Special Delivery Unit

Unscheduled Care Strategic Plan

(Quarter 1, 2013)
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>2</td>
</tr>
<tr>
<td>Background</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Leadership and Governance</td>
<td>7</td>
</tr>
<tr>
<td>Data and Information</td>
<td>9</td>
</tr>
<tr>
<td>Communication and Engagement</td>
<td>16</td>
</tr>
<tr>
<td>Planning</td>
<td>19</td>
</tr>
<tr>
<td>Operational Process Improvement</td>
<td>24</td>
</tr>
<tr>
<td>References</td>
<td>29</td>
</tr>
<tr>
<td>• Appendices</td>
<td>31</td>
</tr>
</tbody>
</table>
Executive Summary

Prolonged occupancy of Emergency Departments (ED) leads to poorer outcomes for patients. This not only involves longer in-patient length of stay but increased morbidity and mortality (Liew et al 2003, Richardson 2006, Spivulis et al 2006, Richardson and Mountain 2009). Therefore, the need to address this is not simply an issue of poor resource utilisation but one of patient safety.

The Unscheduled Care Strategic Plan (Q1, 2013) describes the process that will operate in 2013 for delivery of improved performance. The Unscheduled Care Strategic Plan (Q1, 2013) is framed in the context of Future Health (2012-2015) and outlines accelerated efforts towards key targets balanced with enhancing capacity and capability building. The SDU continues to work closely with the National Clinical Care Programmes in delivering the performance improvement agenda for Unscheduled Care.

In that regard meeting Emergency Department Patient Experience Times (PET) is fundamentally about the overall quality of the patient journey and not merely about meeting a target. Meeting a target is not the same as improving performance.

The use of key metrics as evidenced currently by TrolleyGAR and CompStat and taken together with the expansion of Patient Experience Times (PET) measurement, will form the basis of key performance indicators for Unscheduled Care.

The SDU performance improvement approach remains congruent with the HSE Escalation Framework and is triggered by key indicators evidenced by TrolleyGAR, Patient Experience Times and Compstat.

The SDU intends to increase engagement with hospitals where there is a major concern that the trajectory towards a maximum wait of 9 hours for all patients by July 2013 will not be achieved.

Maximum waiting times are set with reference to the risks associated with prolonged ED waiting times. Consequently anyone exceeding 24 hr wait in ED from 30.1.13 will be a notifiable serious incident.

An Executive Lead, identified by each site, will be responsible for delivery of performance improvement for Unscheduled Care in their service (Appendix 1).

The SDU intends to issue a suite of resources to support organisations in addressing the principal targets associated with Unscheduled Care throughout 2013.

In keeping with the balance between delivering on identified performance measures and building capability, the SDU will facilitate the development of Innovation sites.

There will be an increasing emphasis on Integrated Planning across Unscheduled Care that will create incentives to ensure there is a ‘pull’ as well as ‘push’ dynamic between hospital and community services.
The Special Delivery Unit (SDU) was established to release access to acute services by improving the flow of patients through the system. The vision for the SDU is described:

- Create the environment through which cultural and behavioural change in the delivery of unscheduled and scheduled care is implemented;
- Create and embed the tools and techniques required to deliver sustainable hospital access targets in both unscheduled and scheduled care;
- Support the successful delivery of the Clinical Programmes, ensuring that revised clinical pathways reflect the need to deliver high quality, patient centred, safe and sustainable clinical services with national access targets;
- Ensure that any improvement actions are financially viable whilst also being clinically sustainable;
- Support the development and implementation of the performance management framework which can be used to monitor the delivery of both unscheduled and scheduled care access targets;
- Support the transition from the current models of care, to new models of care ensuring that risks to existing service delivery are minimised and that the future system has the capacity and capability to deliver safe and sustainable clinical services.

The launch of Future Health, A Strategic Framework for Reform of the Health Service 2012-2015 (2012) further embeds the SDU role in terms of delivering a more responsive and equitable access to (scheduled and) unscheduled care. The goal of faster, more equitable access is to be delivered in conjunction with the reform agenda incorporating changes to governance associated with hospital groups, the planned establishment of a patient safety agency, increased professional regulation and ultimately the licensing of healthcare facilities. These form part of the broad key objectives of the HSE Service Plan (2013) as is the specific target of 95% of all ED attendees admitted, discharged or transferred within 6 hours of registration (National Service Plan 2013).

Opportunities offered by the ‘Croke Park’ agreement and recent Labour Court rulings with reference to extended working days, consultant commitments, flexibility in rostering etc. are opportune in terms of changes to support unscheduled care. In particular their relevance to High Impact Changes associated with issues such as senior decision making and weekend discharges are important in the context of achieving the desired improvement in performance.
Introduction

The Technical Guidance to Support Unscheduled Care Performance Improvement (2011) identified the need to improve the responsiveness and performance of the whole Unscheduled Care system as the key to eliminating trolley waits. Since this guidance was issued the SDU has adopted a range of approaches to support the national hospital network and to a lesser extent Primary, Community and Continuing Care (PCCC) services in delivering this change. This includes data and information, hospital liaison process, resources to facilitate service transformation and working in tandem with the National Clinical Care Programmes in addition to other key stakeholders in leadership roles. The critical success factors in fulfilling these objectives are outlined below (points 3 (a), (b)).

At this point it is important to reiterate that:

1. The National Clinical Care Programmes continue to represent the services strategy for clinical improvement and the SDU continues to work in coordination with the programmes.

2. The INMO measure of trolley waits continue to represent (through TrolleyGar) the best view of ED (and by extension Unscheduled Care capacity) pressure presently available.

3. Adjustments are currently being made to the national target system to accentuate the delivery of meeting the national targets.

To reiterate these are:

(a) 95% of all new ED patients to wait less than 6 hours. Patient Experience Time (PET) is measured from Arrival to ED Departure time.

(b) 100% of all new ED patients to wait less than 9 hours. Patient Experience Time (PET) is measured from Arrival to ED Departure time.

4. Each hospital site will be required to plot their trajectory to delivering the above targets on an incremental basis

5. The SDU will accentuate the process towards measuring the Patient Experience Times during 2013

The Unscheduled Care Strategic Plan (Q1, 2013) describes the process that will operate in 2013 for ongoing delivery of improved performance. It seeks to outline the approach at a macro level initially with a relentless focus on:

• The use of data and information
• Process and practice changes
• Planning
• Communication and engagement
• Leadership and Governance
The Unscheduled Care Strategic Plan (Q1, 2013) is framed in the context of Future Health (2012-2015) and is sensitive to the changing context whilst providing continuity of focus on performance improvement. In this regard a balance between accelerated efforts towards reaching the targets will be balanced with capacity and capability building.

