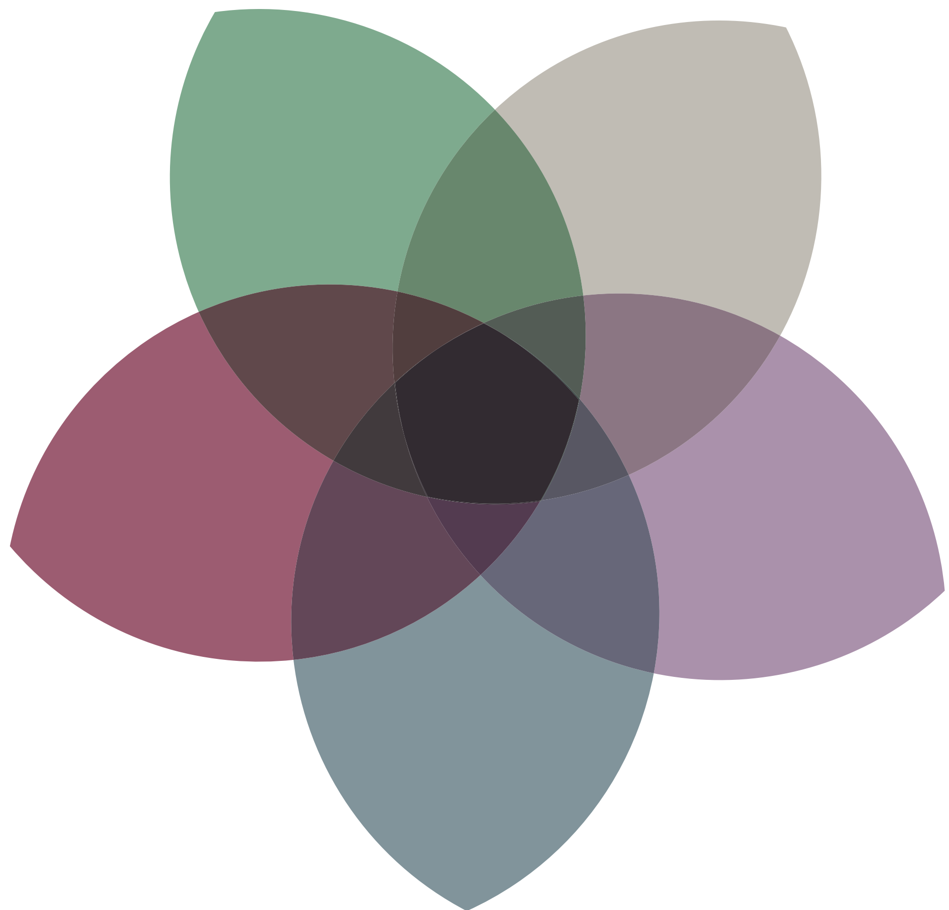
Strategy for the Design of Integrated Outpatient Services 2016-2020



OSPIP
OUTPATIENT SERVICES PERFORMANCE IMPROVEMENT PROGRAMME

HSE
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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FOREWORD

Delivering care to non-admitted patients is a core activity of the acute hospital system, with this service acting as a gateway to diagnostics, consultation, treatment and ongoing support to service-users across their lifespan. The patient's care may result in ongoing management within the outpatient environment or may, alternatively, result in an admission as a day case or overnight stay to avail of a particular treatment or procedure. Patients who are admitted for care after an outpatient consultation may, thereafter, continue their care in outpatient services post discharge.

We have been significantly challenged in recent years, with access to these services being less than optimal, in particular for non-urgent patients within certain specialties such as orthopaedics and dermatology.

Increasing life-expectancy (currently 81.3 years in Ireland), increases in certain chronic diseases, heightened healthcare expectations, advances in technology and a trend to relocate less acute treatment to the outpatient environment have resulted in increased unmet demand. Add to this our redesigned hospital groups and the roll out of activity-based funding (ABF) and change becomes an imperative not a choice if we are to deliver safe, efficient care in a sustainable manner, into the future.

This strategy sets out the vision for the redesign of outpatient services from 2016 to 2020 and builds upon the excellent work of the Outpatient Services Performance Improvement Programme (OSPIP) carried out between 2011 and 2015, including an extensive programme of engagement with the various stakeholders.

Across the next five years, OSPIP, led by Assistant National Director, Mr Oliver Plunkett, will continue to work with our stakeholders to re-conceptualise ambulatory services to deliver the very best in modern healthcare, in the best location, when it is needed, while at the same time, delivering value for money to the population. The programme will place new technologies to the fore in delivering these changes. The programme is supported in its work by an Expert Advisory Group (membership is set out in page 38).

The change programme is ambitious and will require full participation by hospital Chief Executive Officer (CEOs) and their teams, by clinical staff, both within and beyond acute hospitals, by support services such as Information & Communications Technology (ICT), by community-based services and by patients themselves. The end point of this process will deliver evidence-based services to the population, with the least amount of intervention necessary and a focus on outcomes and enhanced quality of life.

Liam Woods
Interim National Director,
Acute Hospitals Division

INTRODUCTION

I am pleased to present this strategic plan for the development of outpatient services for the period 2016 to 2020. The plan contains a number of key strategic objectives which provide the foundation for the design of outpatient services within the context of the broader corporate plan.

The Outpatient Services Performance Improvement Programme (OSPIP) will co-ordinate and participate in an array of change projects that will see the fundamental redesign of the current model of acute ambulatory, outpatient service-delivery. The programme employs a consultative methodology to ensure relevance to stakeholders. These stakeholders include hospitals, primary care, the clinical and integrated care programmes, patients, the professional colleges and the acute hospital division. The programme is supported in its work by an Expert Advisory Group (membership is set out in page 38). The redesign programme builds on the experience of the previous four years' work and a body of international outpatient practices.

The programme is aligned strategically with the Clinical Strategy and Programmes Division, Primary Care Division, the Healthcare Pricing Office (HPO), the Business Intelligence Unit (BIU), the National Treatment Purchase Fund (NTPF), the national iPMS project, and the e-referral programme.

The programme will work with hospital group CEOs and Chief Operating Officer (COOs), along with key staff in the services, interacting as required with the Irish College of General Practitioners, the Royal College of Physicians, the Royal College of Surgeons and Nursing and Allied Health Professional Colleges in agreeing design elements and establishing 'proof-of-concept' demonstration and initiation projects.

The objectives of the programme are to redesign, within the context of the broader corporate plan, in association with the relevant stakeholders, the delivery of services to non-admitted patients, with the aim of establishing safe, modern, patient-friendly healthcare that delivers maximum efficiencies and best outcomes for the population.

The scope of the plan extends to the redesign of acute outpatient services, with the term 'outpatient' covering the areas set out by HPO as all (i) non-admitted face-to-face consultations, (ii) non-admitted diagnostics, (iii) non-admitted procedures and treatments and (iv) non-admitted allied health and/or nurse-led consultations. The redesign programme addresses services delivered face-to-face or via telemedicine, with the utilisation of new technology forming a core component of the programme.
The delivery of this programme will require integration with, and outreach into the community to reposition various elements of the service in appropriate settings.

The programme is dependent on the engagement of the various design partners, including but not limited to the professional colleges, the BIU, the HPO, the NTPF, community and primary care, General Practitioners (GPs), individual specialties, ICT, the clinical programmes and service-users. Implementation will depend on full participation of hospital groups and individual staff members employed therein.

Risks to the programme include insufficient resourcing by hospital groups, disengagement of clinical staff, resistance to change and failure to invest in long-term sustainable change in the favour of achieving short-term goals or targets.

The programme is accountable to the National Director of the Acute Hospital Division for the production of the deliverables, or where dependencies exist, enablement of the production of the deliverables. Hospital groups are accountable to the National Director for the delivery of the agreed change programmes. Specialty teams and administrative staff are accountable to the group CEO for the delivery of the change programme. ICT services are accountable to the Chief Information Officer (CIO) for the delivery of the technological component of the programme.

The redesigned outpatient service will be open and transparent, with the key to this openness being the provision of accurate reliable data that provides visibility of services being provided. OSPIP recognises the fundamental importance of data for transformation at the strategic level and performance improvement at the operational level.

Enhanced integration between hospitals and community healthcare organisations and social care will be required, with closer working relationships and more flexible roles allowing joint working with other professionals beyond the hospital walls. Sustaining change can be challenging, with individuals and teams reverting to old practices and behaviours. A strong performance management and continuous improvement culture will be required to sustain the change. I am confident, however, that my team, in association with highly motivated individuals and teams with a shared vision of our new service, can deliver the improvements required.

Oliver Plunkett
Assistant National Director,
National Lead for Outpatient Services

VISION

Person-centred outpatient services delivering high quality care for all

MISSION

To ensure people can access a high quality, integrated, holistic outpatient services when they need it

STRATEGIC OBJECTIVES

The programme has five strategic objectives, aligned with the HSE's Corporate Goals[1]:

Promote health and wellbeing as part of everything we do so, that people will be healthier

Provide fair, equitable and timely access to a quality, safe health service that people need

Foster a culture that is honest, compassionate, transparent and accountable

Engage, develop and value our workforce to deliver the best possible care and service to them

Manage resources in a way that delivers best health outcomes, improves peoples' experience of using the service and demonstrates value for money

[1]Health Service Executive Corporate Plan 2015-2017

GUIDING PRINCIPLES

Principle 1	People in need of care are at the centre everything we do
Principle 2	Access to outpatient services is equitable and based on clinical need, not ability to pay
Principle 3	Outpatient services are delivered in an open, transparent, accountable manner
Principle 4	Outpatient services are delivered with compassion, ensuring mutual respect between those receiving care and providing care
Principle 5	Outpatient services aspire to standards of excellence and high levels of professionalism in the delivery of care
Principle 6	Outpatient services are delivered efficiently, through effective optimisation of resources
Principle 7	The outpatient service is flexible and responsive to current and future patient needs

CORE VALUES

- Respect for people's dignity
- Compassion and recognition of people's humanity
- Trustworthiness and reliability in the delivery of the best possible care
- Commitment to quality, evidence-based, professionally-delivered care
- Investment in health, wellbeing and holistic care
- Pride and ownership by our population and staff
- A learning environment

