# Emergency Medicine Programme

HSE National Directorate of Quality and Clinical Care
Advisory Committee on Emergency Medicine Training
Irish Association for Emergency Medicine
Irish National Board of the College of Emergency Medicine
Royal College of Surgeons in Ireland

*IAEM Annual Scientific Meeting & Conference,*
*Waterford, October 2010.*

# Outline of the EMP

- What is the EMP?
- Why have a programme?
- Will it make a difference?
- What will it mean for patients?
- What will it mean for Emergency Medicine?

# A Perfect Storm

- Overcrowding
- NCHD staffing shortage
- Economic recession

# A Difficult Background

- Emergency Medicine – "they just don't get it"
- Micheál Martin's failed experiment
- Mistrust – Taskforce, contract negotiations, HSE data
- Reconfiguration – politics, media etc
- Patient expectation – tolerance, convenience vs quality
- Overcrowding – adverse events, working environment, isolation


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

## Inspiration:

# “Failure is the fuel of success”

ConorCounihan 2010

Cork Gaelic Football Manager

*"From the ashes of disaster grow the roses of success"*

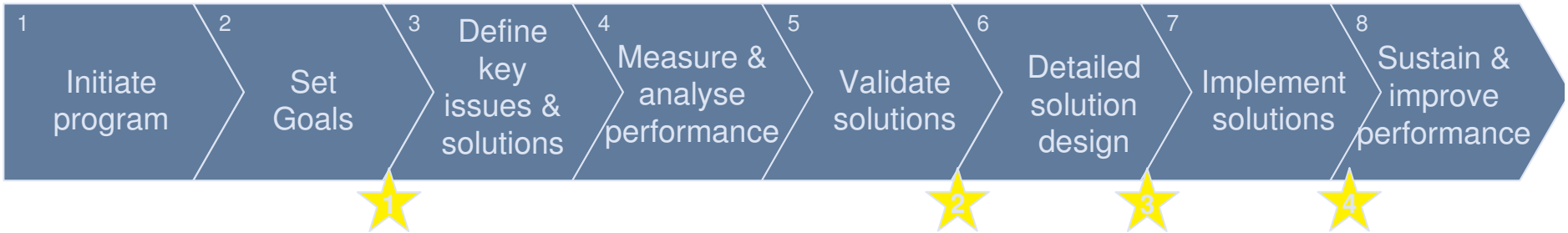
Chitty Chitty Bang Bang
Ian Fleming

# The Positives!

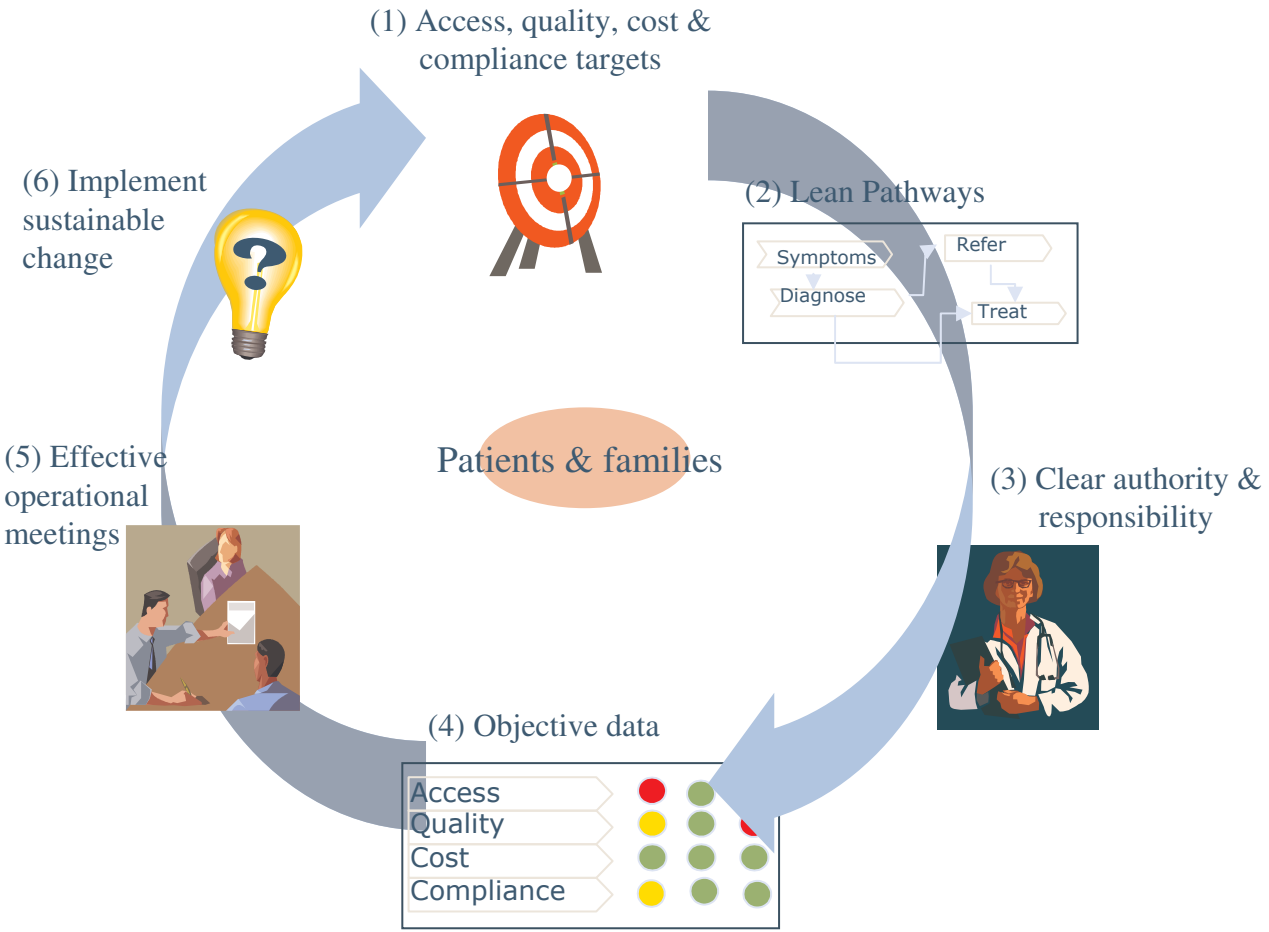
- IAEM
- Patient advocates
- Problem solvers
- Adaptability
- Excel in a crisis
- Altruistic
- Close to patients, communities and “real life”
- Current opportunities through the DQCC

# What is the EMP?

- A collaboration between DQCC and ACEMT, IAEM, INBCEM, RCSI
- Develop and implement a plan to improve patient care
- Quailty, Access, Cost (QAC)
- Change led by clinicians
- Greater HSE organisational responsiveness
  i.e. frontline staff can access HSE management in one step
- Provides a sustained focus for system change



# Design principles for embedding effective operational management




*Adapted from DQCC – programme management slides*