Further Unscheduled Care Strategic Plans, as quarterly updates, will address the ongoing requirement for local capacity planning processes, leadership development and methodologies to improve patient flows based on the concept of High Impact Changes.

The Unscheduled Care Strategic Plan (Q1, 2013) seeks to reiterate the SDU’s approach to supporting performance improvement, including as indicated in Unscheduled Care Technical Guidance (2011):

- The development of a performance diagnostic tool for sites at risk of poor performance
- The continued introduction of formal performance improvement methodologies
- The identification of external intensive support where required
- The use of hospital scorecards as a performance tool

Purpose of Unscheduled Care Strategic Plan

The purpose of the Unscheduled Care Strategic Plan (Q1, 2013) is to set out expectations associated with Unscheduled Care Improvement in 2013, clarify roles and responsibilities, improve the use of data and signal the issuing of further Technical Guidance. It is intended to act as a reference document to outline the context for changes (the why?), provide direction in terms of achieving the improvement (the how?), reiterate clear targets and restate how data is utilised that illustrate the status of those changes (the what?). The Unscheduled Care Strategic Plan (Q1, 2013) is not intended to provide detailed methodological guidance as these issues will be addressed in further guidance and associated resources to be issued throughout 2013.
What informs the SDU Unscheduled Care Philosophy?

Research on overcrowding in Emergency Departments (ED) increasingly demonstrates adverse patient outcomes. Prolonged occupancy of ED leads 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). ED overcrowding is also associated with decreased quality of care for children (Sills et al, 2011). Where ED overcrowding persists, not only is quality of care compromised and outcomes poorer but patient mortality is increased (20-30% excess mortality rate), (Richardson 2006, Spivulis et al 2006, Richardson and Mountain 2009). Therefore, Emergency Department overcrowding is not just an issue of workflow but one of patient safety.

This concern for patient safety underpins the SDU approach in engaging with services. Any resulting performance improvement methodology cannot therefore be simply seen as a mechanistic process concerned with organisational processes (‘hitting the target but missing the point’). It requires a response that is fundamentally driven by the organisational values.

This ‘organisational personality’ (Bell 2003) is an expression of the value system, beliefs, norms and practices that are cultivated and shared by the organisational leadership. The elimination of ED overcrowding is an expression of the organisations ethical integrity whereby values expressed in organisational literature evident in practice.

In the series ‘What makes a top hospital’(Robinson and Briscoe, 2012) report that the delivery of safe, efficient, high quality care is founded on a sustained focus on organisational culture that has a passion for ‘getting things right for patients’ and enables staff to live these values every day.

These values, expressed and lived by organisational leaders, instil a profound sense of purpose and are not just about meeting a target.

In that context the SDU seeks to ensure that clear consistent expectations are supported with appropriate guidance and support, including leadership support. The SDU stance has a bias towards organisational development approaches which respects and values the expertise with the organisation whilst simultaneously seeking to mobilise resources internally and externally to address systemic problems. There is a bias for action using a solution focused, appreciative inquiry framework that seeks to strengthen leadership and governance, process improvement, data and information utilisation and planning through mobilising internal resources.
Leadership and governance

Engagement process
The SDU is mandated by the Minister for Health to accelerate and support performance improvement in the health system. The basis of SDU engagement will be to set clear expectations as well as support and enable capacity and capability building. This is undertaken on the basis of mutual respect and professional courtesy. This is expressed through the SDU doing what it says it will do with a reciprocal expectation that services respond. The approach is selective, based on the circumstances, but largely based on the principle of appreciative enquiry (a belief that organisations want to and have the capacity to improve and possess healthy organisational values that include a bias for learning). The SDU subscribe to the view that high performance will result when the design of the technical system (data, metrics, structures, processes) and the socials systems of work (values, norms, and organisational integrity) are congruent (Nadler and Gernstein, 2006). This can only happen when local leadership is engaged, visible and active participants in the improvement process. In order to address unscheduled care successfully, the need for clear leadership and appropriate governance is critically important.

Leadership
The role of visible, consistent leadership cannot be underestimated in the context of delivering a quality and safe service (Chambers et al 2011, Kings Fund 2011). Where there is engaged, visible leadership, the number of people consistently waiting on trolleys in ED is lower and escalation is managed more effectively where capacity is exceeded. In addition good communication and engagement and planning for predictable events are evident in these areas. However, good leadership is not simply a mechanistic process. It is also a philosophical stance. Recent work by Chambers (2011) suggests that leaders translate national reform agendas into local goals. Chambers (2011) suggests that good leaders; “implement change processes and create meaning and context for individuals. They typically don’t focus on mistakes and shortcomings but on strengths and potential. They create an appetite for radical change and build the capacity of their organisation or system to anticipate, heighten and deliver its positive potential”.

Research by Dorgan et al (2010) for McKinsey and the Centre for Economic Performance at the London School of Economics, Management in Healthcare: Why good practice really matters, report a link between distributed leadership and performance. This international study, involving 1,094 hospitals in the US, UK, Canada, Sweden, Germany, France and Italy further reinforced the importance of leaders defining and communicating a vision for their organisation whilst devolving of power to those able to make the changes.
The report of the King’s Fund Commission on Leadership and Management in the NHS, *The future of leadership and management in the NHS: No more heroes* (2011) go a step further, stating that high performance requires distributed leadership, including clinical champions. “Effective leadership for improvement requires engaging doctors to participate in redesign efforts and to build support for these activities among their colleagues.”

Relevance of Unscheduled Care Strategic Plan to organisational leadership

The Unscheduled Care Strategic Plan (Q1, 2013) is of relevance to everyone involved in healthcare management and delivery within the system whose role impacts on Unscheduled Care. This includes those in executive roles (RDOs, CEO/GM, Clinical Directors, DoNs), senior clinicians, middle and front line managers (ADoNs, Bed Managers, CNMII,) and front line clinical staff. Whilst each grade has an obligation to pay attention to the issue of unscheduled care it is vital that those in leadership roles (clinical and managerial) are aware of their organisations plan to address unscheduled care. In order to formalise this however, each organisation will be asked to (re)confirm their Executive Lead for Unscheduled Care. The Executive Lead is responsible for delivery of performance improvement for unscheduled care in their service. In addition, the changes underway in terms of Consultant work practices (accelerated by outcome of the LRC process, 22.11.12) consolidates and clarifies the significant role senior decision makes will play in addressing Unscheduled Care.

Role of Executive Lead for Unscheduled Care

The Executive Lead for Unscheduled Care will be (re)confirmed on a site by site basis (as per correspondence previously issued, ref: L. Mc Guinness, Jan 2011). The lead for Unscheduled Care will be accountable for the Unscheduled Care component of service delivery internally and externally. This Executive Lead will be required to familiarise themselves with the strategic plan and associated material, consider how the guidance is disseminated and ensure that the elements are understood and integrated into their services Performance Improvement Plan for Unscheduled Care.