OUTPATIENT SERVICE FACTS

Outpatient services saw

3.3 million

patients in 2015

922,542 new patients
2,374,933 review patients

908,969 new referrals

to acute outpatient services in 2015 (excluding orthopaedic traumas)

Top 10 specialties for new referrals received, 2015

Specialty	N referred	% of all
General Surgery	135,499	14.9%
Orthopaedics	93,815	10.3%
Obstetrics	59,803	6.6%
Otolaryngology (ENT)	59,318	6.5%
Ophthalmology	54,909	6.0%
Gynaecology	49,301	5.4%
General Medicine	47,549	5.2%
Dermatology	47,337	5.2%
Paediatrics	39,755	4.4%
Urology	35,928	4.0%

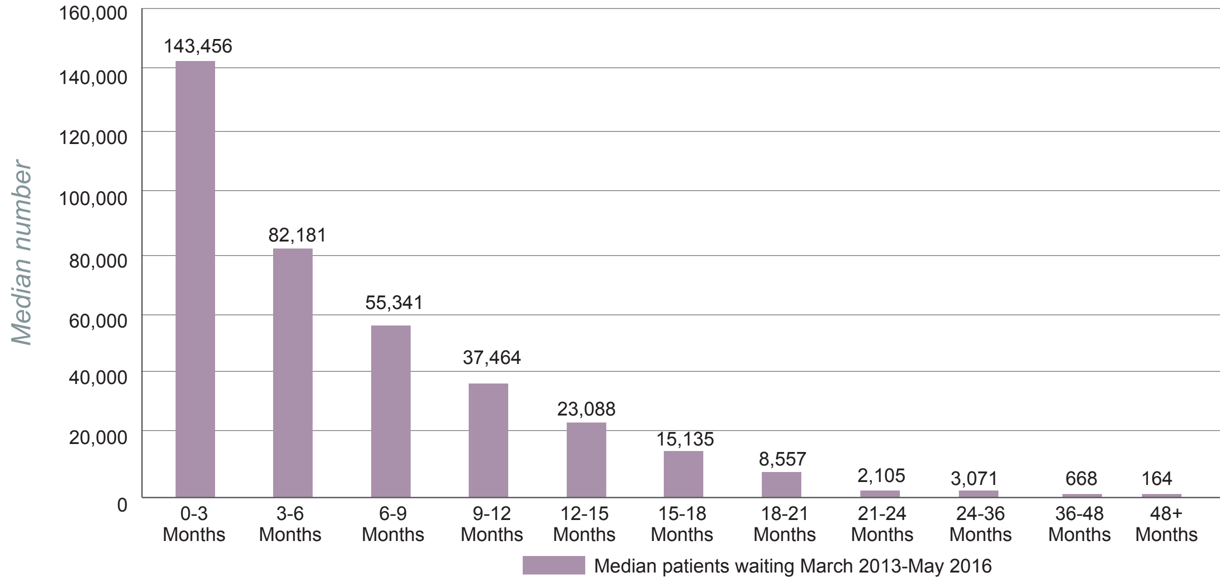
Top 10 specialties receive 68.5% of all new referrals. Thirty-nine individual specialties receive the remaining 31.5% of referrals.

Hospitals with highest volume outpatient activity in 2015

Hospital	All activity
Mater Misericordiae University Hospital	233,383
Galway University Hospitals	232,141
St. James's Hospital	200,637
Cork University Hospital	174,581
University Hospital Waterford	153,016
University Hospital, Limerick	150,549
Beaumont Hospital	149,460
St. Vincent's University Hospital	144,566
National Maternity Hospital	124,840
Tallaght Hospital - Adults	120,985

Specialties with highest volume outpatient activity in 2015 (ranked by all activity)

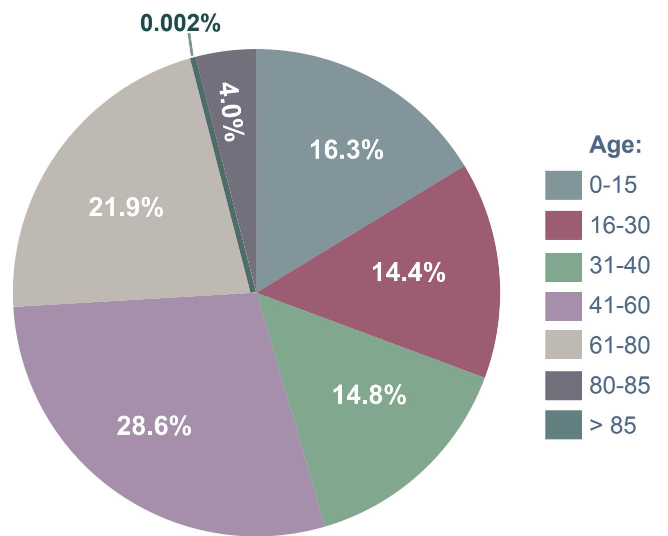
Specialty	Sum of new	Sum of review	Sum of all activity	New to review ratio 1:
Orthopaedics	133,747	264,334	398,081	2.0
Obstetrics	97,509	293,072	390,581	3.0
General Surgery	113,705	157,353	271,058	1.4
Haematology + warfarin	20,927	179,202	200,129	8.6
Ophthalmology	55,349	144,684	200,033	2.6
General Medicine	32,485	144,411	176,896	4.4
Otolaryngology (ENT)	49,038	75,549	124,587	1.5
Gynaecology	39,150	74,166	113,316	1.9
Paediatrics	29,223	80,431	109,654	2.8
Dermatology	42,603	65,836	108,439	1.5



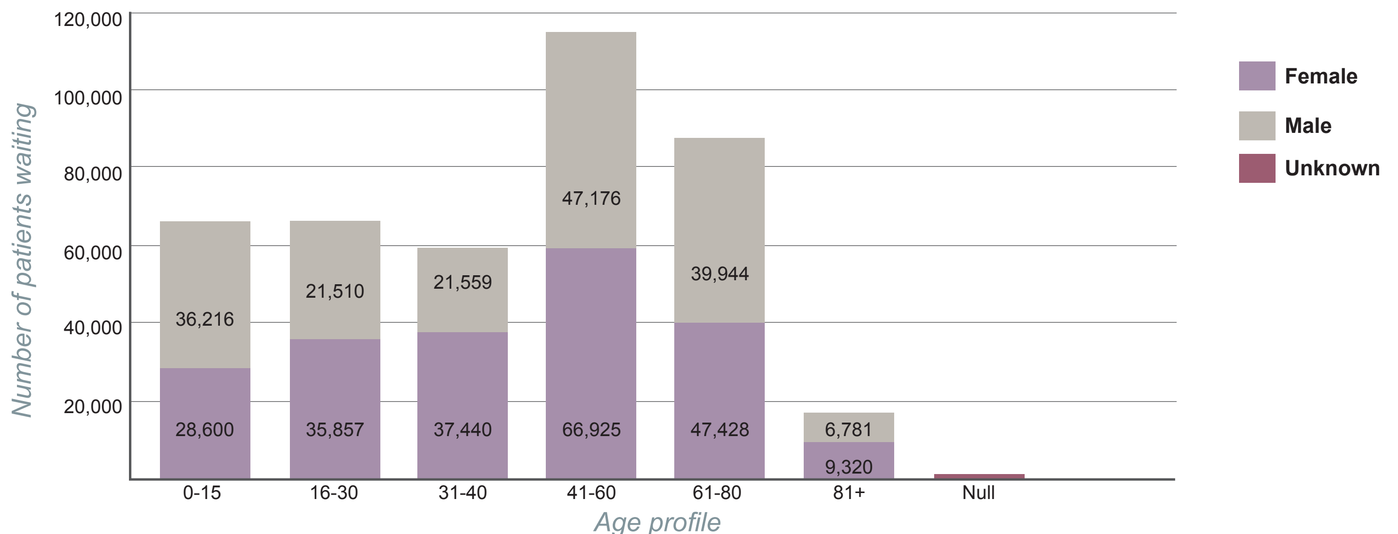
Source: NTPF

487,180

patients failed to attend for outpatient appointments in 2015



Source: NTPF



Source: NTPF

STRATEGIC CONTEXT

BACKGROUND

Ireland's public hospital outpatient services provide scheduled medical, nursing and allied health services to non-admitted patients, which are in turn, supported by a range of diagnostic services. Patients are referred to outpatient services from a range of sources, including general practitioners (GPs), public consultants, emergency departments (ED), inpatient wards and private providers. On average, over one million patients are referred to outpatient services each year.

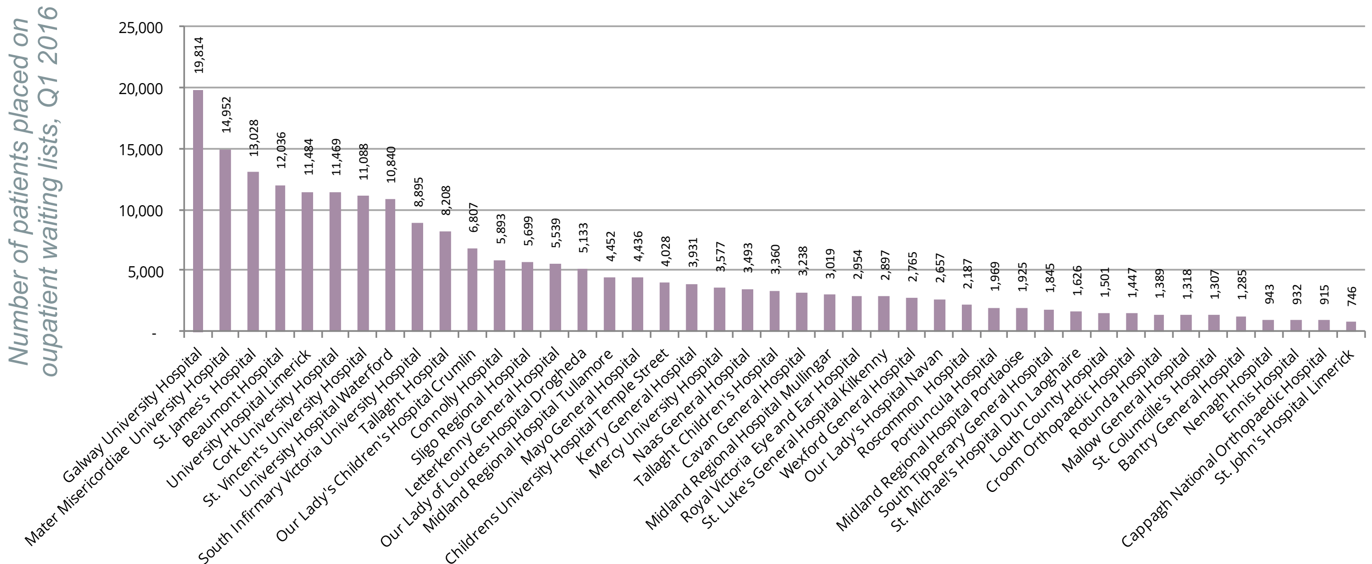
Approximately 150,000 of these are obstetric patients and orthopaedic traumas. Demand for services for Quarter 1, 2016 is set out by hospital in **Figure 1,** with national acute services currently receiving 72,342 referrals per month (average for Quarter 1, 2016). This figure excludes orthopaedic trauma patients who are currently not conceptualised as 'referrals' for the purpose of data collection. The figure shows high volume hospitals receiving between 10,000 and 20,000 referrals quarterly, with the first ten hospitals receiving 56% of all referrals nationally.