# Why?

- Acute Medicine Programme – critical synergy with EM
- Drivers: NCHD crisis, overcrowding
- Improve care for patients in EM
  1,041,868 new patient attendances in 2009
- CNAG Report 2009:
  - Direct costs of EM - € 196 million (wages = € 164 million)
  - Cost per attendance € 85 to €281
  - Emergency care accounted for 55% of inpatient care
  - Care of emergency cases in hospital € 1.7 billion

# Will it make a difference?

**Figure 1.1 Emergency Care Reviews**

| | Reports[a] | Year | Abbreviated Title for this Report |
|---|---|---|---|
| 1 | Report of the Committee on Accident and Emergency Services | 2002 | – |
| 2 | Acute Hospital Bed Capacity – A National Review | 2002 | Acute Hospital Bed Capacity Report |
| 3 | Admissions and Discharge Guidelines – Health Strategy Implementation Project | 2003 | – |
| 4 | National Review of Bed Management Function – Report to the Employers and Unions | 2003 | Capita Report |
| 5 | The Commission on Financial Management and Control Systems in the Health Service | 2003 | Brennan Report |
| 6 | Report of the National Task Force on Medical Staffing | 2003 | Hanly Report |
| 7 | Report on Nurse Staffing Levels in Emergency Departments in the Republic of Ireland | 2003 | – |
| 8 | Comhairle Na nOispidéal – Acute Medical Units | 2004 | Acute Medical Units Report |
| 9 | A&E Mapping and Efficiency Review Across 10 National Hospitals – Tribal Secta | 2005 | Tribal Secta Report |
| 10 | Emergency Department Task Force Report | 2007 | Task Force Report |
| 11 | Acute Hospital Bed Review – A Review of Acute Hospital Bed Use in Hospitals in the Republic of Ireland with Emergency Departments | 2007 | Bed Review Report |
| 12 | Acute Hospital Bed Capacity Review – A Preferred Health System in Ireland to 2020 | 2007 | Bed Capacity Review Report |

Note:

a The full reference of each report is set out in Appendix C. These reports are referred to throughout the remainder of this report as "the review reports".