Using the thematic components of the Unscheduled Care Assurance Document (*Appendix 1*) the lead will establish the status of their services, establish appropriate structures (if not in existence) and lead the process that provides assurances for internal and external parties that a performance improvement plan for unscheduled care is developed and being systematically addressed. This in turn becomes embedded in the quality and patient safety agenda of the organisation, appearing on governance meeting agendas and in turn on executive board agenda etc.
The collection, organisation and utilisation of data is critical to successfully addressing Unscheduled Care. Making good use of business intelligence (BI) in understanding trends, peaks in demand and consequently anticipating predictable events is not common practice, despite the significant time and effort spent gathering and reporting information. Since the first Technical Guidance on Unscheduled Care (2011) was issued, an architecture has evolved to enable improved use of BI. This includes CompStat, Trolley GAR and increasingly data on Patient Experience Time (PET) in ED. Business intelligence (BI) is the ability of an organization to collect, maintain, and organize data. BI technologies provide historical, current and predictive views of business operations. The goal of modern business intelligence deployments is to support better business decision-making. Using a broad definition: “Business Intelligence is a set of methodologies, processes, architectures, and technologies that transform raw data into meaningful and useful information used to enable more effective strategic, tactical, and operational insights and decision-making”, Evelson (2008). Without good data, it does not matter how good the management sponsorship or business-driven motivation is.

Good data in turn feeds into Operational Intelligence (OI). Operational intelligence (OI) is a category of dynamic, business analytics that delivers visibility and insight into business operations. Operational Intelligence provides organizations the ability to make decisions and immediately act on these analytic insights. This type of OI involves dashboards, real time metrics and thresholds which can be placed on these metrics to create notifications or new events. This type of insight and visibility is especially critical in complex process management scenarios such as healthcare.

Performance Improver

The Performance Improver is a web-enabled portal providing a single location for access to key information. This is accessible at hospital level (appropriate access levels are designated by CEO/GM) and allows hospitals to track and compare performance over a particular timescale and/or amongst peers.
CompStat

In 2013 CompStat will replace HealthStat as the performance management system. CompStat is based on an accountability framework constructed around the three pillars of Quality, Access and Resources. (see table) The CompStat Performance Management system is underpinned by:

- Timely performance measurement and reporting
- Monthly engagements
- Web enabled presentation & interpretation

As a performance management system, responsibility for CompStat has devolved to the four Regional Development Officers’s supported by National Directors who will oversee and manage the process at a regional level.

A New Accountability Framework

The CompStat schedule will broadly follow the following outline (table 1, See also Appendix 2)

CompStat – The Process

- Final Receipt of Performance Data from hospitals: 15th March
- Data available on CompStat: 22nd March
- Hospital Preview: 24th Month
- Performance Review: First week of next month
- Overall Hospital Rating & formal feedback on system: 3 days after Compstat performance review
During 2013, the scope of CompStat will include (table 2):

| Level 1 Metrics | Acute Hospital KPI, defined by the Service plan, each with a Green, Amber, Red performance taxonomy. These are currently available |
| Level 2 Metrics | The focus of the Level 2 metrics is:  
  - Day Case Rate;  
  - Day of Procedure Admission Rate;  
  - Consultant Contract Compliance;  
  - National Service Plan Compliance;  
  - Waiting Times for access to diagnostics  
  These are currently available |
| Level 3 Metrics | The focus of the Level 3 Metrics is  
  - Health Protection/Promotion;  
  - Primary Care;  
  - Older Persons;  
  - Disabilities;  
  - Mental Health – Adult;  
  - Palliative Care;  
  - Social Inclusion;  
  - Child Health;  
  - Child and Adolescent Mental Health  
  - Child Protection and Welfare;  
  - Finance  
  - HR – absenteeism and staff ceiling  
  These are expected to be available during Q1 2013. |
**Trolley Counts & Patient Experience Time**

There are two trolley counts,

- Irish Nurses and Midwives Organisation (INMO) Trolley Count
- SDU Trolley Count (TrolleyGAR)

**INMO Count**

The INMO Trolley Count will remain the definitive indicator of (admitted) ED patients waiting on trolleys. The key measure will be the 30 Day Moving Average period to period basis. This data inputted x 3 per day by hospitals and correlated with the INMO each morning represents the performance in terms of accessing an inpatient bed within the target times. The table below outlines the performance for 2012 which saw a 23% reduction in ‘trolley waits’. (table 3)

Access to these charts at a National and individual hospital level and the underlying data in tabular form is provided via a web link on the Department of Health (Note: This will be fully accessible to the general public.)

**TrolleyGAR**

TrolleyGAR is the name given to the SDU Trolley count.

This data is collected a three times a day at (8:00am, 14:00 and 20:00), seven days a week. It is a count of all patients who require admission but who are waiting on trolleys. It differs from the INMO Trolley count in its thrice daily frequency and seven days per week nature, and more importantly, in its grouping of the trolleys into “time buckets” Currently these are:

- 0 – 6 Hours
- 6 – 9 Hours
- 9 – 18 Hours
- 18 + Hours

TrolleyGAR is expected to continue at least through the first half of 2013. Ultimately, the Patient Experience Time (PET) measure will supersede TrolleyGAR in Q3 2013.

**National INMO 30 DMA Trolley Count 2012 v 2011 (table 3)**

![Graph showing trolley counts from 2011 to 2012](image)
Reinforcing the role of TrolleyGAR

Whilst the latter part of 2013 will see TrolleyGAR replaced by PET time measures, its use as a trigger for escalation will be reinforced for Q1 and Q2 (2013). Communication recently issued to the RDOs seeks to reinforce the use of TrolleyGAR in terms of escalating responses based on key trigger points nationally (over 300) and at hospital level (when hospital is RED) (Appendix 3). An additional escalation process, Black Escalation, will be triggered when trolley numbers are over 350 nationally with an enhanced level of regional and national involvement from executive and clinical leaders. (Appendix 3).

This increased SDU focus from Jan 2013 will monitor the extent to which escalation at local level is taking place, review Winter Capacity Planning and assess the fitness for purpose of hospital’s Unscheduled Care Performance Improvement plans. This will be undertaken through both the SDU Liaison meeting and Compstat process.

In Jan 2013 the SDU intends to increase engagement with hospitals where there is a major concern that the trajectory of reduction in the numbers of patients on trolleys is not progressing. This will involve increased frequency of visits, involvement of relevant clinical care programmes and additional support measures that seek to achieve high impact change.

Patient Experience Time (PET)

The Patient Experience Time is the time period measured between

- Registration at the ED
- Physical departure from the ED

There are two targets specified in the Service Plan for PET. These are the same for every Emergency Department and are:

- 95% of all new ED patients to wait less than 6 hours. Patient Experience Time (PET) is measured from Arrival to ED Departure time.
- 100% of all new ED patients to wait less than 9 hours. Patient Experience Time (PET) is measured from Arrival to ED Departure time.