Patients can access diagnostics, face-to-face consultation, procedures and treatment with medical staff, with in many cases, the support of nursing, allied health and technician staff.

Public hospital outpatient facilities provide a very high volume of services with, approximately 3.3 million patients seen each year, of which 900,000 are new patients and 2.4 million are review patients. New and review attendance is illustrated in **Figure 2** from 2013 until February 2016, with an upward trend occurring in both types of activity.

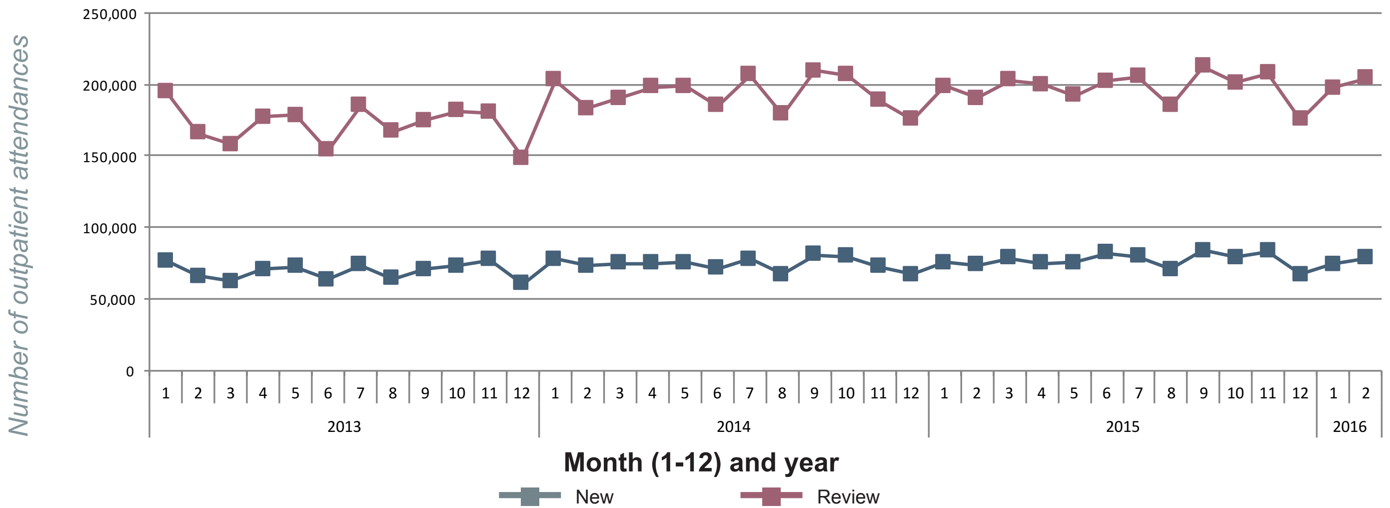
There are approximately 400,000 patients awaiting an outpatient consultation at any given time. **Figure 3** illustrates patients waiting for outpatient services access each month from 2013 until March 2016, with the sharp reductions in December 2013, and again in June and December 2015, being the result of 'financial initiatives' implemented to address waiting list numbers. Each initiative is marked by a subsequent return in number of patients waiting to pre-initiative numbers.

Figure 1: Outpatient referrals (patients placed on waiting lists*) Q1, 2016 by hospital (excluding orthopaedic trauma)



Source: NTPF* draft data

Figure 2: New and review activity outpatient services 2013-February, 2016



Source: BIU

Figure 3: Patients waiting for outpatient services access 2013-March 2016

Source: NTPF

STRATEGIC CONTEXT (CONTINUED)

CURRENT SITUATION

The acute hospital has become the default destination for many people with healthcare needs, despite clinically acceptable alternatives to manage these needs in less medicalised, less acute environments. Diminished access to stand-alone diagnostics, advice, and alternative pathways of care has resulted in an increasing number of patients being referred to acute hospitals by their GP **(See diagram A - Current Situation, page 22).**

WAIT-TIMES

The patient wait-times experience is variable across specialties as set out in **Figure 4,** with 51% of all patients waiting in the specialties of orthopaedics, ear nose and throat, general surgery, dermatology and ophthalmology. The median wait time for first consultation with outpatient services is in the region of 22 weeks, however some specialties and hospitals show longer wait times for first access, with this being particularly the case for non-urgent patients.

Outpatient wait-times by time band are set out in **Figure 5,** showing how the majority of patients have been waiting less than six months, with the largest single group waiting less than three months. The sudden reduction in numbers waiting between the 0-3 month and 3-6 month time bands reflects the manner in which urgent patients are prioritised before those with lesser clinical need. This differential wait-time for urgent and non-urgent patients creates longer waits for those in the latter category. At the end of March 2016, 52,111 (13%) patients had been waiting in excess of twelve months to be seen. This 'long tail' of waiters has persisted despite a number of once-off financial initiatives as illustrated in **Figure 3.**

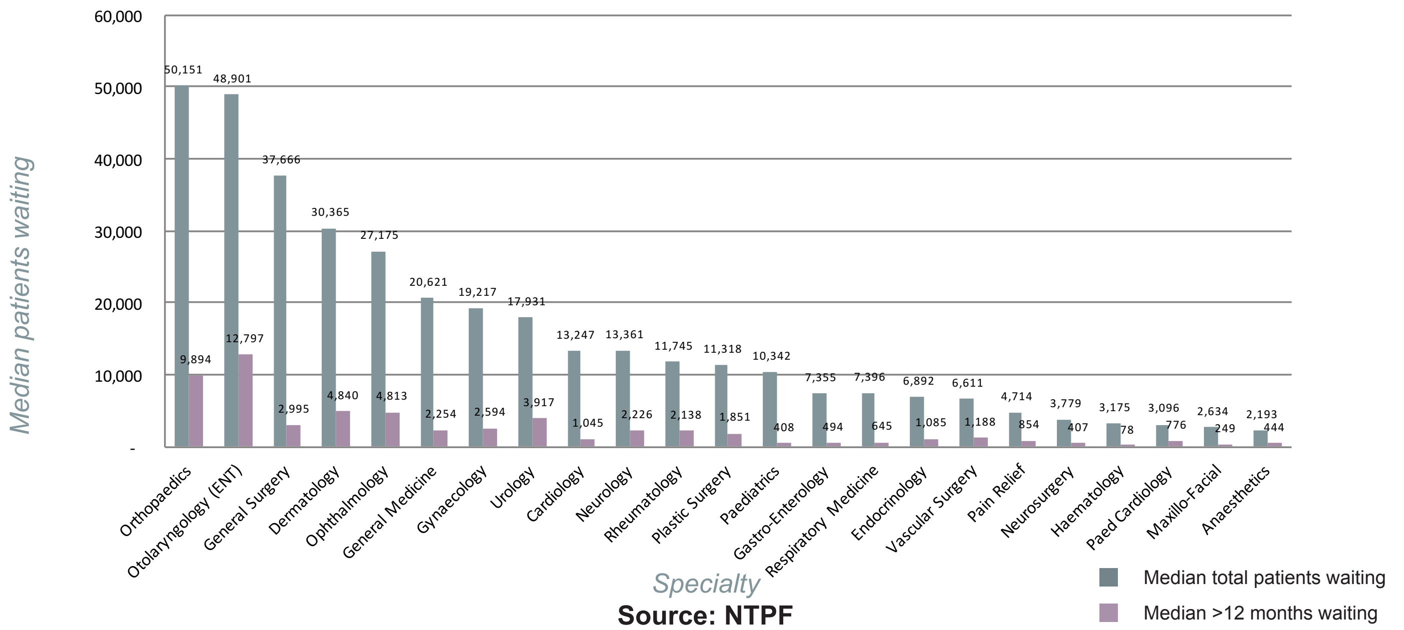
AN AGEING POPULATION

Life expectancy in Ireland is increasing and now stands above the Organisation for Economic Co-operation and Development average at 81.3 years. The Central Statistics Office in their 2016-2046 Population and Labour Force projections state that "the population aged 65 years and over is projected to increase very significantly from its 2011 level of 532,000 to between 850,000 and 860,700 by 2026, and to close to 1.4 million by 2046. The population aged 80 years of age and over is set to rise even more dramatically, increasing from 128,000 in 2011 to between 470,000 and 484,000 in 2046".

