups
- **Money Follows The Patient/ABF**
- New GP Contract
- Economic upswing

Change (Reform)

“All change is difficult,
even from worse to better!
Richard Hooker

Want to make enemies?
Try changing something!
Pres. Woodrow Wilson

Clinical Care Programmes

- National Acute Medicine Programme (50% of all bed days used)
- Older persons, Surgery, Emergency Medicine, Critical Care programmes and Primary Care - all vital partners in integrated care delivery
- IHRP/SDU – assist with performance management & redesign of care processes

National Acute Medicine Programme

Described new model of care with 4 intervention areas

1). Ambulatory Care (AEC, AUC, SDEC)
2). Short Stay Units (< 2/7)
3). Inpatient wards (3-14/7)
4). Complex discharges (> 14/7)

National Acute Medicine Programme – (contd.)

Established Hospital Models 1, 2, 3, 4, (5)

Flow/reverse flow

GP/Hospital Liaison Committees

Move from horizontal to vertical care

('pit stops')

National Early Warning Score (NEWS)

MFTP/ABF/VBF

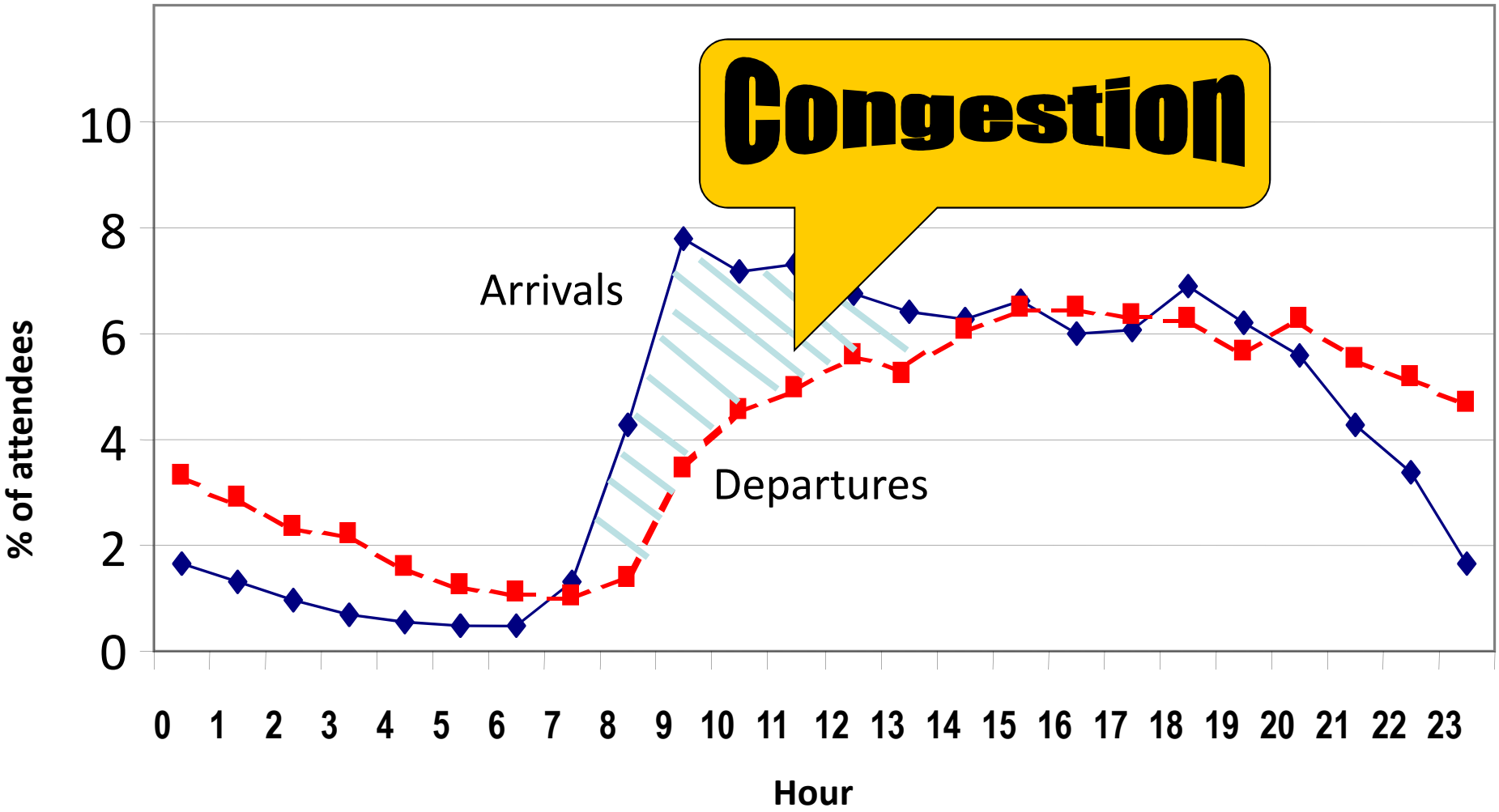
- Abolish perverse incentives
- Support virtuous incentives/VFM
- Fund Ambulatory Care, focused on older patients (Elderly Frail Units) and chronic disease care in the Community
- Must be transparent, accountable, make financial sense and work for the patient
- Facilitates rationale future service planning
- Gets CEOs' attention!