# What's different about the programme?

- A plan not a report
- Developed by the service providers
- Integrated across the healthcare system

# Do service improvement programmes make a difference?

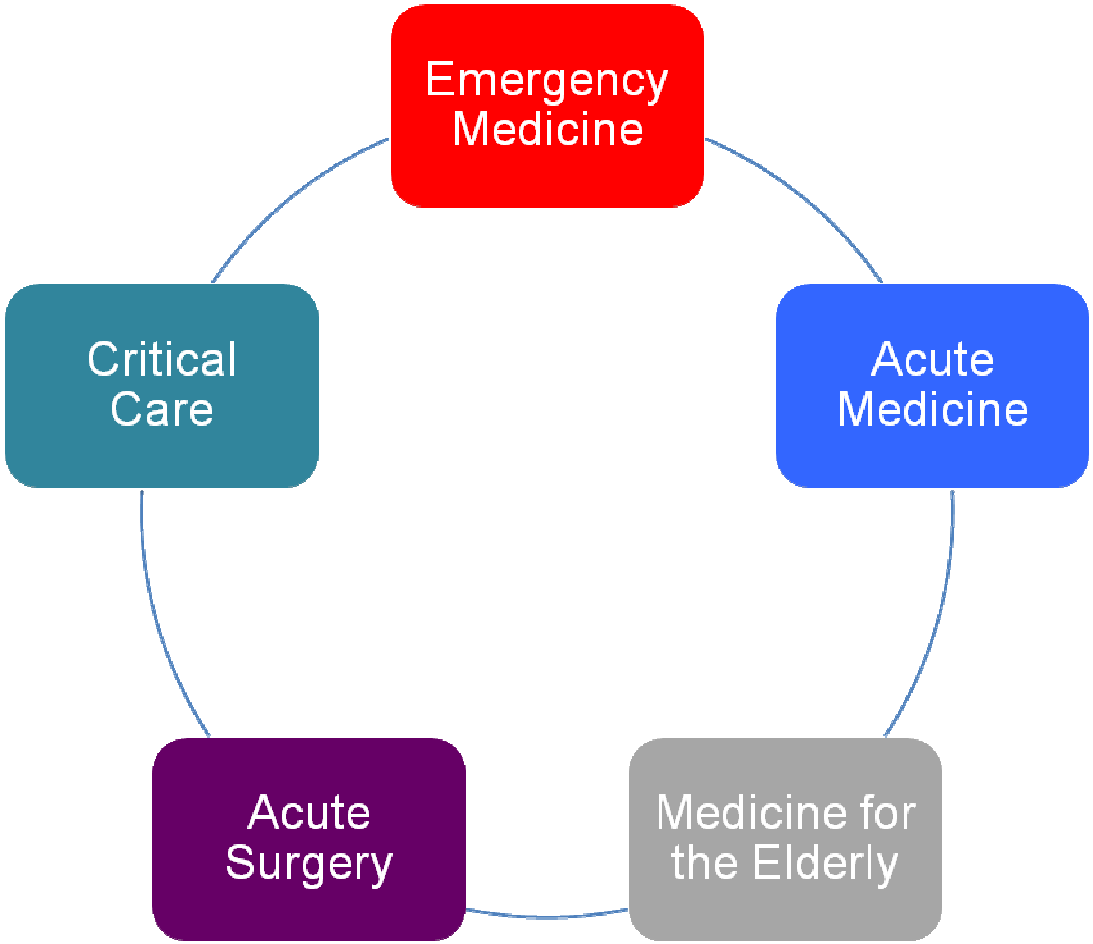
Reforming Emergency Care

New South Wales experience

Western Australia experience

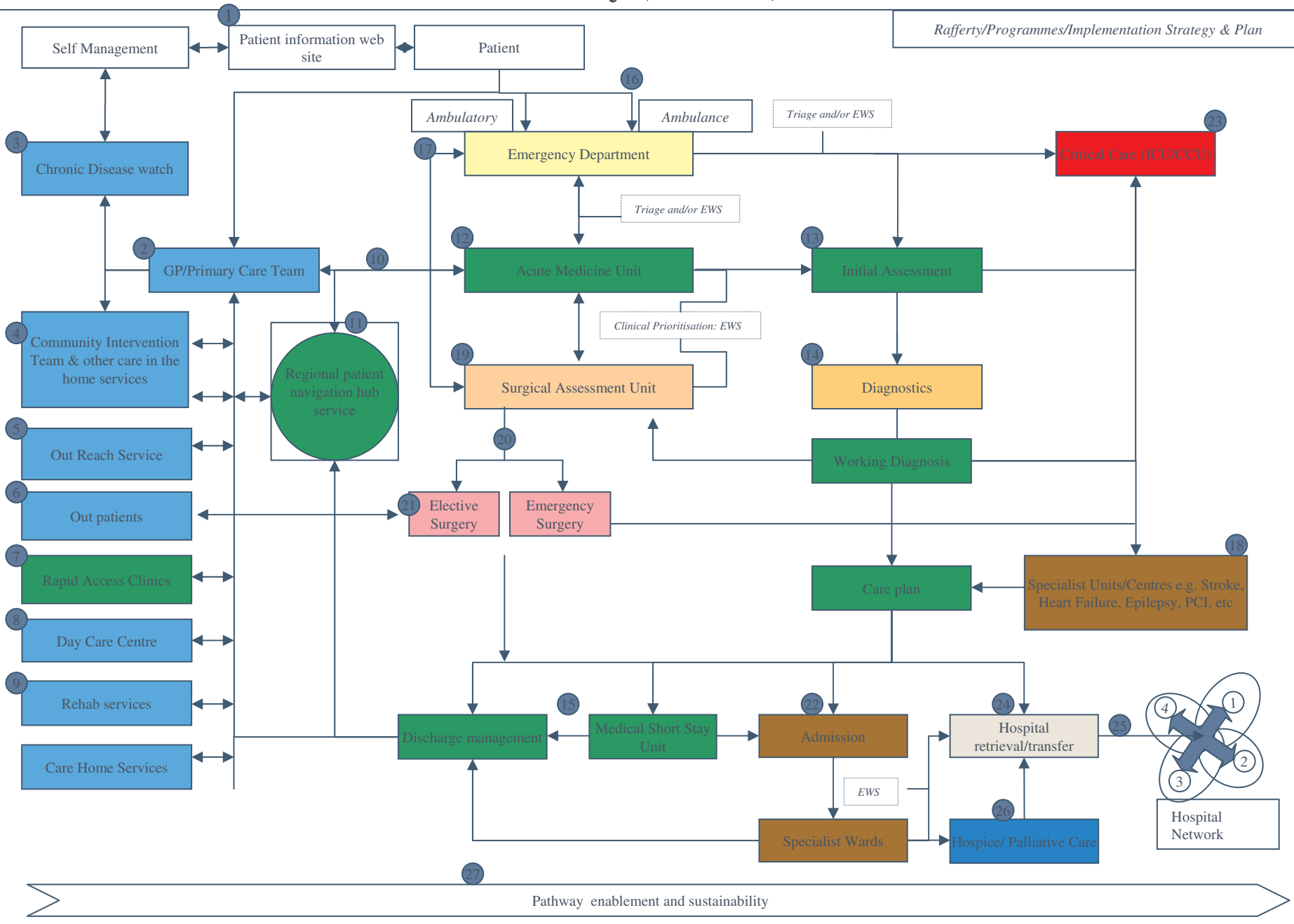
# The House of Toyota – Lean Systems Thinking

# DQCC Five Key Emergency & Acute Programmes



# 3. Patient Pathway (Phase 1) Blue Print

*Rafferty/Programmes/Implementation Strategy & Plan*



# EMP Team

## Working Group

- Una Geary (Programme Lead)
- ANP- Val Small
- Nursing Co-leads – Fiona McDaidand Mary Forde
- AHP – MaireBríd Casey
- Primary Care – Joe Clarke
- Pre-hospital – Geoff King
- Ronan O'Sullivan - PEM
- Cathal O'Donnell - MAC to PHEC
- John McInerney (DATHsEDs)
- Medical Informationist- Maura Flynn
- Service planner – Susanna Byrne