As of November 2102, the arrival and departure time for 77%1 of all patients is captured within the Emergency departments. This will be increase to 98% by Q1 2013.

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1 As measure by all ED Attendances in all hospitals for the 12 month period November 2011 to October 2012.
Patient Experience Time (internal detail)

There are a number of discrete stages within the patient pathway between arrival at and departure from the Emergency Department which lend themselves to being measured by a simple time and date-stamp. These internal date and time-stamps are designed for the analysis of the internal elements of the emergency pathway. These are summarised in the following table. (Table 4)

It is the intention of the SDU to incrementally increase the collection of these “internal” data points during 2013 on a daily basis.

<table>
<thead>
<tr>
<th>Provider Code</th>
<th>MRN</th>
<th>Ambulance Date and Time</th>
<th>Triage Time</th>
<th>ED Clinician Date and Time</th>
<th>ED Disposition Date and Time</th>
<th>Non ED Clinician Date and Time</th>
<th>Non ED Assessment Date and Time</th>
<th>PAS Admission</th>
<th>DOB</th>
<th>Arrival Date and Time</th>
<th>Departure Date and Time</th>
<th>Discharge Destination</th>
<th>Attendance Type</th>
<th>Referral Type</th>
<th>Mode of arrival</th>
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PET Analytics

A comprehensive suite of standard analytics has been developed for all ED PET data, and the outcome is available under the “Emergency Department Daily Charts” icon within the Performance Improver portal.

The PET analytics will include:

• Performance to 6 & 9 Hour Targets
• Internal Pathway Analysis from the perspective of the contribution each internal stage makes towards the total PET time
• Volume analysis inclusive of
  - Attendances
  - Exits by destination (Discharge, Admit, Other care group)

The utilisation of PET analytics will allow an increased focus in early 2013 on ensuring that ED capacity planning is addressing the key critical ingredients to ensure a zero trolley wait over 6 hours is achieved. This includes at a minimum assessment by hospitals of the following best practice points:

• Predictable event planning
• Arrival and departure rate
• Patient pathways that are clinically and age attuned (e.g. Mental health or frail older person)
• Diagnostic workflows
• Demand and capacity sensitive rotas
• Physical infrastructure
• Staffing infrastructure

Maximum Waiting Times

Maximum waiting times are not arbitrary but set with reference to the risks associated with prolonged ED waiting times. In that regard it has been decided that anyone exceeding a 24 hour wait in the ED from January 30th 2013 will become a notifiable serious incident. This will require the event to be escalated through the HSE Serious Incident reporting mechanism and subsequently include in local clinical governance processes.

Further reduction in maximum wait times will take place incrementally as follows;

• 24 hours by 30.1.2013
• 18 hours by 31.3.2013
• 9 hours by 31.7.2013
Key relationships

The SDU takes the view that its work is contextually embedded and in that regard it seeks to continue its engagement with key stakeholders. The SDU appreciates that many of the process changes underway require input from key individuals and leadership groups. This involves working closely with the strategic and professional leaders in the health system. Although not an exhaustive list these include the following key relationships:

- Ambulance Service
- Health Service Executive - Regional Directors of Operations (and their teams)
- Health Service Executive - Management Team
- Directors of Acute Hospital
- Directors of Primary Care
- Department of Health - Acute Hospitals Division
- Department of Health - Older Persons Division
- Chief Medical Officer
- Chief Nurse
- Lead Clinical Directors
- Quality and Patient Safety Directorate
- HIQA
- Unscheduled Care Leads
- BIU
- IHCA/IMO
- Royal Colleges Representative
- INMO/ICGP

National Clinical Care Programmes

The SDU policy remains that the National Clinical Care Programmes (NCCP) represent the strategy for the development of healthcare services in Ireland. The work of the clinical programmes provides the foundation for a professionally led clinical strategy. In common with the stance adopted in scheduled care the performance improvement emphasis of the SDU will operate on the basis that effective and sustainable improvements can only be delivered through a strong partnership between engaged clinicians and focused senior management. In particular the SDU continues to work closely with the clinical care programmes most involved in the short-term performance improvement agenda for Unscheduled Care.

The launch of the Care of the Elderly programme will represent a significant development in the trajectory of improvement associated with Unscheduled Care. The proportion of frail older people who avail of health services and whose outcomes are potentially compromised by delays in bed allocation due to ED waits or delayed discharges, are a particularly vulnerable and therefore important group. The broad aims of the National Clinical Care Programme for Older People recognise the particular requirements of this group (rapid access to specialist geriatric assessment, admission processes that are age attuned with bespoke care pathways) and is congruent with the SDU aims to eliminate trolley waits and reduce length of stay for this vulnerable group.
The implementation of performance improvement plans continues to be undertaken in a manner that incorporates the NCCP changes and the SDU remain committed to the designs proposed in the clinical programmes. The SDU will continue to support the implementation of the NCCP and closely align the key programmatic aims through the inclusion of key agreed metrics in the performance infrastructure as it develops.

**Accelerated Improvement Measures**

The Unscheduled Care targets for 2013 remain the elimination of trolley waits and to ensure that no patient waits more than 9 hours in ED and 95% of patients are treated, admitted or discharged within 6 hours. In 2012 many sites have found these targets to be extremely challenging, and the problem of overcrowding in EDs is proving to be persistent in a number of locations. Despite this, the evidence that harm to patients increases with overcrowding is such that we are maintaining this target for 2013 and increasing the pressure on sites to take the necessary measures to resolve this longstanding problem.

The SDU will reassess challenged hospitals in January 2013. Hospitals that are still reporting significant trolley waits at the end of December 2012, and/or that are not showing strong progress towards the 95%, 6 hour target will have accelerated improvement measures introduced in order to produce and deliver on detailed improvement plans as a matter of immediacy.

This plan will be congruent thematically with Unscheduled Care Strategic Planning (leadership and governance, planning, Operational process, data and information use and communication and engagement. The plan will typically (but not exhaustively) address:

- Demand and Capacity planning process
- National Clinical Care Programme implementation compliance
- Staffing rota and utilisation
- Robust operational processes particularly associated with admission and discharge processes
- Staffing rotas in ED and the analysis of patterns of ED demand
- Workflows that are aligned with diagnostics

All hospitals, implemented on a phased basis, will increasingly be required to comply with a new daily reporting requirement from January 2013. This single report will replace all present requirements for returns and will enable the creation of a detailed, consistent and valid national pressure monitoring system. This in turn facilitates the role of the Executive Lead for Unscheduled Care and enables information to be utilised in operational process improvement and for planning purposes.