ABF

- Streamlines flow to and from primary and secondary and tertiary care
- Identifies and removes delay, duplication and cost by peer reviewed comparative analyses
- Builds confidence and interdisciplinary cooperation between GPs and hospitals and within and between hospitals
- Should cross all care interfaces
- **Reduces variation and risk and improves clinical outcomes for patients**
- Ensures costs/rewards are fairly apportioned between GPs/Community/Hospitals

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

'every system is perfectly designed to get the results it gets'



ACUTE MEDICINE

% all Medical patients on AMAU Pathway

Year	% AMAU Pathway
2012	21%
2013	29%
2014	32%

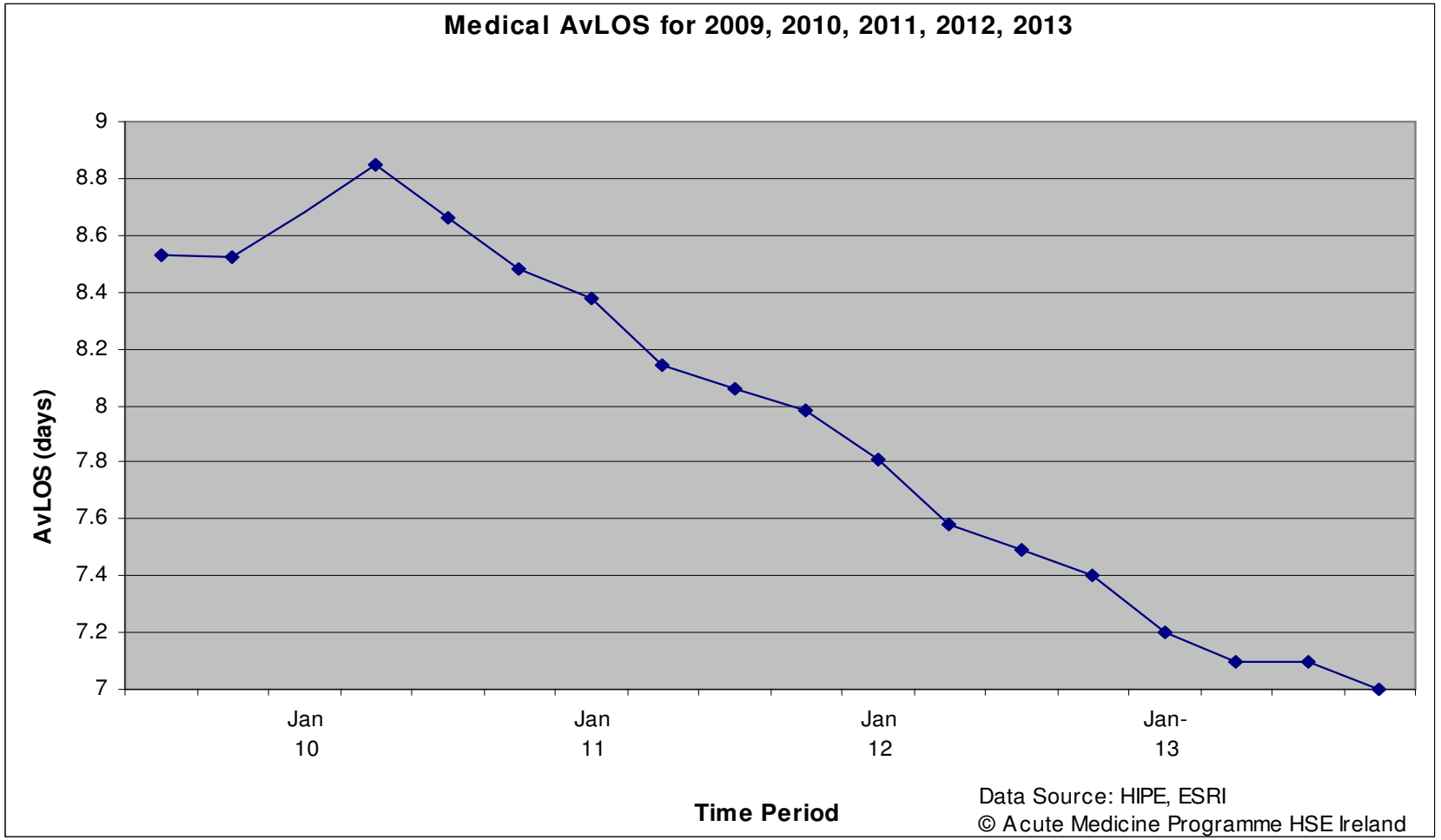
Current % across all hospitals ranges from 16% (lots of trolleys/terrible PETs) to 74% (few trolleys/great PETS)