## Regional Leads

- Fergal Hickey (West (NW))
- Gareth Quin (West (MW))
- Gerry McCarthy (South)
- ConorEgleston (Leinster NE)

## Programme Support

- Kieran Tangney Programme Manager
- Caroline McGuinness Administrator

## Advisory Group

| | |
|---|---|
| Mark Doyle | (South East) |
| Rob Eager | (Midlands) |
| Niall O'Connor | (Navan) |
| James Binchy | (Galway) |
| Steven Cusack | (Academic) |

## Sub-groups

Major Incident Planning Mark Doyle

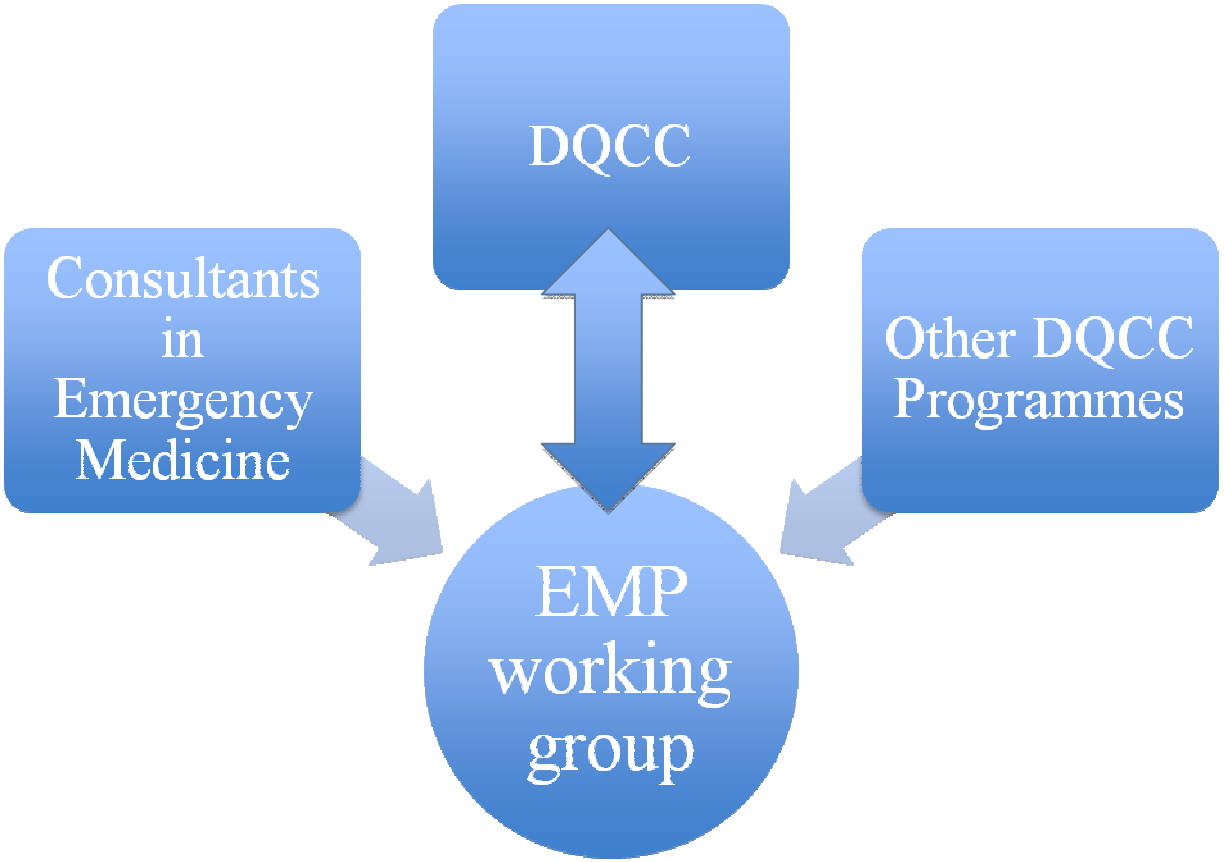
Primary Care Interface John McInerney

Peadar Gilligan

Brendan McCann

Emergency Medicine Programme

# Communication



# To Improve the Safety and Quality of Care in EDs and Reduce Waiting Times for Patients

*Examples of programme objectives:*

Quality:

- Maximised access to consultant provided care resulting in decreased mortality and morbidity
- Attainment of quality targets (HIQA compliant)

Access:

- Patients admitted or discharged within 6 hrs (X% compliance)
- Triage completed within target time
- Patients with high-risk conditions to be assessed by a consultant/middle grade.
- Decreased number of patients leaving without completion of treatment (LWOCT)

Cost:

- Reduction in number of admissions from X to Y over Z period
- Decrease LOS for in-patients referred from ED from X to Y over Z period

# Key Solution Areas

1. Develop ED Model of care:

- Staffing, work practices, role &responsibilities etc
- Workforce models/nurse skill mix
- Define governance & clinical audit system requirements
- Pre-Hospital interface
- Pediatric Emergency Medicine in ED models of care
- CDU/observation medicine
- Interface with other programmes & services
- Business case for models of care

# Key Solution Areas

2. Performance Improvement:

- Implement national clinical guidelines (ACIAEM appraisal) & DQCC programmes
- Suite of KPIs for process efficiency and quality of clinical care (Delphi Process)
- Develop data definitions around measures – pilot – implement - governance
- International benchmarking
- Case-mix/clinical acuity measures
- Best Practice Project

# Best Practice Project

Coming to your region soon…….. Survey and Group Meetings

Aims:

- Baseline current service
- Identify existing good practice & share
- Identify common areas for improvement and targetsolutions
- Communication and participation
- Avoid re-inventing the wheel

# Key Solution Areas

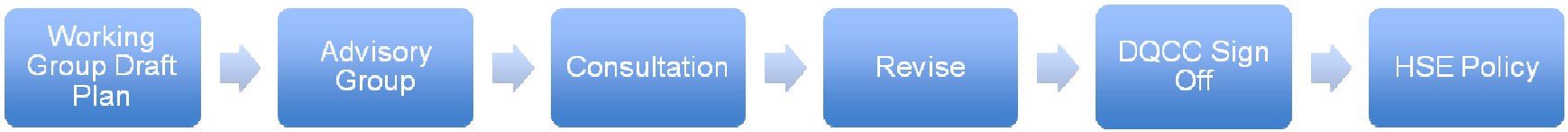
3. Sustaining Improvement:

- Strategic plan for EM
- Inter-programme implementation across acute hospital system and regions
- Change management and embed continuous improvement
- Governance, leadership, support

