



National Acute Medicine Programme 2010

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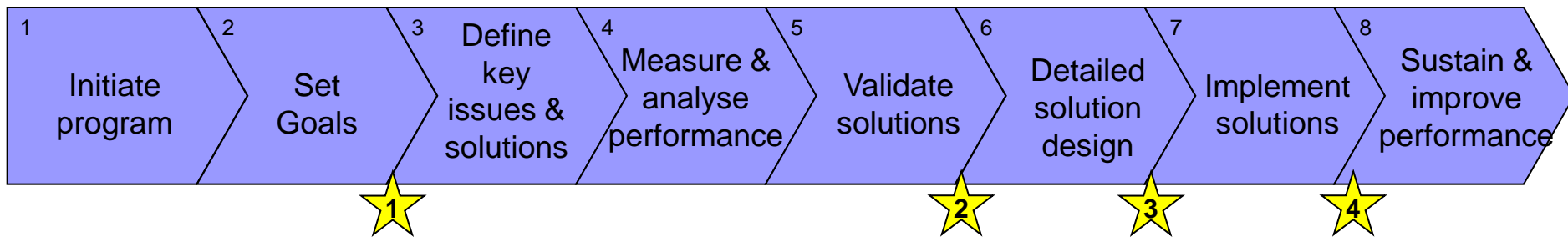
Why is Acute Medicine the priority?

- Trolleys waits and poor patient experience
- Preventable mortality - 1 per day in stroke
- Limited access to senior decision makers
- Cost – acute medicine using more beds than is required (1/2 of beds, 2/3 costs)
- Impact on other services e.g. elective surgery



Key features of National Clinical Care Programmes

- All based on generating gains in quality, access and cost
- Similar to national cancer programme
- Jointly led with Colleges and DQCC
- GPs, Consultants, Nursing, AHPs and Patients embedded in programme
- Similar methodology



Acute Medicine Programme

This Programme will ensure that all acute medical patients will experience :

- expedited diagnosis,
- the correct treatment,
- an appropriate environment,
- respect of their autonomy and privacy,
- timely care from a senior medical doctor working within a dedicated multidisciplinary team,

Objectives

- **Quality:** Reduce the admission rate of medical patients by 10% to 50% without increasing 30 day readmission
- **Access:** Every medical patient presenting to the hospital will be seen by a senior medical doctor (i.e. consultant/specialist registrar/registrar) within one hour
- **Cost:** Generate medical bed day savings of 10% per year for 3 years post full implementation

Currently use 1,265,671 acute medical bed days p.a. i.e. 3465 beds

Year 1: 10% reduction = 350 beds saved

Year 2: 10% reduction = 700 beds saved (cumulative)

Year 3: 10% reduction = 1,050 beds saved (cumulative)

Trolley issue

- In the worst month of this year to date (i.e. January) the daily average of trolleys was 157 (HSE)
- (INMO average for month of January = 283)
- Year 1 bed savings will solve trolley problem.

Are bed savings achievable?

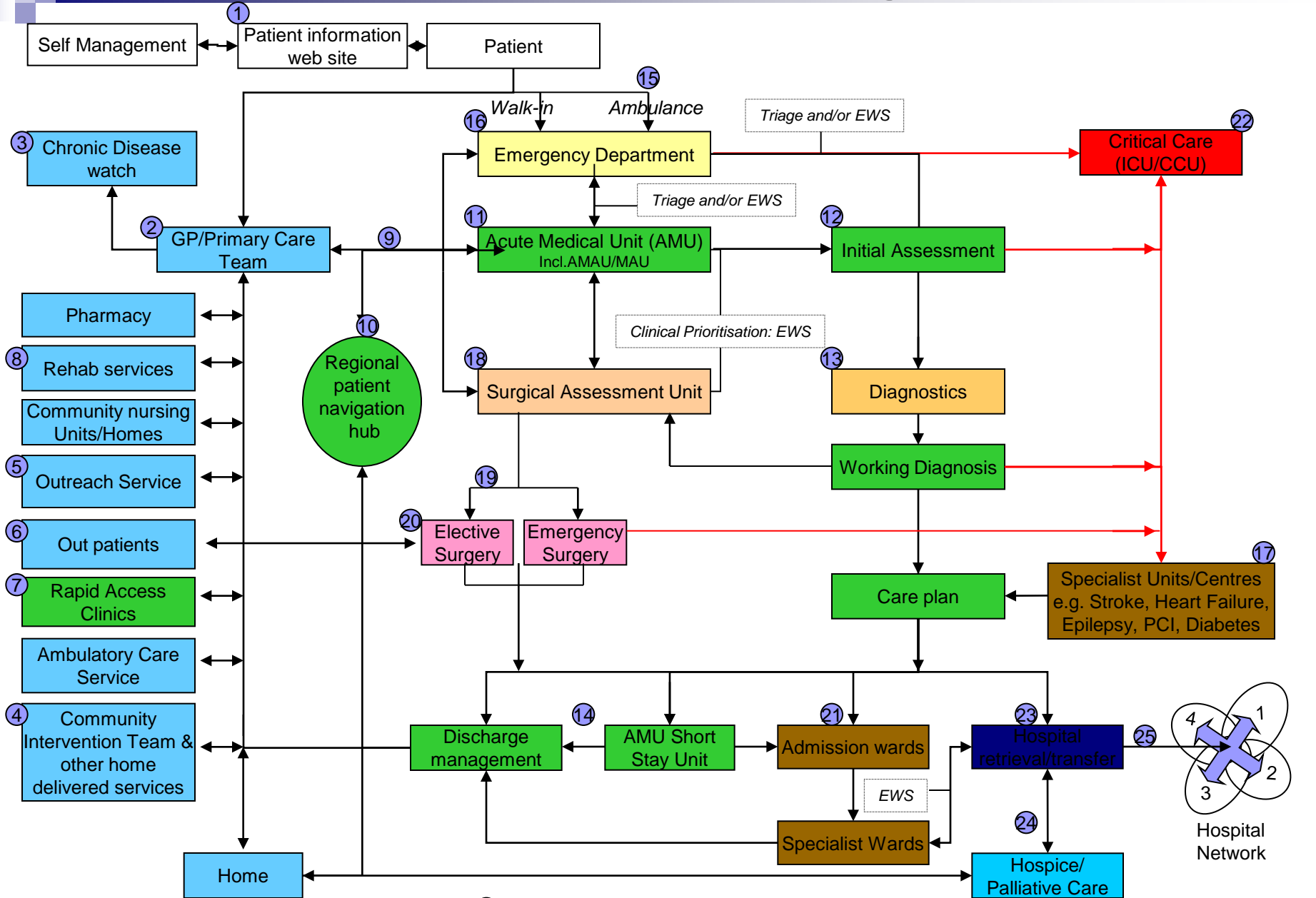
Decrease in AvLOS by 1 day each year for the next 3 years i.e. from 9 to 6 days (which brings all hospitals to performance of the current top 25%):

- 4% - awaiting consultant decision to discharge (AEP, 2008)
- 8% - of inappropriate admissions due to inability to access diagnostics as out-patient (AEP, 2008)
- Increase weekend discharges
- Increase proportion of LOS <72 hours

Why is this different?

- Driven by quality agenda
- Clinically led, taking a whole system approach
- Multi-disciplinary team selected by their professions
- Multi-programme approach allowing integrated solution e.g. AMP links with ED, Critical Care, Surgery, Care of the Elderly, Diagnostics, etc., jointly led with Colleges, with widespread consultation and support
- Acute Medicine Programme team follows through on implementation

Blueprint for National Clinical Programmes



Key features of the Programme

- Hospital models (1,2,3,4 in order of increasing acuity)
- Acute Medical Units, Acute Medical Assessment Units and Medical Assessment Units
- National Early Warning Score
- Rapid access to out-patients
- Navigation hub/bed bureau and Case Manager
- Metrics
- New working practices/continuous presence
- New approach to education, training and development
- Retrieval service

Who benefits – Patients, Clinicians, Management, representative groups

- Strengthens future for local hospitals by enhanced non emergency role. Increased volume of services provided in model 2 hospitals which will be developed as centres of excellence for day surgery, chronic disease management and rehabilitation. Chronic diseases are the commonest cause of death and severe illness and include diabetes, asthma, emphysema/bronchitis, heart disease and stroke.
- Same day access to key services e.g. AMU/AMAU/MAU, imaging, endoscopies, laboratory, etc.
- Contribute to improvement in trolley issues
- Rapid access to senior decision maker

Patient benefits

All acute medical patients will receive an expedited diagnosis and the correct treatment, administered in an appropriate environment, respectful of their autonomy and privacy, by a senior medical doctor working within a dedicated multidisciplinary team.

- No patient will be cared for on a trolley for an extended period
- All patients will get the correct treatment in the appropriate setting
- Unnecessary delays and duplication in assessment, diagnosis and treatment will be prevented
- All patients will be seen by a senior medical doctor (consultant, specialist registrar or registrar) within 1 hour
- All key decisions will be reviewed by a consultant
- The patient and family/carers will be afforded the opportunity to have discussions with the consultant

Hospital models

- The National Clinical Programmes propose models for 4 levels of acute hospitals in relation to acute medicine patients
- These are generic models
- The specifics of implementation and staffing arrangements for each model will be agreed locally in consultation with the Programme
- The purpose of the models is to enhance the safe provision of patient care relating to available facilities and staffing
- The level of service which can be safely provided in any hospital will determine which model applies
- Protects patients and staff

Hospital models (continued)

- Model 4: tertiary hospital
- Model 3: general hospital
- Model 2: local hospital with selected (GP-referred) medical patients, day surgery, diagnostics
- Model 1: community/district hospital

Acute medical units

- There are 3 types of acute medical units which care for patients in different hospital models.
- Model 4 hospitals have an AMU, which is a facility whose primary function is the immediate and early specialist management of adult patients (i.e. aged 16 and older) with a wide range of medical conditions who present to hospitals (+ medical short stay unit, MSSU)
- Model 3 hospitals have an AMAU (-MSSU)
- Model 2 hospitals have an MAU (-MSSU)



Implementation strategy

High level implementation approach

1. No.1 HSE/DoHC priority for 2011 (incl. for HR, IT, etc)
2. Business case & Implementation plan (next 6 weeks)
3. Expressions of interest (8 – 12 weeks)
4. Prioritisation and triage into 5 work-streams
 - Critical Care
 - Ambulance
 - Diagnostics
 - Facilitated support
 - Education and training (www.jrcptb.org.uk)
5. Baseline current performance vs key targets
6. Diagnostic & Gap analysis
7. Local implementation planning
8. Plan sign-off
9. Progress reporting
10. Monitoring

Key Risks

1. New working practices for doctors, nurses, therapists
2. Phased implementation will lose momentum
3. Staffing requirements (Consultants)
4. Matching trainees to consultant posts in new training scheme
5. Conflict with other services due to resource limitation
6. Ambulance requirements
7. Unrealistic expectations
8. Discharge delays
9. Removal of beds ahead of the programme timelines
10. Need to provide additional resources in current economic climate

Key questions

- Medicine/Surgery in model 2 – pre selected, ACLS, EWS and Retrieval
- Critically ill patient in model 2 – Pre-selected, EWS, ACLS, Rotation and Retrieval
- NCHD training/skill sets (Network/Integrated Service Area rotation)
- Acute Medicine Training Scheme (Acute Med as primary specialty or combined with another relevant specialty)
- Funding stream
- HIQA/Licensing 2012