2015 Target = 40%

2016 Target = 50%

} Needs 7/7 working

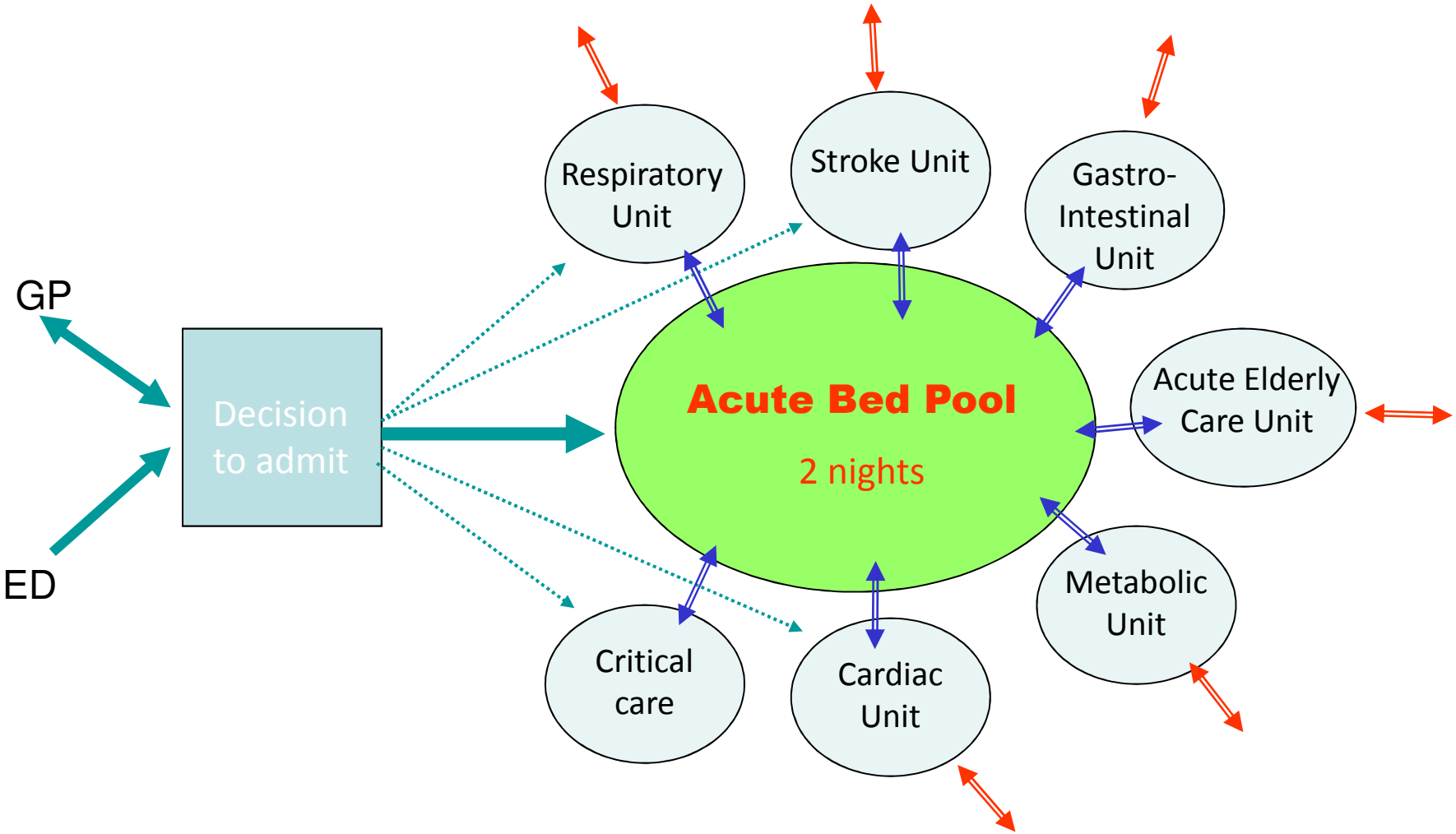
ACUTE MEDICINE



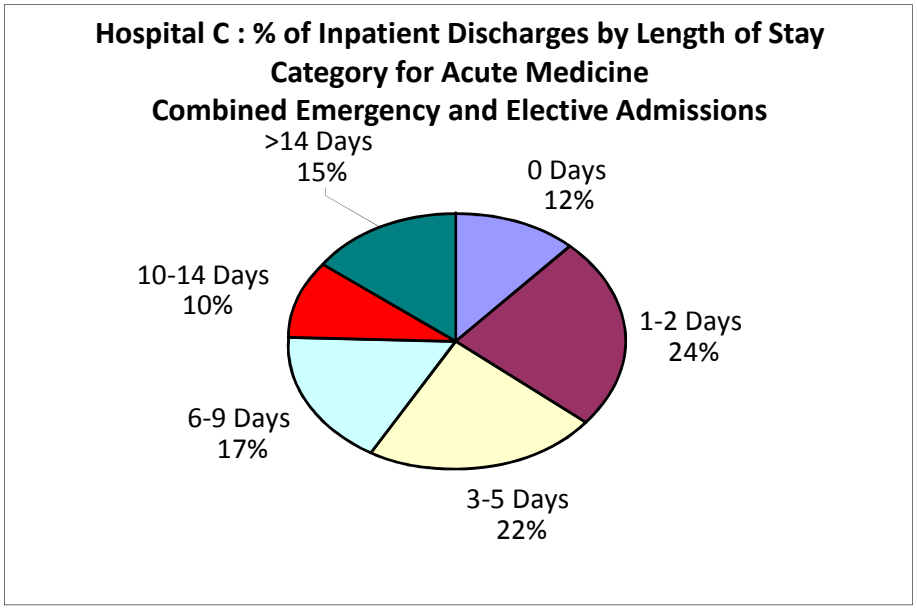
Why AMAUs work

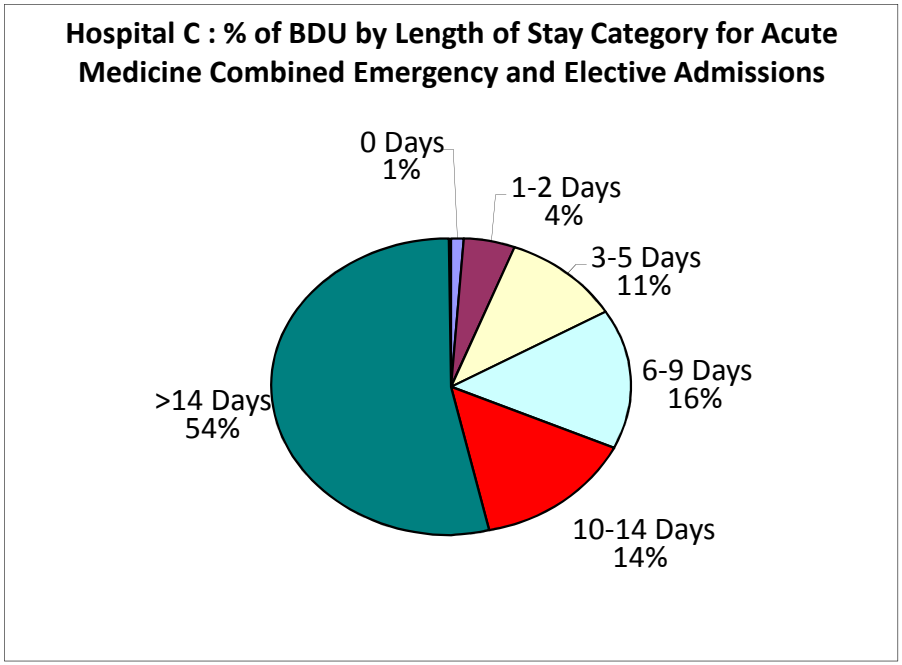
- Multidisciplinary Team working
- Clearly defined roles/responsibilities
- Mindsets of staff (can do attitude)
- Investigate to discharge, **NOT** admit to investigate
- Ability to change ‘tempo’ in response to unit demands
- Coordinated/organized
- Older patient focused
- Systems set up for Safety
- & Quality
- & Speed
- Reduce LOS
- Improve PET

Model of Care (NAMP)



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive





INDI
Irish Nutrition +
Dietetic Institute

IRISH
SOCIETY OF
CHARTERED
PHYSIOTHERAPISTS

IASLT

AOTI
Association of Occupational
Therapists of Ireland

Health Reform and the Quality Agenda

- **Includes all groups:**
  - DOH/Government
  - HSE
  - GPs
  - Community
  - Hospitals
  - ICT/Analysis/Governance/ABF
  - Patient groups

has significant start up costs and quality has a price!
(recouped later in efficiency gains and risk reduction)

