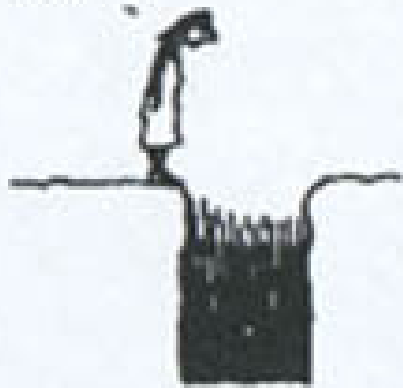


IEQAS conference 7<sup>th</sup> October 2010

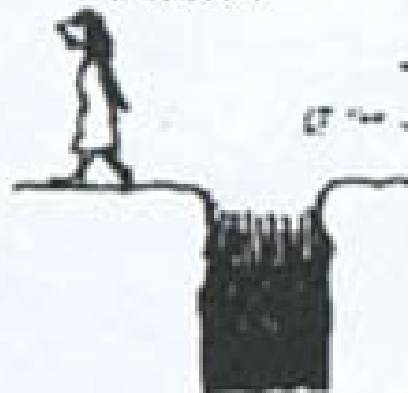
*Working together to ensure  
Strong, effective governance and  
Safer, better care*

Dr. Joe Devlin,  
Quality and Clinical Care Directorate, HSE

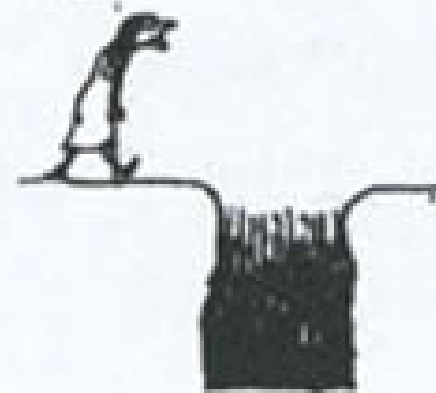
I CAN'T



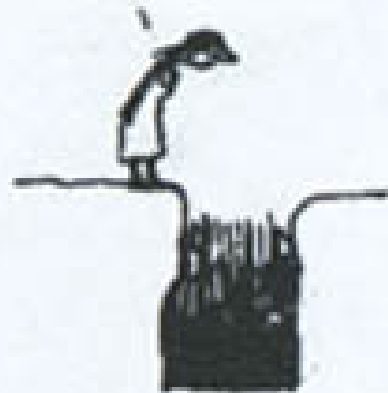
I WON'T



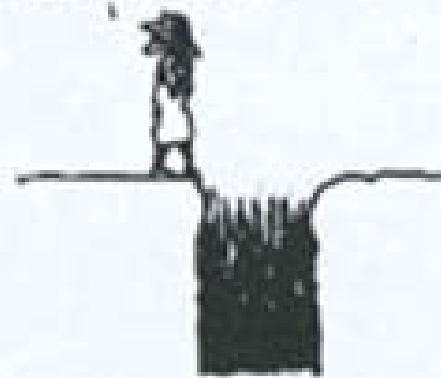
I MUST



I'LL DIE IF I TRY



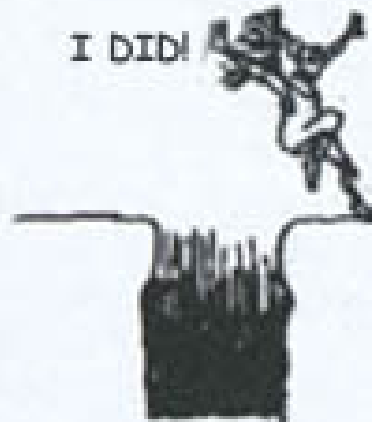
I'LL DIE IF I DON'T TRY



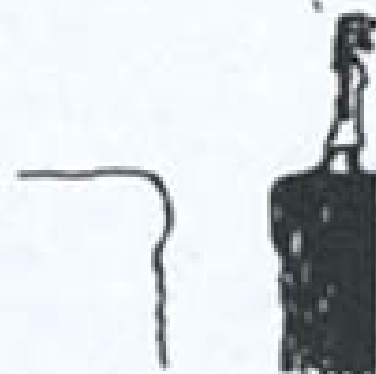
I WILL



I DID!



WHAT DID I DO?



# **Vision**

Knowledgeable patients receiving safe & effective care  
from skilled professionals in appropriate  
environments with assessed outcomes

# Challenges

- Ageing population
- Continuing shift in the pattern of disease towards long-term conditions
- Growing numbers of older people with multiple conditions and complex needs and the impact of this on them and their immediate carers
- More older family carers too many of whom will have their own health needs
- Developments in technology and in information and communications technology in particular
- Increased public awareness, diversity and intelligence creating different expectations and requirements around treatments, equipment, access, drugs and therapies
- Added to these challenges are the new challenges we face in the current economic climate with tightening financial resources

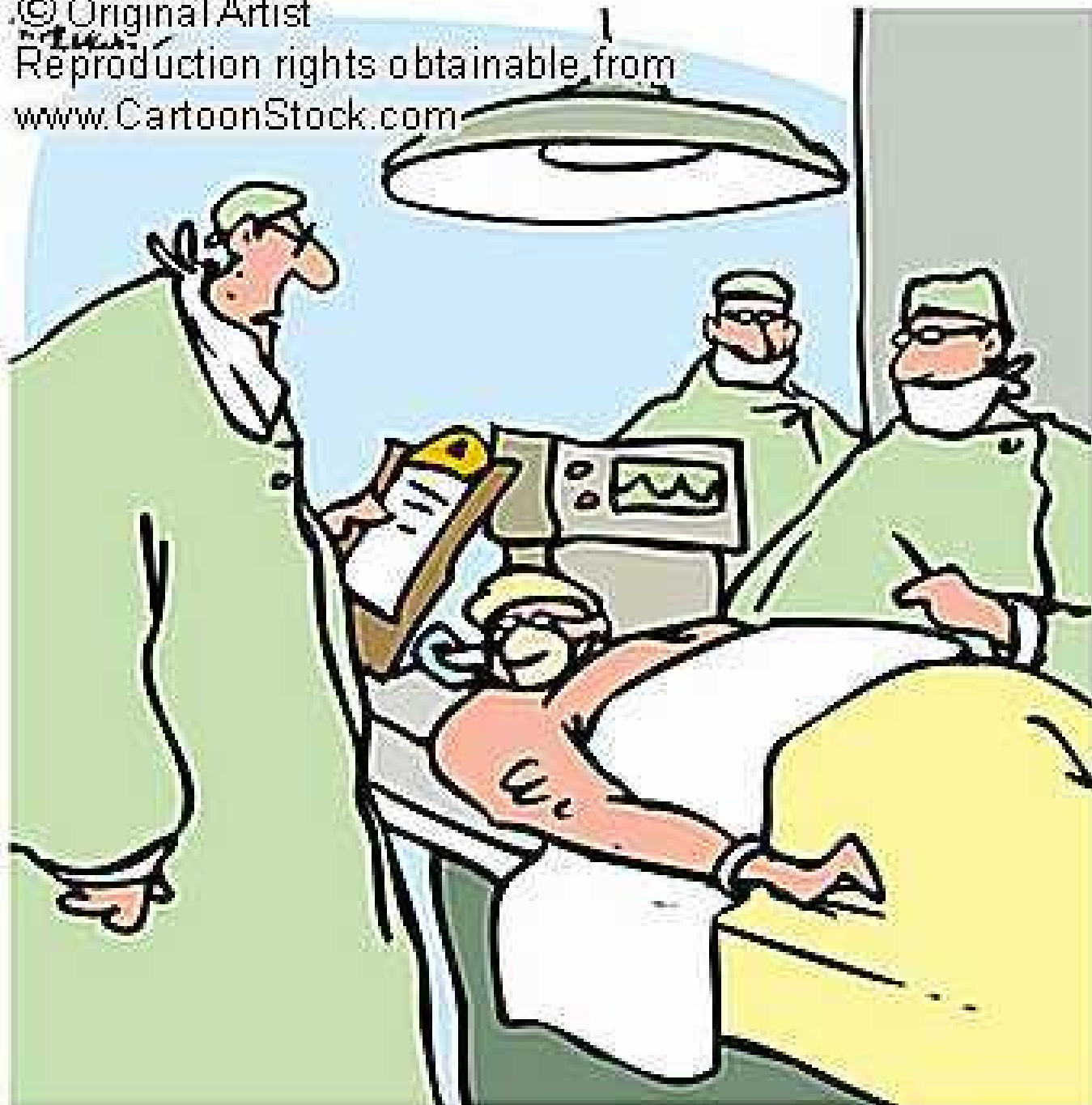
# Approach

- True alignment from national strategies to individual behaviours
- The approach to the strategy is thus based on four levels of involvement. These are categorised as follows:
  - 1. Corporate
  - 2. Organisational
  - 3. Team
  - 4. Individual

# Drivers

- The Commission vision of health system-wide governance framework for patient safety and quality was built on the following dimensions of Quality:
  1. Openness
  2. Person centeredness
  3. Learning
  4. Effectiveness
  5. Governance and accountability
  6. Safety
- It is proposed that six dimensions will remain the key foundation of our approach to systems-based healthcare quality improvement. We will concentrate our priority actions and interventions on these six dimensions.

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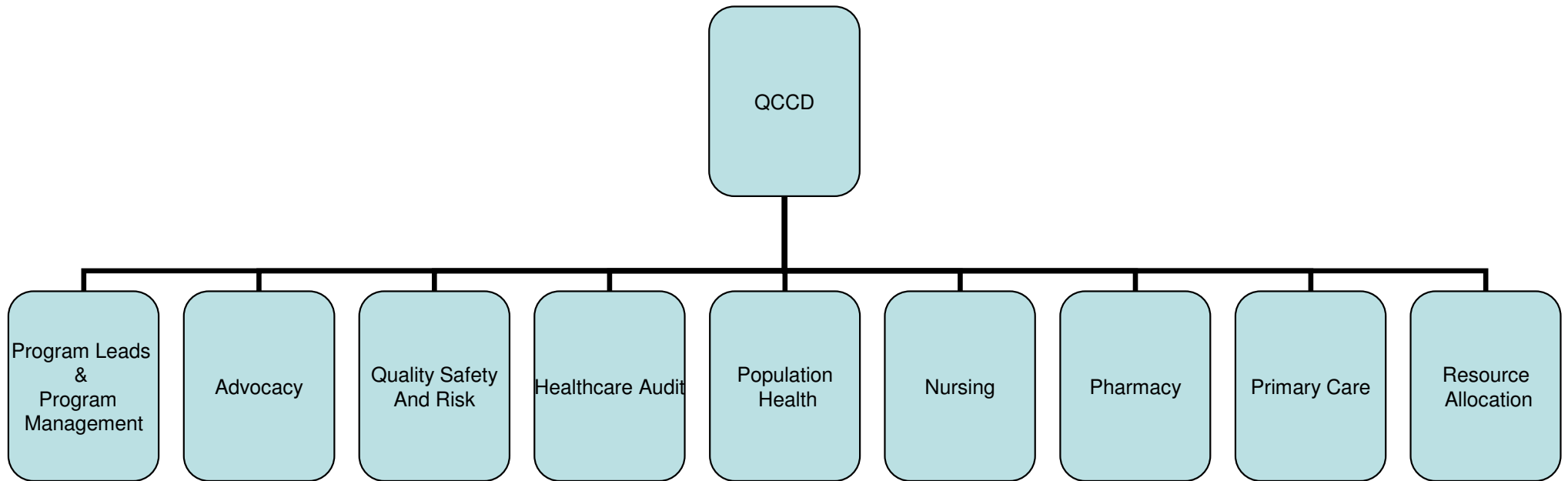


“Wait, this one’s a lawyer. We’d better wash our hands.”

# Interventions

- Integrated Framework for Quality Safety and Risk Management
- Quality and Safety Programme
- Clinical Care Programmes (related to Clinical effectiveness – ref Framework)
- Quality Infrastructure

# What is the structure of the Directorate



## What is the mission of the Quality & Clinical Care Directorate?

*The Mission of the Quality & Clinical Care Directorate is to enable better clinical and social care at less cost that results in high quality and safe sustainable services*

# Clinical care programmes

# What are the clinical programs & initiatives?

## 1. Chronic disease management programs

- Stroke
- Acute coronary syndrome
- Heart failure
- Asthma/COPD
- Diabetes
- Epilepsy
- Mental health

## 2. Outpatient management programs

- Dermatology
- Neurology
- Rheumatology
- Orthopaedics

## 3. Emergency function related programs

- Acute Medicine
- Elective surgery
- Diagnostic Imaging
- Care of the elderly

## 4. Other Clinical program areas

- Obstetrics
- Paediatrics
- ICU
- HCAI
- Primary care
- Neurorehab

## 5. Enabling programmes

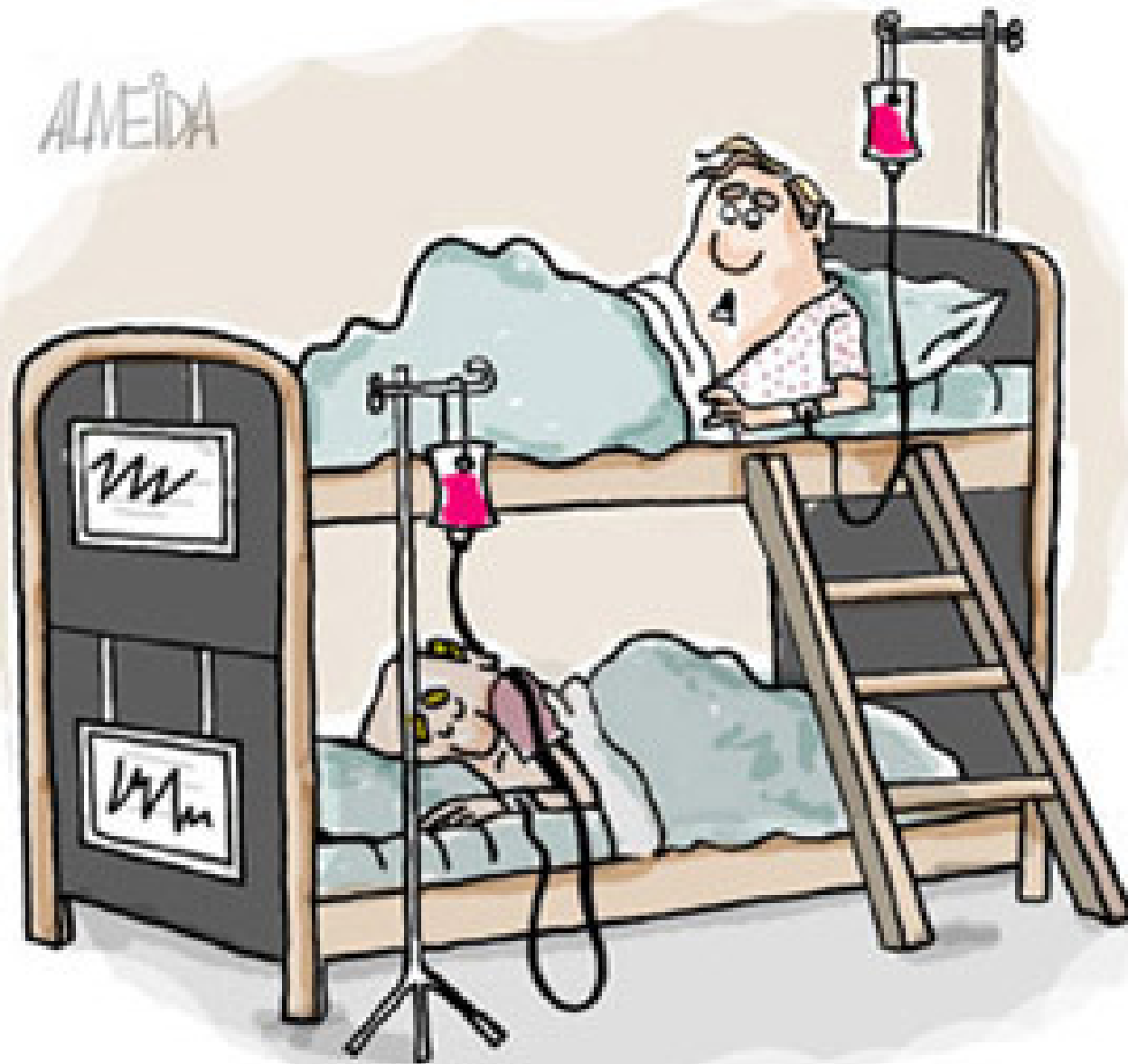
- Development of a resource allocation model
- Pharma strategy
- Implementation of Clinical Directorates
- Defining a standard approach to delivering change

## Why take a programmatic approach to change?

- Structured approach to disease management to ensure patients gets the right treatment
- Change is led by experienced clinicians with expertise in disease and service delivery.
- Generates clinical buy-in and ownership from the start. Also provides opportunity for bottom-up and top down change by engaging Colleges and professional bodies.
- Enables greater organisational responsiveness i.e. frontline staff can access the top of the organisation in one step via the national lead.
- Provides a sustained focus
- The appointment of Prof. Keane as the Director of the National Cancer Control Programme (NCCP), demonstrates the importance of having an expert in the relevant clinical area to engage with evidence to the public, media, politicians and other clinicians

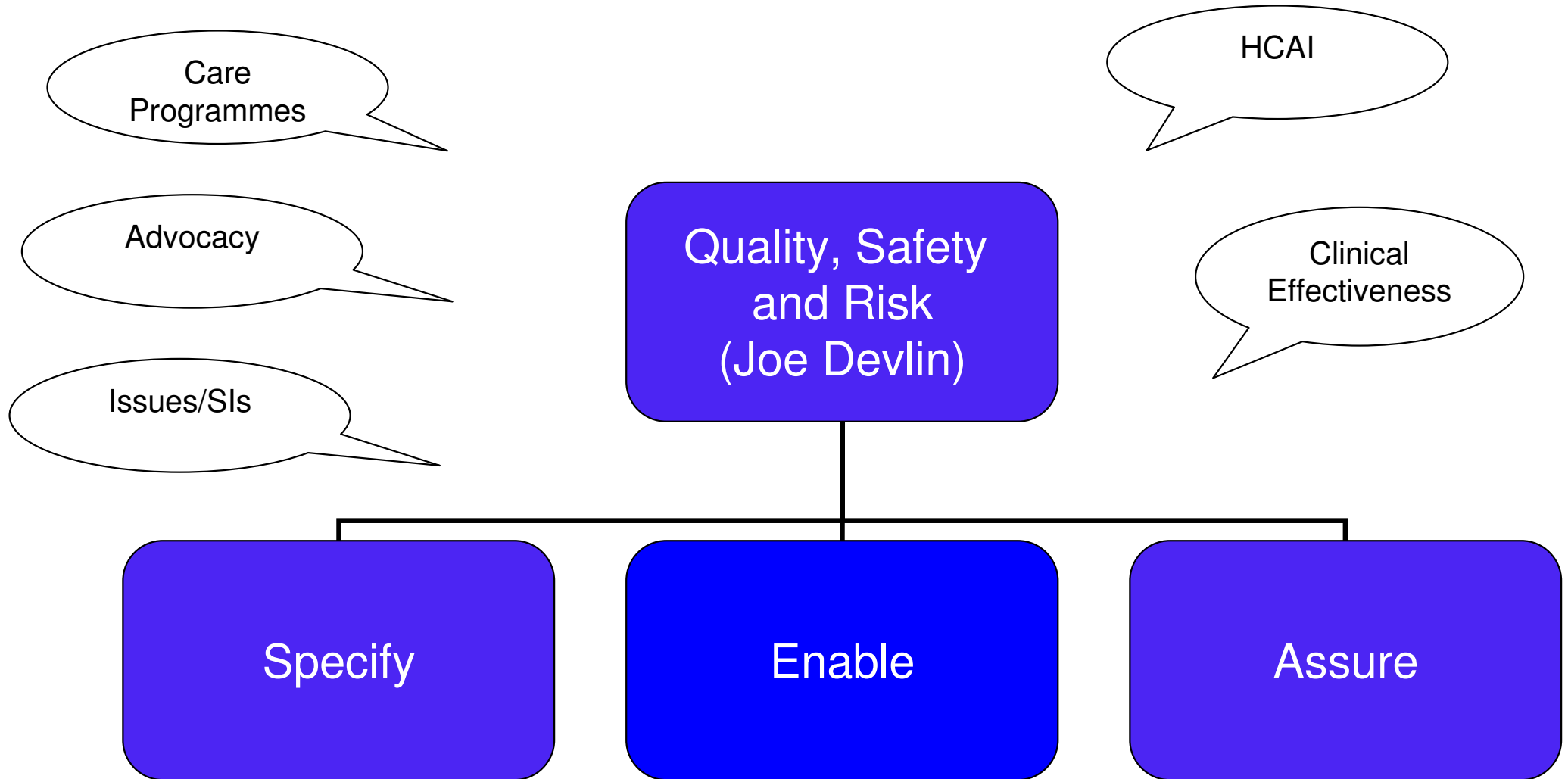
# Quality, Safety & Risk

ALMEIDA



**"Medical care certainly ain't what it used to be!"**

# Structure



# Specify

Receive and determine standards and recommended practice guidelines for care quality, safety and risk management together with related key performance indicators for the entire organisation

- Status of Standards
- Updates & Reviews of Standards
- Receipt of Standards
- Guidance documents to support implementation of Standards
- Interface with external stakeholders (e.g. HIQA)
- Integrate care programmes when complete
- Work with 'enable' & 'assure' arms to agree implementation & monitoring schedule and reports

# Enable

Build capacity within the organisation to deliver on the quality, safety and risk management agenda by providing support, documented guidance, education, training and direct assistance to enable local service providers to demonstrably improve the safety and quality of care provided to patients/service users

- Workplan for implementation of each Standard/recommended practice/ Framework element
- Develop self-assessment tools & peer review materials
- Develop training materials
- Organise and run training sessions/ programmes
- Activate & support self-assessments
- Support for development of QIPs
- Build & support capacity in the system
- Share best practice
- Share learning

# Assure

Monitor compliance with key health and personal social services standards together with performance against key clinical and other performance indicators to provide assurances to the National Directors of QCCD/ISD

- Collate information (national) from self-assessments & peer review
- Collate information (national) from implementation of QIPs
- Collate information on performance targets
- Receive information from SIMT/corporate risk register/complaints/incidents/PMU/HealthStat/CPCP, etc
- Review relevant reports from external stakeholders (e.g. HIQA/MHC)
- Analyse information
- Identify national priorities/areas for improvement/areas of concern (may require close monitoring/liaise with healthcare audit)

# QSR priorities for 2010

## **Core Processes**

- Clinical Audit
  - Surgical Audit
- Risk Register
- Incident Management (Incl. Complaints)
- Investigation Processes
  - Underperforming clinicians

## **Low scoring areas 2009 SA**

- Service user involvement
- Accountability – organisational design
- Communication & Consultation

# QSR priorities for 2010...contd

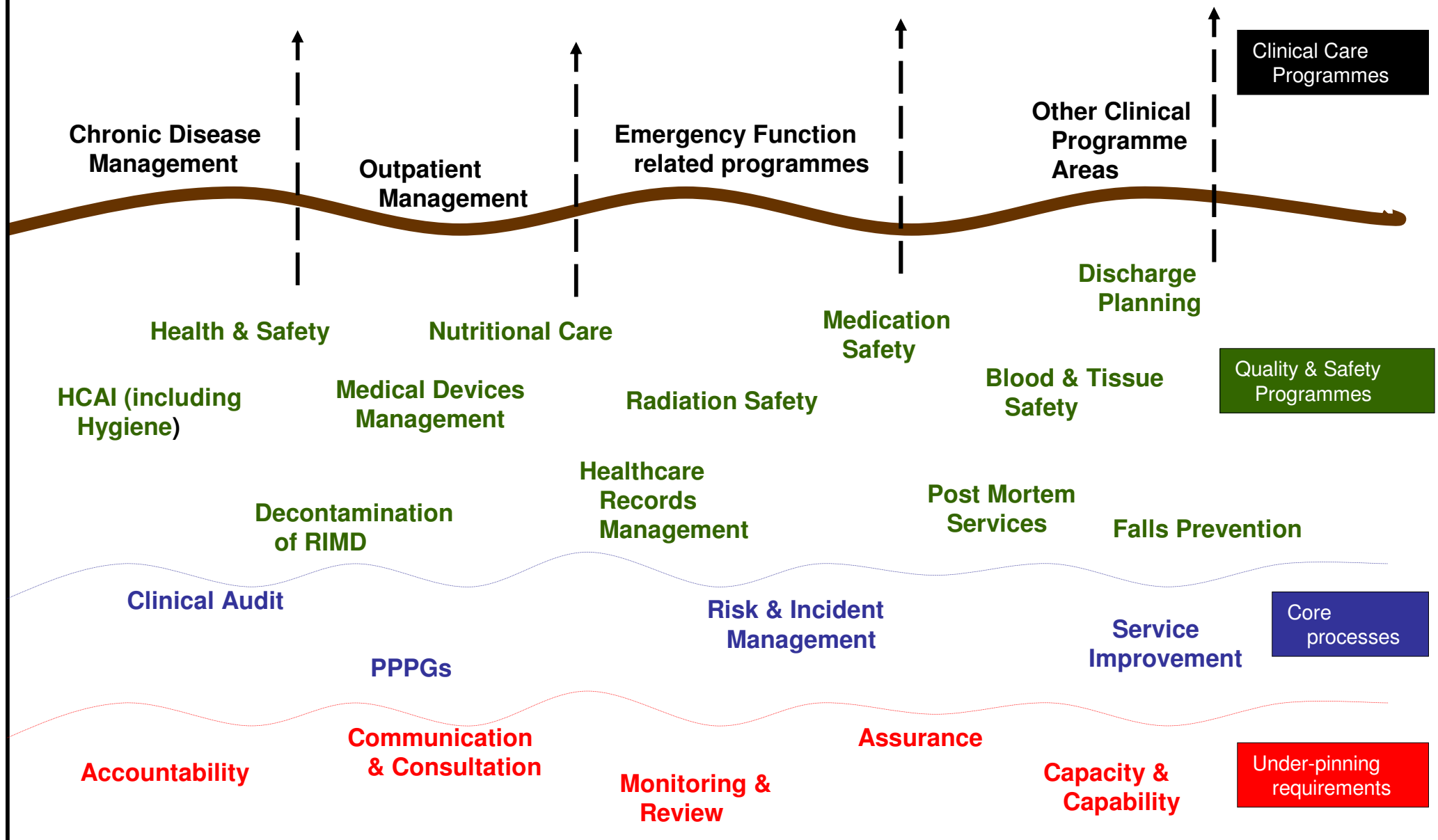
## **Standards**

- Review Standards & self-assessments
- Link with HIQA
- Collapse self-assessments where possible
- Develop 'register' of Standards/legislation for HSE
- Peer review programme

## **Process**

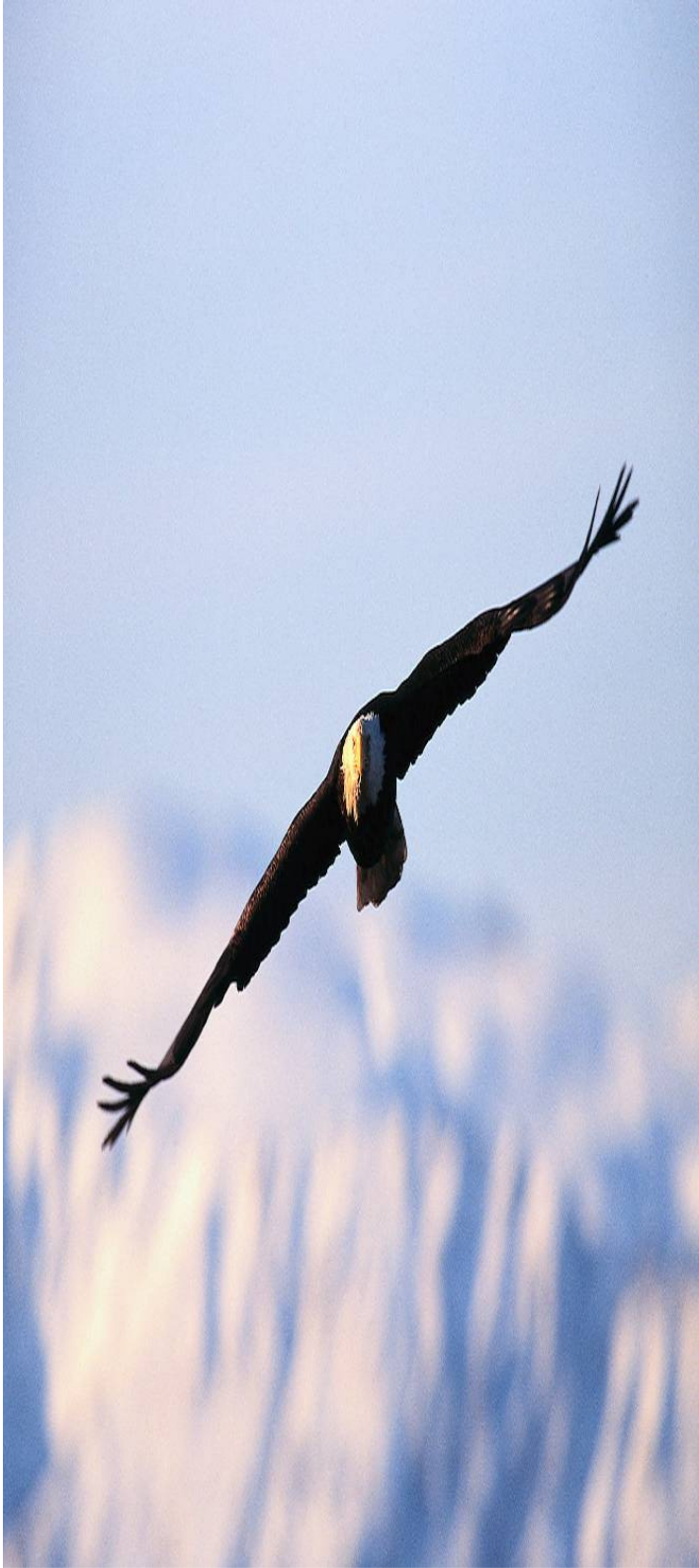
Define & agree process for specify/enable/assure functions

*Knowledgeable patients receiving safe & effective care from skilled professionals in appropriate environments with assessed outcomes*



How do we engage clinicians

Clinician = where there is a service user, and health-care professional and a decision to be made



## What does the future look like?

Knowledgeable patients

Receiving care from skilled professionals

Providing safe and effective care

In appropriate environments

With assured outcomes

Commission on Patient Safety and Quality Assurance

## Options

Quality, Safety and Risk “light”?

Selected Quality, Safety and Risk?

Delegate to “other clinicians”?

Ignore? (Status Quo)

None of these are realistic, however:

Dialogue

Reflection

Early engagement

Patience

Use of champions

Use of AHPs, Nursing colleagues

Use of Users of the Service

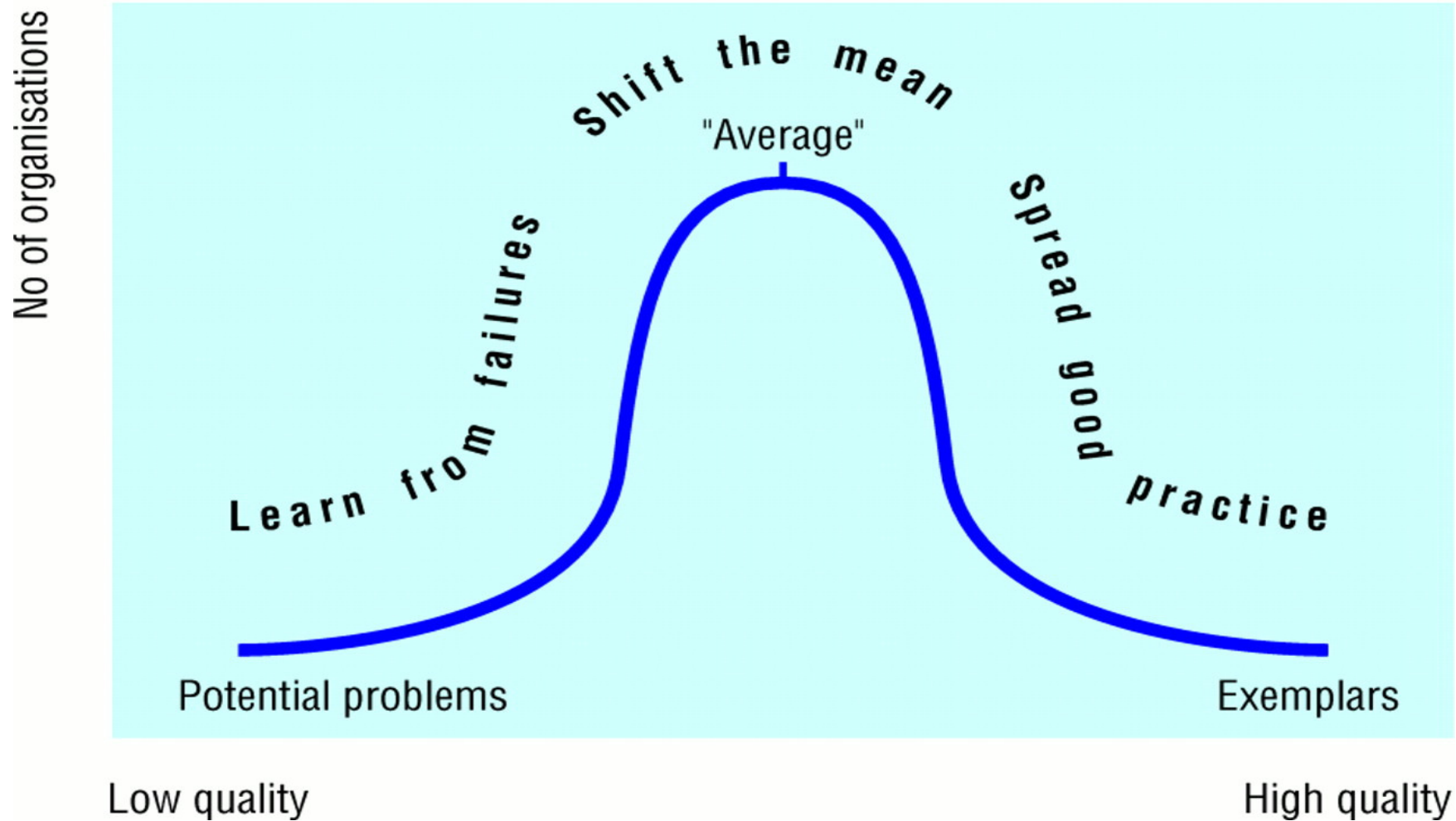
Variation (Enemy and Friend)

Use of new structures (especially Clinical Director)

Use of CPD requirement

Finally, use of disciplinary and regulatory processes

# Changing the quality curve



Scally, G. et al. *BMJ* 1998;317:61-65



*"What's the opposite of 'Eureka!'?"*