INCREASING DEMAND FOR OUTPATIENT SERVICES

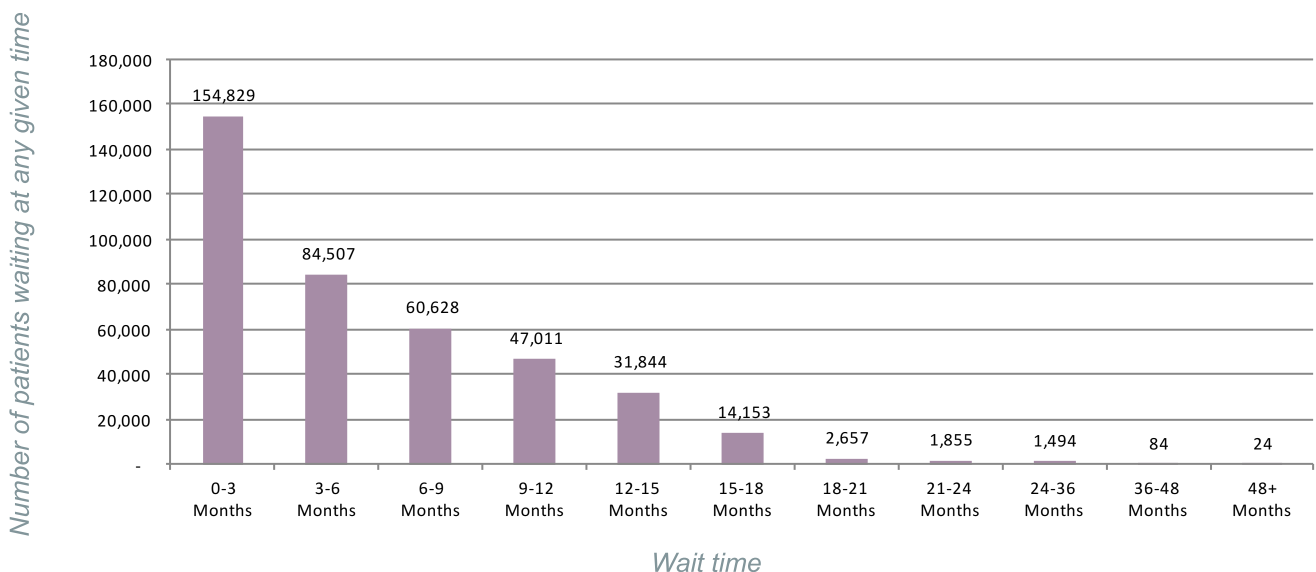
The growing number of frail elderly with associated complex needs, coupled with the increase in chronic diseases in the broader population, and the trend to decant patients from day case services to the outpatient environment, creates an urgent need for change. The core challenge for outpatient services is therefore, the continued provision of quality, timely access for all patients. 'Urgent' patients with significant clinical need should be seen within agreed urgent time-frames and less acute patients need to be seen within agreed non-urgent turn-around times. If change does not occur, the current service model will see increased waiting times as the fixed capacity to deliver is overwhelmed by this burgeoning demand.

Figure 4: Median patients waiting (for top 95% of outpatient specialties) March 2013 - May 2016



Source: NTPF

Figure 5: Patients awaiting outpatient access, March 31st, 2016 by time band



Source: NTPF

THE CASE FOR CHANGE

DESIRED FUTURE SITUATION

REFERRAL PATHWAYS

The current service-provision model is unsustainable, as evidenced by our difficulty delivering waiting time guarantees. An integrated model is required, providing greater GP access to diagnostics and advice, with sub-acute healthcare interventions being delivered in primary care settings. This will bring our service in line with models of delivery in the best international systems. Explicit referral pathways are required for all specialties to include inclusion and exclusion criteria for referrals, alternative access pathways and decision and management support structures. Efficiencies will be delivered by reconceptualising the service to deliver care through 'telemedicine' and virtual clinics. These new types of clinic-delivery, designed by OSPIP in association with the clinical programmes, will be enabled by an intelligent referral management system. Within these referral pathways, management options will be set out for those who do not meet the criteria for acute specialist care.

The programme will, in addition, work with the older persons, chronic disease, patient flow, prevention and management of chronic disease, and children and maternity integrated care programmes in delivering these new referral pathways. A core design element of the referral pathways is the standardisation of the clinical prioritisation of patient conditions to ensure equivalent assessment and management utilising an objective, appropriately flexible, nationally agreed procedure. **See Diagram B - Future Outpatient Services, Page 23.**

PREVENTION AND POPULATION HEALTH

Improving patient experiences and outcomes requires us to focus more on health promotion, prevention and early intervention. We need to put in place enhanced referral pathways offering a variety of access routes better suited to a broader range of acuity of conditions than is currently the case. Integrated care will be provided through the provision of outreach, telemedicine, virtual health services, integrated assessment services and cross-sector working which will support independence and choice for people in the community. Projects associated with Healthy Ireland, a framework for improved Health and Wellbeing 2013-2025, need to be invested in and extended nationally along with structured chronic disease management through the new outreach programmes. These new services will utilise the expertise of ambulatory specialists and interventions such as rapid access through Clinical Nurse Specialist liaison links in general practice. These telemedicine and virtual health solutions will greatly enhance prevention and chronic disease management services.

STRUCTURAL CHANGE

Ongoing structural change within services, including the move to hospital groups, new community healthcare organisations, a healthcare commissioning model and activity based funding (ABF) constitute fundamental reorganisation of the manner in which health services are to be delivered in Ireland in the future. Outpatient services need to prospectively plan healthcare delivery, setting out a quantum of care to be delivered, with delivery of service resulting in reimbursement under ABF by the Healthcare Pricing Office. The current system requires significant reform for these funding models to be implemented, with the core foundation requirement being the provision of reliable, timely, valid data.

At a service-delivery level, the patient experience while attending acute services has been highlighted as an area that requires significant change. The experience of the physical environment will be enhanced through the provision of clearer signage, improved staff badges, visual displays with targeted messages to patients, and more intelligent queuing systems. A core development will be the implementation of timed appointment slots to replace the current practice of ‘batch appointments’. All patients, regardless of geographic location or hospital size should experience a basic minimum standard of outpatient service-provision and a physical environment that is efficient, comfortable, and above all else, person-friendly.

ADVANCES IN TECHNOLOGY

Advances in technology offer a myriad of opportunities to enhance and improve the service offered and the management, governance and oversight of the delivery of that service. A consequence of the historical underinvestment in ICT in outpatient services is the inability of current services to capitalise on this technological potential. In consultation with the clinical programmes, OSPIP has initiated the design of a range of outpatient technological solutions. This enhanced infrastructure will include an integrated referral management system with decision support to GPs, electronic referral at the point of acute hospital contact, enhanced patient administration systems and eventually, electronic patient records. Telemedicine and virtual health solutions will also be provided, linking hospital, community and the patient’s home, bringing truly integrated services to the population. New infrastructure conceptualised and signed off by OSPIP, the Expert Advisory Group, hospital groups and various stakeholders will be enabled by the Office of the Chief Information Officer.

DATA MANAGEMENT

Service-provision is not quantified effectively or consistently at present, with many of the data items required to performance measure and manage the system absent or collected without adherence to agreed definitions. Hospitals currently provide data to the Business Information Unit (BIU), the

THE CASE FOR CHANGE (CONTINUED)

National Treatment Purchase Fund (NTPF) and the Healthcare Pricing Office (HPO), along with a number of smaller data feeds to agencies such as the National Cancer Control Programme and the Clinical Strategy and Programmes Division. However, these current outpatient/non-admitted data outputs do not consistently deliver valid and/or reliable data to accurately evaluate the nature and quantum of service delivery. A reliable and valid set of meaningful data is required to underpin the change process with a foundation of solid information, with which we can evaluate services during the re-design process and beyond. A new minimum data set (MDS) has been devised by OSPIP, in association with service stakeholders. This MDS will require the office of the CIO to progress relevant patient administration system upgrades.

FACILITATING THE CHANGE PROCESS

A lot of excellent work has already been done, with islands of excellence evident across the health system. This expertise and learning will inform the redesign process, enabling meaningful change programmes that are flexible and responsive within the developing service.

OSPIP, operating at national level, and advised by the expert advisory group **(see page 38)** will co-ordinate and participate in an array of change projects that will see the fundamental redesign of the current outpatient delivery model. These projects will be owned by the relevant stakeholders and will cover the areas of access pathways and associated delivery models, ICT enablement, staff training, and ongoing performance measurement and achievement of set goals.

The various projects conceptualised in this strategy are aligned with the broader corporate objectives and are tailored for the outpatient environment. The stakeholders with responsibility for the projects will be accountable to the relevant national director of that particular division for the implementation of the agreed process.

The programme will work in tandem with the Clinical Strategy and Programmes Division, the professional colleges, the Primary Care Division, the National Treatment Purchase Fund, the Business Intelligence Unit, the Healthcare Pricing Office, Population Health and the Chief Information Officer on the work streams required to deliver the objectives.

The OSPIP programme will act to facilitate this major change process and progress the initiation of proof of concept projects. Advice will be given to stakeholders responsible for each project or change component in regard to embedding change. All relevant information will be shared on the OSPIP shared learning hub for

all staff to access. The programme will closely monitor the progress of projects using a best-practice project management system supported by the software Project Vision. OSPIP will report on the progress of projects set out in the strategy to the HSE Programme for Health Service Improvement. Details of all projects will be included in the OSPIP Implementation Plan for the Design of Integrated Outpatient Services 2016-2020.

CONTINUOUS QUALITY IMPROVEMENT

In general, there is a growing emphasis on continuous quality improvement, flexibility and innovation in health service delivery. This approach requires us to continually asses our performance against a set of meaningful indicators and to adjust accordingly where required. A core component of the continuous quality improvement model is this strategic plan which sets out the road map for the coming years, providing a framework within which to work, while providing flexibility to amend plans should the service determine if necessary.

ROADMAP FOR OUTPATIENT SERVICES

This strategy sets out this roadmap for outpatient services and will act as the guiding document upon which to base change as the programme and broader reform programme is rolled out.
The current model of access for outpatient services is shown on **Page 22.** This programme will redesign the current access model, replacing it with the model depicted on **Page 23**. This new model will see a complete redesign of the manner in which patients are referred to and managed in outpatient services. The diagrams on **Pages 24 and 25** show the before and after state for the referral management process.

Working groups will be established to support the design and implementation process to include: overall programme implementation group (national) with hospital group equivalents; ICT enablement group (including electronic referral, virtual clinic, telemedicine); central referral design group; outpatient data and information group; outpatient referral pathway implementation groups; outpatient quality and standards group (protocols, policies, audit, etc.); and outpatient people management and training group.