In addition a new TrolleyGAR Escalation Framework (see Appendix 3) will be instituted where TrolleyGAR is over 300 nationally OR where individual hospitals are red and where there is limited confidence that their escalation measures will enable a significant reduction.
The intervention and trigger levels will be determined by a number of factors. As indicated, primary amongst these will be a repeated pattern of escalation to Full Capacity Protocol (FCP) resulting in frequent enactment of the TrolleyGar Escalation Process (see Appendix 3). Escalation to FCP will be seen as a proxy for systemic issues of capacity or capability not being addressed. Following escalation, SDU intervention will follow a number of potential routes that include some or all of the following measures;

- Adjustment of Unscheduled Care Performance Improvement plan with additional intensive support from SDU Liaison Officers
- Increased intensive support from SDU Liaison Officers with specific additional organisational supports based on a focus on one or a number of the following areas (process, data and information use, leadership and governance, planning, engagement).
- Increased intensive support with involvement from Quality and Patient Safety Directorate (National Incident Management Team)
- Increased intensive support with involvement from Health Information and Quality Authority
Planning

Acute Hospitals
The current financial climate is such that the focus is on “doing more with less”. This requires that we adopt a more planned approach to day to day delivery and to system reform. There are ways in which we can enhance “relative capacity” by standardisation and implementing High Impact Changes.

This can be divided into three related categories some of which may require to be advanced using the Industrial Relations machinery under the “Croke Park” agreement and recent Labour Court rulings:

Adjusting working practices to better match the general patterns
- Extended working day/week
  • Improve access to diagnostics, weekend discharging, community services out of hours etc.
  • Alignment of on call systems to meet Unscheduled care requirements

- Rostering
  • Better matched services with need. e.g. team on call working in EDs, weekend and out of hours service options
  • Providing a greater range of services in community settings including on a planned basis in the evenings and at weekends e.g. wound care clinics, IV services, catheterization

- Skill mix
  • Optimum use of the human resource, transfer of duties to other grades/professionals, e.g. delegated discharging
  • Expanding the roles of health professionals across the health service to ensure optimal clinical outcomes.

- Service integration
  • Cross cover, work across traditional boundaries

Increasing capacity in the system through lower bed occupancy
- More appropriate service provision and service usage
  • Appropriate patient streaming options, alternative service options in non-acute settings

- Reduced length of stay for key conditions/procedures
  • Working as part of a system, implementation of care programmes, audit and monitoring

- Alternative service options in community/primary care
  • IV therapies, access to clinics/diagnostics
- **More effective patient streaming**
  - Minor injuries units, acute medical and surgical units, rapid access clinics for specific conditions/procedures, working practices to support new service options and access to Senior decision makers

- **More efficient discharge planning**
  - Use of Estimated Length of Stay (ELoS) and Estimated Date of Discharge (EDD), weekend discharge, conduct of ward rounds, delegated discharging within teams and to other professionals

- **Operational planning to anticipate day to day supply and demand, together with the capability to take steps to attempt to match them.**

- **Management of Emergency Demand**
  - Flexible rosters to meet need, access to senior decision makers

- **Management of Elective Demand using Scheduled Care Guidance (2013)**
  - Revised schedules to suit system need
  - Pre-assessment clinics/admission on day of surgery

- **Management of supply through discharge management**
  - Conduct of ward rounds, use of ELoS/EDD, delegated discharging, earlier discharges, nurse facilitated discharge

- **Whole System Escalation Procedures and Process**
  - Compliance with national frameworks and improvement plans
  - Review of Winter Capacity Planning exercise

---

**Primary, Community and Continuing Care Services**

A major focus in health service delivery internationally and nationally is the need to provide integrated care (Shorthall 1993, Ham 2010, Future Health 2012-2015). This is defined by Shorthall (1993) as an approach to health care delivery which includes:

- focusing on the communities health needs
- matching capacity to need
- coordination and integration across the continuum
- integrated information systems
- being accountable to multiple stakeholders
- using financial and organisational structure to align clinical and strategic objectives
Whist at present the focus of performance improvement is largely focused on hospital metrics, the further development of Compstat and the development of community service metrics which will impact on Unscheduled Care will increase the focus on integrating performance improvement plans at hospital and community level.

In 2013, as the reform of the care system takes shape in the context of hospital groups there will be an increasing emphasis on Primary, Community and Continuing Care that will create incentives to ensure there is a ‘pull’ as well as ‘push’ dynamic in relation to discharge planning. This will include financial incentives and penalties that ensure that integrated planning is sensitive to the needs of the population and barriers to integrated care are broken down.

Resources (Q1, 2013)

The SDU will issue a suite of resources to support organisations in addressing the principal targets associated with Unscheduled Care throughout 2013. The resources will reinforce the SDU philosophy around clear, evidence based performance targets, coupled with organisational capacity building. The suite of resources will include toolkits, checklists, organisational diagnostic material, capacity planning resources and guidance which will be delivered and supported through workshops (Appendix 5).

The repository of resources and information will be available through a number of sources including direct provision by SDU Liaison Officers, Workshops, Webinars and Websites (SDU, DOH, and HSE).

The first of these will be issued in Q1 2013 and will address **3 High Impact Changes that Improve Patient Flow**.

A further series of SDU Toolkits, Checklists and Guidance will be issued to enable services to build capacity to address unscheduled care both systematically and systemically. The toolkits will adopt the same thematic methodology for organisational improvement issued for Performance Improvement for Scheduled Care-Waiting List Management (NTPF, 2013). This consistency of approach will enable a familiar common language that drives systemic improvement. These will be based around **5 Essential Capabilities** (Leadership and Governance, Planning, Data and Information, Process change, Communication and engagement). The development and distribution of further toolkits with take place throughout 2013. These will be thematically consistent and address High Impact Changes associated with process change, data and information, leadership and governance, communication and engagement and planning.
How should the toolkits be used?

The Unscheduled care support toolkit aims to introduce unscheduled care management concepts to hospital Operational Directors, Medical Directors and other relevant staff. The toolkit can be used either to support systematic improvements or it can be used on an ad-hoc basis as required. It will be of particular interest to the Executive Lead for Unscheduled Care who will utilise the resources to implement the organisations Unscheduled Care Performance Improvement Plan.

Other resources

In the context of its role to accelerate performance improvement associated with Unscheduled Care, the SDU will make available other resources as required both directly accessible and bespoke resources as part of the Liaison Officer role. This will include resources within and outside the system. (See Appendix 5 for examples).

Escalation and Intensive Support

The Admission, Discharge and System Wide Escalation Framework and Procedures (HSE, 2011) took a comprehensive, multi-faceted and balanced approach to improving admission and discharge processes and reducing overcrowding. It remains as the current national policy and provides the mechanism for escalation, de-escalation and associated learning.