Future Health

A Strategic Framework for Reform of the Health Service 2012 – 2015

Department of Health

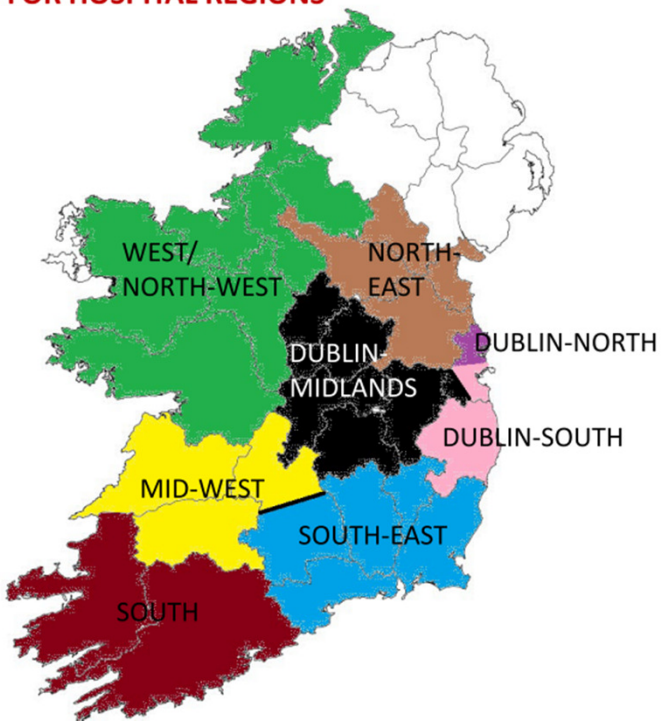
November 2012

The Establishment of Hospital Groups as a transition to Independent Hospital Trusts

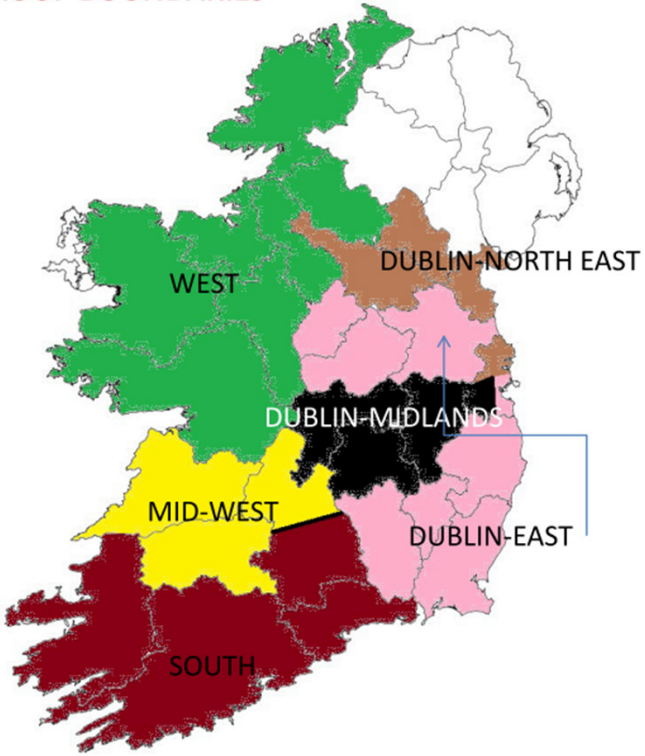
A report to the Minister for Health, Dr James Reilly, TD

ABF encourages competition!

OLD BOUNDARIES FOR HOSPITAL REGIONS



NEW HOSPITAL GROUP BOUNDARIES



NHS
Improving Quality

ACADEMY OF MEDICAL ROYAL COLLEGES

Seven Day Consultant Present Care Implementation Considerations

November 2013

Conclusion - we need to:

- Re-engineer healthcare systems based on cooperation, interdisciplinary working and flow modelling

- Achieve highest quality of safe, efficient care with lower mortality and length of stay with improved patient outcomes and increased staff satisfaction

- Develop Acute Physicians who can manage complex, co-morbid illnesses, leading multidisciplinary teams and who embrace performance improvement skills as core competencies

Absolute need for:

- New thinking, communication and collaboration
- Clinical/Financial Management Systems (ICT) to administer ABF fairly and transparently
- National Quality Improvement Programmes (e.g. NQAIS Medicine)
- Realistic health budget
- Clinical, Managerial, Political Leadership
- Media engagement

New approach

- Invest-return cycle
- Business Cases
- Never get discouraged, never give up!
- Set goals – something to aspire to
- Celebrate success
- Don’t founder on cherished outcomes
- Relentless focus on opportunities

- Oh, did I mention BRAVERY?

I'm sure glad the
hole isn't in our end...