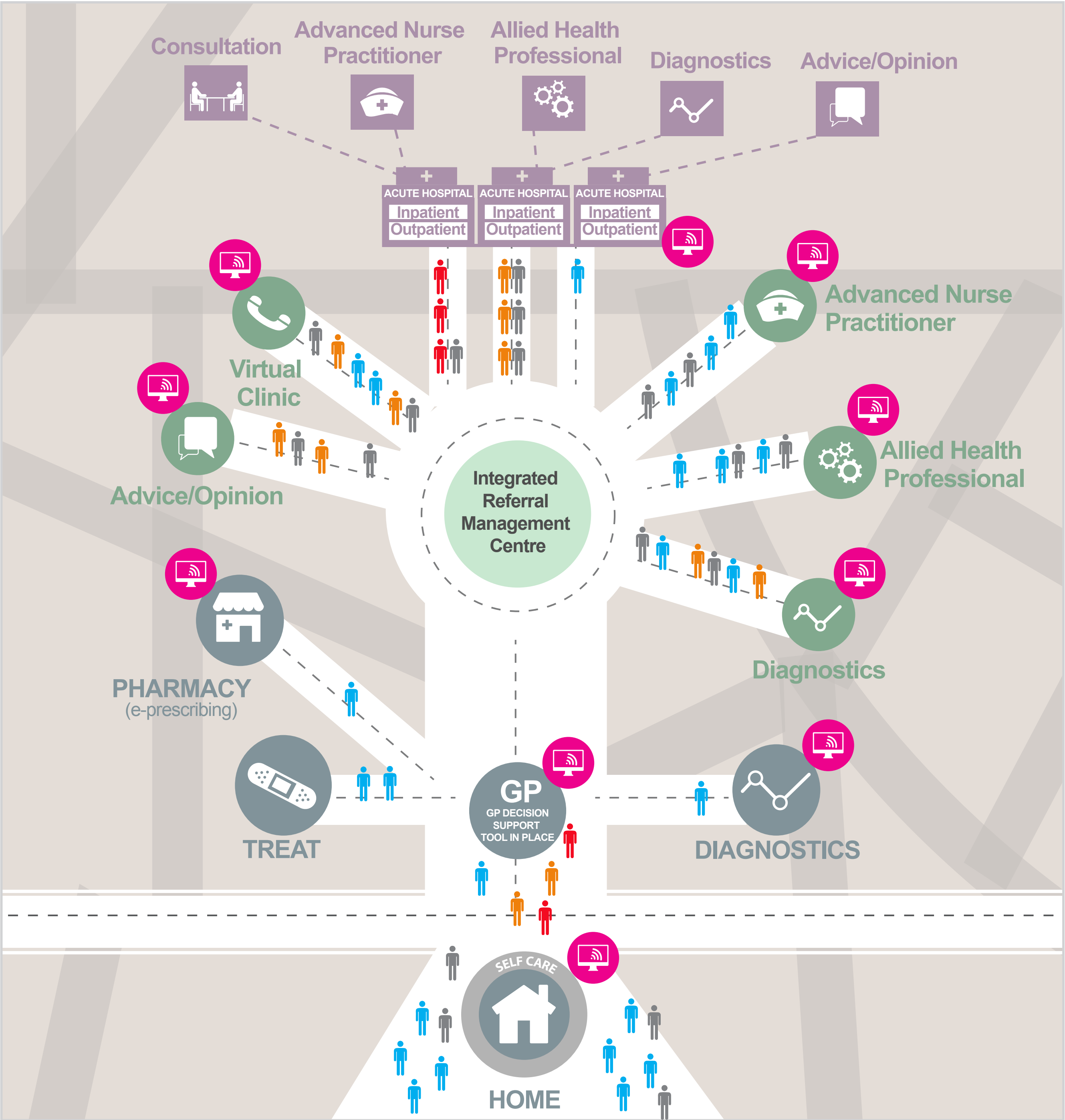
DIAGRAM A - CURRENT SITUATION

Our current outpatient service offers, in the main, only one option to the GP when the patient requires diagnostics and/or care not available in that practice. This single option is a referral to acute services. The GP has limited access to diagnostics and specialist advice and little or no access to support regarding management of chronic disease. Urgent, semi-urgent and non-urgent patients wait for service in a single queue, with the result being that the non-urgent patients are de-prioritised behind those with acute need, resulting in longer wait times for these patients.

PATIENT

URGENT: SEMI-URGENT: NON-URGENT: REVIEW:

DIAGRAM B - FUTURE OUTPATIENT SERVICES



Standardised referral pathways, operationalised through a GP decision support tool and centralised referral services, will place patients on the appropriate route from the commencement of the care process. Those with urgent and semi-urgent healthcare need will be fast-tracked to acute specialist services. Those with non-urgent healthcare need will be seen in a timely manner in the acute hospital by specialist teams or in integrated care services delivered in the community. GPs will have enhanced access to diagnostics, one-stop shops and advice delivered through their ICT systems or via telemedicine. Telemedicine will be available within integrated care services and eventually, in the patient's home.

PATIENT

URGENT: SEMI-URGENT: NON-URGENT: REVIEW: TELE MEDICINE/ VIRTUAL CLINIC

DIAGRAM C - CURRENT E-REFERRAL PROCESS

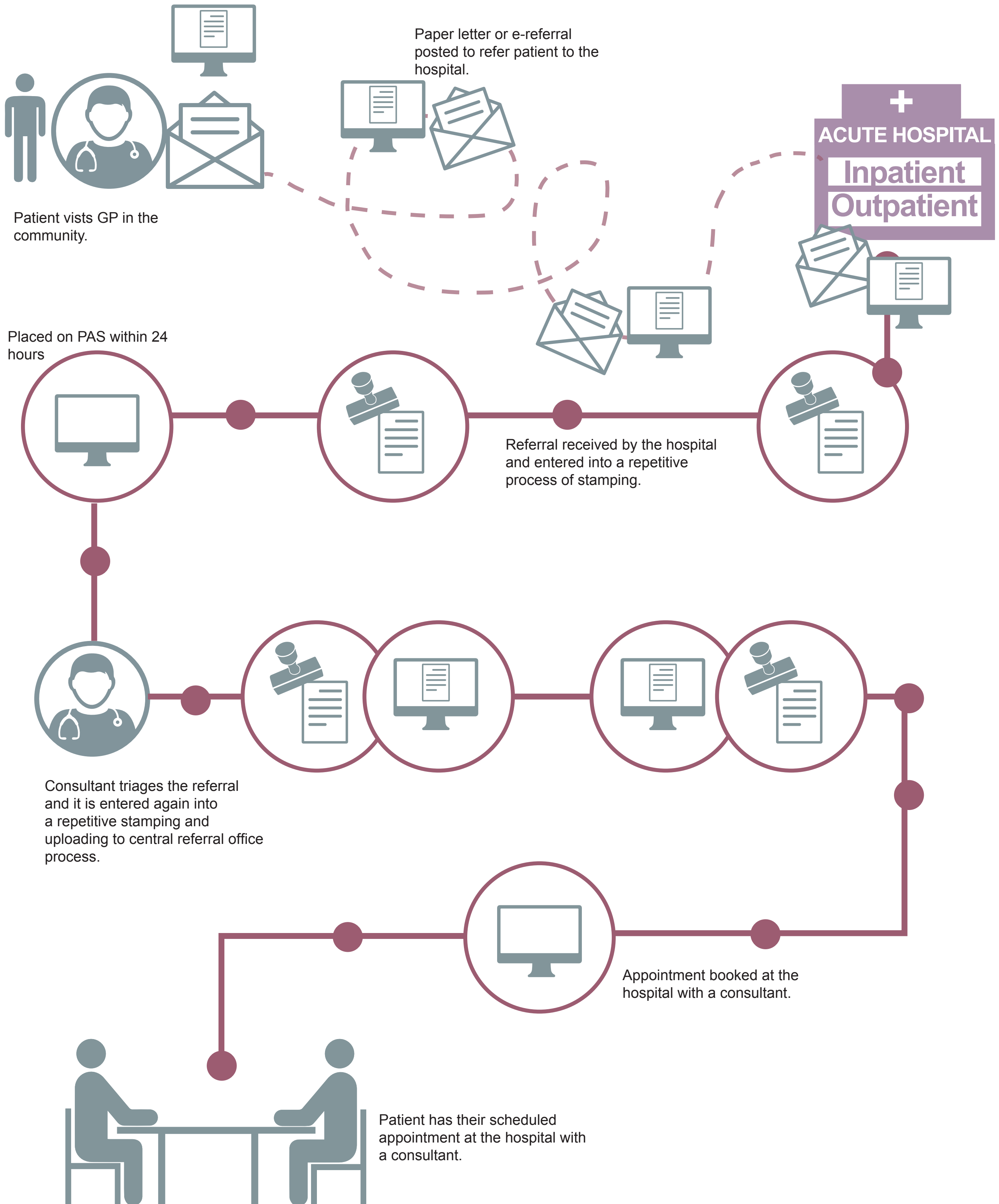
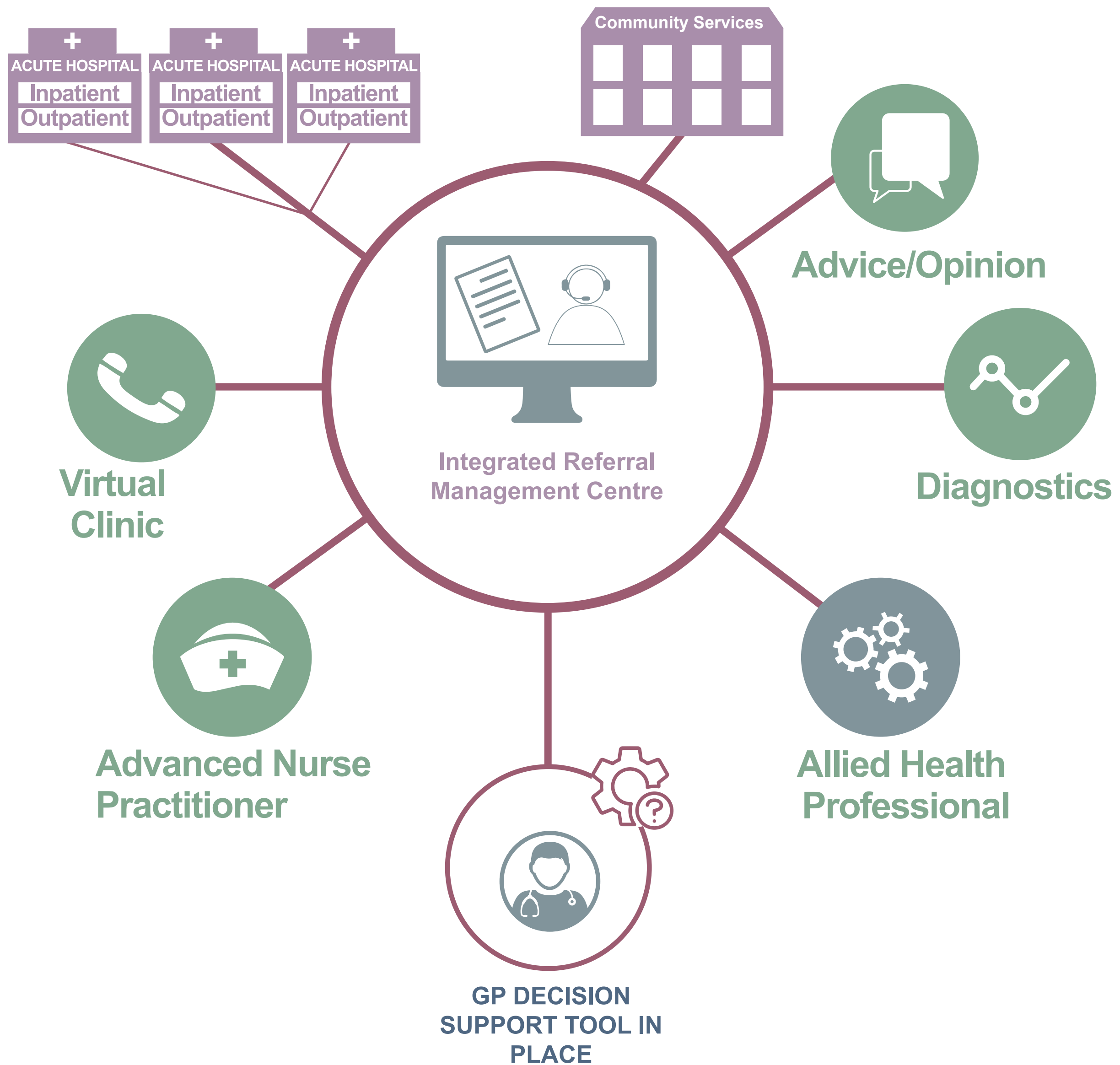
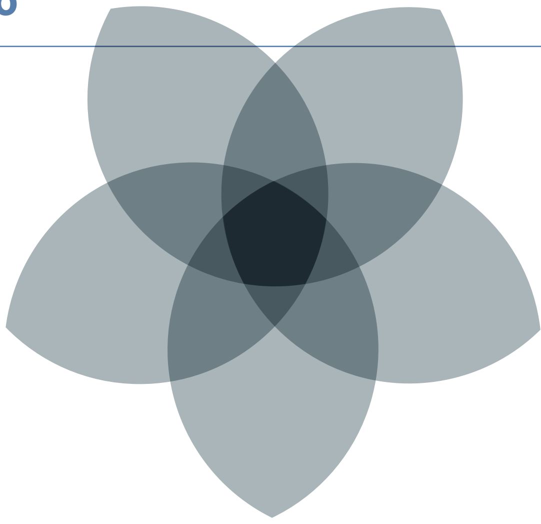
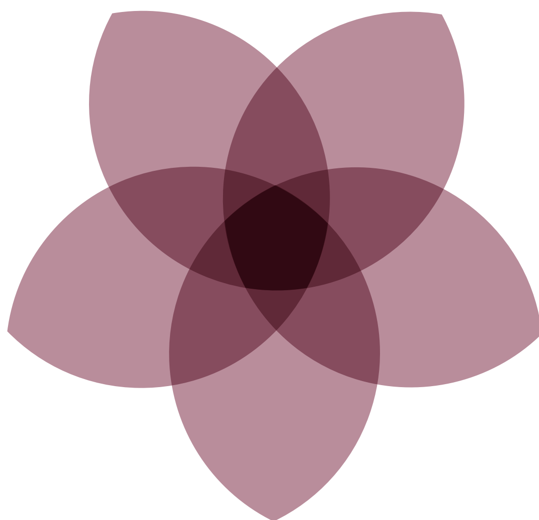