The Admission, Discharge and System Wide Escalation Framework and Procedures (HSE 2011) consists of an incremental suite of actions which are intended to be adapted by Hospitals with an Emergency Department (ED) and adjoining community care areas as part of a multi-disciplinary health system response to avoid Emergency Department overcrowding. The framework fundamentally highlights the importance of ensuring that basic systems, practices and processes are fit for purpose to avoid the need for escalation measures where possible.

The framework required that local strategies and plans were in place using the escalation and full capacity protocol as the mechanism. This is based on local service planning that understands and responds to surges in demand in a planned way. The Framework involves a Full Capacity Protocol (FCP). This is utilised after systems-wide measures to resolve the mismatch between service demand and available in-patient bed capacity have been exhausted. (This is in line with recommendations made in the ED Task Force Report in 2007).
The framework aims to escalate responses in a controlled and incremental manner, with patient safety as the key driver and as such the framework is employed within a well-defined governance framework. The escalation framework includes potential for further escalation where all possible steps have been taken across the health system to ensure bed utilisation and system capacity has been optimised appropriately.

At that point the escalation process will include the SDU working with senior executive involvement nationally, regionally and locally in order to:

1. Bring about swift resolution of high numbers returning to safe capacity levels

2. Increase the focus on more sustainable changes identified during escalation process

The procedures issued under cover of correspondence from the Integrated Services Director and National Director of Quality and Clinical Care (10.1.11) seeks to improve integrated responses to capacity problems that emerge when ED overcrowding takes place.

The SDU performance improvement approach remains congruent with the Escalation Framework and is triggered by key indicators evidenced by TrolleyGAR, PET and Compstat.

Planning for Predictable Events

As part of normal capacity planning and preparation in the health services, it is recommended that organisations have robust arrangements in place to deal with predictable events, which under normal circumstances, will put pressure on the system. These include holiday periods and, in particular, extended national holidays such as Christmas and New Year and Easter.

Historically, during these periods, an initial increase in discharge of patients occurs followed by an increase in admissions and longer waits in emergency departments. Other predictable events include junior doctor changeover in January and July. There are also predictable impacts from adverse weather conditions and any outbreaks of influenza in the community.

It is recommended that arrangements to deal with this extra pressure are in place for these predictable events and that these arrangements include all partners in primary, secondary, ambulance, social and voluntary care in their development.

See predictable events examples (Appendix 4)
## High Impact Changes

The SDU will issue guidance throughout 2013 in support of performance improvement in key areas associated with Unscheduled Care. These High Impact Changes will focus on key areas that international evidence indicates have the greatest impact in achieving positive outcomes for patients. The high impact change series will largely focus initially on process change to improve patient flow.

The methodology will be consistent across Scheduled and Unscheduled care. During 2013 the High Impact Change series will include other key determinants that improve patient safety in the context of patient flow such as (ED) process change, Leadership and Governance and Planning.

The initial High Impact Change toolkit will be issued in February 2013 and will focus on discharge processes and delayed discharge.

The initial three (3) areas will address the following:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>There is a plan of care for every patient that includes an estimated day of discharge (EDD)</strong></td>
<td>Proactive discharge planning occurs such that each person has a defined estimated discharge date identified within 24 hours of admission. &lt;br&gt; ED is agreed by specialty and proactively managed against a treatment plan by a named accountable person. &lt;br&gt; EDD is tracked and documented in the healthcare record.</td>
</tr>
<tr>
<td><strong>Home by 11</strong></td>
<td>Proactive discharge planning is visual and involves the MDT. &lt;br&gt; Discharge logistics (including ambulance transport) planned. &lt;br&gt; Discharge arrangements are confirmed 24 hours before discharge. &lt;br&gt; The discharge is completed no later than 11 am on the day of discharge to align with times of maximum bed demand for new admitted patients.</td>
</tr>
<tr>
<td><strong>Weekend Discharges</strong></td>
<td>Clinical teams conduct discharging ward rounds at weekends. &lt;br&gt; There are processes in place for delegated discharging to occur between clinical teams or to other disciplines, within agreed parameters. &lt;br&gt; Diagnostic availability are aligned with the objective of weekend discharges.</td>
</tr>
</tbody>
</table>
Innovation Sites

In keeping with the balance between delivering on clear performance measures and building capability, the SDU will facilitate the development of Innovation sites. The concept of Innovation Sites is well established in academic, entrepreneurial and healthcare environments. The common aim is to foster ‘start ups’, nurture new enterprising ways of delivering goods or services, share knowledge and essentially to test ideas that may have widespread application.

Without innovation, public services costs tend to rise faster than the rest of the economy with the inevitable pressure to contain costs can only be met by forcing already stretched staff to work harder, Mulgan, G. & Albury, D. (2003). When applied to healthcare this involves the use of new technologies (including ICT and treatment modalities) engineering process change, research and consultation.

The SDU intends to support the development of Innovation Sites that promote practices that focus on addressing the fundamental areas of SDU interest in Unscheduled Care.

The need to achieve a balance between local innovation and centralist control is important if the methodology of appreciative enquiry stands up. This is echoed by Connors (2011) who suggests local innovation cannot be driven from the top down. The SDU will therefore seek to support local innovation centred on core performance imperatives associated with unscheduled care.

Visual Hospital as an example of Innovation Site in Development

The Innovation Site concept commenced with the launch of the first ‘Innovation Site in Development’ in December 2012 at Beaumont Hospital. Beaumont has taken significant strides in reorganising its patient flow processes reflected in the emergence of the Visual Hospital.

Although not yet complete (and the nature of Innovation is of continuing development) the Visual Hospital is a physical manifestation of lean process reengineering. It is driven by local leadership and a sense of organisational urgency to address ED overcrowding. This includes measures to address delayed discharges, patient streaming to reduce risk and improve access. In addiction it requires role adaptation at all levels of the organisation.
The potential to become an innovation site is not restricted but must meet 5 essential capabilities. In working towards Innovation site status a service (Hospital or Community) may seek recognition for one or more of the essential capabilities.

The nature of innovation is not to be prescriptive but to ensure connectivity between ideas. In that regard the table overleaf (Innovation Site Indicators, table 5) is meant to be indicative rather than prescriptive of an Innovation site.

The SDU is interested in fostering this approach across a number of services and will be supporting this during the course of 2013.

1. Data and information.
2. Leadership and governance
3. Process Improvement
4. Planning
5. Communication and Engagement

Visual Hospital Board
### Innovation Site Indicators (table 5)

<table>
<thead>
<tr>
<th>Essential Capability</th>
<th>Indicative Criteria</th>
<th>Indicative Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Data and information</td>
<td>The collection and utilisation of data is intrinsic to how the organisation addresses Unscheduled Care issues.</td>
<td>Visible evidence of data in use strategically and operationally. (Ward level, Medical Board Meetings, Executive level, Productive Ward)</td>
</tr>
<tr>
<td>2. Leadership and governance</td>
<td>There is a nominated executive leader for Unscheduled Care whose mandate to improve performance is founded on delivering an ethical organisation climate in support of patient safety.</td>
<td>Visible evidence of Unscheduled Care performance methodology and strategy on Hospital Board and Departmental agendas. Senior executive leadership ownership and involvement evident.</td>
</tr>
<tr>
<td>3. Process Improvement</td>
<td>There are clear process improvement technologies being applied to address Unscheduled Care problems.</td>
<td>Evidence of Lean Methodologies, PDSA, written organisational strategies, QIPS embedded in fundamental standards (HIQA standards for safer better Healthcare, ‘Tallaght’ Report)</td>
</tr>
<tr>
<td>4. Planning</td>
<td>Forecasting, contingency planning, impact analysis, predictable event planning is embedded in the operational life of the organisation.</td>
<td>No breeches of PTL and Unscheduled Care targets.</td>
</tr>
<tr>
<td>5. Communication and engagement</td>
<td>There are vibrant processes in place to communicate organisational aims in relation to Unscheduled Care</td>
<td>An understanding of the organisational goals is visible and understood at all levels of the organisation and evident to patients. This includes posters, patient/public information boards advising of process change, service user feedback systems.</td>
</tr>
</tbody>
</table>
Partnership and facilitation

The SDU will work in partnership with potential Innovation sites in order to support and develop innovative practices. This will focus on facilitating process changes, facilitating communities of practice, developing national and international linkages, formal and informal learning networks.

Service user input

The Patient Advocacy unit in the HSE (2012) suggest that the measurement of service user experience is an important component of health services evaluation. User feedback and indeed involvement in service reform are important indicators of service quality and indeed organisational ethical ecology. Norway, Denmark and Holland have all had substantial service user experience programmes in place since the mid 1990’s. Service user surveys that have a meaningful focus on service experience (as opposed to hotel services) allow local performance management information as well as benchmarking at national level.

The SDU supports the requirement for service user feedback, participation (in survey design and utilisation) as well as service user involvement in training and indeed in service design and delivery. Services users are often excluded from the initial process of improvement (“we will wait until we get our act together before we get patients involved”) rather than leveraging service user experience to shape the improvement process in order to sensitise it to user experience.

The Emergency Medicine Programme Report (HSE, 2012) has included service user feedback as a key metric. The work of the advocacy unit (Quality and Patient Safety Directorate HSE) will play an instrumental part in developing the voice of the service user. The SDU will work in concert with the Quality and Patient Safety Directorate (Patient Advocacy Unit) in order to support this important indicator of performance.

Training and Development

The SDU facilitated a number of training and capacity building events in 2012. These included action learning sets for Bed Managers and training in capacity planning for Directors of Nursing and leadership development.

This work will continue in 2013 with a focus on key enabling education and training. This will be embed in the organisations own learning and development strategy and aligned with other strategic priorities such as the implementation of the National Clinical Care Programmes. A blended learning approach to work based learning will be promoted. This will ideally be interdisciplinary in nature and always with a focus on Unscheduled Care.
References


Connor, M (2011) Local Innovation cannot be driven from the top down, BMJ 343.d5719


Future Health (2012) A strategic framework for reforms of the health service 2012-2015, Department of Health,


Santora C, Viccellio P (2005). Impact of hospital length of stay and emergency department turnaround time when admitted patients are moved to hallway beds.


The King’s Fund Commission on Leadership and Management in the NHS (2011): The future of leadership and management in the NHS: No more heroes. The King’s Fund.


Appendix 1

Unscheduled Care Risk Assessment

[Hospital Name]

Please type answers into the document and submit to regions as part of the regional planning process. Please keep answers concise.

Responses will be reviewed by regions, SDU and clinical programmes as a part of the 2013 risk assessment process.

<table>
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<th>Yes/No</th>
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<tbody>
<tr>
<td>CEO approved</td>
<td></td>
</tr>
<tr>
<td>Clinical Director approved</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Director of Nursing approved</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Executive Lead nominated and approved</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**Theme One: Approach To Delivery**

1. Is the hospital clear about how many patients can be safely managed in ED on trolleys whilst their care and disposition is being determined? What is that number?

2. Please outline the main approach the hospital plans to take to the elimination of long trolley waits and ED overcrowding by July 2013?

1. Please outline the main approach the hospital plans to take to the delivery of 95% of patients being discharged or admitted within 6 hours, and no patient waiting more than 9 hours in ED.

**Theme Two: Clinical Programme Implementation**

2. The clinical programmes represent the services strategy for Ireland. Are there any obstacles to implementation in 2013 of the main elements of the key programmes associated with unscheduled care - especially Acute Medicine (and the key component programmes Stroke, COPD, Heart Failure, Epilepsy and ACS) Emergency Medicine, Stroke, Surgery, Paediatrics, Care of Older Persons, COPD, Heart Failure, Epilepsy and ACS?
Theme Three: Information Management

6. Is the hospital in a position to submit data derived from the 9 point intervals associated with the patient’s ED journey? Please describe the level of confidence in this data and its present use within the organisation.

7. Is the hospital in a position to monitor journey times in its MAU/AMU/AMAU? If so, what is the present frequency of reporting and how is it presently used in the organisation?

8. Is the hospital in a position to submit (via web form) the daily status report data (TrolleyGAR, ED attends, ED admissions, PET time, delayed discharges, bed closures)? Please comment on any difficulties with the collection or submission of this data in this format?

Theme Four: Patient Flow

9. Are paediatric presentations to ED streamed separately? If not, is there a credible plan in place to introduce this and when will this go live?

10. Have the acute medical, surgical and care of the older person bed capacity requirements for the hospital been reviewed in the light of the work done by the clinical programmes? Is there clarity about the bed day requirement for each of these areas that is agreed between the hospital and the region? Is there a plan for this be provided reliably from quarter 1 2013?

11. Has the requirement for alternatives to acute care been determined and agreed by hospital and community leadership? (ISA manager, CEO/GM, CD)

12. Has the range of the weekly number of home care packages required to eliminate delayed discharges been identified and agreed? What is this range for the hospital? What methodology was used? Is there a plan for these to be provided reliably from quarter 1 2013?

13. Are logistics to support discharge thought through? Is there a nominated individual that leads on logistical issues associated with patient flow? Does this person act as a single point of contact for Ambulance Services, Pharmacy, etc. Are the daily requirements for Intermediate Care Vehicles (ICV), interhospital transport and repatriations worked out in advance, agreed and dependable? Is this audited?
Theme Five: Within Ed

14. Has the ED management group, physicians and surgeons undertaken an analysis of ED presentations and admissions (including by time of day and ideally over 6 weeks) to determine the variation in demand?

15. Please describe any work that has been undertaken to adjust diagnostic availability, skill mix and rostering on the basis of the demand analysis?

16. Have any ED capacity limitations that have infrastructure and capital requirements been identified and included in the risk register and planning process?
### Appendix 2

#### CompStat Forum Calendar 2013

<table>
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<th>Region</th>
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<th>Venue</th>
<th>Time</th>
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<td>DNE</td>
<td>04/12/2013</td>
<td>The Conference Room, Regional Education Centre, St Brigid’s Complex, Ardee, Co Louth.</td>
<td>2.30pm</td>
<td>October</td>
</tr>
<tr>
<td>South</td>
<td>05/12/2013</td>
<td>Conference Room, Ground Floor, HSE Offices, Model Business Park, Model Farm Road, Cork.</td>
<td>10.30am</td>
<td>October</td>
</tr>
</tbody>
</table>

Notes:
No meetings scheduled for December
Venue for meeting needs to have capacity for high speed internet access-preferably via HSE network
January 2013 data will be revised at meetings 1st week March etc
Appendix 3

Trolleygar Escalation Process

8am
Trolleys above 300 nationally

9.30pm (Based on 8pm count)
National SDU Officer of the Day:
• If numbers acceptable and clear plans in place for next 24 hours – no further action
• If numbers are still high and predicted demand high then continue monitoring. If above a defined threshold declare escalation to continue into tomorrow – process repeats

National SDU Officer of the Day:
• Declare Red Escalation
• Escalates to Executive Team on call for action
• Informs SDU Director
• Arranges direct contact with Red Hospitals
Acute Hospital Lead
• Triggers 9.30 am conference call

4.30pm
National SDU Officer of the Day:
• Continue reviews of all action plans with RED hospitals
• Decides if escalation status remains

9.30am – Conference Call (Based on 8am count)
• Review all action plans and demand predictions

3.00pm Onwards
• Additional actions enabled by HSE/SDU/RDO informed to Hospital via RDO

3.00pm
• If no improvement the SDU & RDO inform HSE Executive to identify additional actions

Notes:
1. Actions with specific assigned responsibilities are stated
2. RED Hospital CEOs or their representatives are required for all conference calls
**Trolleygar Escalation Process**

**8am**
Trolleys above 350 nationally

**9.30pm (Based on 8pm count)**

**National SDU Officer of the Day:**
- If numbers acceptable and clear plans in place for next 24 hours – no further action
- If numbers are still high and predicted demand high then continue monitoring. If above a defined threshold declare escalation to continue into tomorrow – process repeats

**National SDU Officer of the Day:**
- Declare Black Escalation
- Escalates to Executive Team on call for action
- Informs SDU Director & HSE COO
- Mobilises all available Liaison Officers
- Arranges direct contact with high Hospitals (not limited to RED)

**Acute Hospital Lead**
- Triggers 9.30 am and 4.30pm conf. calls

**4.30pm – Conference Call**
- Reviews all action plans on conf. call
- Decides if escalation status remains

**National SDU Officer of the Day:**
- Brief to Minister updated

**9.30am – Conference Call (Based on 8am count)**
- Review all action plans and demand predictions on

**National SDU Officer of the Day:**
- Ministerial briefing prepared

**3.00pm Onwards**
- Additional actions enabled by HSE/SDU/RDO informed to Hospital via RDO

**3.00pm**
- If no improvement the SDU & RDO inform HSE Executive to identify additional actions
- Inform of 4.30pm conference call

**Notes:**
1. Actions with specific assigned responsibilities are stated
2. RED Hospital CEOs or their representatives are required for all conference calls
## Appendix 4

### Typical Predictable Events Calendar 2013

<table>
<thead>
<tr>
<th>Month</th>
<th>Events</th>
</tr>
</thead>
</table>
| January  | Potential weather issues  
|          | Changeover of NCHDs  
|          | Restart of Elective work  
|          | Bank holiday |
| February | Potential weather issues  
|          | Mid term break |
| March    | Easter - extended bank holidays and school break  
|          | St Patricks Day |
| April    | Easter |
| May      | Bank Holidays  
|          | Potential weather issues |
| June     | Potential weather issues  
|          | Increase in seasonal demand for some (tourist) areas |
| July     | Potential weather issues  
|          | Changeover of NCHDs  
|          | Increase in seasonal demand for some areas |
| August   | Potential weather issues  
|          | Main school holidays  
|          | Increase in seasonal demand for some areas |
| September| Restart of elective activity |
| October  | Mid term break |
| November | Potential weather issues |
| December | Potential weather issues  
|          | Extended bank holidays  
|          | School holidays |

NB: Remember large local events, concerts, sports etc which attract crowds
Appendix 5

Sample of Web Accessible resources

General resources

Planning (managing predictable events) see:

Leadership, Communication and Engagement resources
6. www.1000livesplus.wales.nhs.uk
7. www.tophospials.chks.co.uk
8. www.ihm.org.uk/education/accredited_manager_programme

Operational Process improvement resources
## SDU Calendar of Activity (Q1, 2013)

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch Unscheduled Care Strategic Plan (2013)</td>
<td>Engage ABC partners (Academic, Business, Clinical)</td>
<td>Identify Innovation Centres</td>
</tr>
<tr>
<td>Write to hospitals to confirm Executive Leads for Unscheduled Care</td>
<td>Align SDU/NCCP agenda</td>
<td>Workshop: Demand and Capacity Planning</td>
</tr>
<tr>
<td>Identify hospitals for enhanced SDU intervention</td>
<td>Hospitals to review Escalation (inc Winter Capacity Plan)</td>
<td>Finalise SDU recommendations to Delayed Discharge processes</td>
</tr>
<tr>
<td>Finalise TrolleyGAR and Wardwatch methodology</td>
<td>Establish priority sites for Frail Older Persons with programme</td>
<td>Launch Technical Guidance 1: High Impact Changes: Patient Flow (Part 2)</td>
</tr>
<tr>
<td>Confirm compliance with lead CD letter</td>
<td>Engage challenged hospitals requiring enhanced input</td>
<td>Hospitals return Unscheduled Care Performance Improvement Plans to achieve 95% target</td>
</tr>
<tr>
<td>Agree SDU Team Leads on projects</td>
<td>SDU to develop critical Unscheduled Care Quality Indicators</td>
<td></td>
</tr>
<tr>
<td>SDU maps key stakeholders and associated tasks</td>
<td>Finalise and submit SDU recommendation on manpower planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Populate talent pool</td>
<td></td>
</tr>
</tbody>
</table>
Special Delivery Unit

Unscheduled Care Strategic Plan

(Quarter 1, 2013)