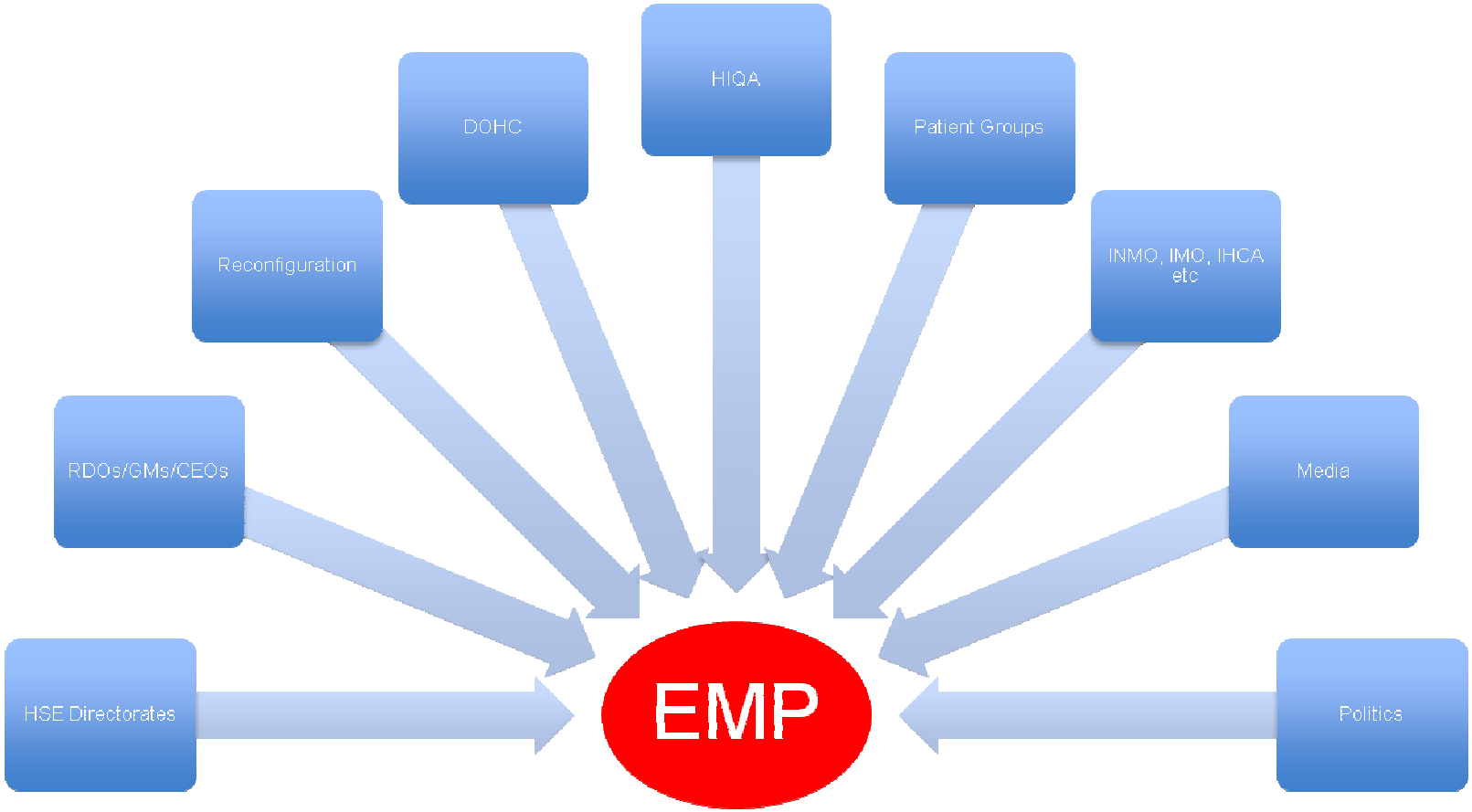
# Emerging Themes

- Emergency Department < Emergency Medicine < Emergency Care
- Key relationship with the ambulance service
- Network models in other programmes – EM also?
- Increasing consultant numbers will change current work practices
- Need for IT, data, case-mix, system metrics
- Development of Academic Emergency Medicine
- Interdependencies between programmes

# Time Line


Working Group Draft Plan
Advisory Group
Consultation
Revise
DQCC Sign Off
HSE Policy

# EMP External Stakeholder Communication



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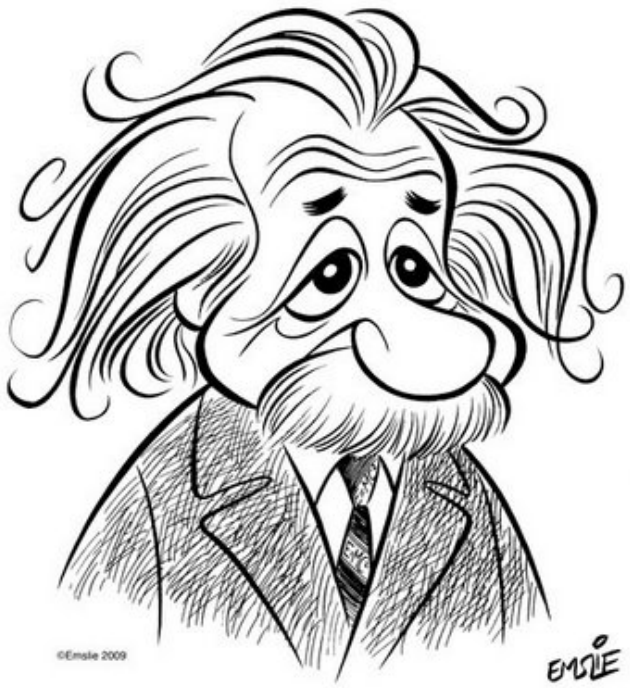
- What will it mean for patients?

# "Patients want someone who ……

- knows what is wrong and explains
- knows what to do and makes it happen
- is easy to get along with
- works in a clean and dignified environment"

*after Kennedy (Simon Walford)*

# Problem Solving According to Einstein




We cannot solve

problems by using the same

kind of thinking that we used

when we created them.

Thank-you!