DIAGRAM D - FUTURE E-REFERRAL PROCESS

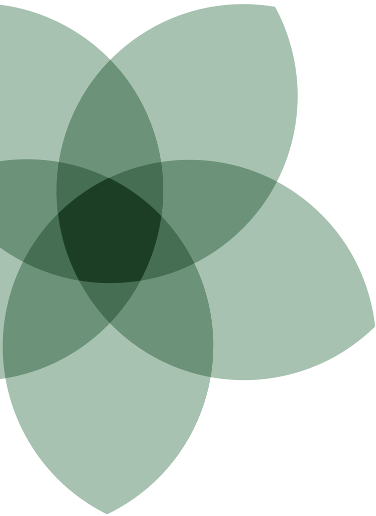


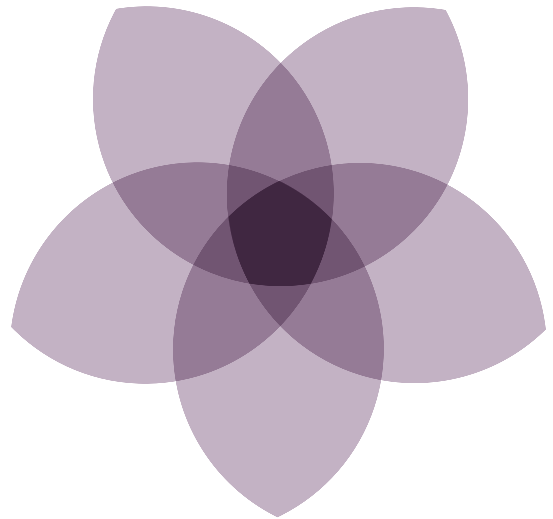
GP uses decision support tool on patient management system to assist in effectively managing the patient's care. Through a series of screens and algorithms (developed by OSPIP in consultation with clinical programmes and primary care) the GP can make informed decisions about the patient's care and has a range of options available including: to treat, discharge, request diagnostic, request advice from specialist consultant, arrange virtual clinic/telemedicine with consultant, refer to allied health professional, clinical nurse specialist. If the GP chooses to request advice/opinion an electronic request can be sent to the consultant attaching X-ray or blood results, etc.

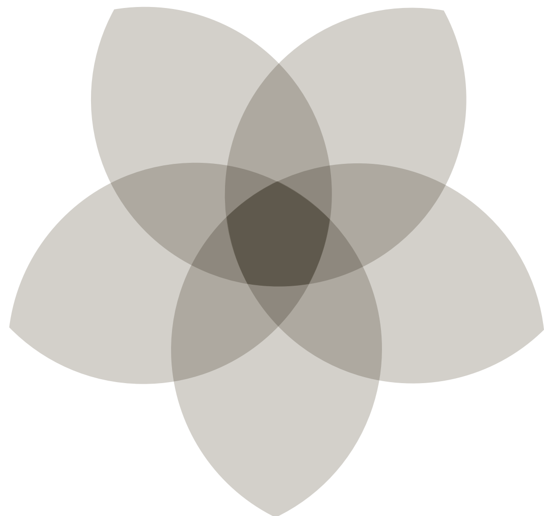




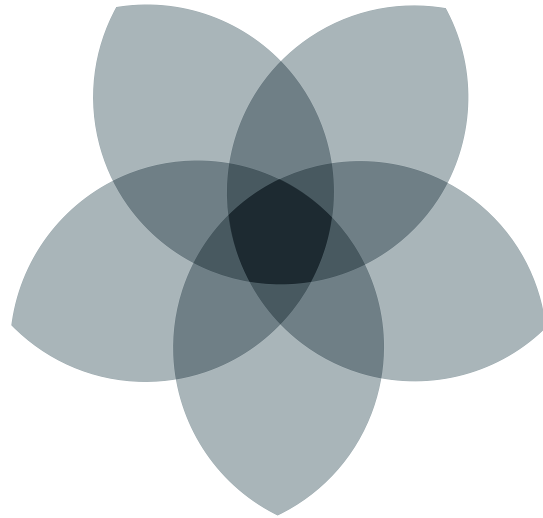
STRATEGIC OBJECTIVES







OBJECTIVE 01



WHAT WE WILL DO

1. Facilitate, enable and co-ordinate the development of a set of standardised outpatient referral pathways that cross the care continuum. These pathways will encompass both prevention and treatment across a wide range of conditions. Areas of focus will include musculoskeletal system, skin, blood, blood forming and immune mechanisms, the digestive system, the eye, the ear, the cardiovascular system, the neurological system, the respiratory system, the endocrine and metabolic system, the urological system, pregnancy/childbearing, the male and female genital systems and general and unspecified complaints.

2. Facilitate, enable and co-ordinate preventative services, health promotion and well-being promotion, in keeping with the goals set in Healthy Ireland (2013-2025), throughout outpatient services. Work with professional colleges, primary care, social care, mental health, healthcare staff and patient groups to develop integrated, holistic programmes of care that will ensure services are delivered in a proactive manner in the most appropriate setting for the individual.

3. Facilitate, enable and co-ordinate educational opportunities to service-providers and users. Methods will include regular communication, creating and making available appropriate documentation and establishing and maintaining a corporate website incorporating an accessible outpatient interface.

4. Facilitate, enable and co-ordinate the provision of chronic disease management services through outreach into the community, utilising telemedicine and individualised service-user contact. Outreach will include integrated community assessment services, one-stop diagnostic services, community liaison and patient-managed telemedicine services. This will be achieved through working with the integrated care programme to develop strategies to manage chronic, ongoing healthcare needs, through population health involvement to support the well population, and through ICT delivery of telemedicine solutions.

PROMOTE HEALTH AND WELLBEING AS PART OF EVERYTHING WE DO SO THAT PEOPLE WILL BE HEALTHIER

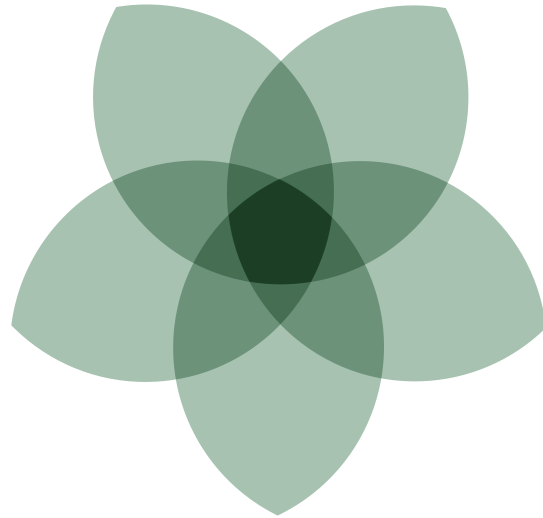
MEASURES OF SUCCESS

1. Enhanced, clinically-approved referral pathways enabling appropriate access, from prevention to treatment, within clinically-recommended timeframes for people in need of healthcare.
2. Nationally agreed clinical prioritisation terminology and procedure, with associated clinically recommended timeframes (CRTs).
3. An enhanced referral management system, providing decision support and enhanced access to appropriately-delivered healthcare.
4. Appropriate routing of referrals to the best location for management of the various level of acuity, with telemedicine and virtual clinic solutions offering increased efficiency and flexibility for service-providers and service-users.
5. An outpatient service where the most acute conditions are managed in an acute environment, with structures in place to enable less acute conditions to be managed through outreach, in the community or in the patient's home.
6. Enhanced chronic disease management by acute hospitals, in association with community and primary care.
7. Healthcare services that make every outpatient contact count, with risk factor and prevention-focussed interventions recorded in the pathway management component of the integrated referral management system.
8. Communication of health education material through regular communication with service-users.

KEY DEVELOPMENTS

- **Outpatient referral pathways per specialty**
- **Enhanced electronic referral management system**
- **Embedded health education and promotion ethos**
- **Outreach/interface services**
- **Integrated outpatient services**
- **Telemedicine and virtual clinics**

OBJECTIVE 02



WHAT WE WILL DO

1. Progress the development of integrated, hospital group-wide, specialties and disciplines to realise person-centred referral pathways and appropriate resource utilisation, underpinned by the production of the 'specialty provision agreement', feeding annually into the group and/or national service plan.
2. Determine the most common presenting complaints and work with primary care and acute service providers to put in place integrated programmes that will provide appropriate care to patients depending on clinical need and acuity.
3. Facilitate and drive the operationalisation of the referral pathways electronically, in association with the Chief Information Officer commencing with e-referral, decision-support and intelligent referral and culminating in the integration of the outpatient care process into the electronic patient record.
4. Facilitate, and co-ordinate the design and implementation of group central referral services to receive, co-ordinate, and appropriately prioritise and direct requests for service to the most appropriate service for the individual's need.
5. Enable service demand to be matched with capacity through the implementation of a prospectively planned system of service-provision enabled by a demand and capacity planning tool and high quality data and information.

PROVIDE FAIR, EQUITABLE AND TIMELY ACCESS TO QUALITY, SAFE HEALTH SERVICES THAT PEOPLE NEED

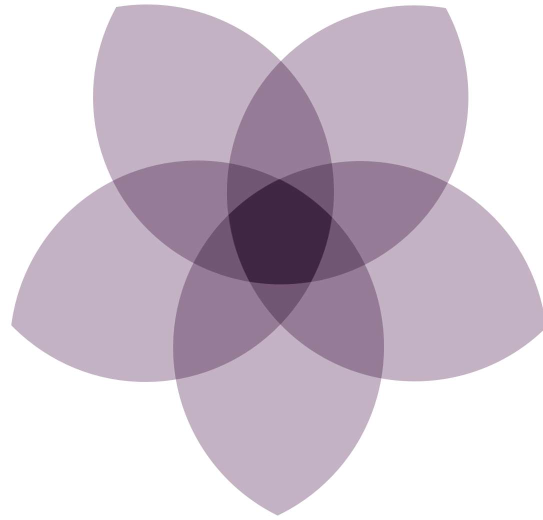
MEASURES OF SUCCESS

1. Integrated, joint specialties operating group wide, nationally agreed referral pathways at local level.
2. A paperless outpatient environment, enabling electronic referral and digital management of the patient's journey.
3. Group central referral management services, receiving, processing and managing all requests for service to non-admitted acute and associated services.
4. Structured performance management processes within hospital groups, working to ensure adherence to service agreements and achievement of key targets and performance indicators.

KEY DEVELOPMENTS

- **Electronic referrals**
- **Referral and exclusion criteria for major conditions**
- **Electronic decision support tools for GPs and other sources of referral**
- **Integrated hospital-group central referral services**
- **Group service provision agreements per specialty/discipline**
- **Meaningful outpatient service KPIs**
- **A minimum data set for outpatient services**
- **Prospective planning of outpatient services**
- **Capacity planning tool for outpatient services**

OBJECTIVE 03



WHAT WE WILL DO

1. Progress the development of robust outpatient information systems to enable transparency and accountability, with enhanced access to this information by the people who use the service.
2. Design and enable the development of structured processes to ensure service-users' needs are incorporated into service design, enabling an effective and compassionate service that is responsive to individual patient needs.
3. Progress the enhancement and development of a formal patient satisfaction assessment tool and hospital group-based patient liaison process that will be embedded in the health system, feeding results and interactions into ongoing service developments giving patients a voice in the development of their outpatient service.
4. Progress the development of robust accountability systems commencing with the development of a set of key performance indicators and continuing with a formal structure to evaluate achievement of these goals.
5. Progress the implementation of formal audit process to assess scientifically the quality, safety and appropriateness of outpatient service-delivery, in administrative and clinical areas.

FOSTER A CULTURE THAT IS HONEST, COMPASSIONATE, TRANSPARENT AND ACCOUNTABLE

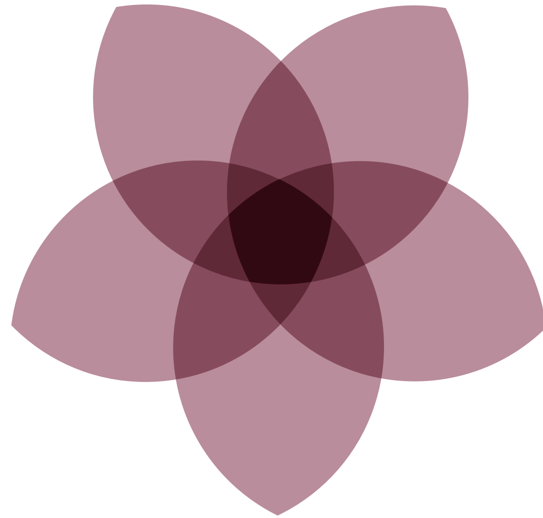
MEASURES OF SUCCESS

1. Hospital patient administration systems upgraded to deliver an agreed minimum data set that enables tracking of the patient from referral until discharge.
2. A formal system that reviews performance against key performance indicators in a structured manner enabling ongoing adjustment to service delivery where required.
3. A formal outpatient service-user group that meets regularly with healthcare representatives.
4. A formal and continuing patient satisfaction measurement process as an input into ongoing outpatient design process.
5. Group specialties producing annual service provision agreements, feeding into the annual service plan, delivering a ground-up planning approach and local accountability.
6. A formal audit process delivering representative reviews of administration, quality and practice in the outpatient environment.

KEY DEVELOPMENTS

- **Enhanced patient administration systems**
- **A reliable and valid set of outpatient data**
- **Formal measurement of performance against agreed KPIs**
- **Outpatient service-user groups and patient satisfaction measures feeding into the ongoing design process**
- **Formal, group-wide, joint-specialty plans for the delivery of outpatient services**
- **A formal audit process addressing process and clinical outcomes, and implementation of Healthy Ireland plans**

OBJECTIVE 04



WHAT WE WILL DO

1. Support and enable hospital groups to standardise the delivery of safe, evidence-based care through the provision of a set of minimum standards for the delivery of outpatient services.
2. Work with hospital groups to implement standardised care through the roll-out of 'proof of concept' initiation projects, leading to national roll-out of successful models.
3. Co-ordinate the development of a process to promote a learning organisation which has at its core a culture of professional development and best-practice services that enable staff to reach their full potential.
4. Provide training to hospital groups during the change process to enable needs assessment and the development of required skill sets to utilise standard procedures and person-management in achieving the goals and outcomes set out in the redesign programme.
5. Enable staff to implement minimum standards through the provision of ICT-enabled, user-friendly information systems and patient management systems culminating in the move to a 'paperless' outpatient environment.
6. Enable and progress the development of a staff hub to promote the sharing of information, good practice, and problem-solving strategies and to act as a repository of news, information, documentation and ideas regarding the provision of outpatient services.

ENGAGE, DEVELOP AND VALUE OUR WORKFORCE TO DELIVER THE BEST POSSIBLE CARE AND SERVICES TO THE PEOPLE WHO DEPEND ON THEM

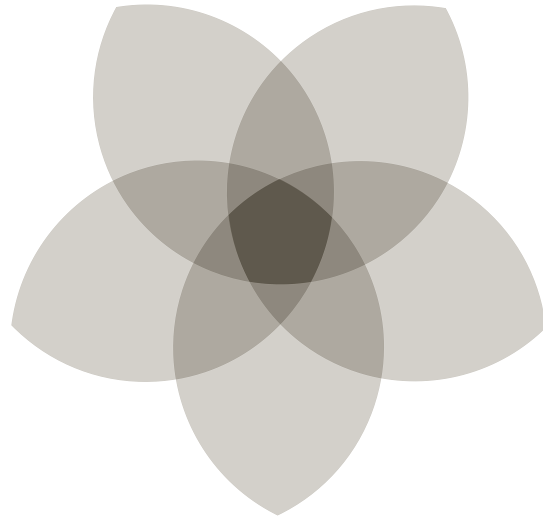
MEASURES OF SUCCESS

1. Hospitals are working to standardise care within agreed models.
2. A best practice people-management process is implemented in line with the Health Services People Strategy, that ensures staff 'are equipped, to confidently deliver, problem-solve and innovate safe, better healthcare'.
3. Outpatient services staff express pride in the service they deliver and feel a sense of ownership for the service.
4. A learning-focussed outpatient service, assessing staff needs in an ongoing basis and providing training where required.
5. Staff have been trained to 'make every contact count' in the outpatient, ambulatory care environment.
6. A functioning digital outpatient staff hub.

KEY DEVELOPMENTS

- **A set of standards and guidance documents**
- **Policies and procedures set out by hospital groups**
- **'Proof of concept' projects for national roll-out**
- **Assessment of training needs**
- **A learning culture**
- **Tailored training programmes**
- **ICT enablement of staff**
- **Outpatient services digital staff hub**

OBJECTIVE 05



WHAT WE WILL DO

1. Enable hospital groups to complete formal group wide specialty plans for the delivery of outpatient services, and hold these groups to account for achieving the outcomes in these plans.
2. Ensure hospital groups plan services on the basis of need and that capacity planning ensures equity and efficient distribution of services and prioritisation of resources across the group.
3. Ensure all service developments, including manpower increases, are conceptualised as business plans setting out full resource implications and ensuring value for money.
4. Design and enable an outpatient score card and set of KPIs against which to measure performance, adherence to KPIs and value for money.
5. Ensure optimal use of resources through a robust prospectively-planned, performance-managed, goal-oriented system.
6. Ensure efficiencies across the system through the setting of standards, maximising resource utilisation and minimising variation in practice. A core component of ensuring efficiencies is the provision of care at appropriate levels of complexity and managing patients through telemedicine and virtual services where possible.

MANAGE RESOURCES IN A WAY THAT DELIVERS BEST HEALTH OUTCOMES, IMPROVES PEOPLE'S EXPERIENCE OF USING THE SERVICE AND DEMONSTRATES VALUE FOR MONEY

MEASURES OF SUCCESS

1. Formal specialty agreements setting out service delivery completed within hospital groups, feeding into the annual service plan.
2. Transition to a population-health approach utilising epidemiological information to determine need for services.
3. A standardised outpatient business-development process operating in each group, enabling management and clinical staff to feed into the service planning process.
4. Real-time practical scheduling of resources supported by integrated ICT systems.
5. An outpatient services performance scorecard.

KEY DEVELOPMENTS

- **Service provision agreements**
- **Prospectively-planned outpatient services**
- **Population health outpatient services model**
- **Outpatient capacity planner**
- **Embedded outpatient services business planning model**
- **Performance management system**
- **Scorecard and KPIs**
- **Target and quality achievement**

OUTPATIENT SERVICES PERFORMANCE IMPROVEMENT PROGRAMME EXPERT ADVISORY GROUP

WORK AREA	NAME	ROLE
Acute Hospital Division	**Mr. Liam Woods,** Interim National Director, Acute Hospitals Division	Sponsor
Outpatient Services Performance Improvement Programme (OSPIP)	**Mr. Ollie Plunkett,** Assistant National Director, National Lead for Outpatient Services	Chairperson
Outpatient Services Performance Improvement Programme (OSPIP)	**Ms. Trina Dunne,** Project Lead, Outpatient Services Performance Improvement Programme	Group Secretary
Outpatient Services Performance Improvement Programme (OSPIP)	**Ms. Ita Hegarty,** Planning & Development Manager, Outpatient Services Performance Improvement Programme	Group Member
Clinical Strategy and Programmes Division	**Dr. Colm Henry,** National Clinical Advisor and Group Lead, Acute Hospitals Division	Group Member
National Surgery Programme	**Prof. Frank Keane,** Joint Lead National Surgery Programme	Group Member
National Acute Medicine Programme	**Prof. Garry Courtney,** Clinical Lead of the National Acute Medicine Programme	Group Member
Clinical Strategy and Programmes Division	**Ms. Sinéad Fitzpatrick,** National Programme Manager, Integrated Care Programme for Patient Flow, Clinical Strategy and Programmes Division	Group Member
Quality Improvement Division	**Dr. Philip Crowley,** National Director, Quality Improvement Division, HSE	Group Member
Clinical Strategy and Programmes Division – Group Lead Primary Care	**Dr. David Hanlon,** Group Lead Primary Care, Integrated Care Programme for Chronic Disease, Clinical Strategy and Programmes Division	Group Member

WORK AREA	NAME	ROLE
Primary Care	**Mr. Brian Murphy,** Assistant National Director, Head of Planning, Performance and Programme Management Primary Care	Group Member
Hospital Group CEO	**Dr. Susan O' Reilly,** Chief Executive, Dublin Midlands Hospital Group	Group Member
Hospital Group COO	**Mr. Trevor O'Callaghan,** Chief Operations Officer (COO), Dublin Midlands Hospital Group	Group Member
National Directorate for Health & Wellbeing	**Dr. Kevin Kelleher,** Assistant National Director for Public Health & Child Health, Health & Wellbeing Division	Group Member
Office of CIO	**Mr. Richard Corbridge,** Chief Information Officer, HSE	Group Member
Office of CIO	**Mr. Eugene Farrell,** Information Services, Office of the Chief Information Officer	Group Member
Social Care Division	**Dr. Siobhán Kennelly,** National Clinical Advisory Group Lead, Social Care Division	Group Member
National Clinical Programme for Paediatrics	**Prof. Alf Nicholson,** Clinical Lead, National Clinical Programme for Paediatrics, Consultant Paediatrician, Temple Street	Group Member
Mental Health Division	**Dr. Margo Wrigley,** National Clinical Advisor and Clinical Programmes Group Lead, Mental Health Services	Group Member
GP-St Luke's Hospital Liaison Committee	**Dr. Ronan Fawsitt,** Chair, GP-St Luke's Hospital Liaison Committee Carlow-Kilkenny	Group Member

OSPIP projects mapped against patient pathway

	Major Projects – OSPIP Programme	Patient self care/self management	Patient presents to GP	GP decision support tool in practice system	Suite of management guidelines	Enhanced access to diagnostics	Access to acute consultant / team advice and support via integrated referral management system	Referral criteria and specialty referral for
1	Referral pathways per specialty/referral and exclusion criteria for major conditions, including referral forms, access options, discharge forms, self-care advice, care plans, clinical prioritisation, etc.	✓	✓	✓	✓	✓	✓	✓
2	Outreach/interface services integrated outpatient services, including virtual clinics and telemedicine	✓	✓	✓	✓	✓	✓	✓
3	Embedded health education and promotion ethos, population health	✓	✓	✓	✓			
4	Population health outpatient services model	✓	✓	✓	✓	✓	✓	✓
5	A reliable and valid minimum data set for outpatient services					✓	✓	✓
6	Enhanced electronic referral management system/electronic referrals		✓	✓	✓	✓	✓	✓
7	Electronic decision support tools for GPs and sources of referral	✓	✓	✓	✓	✓	✓	✓
8	Enhanced patient administration systems							
9	ICT infrastructure	✓		✓	✓	✓	✓	✓
10	Integrated hospital-group central referral services			✓		✓	✓	✓
11	Physical environment of outpatient services					✓		
12	Dedicated outpatient centres	✓	✓	✓	✓	✓	✓	✓
13	Capacity planning tool for outpatient services							
14	Hospital group service provision agreements per specialty/ discipline							
15	Prospective planning of outpatient services/embedded outpatient services business planning model							
16	Meaningful outpatient services KPIs			✓				
17	Formal measurement of performance against agreed KPIs			✓	✓	✓	✓	✓
18	People management strategy, assessment of training needs, a learning culture, tailored training programmes, etc.		✓				✓	
19	Outpatient service-user groups and patient satisfaction measures feeding into the ongoing design process	✓		✓	✓	✓	✓	✓
20	Outpatient services digital staff hub and website							
21	A set of standards and guidance documents, policies and procedures set out by hospital groups			✓	✓	✓	✓	✓
22	A formal audit process addressing process and clinical outcomes			✓	✓	✓	✓	✓

✓ - Patient pathway effected by project

d ms	Enhanced electronic referral	Range of options for patient in community, telemedicine/ virtual clinic, primary care centre, at home, in acutes	Clinically recommended timeframes (triage)	Central booking with advances booking options	Attendance with outpatient services in range of locations	Timed appointment slots	Prospectively planned service adding additional capacity	Diagnostics, consultation, treatment, possible admission	Follow up appointment or discharge to GP, with electronic discharge summary	Patient manages self, and/ or requires community based input or returns to GP / SOR, and/or has access route back to acute services
	✓	✓	✓	✓	✓		✓		✓	✓
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MAJOR PROJECTS – OSPIP PROGRAMME

(All timeframes are indicative and have critical dependencies for delivery)

1	Referral pathways per specialty/referral and exclusion criteria for major conditions, including referral forms, access options, discharge forms, self-care advice, care plans, clinical prioritisation, etc.
2	Outreach/interface services integrated outpatient services, including virtual clinics and telemedicine
3	Embedded health education and promotion ethos, population health
4	Population health outpatient services model
5	A reliable and valid minimum data set for outpatient services
6	Enhanced electronic referral management system/electronic referrals
7	Electronic decision support tools for GPs and sources of referral
8	Enhanced patient administration systems
9	ICT infrastructure
10	Integrated hospital-group central referral services
11	Physical environment of outpatient services
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14	Hospital group service provision agreements per specialty/discipline
15	Prospective planning of outpatient services/embedded outpatient services business planning model
16	Meaningful outpatient services KPIs
17	Formal measurement of performance against agreed KPIs
18	People management strategy, assessment of training needs, a learning culture, tailored training programmes, etc.
19	Outpatient service-user groups and patient satisfaction measures feeding into the ongoing design process
20	Outpatient services digital staff hub and website
21	A set of standards and guidance documents, policies and procedures set out by hospital groups
22	A formal audit process addressing process and clinical outcomes

2016		2017		2018		2019		2020	
1ST HALF	2ND HALF	1ST HALF	2ND HALF	1ST HALF	2ND HALF	1ST HALF	2ND HALF	1ST HALF	2ND HALF

Building a Better Health Service

CARE COMPASSION TRUST LEARNING

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive