Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

A summary of the key health system and policy recommendations and decisions that have impacted urgent and emergency healthcare services in the Health Service Executive Mid West health region (2000 to 2024)

Appendix 4: Extracted information

Work stream 1 of the Review of urgent and emergency healthcare services in the Health Service Executive Mid West health region

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Table 1 Mid-Western Health Board Service Plan [2001]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource**	Mid-Western Health Board[1] Service Plan [2001] Service plan
The health service system (including health service reform)	The opening of the High Observation Unit in A&E and additional bed capacity are subject to the National Bed Capacity Review.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	Inpatient: Activity is ahead of the Service Plan target by 4% overall and this is projected to continue to year-end. Medical admissions are 4.19% ahead of target due mainly to emergency admissions. A&E: Activity is ahead of target by 4%. New patients are 7% ahead of target, but reviews are significantly below target by 15%. A&E, Anaesthetics, Theatre & ICU: ▪ The commissioning of the new A&E Department was completed with the exception of the Observation Unit and the minor operating room. ▪ A review of A & E services commenced. ▪ Commissioning of the ICU was completed with the opening of the 7th ICU bed. ▪ An additional Consultant Anaesthetist commenced. ▪ A Casualty Officer was appointed to Ennis General Hospital. Winter Initiative: contract 35 additional beds in the nursing home sector. A Management Group is in place to ensure that bed blocking does not occur where contractual arrangements are in place. Revised admission and discharge policies for those benefiting under this arrangement have been agreed and circulated. A & E, Theatre, ICU & Anaesthetics: ▪ An alternative minor injuries clinic in Limerick City. ▪ The opening of the Observation Unit and minor operating theatre area. ▪ The appointment of an A & E Nurse Practitioner. ▪ A proper transport system for inter hospital patient transfers.
Governance	No information identified.

Community healthcare (including GPs, and nursing homes)	**For information:** Two person crewing (ambulance) is operational only in Limerick City and in Ennis (at night). A comprehensive and effective service will not be realised until two-person crewing is implemented region-wide. Appointment of a Director of Primary Health Care Services and review of the Primary Care Unit. A 6-place residential respite facility for adults with significant physical disability will be opened during 2001. The Board, in collaboration with the Cheshire Foundation will develop a rehabilitative residential facility for persons with acquired brain injury (The current absence of appropriate residential facilities for adults with acquired brain injury is a cause for concern).
Staffing (including workforce planning, recruitment and retention)	▪ Increased consultant numbers in A&E and Anaesthetics under the Winter Initiative. ▪ Current deficits such as staffing levels at Ennis and Nenagh General Hospitals and the Regional Maternity Hospital will be addressed. However, additional funding provided in 2001 will progress implementation of two person crewing (ambulance). There are recruitment, station accommodation and relocation issues. Activity exceeded targets for patient transport and emergencies during 2000. ▪ The appointment of a sixth Orthopaedic Consultant and a Registrar in Ophthalmology will lead to further reductions over the coming month. ▪ The appointment of an A & E Nurse Practitioner. ▪ A total of 16 additional staff will be appointed to Ennis General Hospital to address core service deficits in medical, surgical, paramedical services and clerical support. The Medical Day Unit will open during 2001. The appointment of a Consultant Physician for this service is in process ▪ A & E, Theatre & ICU Three additional A & E Consultants and two additional Consultant Anaesthetists will be appointed subject to funding from the Department of Health & Children and approval from Comhairle na n-Ospidéal. ▪ The High Observation Unit will open subject to funding under the national review of bed capacity. ▪ A review of anaesthetic services will commence early in the New Year. The opening of an additional theatre will be considered in the context of the review.
Funding	The allocation for 2001 is £309.119m - an increase of 15.9%. The overall net value of additional funding is £26.143m. Acute Hospitals £3.550m. A further item of note is funding of £1.5m in respect of funding pressures being experienced in core services. This, though most welcome, will, however, not fully address the core funding issues being experienced, particularly in Acute Hospitals.
Other	**Evaluations** An evaluation of A & E, Pathology and Out-patient services commenced. Validation of in-patient waiting lists continued throughout the year and the validation of out-patient waiting lists commenced.
Impact	No information identified.

Table 2 Quality and Fairness - A Health System for you [2001]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Department of Health and Children[2] Quality and Fairness - A Health System for You Health Strategy [2001] Strategy
The health service system (including health service reform)	**Recommendation/considerations:** Objective 1: Standardised quality systems support best patient care and safety **Action #71** **Description:** Format for implementation plans agreed; Framework for linkages between service plans, national policy and implementation plans established **Target Date:** Early 2002; End 2002 **Responsibility:** DoHC/health boards **Action #72** **Description:** Service agreements between the health boards and the voluntary sector will be extended to all service providers and associated performance indicators will be introduced **Deliverable:** Service agreements for all voluntary providers **Target Date:** 2002-2003 **Responsibility:** Health boards/voluntary providers An independent audit of functions and structures in the health system will be carried out The Department of Health and Children will commission an audit of organisational structures and functions in the health system, to ensure clear lines of accountability and communication between each part of the system, no overlap or duplication between organisations, and a proper alignment of the structure as a whole to the vision and objectives outlined in the Health Strategy. The audit will consider the number and configuration of existing health boards and other agencies and the scope for rationalisation.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Planned actions: Acute hospital care will be developed and reformed through the creation of 3,000 extra hospital beds for public patients and a range of other measures. No public patient will wait longer than 3 months from the date of referral for the scheduling of treatment. Additional acute hospital beds will be provided for public patients ▪ Over the next ten years a total of 3,000 acute beds will be added to the system. This represents the largest ever concentrated expansion of acute hospital capacity in Ireland. The study of acute hospital bed requirements

	concluded that a figure of between 2,800 and 4,300 beds would be required over the period to 2011. The Government has decided to provide for a total of 3,000 beds, taking account of investment in non-acute facilities and community support services, increased use of day beds and a number of other factors ▪ 650 of the extra beds will be provided by the end of 2002, of which 450 will be in the public sector, thus providing extra capacity for the treatment of public patients on waiting lists. The private hospital sector will be contracted to provide 200 beds, all for treatment of public patients on waiting lists. <u>A strategic partnership with private hospital providers will be developed</u> The Government is committed to exploring fully the scope for the private sector to provide additional capacity. Accordingly, the extra beds in the period to 2011 will be provided by a combination of public and private providers. To achieve this, a strategic partnership will be developed with the private hospital sector to provide more treatment for public patients. This will be progressed by setting up a Forum under the aegis of the new National Hospitals Agency (described below) involving the public and private sectors and insurers. The key objective is to provide the required extra capacity, whether this is in the public or private hospital sector. <u>A National Hospitals Agency will be established</u> This Strategy commits the Government to a significant increase in the number of hospital beds over the next ten years. An objective, evidence-based means is required to determine the specialties in which these extra beds will be provided and their location around the country. Key decisions will need to be taken about the future configuration of existing hospitals. Co-operation between hospitals needs to be reinforced so that a fully integrated hospital system is achieved. In addition, specialist advice is regularly required on the priority that should be attached to the development of individual specialties and services in acute hospitals throughout the country. An independent agency is required which can provide expert, objective advice on these matters as they arise. A National Hospitals Agency will be established on a statutory basis under the aegis of the Department of Health and Children. Its staff will have or draw upon appropriate expertise and specialist knowledge to carry out its tasks. <u>A comprehensive set of actions will be taken to reduce waiting times for public patients, including the establishment of a new ear-marked Treatment Purchase Fund</u> A new focus will be placed on waiting times. The target is that by the end of 2004, all public patients will be scheduled to commence treatment within a maximum of three months of referral from an out-patient department. The target improvements in waiting times will be achieved by: ▪ a major expansion in acute bed capacity, as described above, together with reform of primary care, strengthening of Accident and Emergency services and provision of additional non-acute places

	▪ an ear-marked Treatment Purchase Fund which will be used to purchase treatment from private hospitals in Ireland, and from international providers. It may also make use of any capacity within public hospitals to arrange treatments for patients. A National Treatment Purchase Team appointed by the Minister for Health and Children will manage the new Treatment Purchase Fund, working closely with the health boards. The team will commence its work immediately, in parallel with other reforms below. It will work in partnership with the health boards, hospitals and consultants to ensure that waiting times for public patients are reduced as quickly as possible. The National Treatment Purchase Team will enter into immediate discussions with relevant hospitals and consultants to make streamlined arrangements to ensure that patients are offered the treatment they need. It is essential for the successful operation of the scheme that management procedures are highly efficient and that there is no avoidable delay in sourcing and referral of patients to the treatment needed. <u>Management and organisation of waiting lists will be reformed</u> The National Hospitals Agency, working with the health boards and ERHA, will, in consultation with relevant professional bodies, lead the development of guidelines for referral and prioritisation of patients within and between specialties, particularly those where there are lengthy waiting times. The guidelines will assist general practitioners in making referrals in keeping with best clinical practice and consultants in managing waiting lists/times. <u>One-day procedures will be used to the maximum consistent with international best practice</u> The National Hospitals Agency will work with the health boards and the ERHA to achieve increases in one-day procedures in line with international best practice. The target improvements in waiting times will be achieved by: ▪ a major expansion in acute bed capacity, as described above, together with reform of primary care, strengthening of Accident and Emergency services and provision of additional non-acute places ▪ an ear-marked Treatment Purchase Fund which will be used to purchase treatment from private hospitals in Ireland, and from international providers. It may also make use of any capacity within public hospitals to arrange treatments for patients. A National Treatment Purchase Team appointed by the Minister for Health and Children will manage the new Treatment Purchase Fund, working closely with the health boards. The team will commence its work immediately, in parallel with other reforms below. It will work in partnership with the health boards, hospitals and consultants to ensure that waiting times for public patients are reduced as quickly as possible. The National Treatment Purchase Team will enter into immediate discussions with relevant hospitals and consultants to make streamlined arrangements to ensure that patients are offered the treatment they need. It is essential for the successful operation of the scheme that management procedures are highly efficient and that there is no avoidable delay in sourcing and referral of patients to the treatment needed.

	<u>A substantial programme of improvements in accident and emergency departments will be introduced</u> Significant initiatives will be taken to improve the operation of accident and emergency departments by directing patients to the most appropriate form of care and ensuring that those who need treatment are seen as quickly as possible. ▪ Additional A&E consultants will be appointed to organise and run A&E departments. The increased availability of senior medical staff will facilitate rapid clinical decision making, enhanced management, diagnosis and treatment of patients. ▪ Triage procedures will be put in place to help channel patients quickly to the most appropriate form of care. ▪ The establishment of 24-hour GP co-operatives as part of the strengthening of primary care will help to reduce demand from, and treat appropriately, patients who would otherwise have to attend at an A&E department. ▪ Minor injury units will be established to ensure appropriate treatment and management of non-urgent cases. ▪ Chest pain clinics, respiratory clinics and in-house specialist teams will be used to fast-track patients as appropriate. ▪ Diagnostic services will be organised to ensure increased access to and availability of services at busy times in A&E departments. ▪ Advanced Nurse Practitioners (ANPs) (Emergency) will be appointed in acute hospitals. ANPs diagnose and treat certain groups of patients independently within agreed protocols. ▪ Admission protocols will ensure that emergency patients will be the only group of patients admitted to hospital through the A&E department. ▪ Hospitals will ensure that a member of staff will be available to liaise with patients while they await diagnosis and treatment at A&E departments. ▪ Information systems will be introduced that record comprehensive, comparable and reliable data on activity in A&E departments. Such information will provide staff with a valuable tool in structuring services to meet the needs of patients. <u>The extra acute beds in public hospitals will be designated for use by public patients</u> All of the extra acute hospital capacity within the public sector, both in-patient beds and day beds, will be designated for use by public patients. The only exceptions will be Intensive Care Units, Coronary Care Units and other specialised beds which will continue to be non-designated. The provision of additional beds announced in this Strategy will be a significant step forward in ensuring that the needs of public patients are adequately met. **Acute Hospital System Actions (78-91**) **<u>Action #78</u>** **Description:** Additional acute hospital beds will be provided for public patients **Deliverable:** 650 extra beds; Rising to 3,000 extra beds **Target Date:** End 2002; 2011 **Responsibility:** Health boards

	Action #79 **Description:** A strategic partnership with private hospital providers will be developed **Deliverable:** Forum established under National Hospitals Agency **Target Date:** 2002 **Responsibility:** National Hospitals Agency/health boards **Action #80** **Description:** A National Hospitals Agency will be established **Deliverable:** Agency established **Target Date:** End 2002 **Responsibility:** DoHC **Action #81** **Description:** A comprehensive set of actions will be taken to reduce waiting times for public patients **Deliverable:** Targets to ensure that no public patient will wait longer than three months for treatment following referral from an out-patient department **Target Date:** End 2004; Intermediate targets in end 2002 and end 2003 **Responsibility:** DoHC/National Treatment Purchase Team/Health boards **Action #82** **Description:** Management and organisation of waiting lists will be reformed **Deliverable:** Set of measures implemented **Target Date:** Ongoing **Responsibility:** Health boards/service providers **Action #83** **Description:** One-day procedures will be used to the maximum **Deliverable:** Increase in proportion of one-day procedures **Target Date:** Ongoing **Responsibility:** Health boards/service providers **Action #84** **Description:** The organisation and management of services will be enhanced **Deliverable:** Set of short-term measures; Long-term measures **Target Date:** Jun 2002; Ongoing

	Responsibility: Health boards/service providers **Action #85** **Description:** The operation of out-patient departments will be improved **Deliverable:** Provision of individual appointment times; Referral protocols development **Target Date:** Immediate; Ongoing **Responsibility:** Health boards/service providers **Action #86** **Description:** A substantial programme of improvements in accident and emergency departments will be introduced **Deliverable:** Additional A & E consultants appointed; Assessment unit to channel patients quickly; Advanced nurse practitioners (emergency) appointed; Improve facilities **Target Date:** Ongoing **Responsibility:** Health boards/service providers **Action #87** **Description:** Diagnostic services for GPs and hospitals will be enhanced **Deliverable:** Strengthening of diagnostic facilities for GPs; Enhanced arrangements for GP access to hospital diagnostic facilities; Extended service hours for diagnostic departments **Target Date:** Ongoing **Responsibility:** Health boards/service providers **Action #88** **Description:** The extra acute beds in public hospitals will be designated for public patients **Deliverable:** Formal designation order **Target Date:** Immediately as beds are provided **Responsibility:** DoHC **Action #89** **Description:** Greater equity for public patients will be sought in a revised contract for hospital consultants **Deliverable:** Agreement on revised contract **Target Date:** End 2002 **Responsibility:** DoHC **Action #90**

	Description: The rules governing access to public beds will be clarified **Deliverable:** Implementation of rules **Target Date:** End 2001 **Responsibility:** DoHC/Health boards/service providers **<u>Action #91</u>** **Description:** Action may be taken to suspend admission of private patients for elective treatment **Deliverable:** Monitoring of public/private mix **Target Date:** Ongoing **Responsibility:** Health boards/service providers
Governance	**Recommendation/considerations:** Implementing the Strategy in the health system ▪ A National Implementation Team will be established within the Department of Health and Children to drive the implementation of this Strategy within the health system at national level. It will co-ordinate and monitor actions within the Department, at Government and inter-departmental level and within the health boards and other agencies in the health services. This Unit will service the Cabinet Sub-Committee and the Inter-Departmental Group of senior officials. ▪ **The National Implementation Team will prepare an annual report to the Cabinet Sub-Committee on the progress achieved in implementing each key aspect of the Strategy,** and identifying the next steps to be taken in the coming years. This report will be submitted to the Joint Oireachtas Committee on Health and Children, and made widely available. ▪ A National Steering Group, to include a number of people outside the health sector who have practical experience of change management, will be established to work with the Department and health agencies. It will oversee and report to the Minister for Health and Children on the implementation of the Strategy. The National Steering Group will provide expertise and hands-on experience in achieving the momentum needed for the changes set out in the Strategy. The Department of Health and Children will, as part of the service planning process, require each health board to specify the formal evaluations to be undertaken by their respective monitoring and evaluation units. In the case of the eastern region, the service areas selected for review will be identified by the Eastern Regional Health Authority rather than the three Area Health Boards in the region. *Wider stakeholders* ▪ National Forum of all stakeholders to review implementation reports of the Department's Health Strategy Unit and reports on monitoring and evaluation ▪ Further development of partnership structures for staff involvement in implementation of Health Strategy at local

	and national level
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Planned actions in primary care: <u>A new model of primary care will be developed</u> The detailed description of the new model, Primary Care: A New Direction, is being published alongside this Strategy, and will be circulated to all key stakeholders. The model described sets out the principles for progress; it does not purport to address all of the detailed issues that will need to be worked through in the implementation phases. This will require consultation on an ongoing basis with all the relevant stakeholders. The model will be implemented on a phased basis over a two to ten-year timeframe. <u>A National Primary Care Task Force will be established</u> A small full-time task force will be established to take responsibility for driving the implementation of the changes and developments set out in the model. The task force will be inter-disciplinary and will report to a wider representative Steering Group which will be chaired by the Department of Health and Children and include representation from health boards, primary care professional groups, unions, and other relevant stakeholders. <u>Implementation projects will be put in place</u> Locations for implementation projects will be chosen in each health board region for the development of primary care teams over the next two to four years (40-60 teams nationally). The concentration in the initial stages will be in locations where there is already evidence of successful partnership and co-operation between general practice and health board services. Evaluation of these implementation projects will inform the further phased development of teams in remaining parts of the country which will lead to the development of 400-600 teams to cover approximately two-thirds of the population by 2011. <u>Investment will be made in extension of GP co-operatives and other specific national initiatives to complement the primary care model</u> ▪ In the short-term, GP co-operatives will be established on a national basis so that effective out-of-hours services are available in all parts of the country. In addition, other specific developments on a national basis will include: general increases in personnel needed for primary care teams and wider networks leading to improved out of-hours services ▪ new physical infrastructure and equipment ▪ improvements in information and communications technology **Objective 2: Appropriate care is delivered in the appropriate setting** **<u>Action #53</u>**

	Description: Initiatives will be developed and implemented to ensure that care is delivered in the most appropriate setting **Deliverable:** Primary care development; Review of clinical pathway systems; Review of charges **Target Date:** Ongoing; Ongoing; Completed 2002 **Responsibility:** Health boards/HeBE **Action #54** **Description:** Community and voluntary activity in maintaining health will be supported **Deliverable:** Programmes to support informal carers expanded and extended; Programmes to support voluntarism developed; First responder service developed; Funding arrangements for national bodies streamlined **Target Date:** Commencing 2002 in all health boards; December 2002; Ongoing; From 2002 onwards **Responsibility:** Health boards; Steering Committee for the White Paper on Supporting Voluntary Activity; DoHC/health boards; HeBE **Objective 3: The system has the capacity to deliver timely and appropriate services** **Action #55** **Description:** A programme of investment to provide the necessary capacity in primary care, acute hospital and other services will begin **Deliverable:** Enhanced services across a range of programmes **Target Date:** 2002-onwards **Responsibility:** DoHC **Action #57** **Description:** Measures to provide the highest standard of pre-hospital emergency care/ambulance services will be advanced **Deliverable:** Development of standards; Community training of GPs and other health care professionals; Training in clinical protocols; Resuscitation training for all staff in acute hospitals **Target Date:** All ongoing **Responsibility:** DoHC/Pre-Hospital Emergency Care Council/service providers **Primary care** **Action #74** **Description:** A new model of primary care will be developed **Deliverable:** Primary Care: A New Direction published **Target Date:** Immediate

	Responsibility: Primary Care Task Force/health boards **<u>Action #75</u>** **Description:** A National Primary Care Task Force will be established **Deliverable:** National Primary Care Task Force established **Target Date:** Jan-02 **Responsibility:** DoHC **<u>Action #76</u>** **Description:** Implementation projects will be put in place **Deliverable:** 40-60 primary care teams and networks in place; 400-600 primary care teams and networks in place **Target Date:** End 2006; End 2011 **Responsibility:** Primary Care Task Force/health boards **<u>Action #77</u>** **Description:** Investment will be made in extension of GP co-operatives and other specific national initiatives **Deliverable:** GP co-operatives nationally; Increase in personnel needed in both teams and networks; New physical infrastructure and equipment; Improved information and communications technology **Target Date:** End-2003; Ongoing; Ongoing; End 2011 **Responsibility:** Primary Care Task Force/health boards/Health Service Employers Agency
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** ▪ Nurses/Midwives: 10,000 nurses will be trained over the lifetime of the Strategy ▪ Health and social care professionals: An extra 1,330 physiotherapists, 985 speech and language therapists and 875 occupational therapists will be trained, to meet the requirements up to 2015 identified by the recent report (Bacon, 2001) on these grades ▪ Health care assistants: 340 Health care assistants will be trained by April 2000
Funding	**Planned actions:** **Table 3. Funding, Human Resources, Organizational Reform & Information Actions (92-121)** **<u>Action #92</u>** **Description:** Additional Investment will be made in the health system **Deliverable:** Continued increases for specified purposes **Target Date:** 2002 onwards **Responsibility:** Department of Finance/DoHC

	Action #93 **Description:** Capital funding will be allocated for regular maintenance of facilities and planned replacement of equipment **Deliverable:** Facilities and equipment properly maintained **Target Date:** Ongoing **Responsibility:** DoHC/health boards **Action #94** **Description:** Public-private partnerships will be initiated **Deliverable:** Selected projects **Target Date:** Ongoing **Responsibility:** DoHC/health boards **Action #95** **Description:** Multi-annual budgeting will be introduced for selected programmes **Deliverable:** Movement towards multi-annual budgeting and planning **Target Date:** Ongoing **Responsibility:** Department of Finance/DoHC **Action #96** **Description:** The allocation process will be reviewed by the Department of Health and Children **Deliverable:** Document on allocation system **Target Date:** 2002 **Responsibility:** DoHC **Action #97** **Description:** Financial incentives for greater efficiency in acute hospitals will be strengthened **Deliverable:** Refinement of casemix budget model and extension in coverage **Target Date:** Oct-02 **Responsibility:** DoHC **Action #98** **Description:** Annual statements of funding processes and allocations will be published **Deliverable:** Annual statements by Department and health boards **Target Date:** 2002 onwards

	Responsibility: DoHC/health boards **Action #99** **Description:** The management of capital projects will be enhanced **Deliverable:** Review of process completed/proposals for change **Target Date:** Dec-02 **Responsibility:** DoHC/health boards **Action #100** **Description:** Integrated workforce planning will be introduced on a national basis **Deliverable:** Integrated set of plans for health staff **Target Date:** Ongoing **Responsibility:** DoHC/health boards **Action #101** **Description:** The required number of extra staff will be recruited **Deliverable:** Increases in each targeted area **Target Date:** Specified increases in number trained in 2002; subsequent increases over lifetime of Strategy **Responsibility:** Health boards/other relevant health agencies **Action #102** **Description:** The approach to regulating the number and type of consultant posts will be streamlined **Deliverable:** New procedure in line with the service planning process **Target Date:** 2002 **Responsibility:** DoHC/health boards **Action #103** **Description:** Best practice in recruitment and retention will be promoted **Deliverable:** Guidelines on best practice **Target Date:** Sep-02 **Responsibility:** Office for Health Management/Health Services Employers Agency **Action #104** **Description:** Greater inter-disciplinary working between professions will be promoted **Deliverable:** Adaption of training programmes

	Target Date: Ongoing **Responsibility:** DoHC/professional bodies **Action #105** **Description:** Provisions for the statutory registration of health professionals will be strengthened and expanded **Deliverable:** Revise legislation on doctors; Revise legislation on nurses; New legislation on other health professionals **Target Date:** 2003 **Responsibility:** DoHC **Action #106** **Description:** Registration of alternative/complementary therapists will be introduced **Deliverable:** Independent study of the practical steps required to be published **Target Date:** Mar-02 **Responsibility:** DoHC **Action #107** **Description:** The HR function in the health system will be developed **Deliverable:** Flexible human resource models established **Target Date:** Dec-02 **Responsibility:** DoHC/Health Services Employers Agency **Action #108** **Description:** A detailed Action Plan for People Management will be developed **Deliverable:** Publication of Action Plan **Target Date:** Oct-02 **Responsibility:** DoHC/Health Services Employers Agency **Action #109** **Description:** The Department of Health and Children will be restructured **Deliverable:** Independent review completed; New organisational structure in place **Target Date:** June 2002; December 2002 **Responsibility:** DoHC/independent consultants **Action #110**

	Description: Health boards will be responsible for driving change **Deliverable:** Increased link between service planning and service provision **Target Date:** Ongoing **Responsibility:** Health boards **Action #111** **Description:** An independent Health Information and Quality Authority will be established **Deliverable:** Authority established **Target Date:** 2002 **Responsibility:** DoHC **Action #112** **Description:** The Health Boards Executive (HeBE) will be developed **Deliverable:** HeBE established and operational **Target Date:** Mar-02 **Responsibility:** DoHC/health boards **Action #113** **Description:** The role of the Office for Health Management will be expanded **Deliverable:** Expanded role agreed with Office for Health Management **Target Date:** 2002 **Responsibility:** DoHC/Office for Health Management **Action #114** **Description:** An independent audit of functions and structures will be carried out **Deliverable:** Audit completed **Target Date:** Jun-02 **Responsibility:** DoHC/independent consultants **Action #115** **Description:** The National Health Information Strategy will be published **Deliverable:** Publication of National Health Information Strategy **Target Date:** Dec-01 **Responsibility:** DoHC

	Action #116 **Description:** There will be a sustained programme of investment in health information systems **Deliverable:** Specific developments in the information infrastructure **Target Date:** Ongoing **Responsibility:** DoHC/health boards/Health Information and Quality Authority **Action #117** **Description:** Information and communications technology will be fully exploited **Deliverable:** Implementation of the National Health Information Strategy **Target Date:** Ongoing **Responsibility:** DoHC/health boards/Health Information and Quality Authority **Action #118** **Description:** Information-sharing systems and electronic patient records will be introduced **Deliverable:** Phased implementation of the electronic health-care record **Target Date:** Ongoing **Responsibility:** DoHC/health boards/Health Information and Quality Authority **Action #119** **Description:** A national secure communications infrastructure will be developed **Deliverable:** Health services secure network **Target Date:** 2004 **Responsibility:** DoHC/health boards/Health Information and Quality Authority **Action #120** **Description:** Information system development will be promoted as central to planning **Deliverable:** Enhanced planning protocols in place **Target Date:** 2002 **Responsibility:** DoHC/health boards **Action #121** **Description:** Health information legislation will be introduced **Deliverable:** Bill published **Target Date:** 2002 **Responsibility:** DoHC

Other	**Recommendation/considerations:** **Action #52** **Description:** Provision will be made for the participation of the community in decisions about health service delivery. **Deliverable: E**xtension of key workers; Public information campaigns; Establishment of consumer panels, regional advisory panels, and a National Strategy Forum. **Target Date:** Early 2002 - Oct. 2002 **Responsibility:** DoHC/HeBE, Health boards
Impact	No information identified.

Table 3 Primary Care A New Direction [2001]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Department of Health and Children[3] Primary Care A New Direction [2001] Strategy
The health service system (including health service reform)	**Recommendation/considerations:** There will be greater integration between primary and secondary care: Integration initiatives, aimed at enhancing communication and exchange between primary and secondary care, should be locally agreed but within a national framework to be developed by the National Primary Care Task Force. They will include: ▪ referral guidelines and protocols for consultant care and diagnostic services ▪ discharge plans agreed between the hospital and a key primary care worker ▪ integrated care pathways facilitated by key workers ▪ individual care plans for certain people, appropriate to their needs ▪ shared care arrangements for specific health conditions
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	No information identified.
Governance	**Recommendation/considerations:** Individual health boards will prepare needs assessments for primary care teams A National Primary Care Task Force will be established. A small, full-time task force, called the National Primary Care Task Force, will be established to take responsibility for driving the implementation of the changes and developments set out in the model. The Task Force will be inter-disciplinary and will report to a wider representative Steering Group which will be chaired by the Department of Health and Children and include representation from health boards, primary care professional groups, unions, and other relevant stakeholders. The Task Force will focus on: ▪ driving the implementation of the primary care model as outlined in this strategy ▪ identifying representative locations for the implementation projects ▪ planning human resources, information and communications technology and capital requirements for primary care on a national basis ▪ putting in place a framework for the extension of GP co-operatives on a national basis with specific reference to payment methods and operational processes.

	▪ The Steering Group will give leadership in: – defining a broad set of primary care services which should be provided by primary care teams – co-ordinating the development of quality initiatives in primary care – identifying locations for the establishment of academic centres of primary care as a source of policy and practice advice – developing a national framework for achieving closer integration with the secondary care system – providing policy advice to the Department of Health and Children, health boards and other bodies as appropriate ▪ evaluating progress, including an annual report on implementation, on the basis of an agreed set of performance indicators.
Community healthcare (including GPs, and nursing homes)	**Planned actions:** Suitable locations will be identified for the introduction of implementation projects with a view to having 40 to 60 teams [primary care teams], covering an overall population of approximately 300,000, up and running within 3 to 5 years. The locations of primary care teams for the implementation projects will be selected so that teams can operate in close proximity The level of integration and enhancement required will need to be supported through investment in physical infrastructure, to provide a co-ordinated, user-friendly, inter-dependent range of services in a suitable location and physical environment. ICT: The costs involved per team are estimated at £60,000 (€76,000) start-up and £15,000 (€19,000) per annum on an ongoing basis, exclusive of training costs. Based on this, together with the ICT costs in developing the wider network, the implementation projects will involve an initial investment of some £5 million (€6.3M) with annualised costs running at an additional £1 million (€1.27M). In the longer term, it is estimated that an investment of up to £50 million (€63M) once-off and recurring costs of £10 million (€12.7M) per annum will be entailed at the end of ten years. Further development of current GP co-operative models will take place on a national basis as a key support to the enhanced availability for a defined range of primary care services on a 24-hour basis **Action #1** **Description:** A National Primary Care Task Force will be established. **Deliverable:** Task Force established **Target Date:** Jan-02 **Responsibility:** Department of Health and Children **Action #2** **Description:** Individual health boards will prepare needs assessments for primary care teams.

	Deliverable: 10 needs assessments completed. **Target Date:** End 2002 **Responsibility:** Health boards **Action #3** **Description:** A Primary Care Human Resource Plan will be produced. **Deliverable:** Human Resource Plan for Primary Care. **Target Date:** End 2003 **Responsibility:** Primary Care Task Force, Health Service Employers Agency and health boards **Action #4** **Description:** Primary care teams will be put in place to meet the health and social care needs for a specific population. **Deliverable:** 20-30 primary care teams for implementation projects; 400-600 teams in place by 2011. **Target Date:** End 2011 **Responsibility:** Primary Care Task Force, Health Service Employers Agency, Inter-Departmental Committee, education sector **Action #5** **Description:** Primary care networks will be developed to support the primary care teams. **Deliverable:** Network arrangements for 20-30 implementation projects by 2003; 400-600 teams by 2011. **Target Date:** End 2011 **Responsibility:** Primary Care Task Force and health boards **Action #6** **Description:** Availability of primary care services out-of-hours will be extended. **Deliverable:** Extended hours and GP co-operatives available nationally. **Target Date:** End 2003 **Responsibility:** Primary Care Task Force and health boards **Action #7** **Description:** A system of voluntary enrolment will be introduced for primary care users. **Deliverable:** System in place in each health board. **Target Date:** End 2005 **Responsibility:** Primary Care Task Force, Department of Health and Children, Inter-Departmental Committee, Health Information and Quality Authority

	Action #8 **Description:** An improved information and communications infrastructure will be provided for primary care teams. **Deliverable:** Electronic patient records and supporting ICT infrastructure in place for 40-60 implementation projects. **Target Date:** End 2004 **Responsibility:** Primary Care Task Force; health boards and Health Information and Quality Authority **Action #9** **Description:** A system of direct telephone and electronic access to primary care services will be introduced for each health board area. **Deliverable:** 1850 number, support software, website and trained personnel in place in each health board. **Target Date:** End 2003 **Responsibility:** Primary Care Task Force and health boards **Action #10** **Description:** There will be greater integration between primary and secondary care. **Deliverable:** Frameworks for referral, care pathways, shared care, access to diagnostic services, and discharge arrangements between primary and secondary care in place. **Target Date:** End 2003 **Responsibility:** Primary Care Task Force, health boards and Health Information and Quality Authority **Action #11** **Description:** Community-based diagnostic centres will be piloted. **Deliverable:** Three community-based diagnostic centre pilot projects in place; Diagnostic centre pilot projects evaluated. **Target Date:** End 2007 **Responsibility:** Primary Care Task Force and health boards **Action #12** **Description:** Policy support for the primary care model will be provided by the Department of Health and Children. **Deliverable:** Responsibility for primary care identified in the restructuring of the Department. **Target Date:** Ongoing **Responsibility:** Department of Health and Children

	Action #13 **Description:** Appropriate administrative arrangements will be put in place to support primary care at local level. **Deliverable:** Agreement on local management structures to support the model following audit of functions and structures in the health system. **Target Date:** End 2003 **Responsibility:** Department of Health and Children, Primary Care Task Force and health boards **Action #14** **Description:** Investments will be made in the extension of GP co-operatives and other national initiatives to complement the primary care model **Deliverable:** GP co-operatives available nationally, increases in personnel, physical infrastructure and ICT availability. **Target Date:** End 2003, Ongoing **Responsibility:** Primary Care Task Force, Health Service Employers Agency, Health Boards, Health Information and Quality Authority **Action #15** **Description:** Modules of joint training and education of primary care professionals will be developed. **Deliverable:** Inter-disciplinary training modules (postgraduate) in place. **Target Date:** End 2005 **Responsibility:** Primary Care Task Force, Inter-Departmental Committee, Education Sector **Action #16** **Description:** Continuing professional and personal development programs will be made available to primary care professionals. **Deliverable:** Programs in place in each health board. **Target Date:** End 2003 **Responsibility:** Primary Care Task Force, Health Boards, Office for Health Management **Action #17** **Description:** A framework for quality assurance in primary care will be developed. **Deliverable:** Framework developed and agreed. **Target Date:** End 2004 **Responsibility:** Primary Care Task Force, Health Boards, Irish Centre for Health Excellence

	Action #18 **Description:** Academic practice and research will be developed. **Deliverable:** Five academic centres in place. **Target Date:** End 2006 **Responsibility:** Primary Care Task Force, Education Sector, Health Research Board, Inter-Departmental Committee, Health Information and Quality Authority **Action #19** **Description:** Mechanisms for active community involvement in primary care teams will be established. **Deliverable:** Consultation with consumer panels in each health board about primary care. **Target Date:** Ongoing **Responsibility:** Health Boards **Action #20** **Description:** Strategy for Nursing and Midwifery in the Community will be developed. **Deliverable:** Publication of Strategy for Nursing and Midwifery in the Community. **Target Date:** End 2002 **Responsibility:** Department of Health and Children
Staffing (including workforce planning, recruitment and retention)	**Planned actions:** Primary care teams will be put in place to meet the health and social care needs for a specific population 20-30 primary care teams for implementation projects by end of 2003 40-60 primary care teams for implementation projects by end of 2005 400-600 primary care teams in place by end of 2011
Funding	**Planned actions:** Investments will be made in extension of GP co-operatives and other specific national initiatives to complement the primary care model The full extension of the new model of primary care will require a sustained programme of investment in staffing, buildings and equipment over the next ten years. This increased level of investment will address specific areas needed to complement the new model of primary care including: ▪ GP co-operatives ▪ General increases in personnel needed for primary care teams and wider networks leading to improved out of-hours services ▪ Information and communications technology Primary care centres: Taking an initial 40 to 60 implementation projects, and allowing for the fact that the selection of locations will be guided by the availability of good infrastructure where it exists, it can be expected

	that a capital outlay of approximately £100 million (€127M) will be required during the initial five-year implementation phase. In the longer term, on the assumption that between 400 and 600 core primary care teams will be required for two-thirds implementation in 2011, the capital investment would be in the order of £1,000 million (€1,270M) at current prices. The National Development Plan may provide some of this investment. Staffing: the total cost of the implementation projects would amount to £48 million (€61M).6 Taking into account estimates of existing expenditure, some £25-30 million (€32-38M) additional investment on human resources will be required over the next five years. Assuming two-thirds implementation (400-600 teams) of the model over the next ten years, approximately an additional 500 GPs and 2,000 nurses/midwives will be required, with similar large increases in health and social care professionals, administrative staff, home helps and health care assistants in order to provide in the range of 400-600 teams. Co-operatives: it is expected that a number of teams would come together to provide out-of-hours coverage for population groups. To provide the infrastructure required for the operation of the enhanced 24-hour service an annual cost in the region of £25 million (€32M) is estimated.
Other	No information identified.
Impact	The increases in therapy professionals are in keeping with requirements set out in projections made for the Department of Health and Children in the Bacon Report entitled Current and future supply and demand conditions in the labour market for certain professional therapists.

Table 4 Mid-Western Regional Hospitals Operational Plan [2002]

	Information extract
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Mid-Western Regional Hospitals[4] Mid-Western regional hospitals operational plan [2002] Service plan
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** The balance between public/private bed provision requires adjustment as part of any increase in capacity **For information:** In-patient capacity Inadequate Bed Capacity leading to occupancy levels continuously above 85%, which in turn leads to bed shortages on an ongoing basis. The balance between public/private bed provision requires adjustment as part of any increase in capacity. The commissioning of new units, which commenced in 2000 is not yet complete. In-Patient Activity Overall Inpatient Activity exceeded target levels by 1.8%. Medical inpatient activity was ahead of target by 2.8%, but emergency medical admissions accounted for a 5% increase (see Geriatric Assessment/Rehab, Cardiology and Heamatology), balanced by a reduction of 16% in elective medical admissions. Cardiology and General Medicine elective targets were the main areas affected by the high demand for emergency admissions. A&E Activity A&E new patient activity was down by 5.9% against target levels for 2001 and down (by 4.7%) compared with activity levels in 2000. A&E review attendances were up by 56% on targeted levels for 2001 and were up by 49% on activity for the same period in 2000. This is a mainly attributed to a re-definition of review patients (and counting methods) and structured review clinics recently established rather than a significant increase in review attendances. This is being examined further. The percentage of re-attendances at the A&E Department was 8.5% in 2001 compared with 5.7% in 2000 A new book of Protocols and Policies related to the Emergency Department was produced. - A review of the operation of the Emergency Department is ongoing. The percentage of re-attendances at the A&E Department was 8.5% in 2001 compared with 5.7% in 2000. SIGNIFICANT ISSUES: Gaps in other service areas tend to reflect in inappropriate referrals to A&E Departments, which in turn contribute to long delays or reflect in inappropriate lengths of stay in acute hospitals.

	Developments 2002 A&E, Theatre & ICU - An additional theatre will be opened in conjunction with an increase in bed capacity. 13.5 posts are included for this purpose, which is part of commissioning. The A&E Review has highlighted the following issues requiring attention: ▪ Extension to Paediatrics Waiting room and equipment storage. ▪ Alternative admission pathways for Psychiatric, Geriatric and Opthalmic patients. ▪ Finalise the introduction of the IT system for the Emergency Department. ▪ The need to open the Minor Operations Theatre. ▪ The need to develop the role of A&E Nurse Practitioner. ▪ The need to develop a role of GP Liaison Nurse. <u>Bed Capacity</u> A number of measures to improve bed capacity commenced in 2001 including the observation unit in A&E (9 beds), Minor Injuries Clinic at St. John's Hospital and a High Dependency Unit (4 beds). An additional sum of -0.762m is provided to meet the full year costs of those initiatives. Note: Further Bed Capacity measures to be funded on foot of the commitment in the new Health Strategy, Quality and Fairness: A Health System for you, will be the subject of discussions with the Board. Additional WTE'S are included in anticipation of additional funding for this purpose. An additional theatre will be opened in conjunction with an increase in bed capacity. 13.5 posts are included for this purpose, which is part of commissioning. <u>Waiting Lists</u> The Inpatient Waiting List numbers were reduced by 9% for the period January to October 2001. Much emphasis has focused on the specialities of ENT and Orthopaedics and Ophthalmology where reductions of 23%, 27% and 5% respectively have been achieved. It is evident that further work is necessary to achieve targets in Ophthalmology. Additional measures were also implemented in the last quarter of 2001 to achieve further reductions and improved waiting times. The Inpatient waiting list is projected to decrease by 220 (29%) in the period from January to December 2001. The specialities of ENT, Orthopaedics and Ophthalmology have seen the greatest reductions. The retention of additional support staff, the 'red circling' of beds and the employment of additional staff in the last quarter as a result of additional funding are the key contributory factors. The funding allocated for 2002 (Euro 1,590m) will enable a further reduction of 30% in numbers and waiting times in the targeted specialities and will bring most of the targeted specialties within the proposed national guidelines. <u>New units</u>

	The phlebotomy and ECG services were expanded at the Mid-Western Regional Hospital to provide a weekend service. The High Dependency Unit opened in December. Additional medical beds in General Medicine. <u>Winter Initiative</u> ▪ A Management Group is in place to manage this scheme. ▪ Between January and March 2001, a total of 70 beds were contracted in 23 nursing homes in the region. This service was reactivated from October 2001 and continues as a winter scheme. Thirteen nursing homes are currently participating. ▪ A number of additional proposals are being considered including the expansion of re-habilitation services. ▪ Additional funding was made available to provide a range of supports including medical aids and appliances to facilitate the discharge of older people from acute hospitals and reduce the level of hospital re-admissions. ▪ The Winter Initiative, which commenced in October 2000, will continue with the contracting of nursing home beds to facilitate earlier discharge from acute beds. Other measures under consideration include the expansion of rehab services. ▪ Additional funding (Euro .530m) has been provided to meet the full year costs of consultant appointments under this scheme (A&E Consultants and Consultant Anaesthetists).
Governance	No information identified.
Community healthcare (including GPs, and nursing homes)	**For information:** SIGNIFICANT ISSUES: Gaps in current service provision including some Consultant led services e.g. Neurology, Radiotherapy, inadequate capacity in some services and the absence other specialist provided services e.g. Advanced Nurse Practitioners, Orthoptists places an additional burden on core service providers or on patients who may have to wait for services or travel outside the region.
Staffing (including workforce planning, recruitment and retention)	**For information:** To date all paramedical development posts have been filled in addition to Nursing, Medical and Non Nursing posts in Haematology, Dermatology and A&E The remainder of the development posts are held pending announcements under the bed capacity initiative. The Medical Day Unit commenced in August with the appointment of a Consultant Physician and 9.5 support staff. An additional SHO was appointed at the Mid-Western Regional Hospital to provide improved medical cover for trauma patients. Accident & Emergency, Theatre & ICU - An additional A &E Consultant was appointed on a temporary basis at the Mid-Western Regional Hospital. - The Observation Unit opened in August with 13 additional staff. - A Minor Injuries Unit commenced in July at St. John's Hospital.

	- Clerical support services in A&E were extended to cover the period 8.00a.m. to 12.00a.m. on a 7 day week basis at the Mid-Western Regional Hospital. - A CNM 3 was appointed to Theatre in the Mid-Western Regional Hospital. A total of 16 WTEs to support front line nursing staff and Directors of Nursing were appointed. Winter Initiative: - Two additional Consultant Anaesthetists were appointed to Nenagh and Ennis General Hospitals.
Funding	**For information:** The expectation is that the budget for 2001 will achieve breakeven. Further Bed Capacity measures to be funded on foot of the commitment in the new Health Strategy, Quality and Fairness: A Health System for you, will be the subject of discussions with the Board. Additional WTE'S are included in anticipation of additional funding for this purpose. Additional funding (Euro .530m) has been provided to meet the full year costs of consultant appointments under this scheme (A&E Consultants and Consultant Anaesthetists).
Other	No information identified.
Impact	Further Bed Capacity measures to be funded on foot of the commitment in the new Health Strategy, Quality and Fairness: A Health System for you, will be the subject of discussions with the Board. Additional WTE'S are included in anticipation of additional funding for this purpose.

Table 5 Report of the Committee on Accident and Emergency Services [2002]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Comhairle na nOspidéal[5] Report of the Committee on Accident and Emergency Services (2002) Committee report
The health service system (including health service reform)	**Recommendation/considerations:** Having taken population catchment size, attendance rates, accessibility, demographics, the hospital network, clinical resources, diagnostic resources, staffing profile and national and international best practice into account, the Committee recommends 13 Regional Emergency Departments. Specific recommendations for each health board and hospital are set out in later sections of this report. Structure of Hospital Emergency Services The Committee recommends that a three-tiered Emergency Department system be adopted nationally. Within this system, the three tiers would be as follows: 1. Regional Emergency Departments Such departments would be located in major regional hospitals and would serve a catchment population of about 250,000. Each of these hospitals would function as the major trauma receiving hospital for the region, provide a referral service for local general hospitals, provide advice and stabilisation for complex cases referred from general hospitals and other emergency services and participate in the regional retrieval service. The Regional Emergency Department would provide resuscitation, stabilisation and initial treatment for all emergencies. They would be staffed by a number of consultants in emergency medicine (one of whom should have a special interest in paediatric emergency medicine) and a multi-professional team. Each Regional Emergency Department would be led by a Director who would be one of the consultants in emergency medicine. 2. Hospital Emergency Departments with access to some specialist surgical and medical services on-site Such departments would be linked to the Regional Emergency Department for trauma services, subspecialty services and certain diagnostic services. Each would have access to regional retrieval services. Hospitals with these Emergency Departments would be able to manage most emergencies, including stabilisation and assisted ventilation. They would have an on-site ability to provide a team response and would be staffed by 1- 2 consultants in emergency medicine and a multi-professional team. One of the consultants would function as Head of the Hospital Emergency Department. 3. Hospital Emergency Departments with access to specialist services off-site

	Each of these Hospital Emergency Departments would provide nurse-led services for minor illness and injury together with 24-hour access to medical staff on-site and resuscitation and limited stabilisation prior to referral to the Regional Emergency Department (if necessary). Patients arriving at these Hospital Emergency Departments would have 24-hour access to medical staff. A consultant on the hospital staff would function as the lead clinician in, and have responsibility for, the organisation and co-ordination of the Hospital Emergency Department. There would be access to Consultants in Emergency Medicine in the Regional Emergency Department for support, development and training purposes. Having taken population catchment size, attendance rates, accessibility, demographics, the hospital network, clinical resources, diagnostic resources, staffing profile and national and international best practice into account, the Committee recommends 13 Regional Emergency Departments. Specific recommendations for each health board and hospital are set out in later sections of this report For departments with 20,000 or more new attendances per annum, facilities should include the following, ▪ Separate entrance for ambulance referrals ▪ Dedicated radiology facilities ▪ Separate waiting area ▪ Separate resuscitation room ▪ Separate treatment / procedure room Separate area for patients on trolleys Separate streams for assessment and treatment related to acuity and severity of injury and illness and appropriate treatment areas for children and patients presenting with psychiatric problems. **For information:** Approximately one quarter of all patients presenting to an Emergency Department are admitted to hospital and these represent around 50% of total hospital admissions.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** The Committee recommends that a three-tiered Emergency Department system be adopted nationally. Within this system, the three tiers would be as follows: Regional Emergency Departments would be located in major regional hospitals and would serve a catchment population of about 250,000. Each of these hospitals would function as the major trauma receiving hospital for the region. The Regional Emergency Department would provide resuscitation, stabilisation and initial treatment for all emergencies.

Governance	**Recommendation/considerations:** HOSPITAL EMERGENCY SERVICE COMMITTEE The Committee recommends that a Hospital Emergency Service Committee be established in each hospital. It should be chaired by the consultant in charge of emergency services in that hospital and supported by an appropriate administrative structure including a designated Hospital Emergency Service Manager. The committee should comprise acute medical, acute surgical, paediatric, obstetric, psychiatric, anaesthetic, radiology and pathology staff, together with nursing, health & social care professionals, ambulance staff and general practitioners.
Community healthcare (including GPs, and nursing homes)	**For information:** Emergency services extend beyond the Emergency Department, into the hospital and the community. Hospitals play a central role in this continuum. There is a need for a defined management structure to be established within each hospital so that each hospital can act as the focal point for local emergency services.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Each Regional Emergency Department would be staffed by a number of consultants in emergency medicine (one of whom should have a special interest in paediatric emergency medicine) and a multi-professional team. Each Regional Emergency Department would be led by a Director who would be one of the consultants in emergency medicine. *Staffing the Hospital Emergency Services* The committee recommends the following clinical management structure for hospital emergency services. Regional Co-ordinator of Emergency Services: Each health board should have a Regional Co-ordinator of Emergency Services who would advise the health board on the operation and organisation of emergency services and would be responsible for the development and implementation of agreed protocols across the regional emergency service including each hospital in the health board area. The Regional Emergency Service Co-ordinator would also function as the Director of the Regional Emergency Department where he/she would be based. Director of the Regional Emergency Department: Each Regional Emergency Department would be led by a Director who would be one of the Consultants in Emergency Medicine. The post could rotate between different consultants in the Emergency Department or be filled from a competitive appointment process. It is envisaged that the Director of the Regional Emergency Department would have overall clinical and administrative responsibility for the Emergency Department. All staff in the department would be responsible to the Director on operational matters. *Consultants in Emergency Medicine:* Consultants in Emergency Medicine treat patients of all ages with emergency medical problems and injuries, covering the breadth of medicine. They deal with episodic and emergency care, referring longer-term acute

	care, elective procedures and the follow-up of chronic problems to others. The large majority of the sessional commitment of a Consultant in Emergency Medicine should be clinical as distinct from administrative duties or legal work. His or her clinical duties centre on the stabilisation of patients in order to ensure that all life-threatening causes of illness and injury are investigated. The Consultant in Emergency Medicine is responsible for ensuring that the patient is admitted to the most appropriate service to further explore the problem if such is required. Depending on the number of consultant posts in Emergency Medicine in a service, different rosters and cover arrangements will apply. All Consultants in Emergency Medicine, other than the Regional Directors, should have a majority clinical commitment. **CONSULTANT STAFFING ISSUES** The Committee notes that 75% of patients attend Emergency Departments between the hours of 8am and 8pm. Having regard to the recommendations of the Forum on Medical Manpower, the Hanly Report and the remit of the National Taskforce on Medical Staffing the committee's recommendations aim to put in place structures which facilitate the onsite presence of Consultants in Emergency Medicine in Regional Emergency Departments between the hours of 8am and 8pm, 7 days a week, 365 days a year. The Committee is aware of the industrial relations issues which will need to be resolved to support some of these recommendations. Consultants in Emergency Medicine play a key clinical and managerial role in Emergency Departments. The appointment of additional consultants should contribute to improvements in patient care and the flow of patients through the Emergency Department. However, appointing additional Consultants in Emergency Medicine without ensuring changes in the organisation of Emergency Departments and hospital emergency care will have limited impact. In summary, staffing of the Hospital Emergency Service will involve: ▪ Consultants in Emergency Medicine where appropriate (including one with a special interest in paediatric emergency medicine) ▪ Consultants in Medicine, Surgery and Paediatrics– participating in the clinical governance of the Hospital Emergency Service. Increases in consultant staffing or 105 revised sessional commitments may be required. This particularly applies to smaller hospitals with low attendances in the Emergency Department. ▪ NCHDs in emergency medicine and in a number of other specialties – ideally in accredited training positions ▪ Nursing staff – some of whom may be Advanced Nurse Practitioners (Emergency) ▪ Administrative and clerical staff – including a Manager for the Hospital Emergency Service ▪ Essential support staff.

	Mid-Western Health Board (population 317,069) There are 4 acute general hospitals in the Mid-Western Health Board area:- Mid-Western Regional Hospital, Limerick – with 53,403 new Emergency Department attendances in 2000; Our Lady's Hospital Ennis – with 15,249; Nenagh – with 7,414; and St John's Hospital with 12,901. There is 1 existing post of Consultant in Emergency Medicine in the Mid-Western Health Board area, based in Mid-Western Regional Hospital, Limerick. The Committee took into account the plan for the development of emergency services in the region presented by the MWHB and recommends that a Regional Emergency Service be established in the Mid-Western area. The Director of the Regional Emergency Department, who would also be the Regional Co-ordinator, would be based in the Regional Emergency Department at the Mid-Western Regional Hospital, Limerick, formerly known as Limerick Regional. The Committee recommends that 2 additional posts of Consultant in Emergency Medicine be approved for the Mid-Western Regional Emergency Department – based in Mid-Western Regional Hospital. This would lead - initially - to a total of 3 posts with sessional commitments to Ennis, Nenagh and St. John's hospitals. The Committee also recommends that in the event of: ▪ The putting in place of the internal Emergency Department processes and systems detailed in this report ▪ The development of Hospital Emergency Services and a Regional Emergency Service along the lines set out in this report ▪ Resolution of a number of industrial relations issues which would enable on-site rostering of consultants at busy times in the Emergency Department that 2 additional posts of Consultant in Emergency Medicine be approved for the Mid Western Emergency Service – each post to be based in the Mid-Western Regional Hospital, Limerick - contributing to a total of 5 posts in the Mid-Western region. **For information:** Consultants in Emergency Medicine play a key clinical and managerial role in Emergency Departments. The appointment of additional consultants should contribute to improvements in patient care and the flow of patients through the Emergency Department. However, appointing additional Consultants in Emergency Medicine without ensuring changes in the organisation of Emergency Departments and hospital emergency care will have limited impact.
Funding	**Recommendation/considerations:** The implementation of the first phase will involve the creation of 34 permanent posts of Consultant in Emergency Medicine [nationally] – 5 more than the 29 detailed in the 'Winter Initiative'. The Committee recommends that funding be made available for these additional posts.
Other	No information identified.

Impact	Access to inpatient beds in general hospitals is influenced by the lack of alternative facilities for the elderly and facilities for young chronically sick patients. The Committee agrees with the ERHA (Final Report of the Review of Accident & Emergency Services in the Eastern Region Eastern Regional Health Authority, 2001) proposals in this area and notes that the Health Strategy (1) has made substantial reference to the further development of services for older people – in terms of acute care, rehabilitation, day care, continuing care and enhanced community services. **CONSULTANT STAFFING ISSUES** The Committee notes that 75% of patients attend Emergency Departments between the hours of 8am and 8pm. Having regard to the recommendations of the Forum on Medical Manpower, the Hanly Report and the remit of the National Taskforce on Medical Staffing the committee's recommendations aim to put in place structures which facilitate the onsite presence of Consultants in Emergency Medicine in Regional Emergency Departments between the hours of 8am and 8pm, 7 days a week, 365 days a year. The Committee is aware of the industrial relations issues which will need to be resolved to support some of these recommendations.

Table 6 Acute hospital bed capacity: A National Review [2002]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Department of Health and Children[6] Acute hospital bed capacity: a national review [2002] Government review
The health service system (including health service reform)	**For information:** Reforming A&E A substantial programme of improvements in A&E departments is planned under the Health Strategy.2 Significant initiatives will be taken to improve the operation of A&E departments by directing patients to the most appropriate forms of care and ensuring those that need treatment are seen as quickly as possible. These include: ▪ additional A&E consultants to be appointed to facilitate rapid clinical decision making ▪ triage procedures to be put in place ▪ minor injury units to be established to facilitate treatment of non-urgent patients ▪ chest pain clinics and respiratory clinics to be established ▪ diagnostic services to be organised to ensure increased access ▪ advanced nurse practitioners to be appointed ▪ information systems to be developed. *Estimated Impact on Bed Need* Quantifying the impact of these combined measures on emergency admissions and, therefore, on the need for acute hospital beds is difficult. For the purposes of this Review, it is not possible to make any adjustment at this time to the estimated need for acute hospital beds on the basis of the planned developments in A&E departments.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** It is estimated that approximately 883 beds are required to adjust for the high average bed occupancy levels being experienced in the major hospitals and ICU's nationwide. It is important to note that this assessment is based only on those hospitals with average occupancy levels greater than 85%. In relation to the estimate of need based on ICU occupancy, it is important to note that the additional beds need not be ICU beds. The estimations outlined above of acute bed need suggest that approximately 1,630 additional beds will be required by 2011 in order to meet demographic changes. These estimates are based on the assumption that current treatment patterns and practices regarding admission to hospital in Ireland continue unchanged and in the absence of other developments which might reduce that need. It should be noted that even greater changes to the age profile of the population are projected to take place after 2011. *Additional Acute Hospital Beds Required in Ireland to 2011*

	Acute Hospital Bed Complement in 2000 **11,832** **Current indicators of Inadequate Bed Capacity** Additional beds required to reduce average occupancy in major hospitals 883* Additional beds required to facilitate treatment of waiting list patients 492* **Factors which will Increase the Need for Acute Beds** Additional beds required due to projected demographic changes 1630* Additional beds required to cope with increased demand for healthcare 1330^ **Additional inpatient Beds Required (Gross Estimate)** **4,335** Investment in measures to reduce delayed discharge from acute hospitals 675 Potential use of available capacity in some hospitals 200 Substitution of elective inpatient surgery with day surgery 290 Treatment of one-third of waiting list patients on a day basis 170 Improved management of public and private beds for elective patients 160 **Potential Capacity within the Existing System** **1,495** **Additional Inpatient Beds Required (Net Estimate)** **2,840** **Additional days beds Required (in addition to net estimate** **190** **Adjusted for 85% occupancy* *^Application of the estimate of demand to existing bed complement corrected for occupancy* It is estimated that an additional 1330 beds are required, over and above those required due to projected demographic change, to accommodate increasing demand for healthcare over the coming decade. Approximately 160 beds could be made available for use by elective public patients by strict adherence to an 80/20 ratio of public/private beds in public hospitals. **For information:** Correction of current high occupancy levels in major hospitals accounts for 20% of the estimated gross need; Waiting Lists account for approximately 11%. By far the greatest need will be incurred by projected demographic changes (38%) and by increasing demand for healthcare (31%). Among the strategies with the potential to reduce the need for additional beds, investment in measures to reduce delayed discharge from acute hospitals would have the greatest impact. This alone could 'provide' 16% of the capacity required. Investment in day facilities, and a substantial shift of elective inpatient surgery to day surgery could reduce the need for additional beds by 11%. The potential to use available capacity in some hospitals could provide a further 5% of the need. Strict adherence to an 80/20 ratio of public and private beds for elective patients has the potential to contribute 4% of the need identified. It is essential to record that combined implementation of all of these strategies will not resolve the current capacity deficit. It could provide up to one-third of the beds needed. However, at least two thirds of the required

	capacity must be added to the system, in conjunction with significant parallel investment in the strategies outlined.
Governance	No information identified.
Community healthcare (including GPs, and nursing homes)	**For information:** The total of 19,323 bed days lost due to delayed discharge represented approximately 12% of bed days used in that hospital that year. Major points of note are: ▪ 85% of bed days lost were due to lack of appropriate placement facilities (long-term care, rehabilitation, hospice care, convalescence, etc.) ▪ 15% of bed days lost were due to inadequate social / community support services to enable return to home; ▪ patients over 65 years accounted for 70% of the bed days lost ▪ patients awaiting placement for rehabilitation accounted for 18% of the bed days lost. The need for rehabilitation was not confined to those in older age groups. It is recognised that acute hospital care is just one component of a healthcare delivery system. Hospital services cannot be evaluated in isolation from primary care, community services and specialist care services. The need for hospital services is influenced by the availability and accessibility of those services which can reduce the need for acute interventions, can enable safe discharge to community or home and can act as either substitutes for, or complements to, hospital services. The net estimate assumes parallel investment in strategies aimed at reducing the need for acute hospital beds. These include additional community support services and facilities to allow for timely discharge of patients to more appropriate settings, additional day facilities to allow for substitution of inpatient with day surgery and improved management of existing bed stock. Inappropriate days of stay in acute hospitals may be due to: ▪ bed days lost in the course of treatment due to cancellation of investigations / procedures or inefficient coordination of required medical and allied health professional services; or ▪ bed days lost due to delayed discharge, i.e. the inability to discharge patients who have completed their acute medical care and who could be discharged to more appropriate forms of care. These include appropriate placements and/or community services for elderly patients, rehabilitation facilities for selected patients of all ages and specific facilities for disabled and young chronic sick patients. It is estimated that the equivalent of 675 beds could be made available in acute hospitals if measures to reduce delayed discharge were put in place. These include appropriate placement facilities and community support services, both of which require significant investment and organisation in order to be effective

Staffing (including workforce planning, recruitment and retention)	No information identified.
Funding	No information identified.
Other	**For information:** The number of acute care beds in Ireland (3.4 per 1,000; 1996 data) is 14th of 22 OECD countries and 9th of 13 EU countries for which data are available. In general, acute care beds do not include psychiatric or long-term care beds. Beds in private hospitals in Ireland are not included. The OECD data would suggest that the number of inpatient care beds in Ireland is inadequate when compared with levels in EU and other developed countries, even allowing for the fact that long-term care beds are not included in the Irish data. Data for nine other countries are also presented exclusive of long-term care beds; all of them have higher per capita number of inpatient care beds than Ireland. The number of acute care beds in Ireland is towards the middle to lower part of the OECD range.
Impact	The capacity needs of the sub-acute sector have been assessed separately and are included in the Health Strategy; Quality and Fairness: A Health System For You. Much of the data and the analyses supporting this Review have been compiled in a Technical Report entitled Acute Hospital Bed Capacity: A National Review, Technical Report incorporating Supporting Data and Analyses. This is available on request from the Acute Hospitals' Division, DOHC, Hawkins House, Hawkins Street, Dublin 2 or on the DOHC website, www.doh.ie.

Table 7 Audit of structures and functions of the health system [2003]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Watson Wyatt Worldwide[7] Audit of structures and functions of the health system [2003] Report
The health service system (including health service reform)	**Recommendation/considerations:** We propose four major reforms: ▪ The creation of a consolidated healthcare structure — putting in place a single national Health Services Executive (HSE) to replace the 10 existing health boards and ERHA ▪ The development of supporting processes — a major strengthening of processes and capabilities to deliver value for money and manage ongoing change ▪ The strengthening of governance and accountability across the system legislation — simpler governance and greater levels of accountability ▪ A reorganisation of existing agencies and their functions — a reduction in the number of stand-alone agencies by over a half and direct reports to the Department of Health and Children (DoHC) by almost two-thirds. <u>Reform Proposal 1: Create a consolidated healthcare structure</u> **Recommendation 1.1: Establish a separate national HSE and restructure the DoHC Actions:** ▪ Establish a HSE on a statutory basis as a corporate body with a governing Board ▪ Transfer all executive functions from the DoHC to the HSE ▪ Make legislative provisions to remove existing health board and ERHA governance structures, with these functions being assigned to the HSE ▪ Develop legislation to ensure accountability by the Board of the HSE for the delivery of health and social services; • Legislate to give the HSE employing authority ▪ Restructure the DoHC and reskill staff to support its role in the consolidated model. **Recommendation 1.2: Create two service pillars within the HSE consisting of:** ▪ Acute sector, overseen by the National Hospitals Office (NHO) ▪ Primary, Community and Continuing care ▪ Establish two service pillars within the HSE ▪ Provide for the National Hospitals Office within the corporate structure of the HSE ▪ Organise all publicly-funded hospital services under the NHO ▪ Develop enabling legislation to ensure accountability to the NHO for the reconfiguration of the hospital system, as well as accountability and funding arrangements for the acute services ongoing.

	Recommendation 1.3: Put in place four regional management structures and build on the existing community care structures at local level Actions: ▪ Establish a network of 4 Regional Health Offices, supported by the existing Community Care Area structures (Local Health Offices), to deliver primary, continuing, community and other non-acute services ▪ Ensure existing community care structures have the capacity and support to undertake appropriate service planning, budgetary and decision-making roles ▪ Establish a standard range of services and facilities for each Local Health Office. **Recommendation 1.4: Develop a National Shared Services Centre (NSSC) within the HSE Actions:** ▪ Establish the National Shared Services Centre with a remit for the provision of corporate services to the HSE and the NHO, and the provision of shared services across the wider health system ▪ Develop enabling legislation to require all publicly-funded health agencies to participate in shared services arrangements. **Recommendation 1.5: Strengthen quality assurance and information through the establishment of the Health Information and Quality Authority (HIQA)** Actions: ▪ Establish HIQA as a matter of urgency in line with recommendations in Quality and Fairness ▪ Task HIQA with the preparation and publication of an annual report on the performance of the health system overall against key quality indicators. **Recommendation 1.6: Develop structural mechanisms to increase consumer involvement in decision-making and service delivery** Actions: ▪ Extend the remit of the National Consultative Forum ▪ Develop democratic input at regional level ▪ Build on local consumer panels and other forms of consultation in each Local Health Office area. The consolidated structure is built on four elements: Strong accountability, prioritisation and direction ▪ Setting clear priorities for the system overall ▪ Holding the delivery system to account ▪ Strategic planning on a system-wide basis ▪ Driving system-wide reform Centralised performance management and control ▪ Implementation of national public health priorities ▪ Management of the delivery of integrated healthcare

	▪ Service performance and VFM Coordinated regional delivery ▪ Matching services to identified needs within an overall national plan ▪ Delivery of integrated services within regions Patient-centred local services ▪ Provision of patient-responsive services customised to local need ▪ Stakeholder participation ▪ Integration with wider social and public services. <u>Reform Proposal 2: Strengthen the functioning of the consolidated structure through the development of supporting processes</u> **Recommendation 2.1: Develop strong service planning and funding processes** Actions: ▪ Establish processes for the development of a National Service Plan and assign responsibility to the HSE ▪ Assign responsibility to the NHO for the development of a service plan for acute services to form part of the National Service Plan ▪ Assign responsibility to the RHOs for the development of a service plan for primary, community, continuing and other non-acute services. **Recommendation 2.2: Establish strong links between service delivery and evaluation** Actions: ▪ Task the DoHC with setting out the framework for performance management of the service as a whole ▪ Assign responsibility to the CEO of the HSE for the delivery of the National Service Plan within budget ▪ Devolve budgetary responsibility for primary, community and continuing care services to Directors of Regional Health Offices. **Recommendation 2.3: Put in place enablers to support integration** Actions: ▪ Ensure that the development of supporting processes and infrastructure is designed to promote integration between services ▪ Ensure that service planning at all levels supports identification and development of integrated services ▪ Ensure that integration with service partners is included as a key standard in the Health Services Accreditation Programme ▪ Develop processes and protocols as part of the Primary Care model to ensure leading practice in patient referrals between acute and non-acute services. **Recommendation 2.4: Enhance system capability and performance** Actions:

	▪ Assign responsibility to the strategic HR function of the HSE for the development of leadership capacity, management development, HR effectiveness and organisation development across the health sector ▪ Build a revised leadership model and audit existing leadership and change capability within the system ▪ Expand the personal development planning process to facilitate stronger role clarity, performance planning and communications between managers and employees ▪ Develop an employee engagement process including communications processes as well as national and local partnership structure ▪ Conduct an audit of the critical skills and competencies required to deliver system capability and performance and ensure that these are in place within the system ▪ Implement a system-wide performance management framework ▪ Expand and accelerate the Clinicians in Management programme. <u>Reform Proposal 3: Strengthen governance and accountability across the system</u> **Recommendation 3.1: Clarify and implement governance and accountability arrangements to support the consolidated structure** Actions: ▪ DoHC to ensure oversight of governance arrangements and compliance with governance standards of all statutory agencies ▪ Establish a Board for the national HSE ▪ Revise the Consultant Common Contract to ensure effective accountability for resources used ▪ Strengthen the framework for clinical governance. **Recommendation 3.2: Develop and implement a set of guidelines for governance and accountability for all health and social service agencies** Actions: ▪ Assign responsibility to the DoHC to take a lead role in developing a set of governance and accountability guidelines ▪ Implement governance guidelines throughout the system. <u>Reform Proposal 4: Reorganise existing agencies and their functions in line with the consolidated structure</u> **Recommendation 4.1: Significantly reduce the current number of agencies** Actions: ▪ Mainstream the functions of 27 agencies into the new consolidated structure (establishing sunset clauses where appropriate) ▪ Merge the structures and functions of 5 agencies. **Recommendation 4.2: Change the accountability and funding arrangements for 9 agencies**

	Action: ▪ Transfer the accountability and funding arrangements of 9 agencies from the DoHC. **Recommendation 4.3: Strengthen and develop a number of agencies** Actions: ▪ Strengthen and develop 2 agencies to expand their remit and accountability ▪ Expand the remit of the proposed Health and Social Care Professionals Council to support greater standardisation and cooperation between professions ▪ Make changes to proposed governance arrangements of individual agencies. **Recommendation 4.4: Retain the structures and functions of 11 agencies** 2 Note: The term mainstreaming, as used in this report, indicates the relocation of functions and structures within conventional\responsibility and reporting lines for policy and execution (Department of Health and Children, HSE and its offices or HIQA) 3 Note: The term sunset clause is used to refer to an arrangement whereby the lifespan of an agency is linked to the achievement of specified objectives or a given time span. No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	No information identified.
Governance	No information identified.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	No information identified.
Funding	No information identified.
Other	No information identified.
Impact	The question posed at the outset of the Audit was the extent to which the structures and functions of the health system are organised to deliver on the ambitions of the health strategy Quality and Fairness (2001).

Table 8 Report on Nurse Staffing Levels in Emergency Departments in the Republic of Ireland [2003]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Healthcare Consulting Limited on behalf of The Health Service Employers Agency[8] Report on Nurse Staffing Levels in Emergency Departments in the Republic of Ireland [2003] Report
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** We recommend that periodic audits, using the tool we prepared, be carried out on each site to ensure that staff neither under or overestimate triage scores in respect of patients on their site. We recommend that sites be encouraged to reduce the amount of time spent by patients in the Emergency Department. The staffing model provides for patients in the Emergency Department with triage codes 1 and 2 to wait on a trolley for an average of 3.24 hours. The model allows for patients in triage codes 3, 4 and 5 to wait and average of 4.77 hours. We consider that, over time, the allowance for waiting in Emergency Departments for admission should be targeted to reduce. We recommend that, before staffing establishments are changed, a full year's data be collected on each site. This is to ensure that account is properly taken of the peaks and troughs of activity throughout the year. We recommend that each site should maintain a "rolling year" record of patient activity upon which to measure changes in workload. We consider that managers and staff in Emergency Departments should consider the expanded and core roles of the nurse and their scope of practice in light of the recommendations contained in the Hanly report and the role of Emergency Department nurses in other jurisdictions." We consider that on-going training and audit concerning the accuracy of the allocation of codes is vital if the workload model is to provide an accurate picture of staffing numbers required to care for patients in the department. We consider that the [Emergency Department workload tool developed in conjunction with the five pilot sites] tool should be "rolled out" to all sites in the country. **For information:** On the whole, triage recording [on five pilot sites] was of a high quality. However, there was a tendency to underestimate some codes. This would, if used with the manpower tool developed, result in an underestimate of about 1.8% in staffing requirements.

Governance	No information identified.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** We recommend that in all Emergency Departments, managers and staff should take action to introduce a non-qualified grade of staff where these do not already exist. The role of these staff would be to undertake some of the non-nursing, clerical and associated work tasks identified in the analysis of activity as being currently undertaken by qualified nurses. *For consideration:* We consider that senior staff working in Emergency Departments within the Republic might benefit from visiting other sites in the Republic to identify alternative management strategies and practices which could, if appropriate, be applied locally. Sharing of ideas between sites may assist local managers to identify "best practice" which could then be applied in their own department. We consider that the content of the core role and the expanded role of the Emergency Department nurse is a key issue which requires urgent consideration in light of experience in other jurisdictions.
Funding	No information identified.
Other	No information identified.
Impact	Inform this report: Report of the Commission on Nursing: "A blueprint for the Future" Considerations relating to the role of Nursing will need to take account of the recommendations of the Hanly Report of The National Taskforce on Medical Staffing.

Table 9 Capita's report to the employers and unions: national review of bed management function: final report [2003]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Capita Consulting on behalf of the HSE[9] Capita's report to the employers and unions: national review of bed management function: final report [2003] Report
The health service system (including health service reform)	**For information:** Each hospital's organisational/professional culture is unique, and frequently structures must be established that might only make sense in a certain cultural setting. While establishing national standards for grades and structural support is a desirable goal, we are very cautious about "one-size-fits-all" recommendations. We intend in this review to offer general guidelines within which that sort of autonomy can be exercised. Many larger issues, most of which are outside the control of bed managers, need to be addressed on a national basis. Some of the issues that we have discussed in this review hold much more potential to truly resolve the bed management crisis than structures do. Specific issues that directly affect the quality of care given to patients include: ▪ Lack of sufficient rehabilitation, step-down, nursing home and long term care beds for patients who remain in acute care beds with nowhere else to go. ▪ Proactive changes in Consultant practices to encourage prompt discharge of patients. ▪ Hospitals/Health Boards funding for initiatives that could significantly improve patient throughput. ▪ Community Care services in general are not available outside standard business hours. ▪ Diagnostic Services working hours are inadequate to support effective bed management. ▪ Underdeveloped services nationally for the provision of urgent/ambulatory care and same-day surgery.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**For information:** This review was commissioned to address issues that arose as a result of industrial action taken early in 2002 by nursing staff working in Accident and Emergency Departments nationally. Key observations relating to Admission/Demand Management Strategies include: ▪ Surgical Pre-Admissions Units (SPAUs), which provide for diagnostic investigations to be performed prior to scheduled surgery, are in place in 30% of sampled hospitals; most of these are Band 1 hospitals. ▪ The most common demand strategy currently being used is the Medical Assessment Units (MAU); such units are 12-18 hour wards that perform observation and diagnostic functions for A&E patients who may not require hospitalisation. Currently 8 of the hospitals visited have such units, and another 6 have them included in their 2003 service plans. ▪ Clinical pathways are beginning to be used in A&E departments; currently only 4 Band 1 facilities have initiated

	them. ▪ Ambulatory or Urgent Care facilities have proven extremely effective in reducing A&E attendances and inpatient occupancy in the UK, Europe, the US, Australia and New Zealand. Such services are not yet developed in Ireland, reflected by the lack of such facilities among visited hospitals. ▪ The allocation of beds to clinical units should be notional; a flexible bed base should be built into the operating requirements to accommodate fluctuating bed demand. ▪ Diagnostic Laboratory and Radiology services are often only available 9-5, Monday-Friday; if diagnostics could begin to accommodate evening surgery, for example, significant bed pressure could be eased. More flexibility from these services is desired.
Governance	**Recommendation/considerations:** Capita recommends that Bed Manager posts structurally report to the highest level of general management within the hospital, i.e., to the CEO, Deputy CEO or General Manager, with a dotted line relationship to the Director of Nursing**.** ***Guiding Principles*** Effective management of bed utilisation requires Bed Management Departments to encompass all aspects of activity impacting on bed utilisation. For smaller hospitals where annual occupancy rates are consistently lower than 85%, a Bed Management Department is not needed and should not be required. Discharge planning is a function that all hospitals require, regardless of size or occupancy. Within Hospital Groups, inpatient bed management activity varies considerably. ***Capita recommends the following support structure for Group A Hospitals:*** 1.The role of the Bed Manager should be primarily strategic in focus. 2.The Bed Manager should be supported by 2 or more Assistant Bed Managers (at Grade 7 level), who would mostly focus on operational tasks. 3.The Bed Manager should be supported by 1 or more Discharge Coordinators (at CNM3/Grade 7 level, the current level of most discharge coordinators), who would be absorbed into the Bed Management Department and report to the Bed Manager. 4. The Bed Manager should be supported by a Waiting List Coordinator if a separate function is required by the hospital or is in post (at current grade level). 5. The Bed Manager should be supported by an Administrative Assistant (at Grade 3 level, the current level in practice). 6. Admissions Office functions should come under the responsibility of the Bed Manager. ***Capita recommends the following support structure for Group B Hospitals:*** 1.The role of the Bed Manager should be a combination of operational and strategic, depending on the activity

	levels and the requirements of the hospital. 2. The Bed Manager should be supported by at least 1 Assistant Bed Manager (at Grade 6 level), who would mostly focus on operational tasks. 3. The Bed Manager should be supported by a Discharge Coordinator (at CNM3/Grade 7 level), who would be absorbed into the Bed Management Department and report to the Bed Manager. 4. The Bed Manager should be supported by a Waiting List Coordinator if a separate function is required by the hospital or is in post (at current grade level). 5. The Bed Manager should be supported by an Administrative Assistant (at Grade 3 level) for at least half of the time. Sharing of clerical officers by hospital managers should be encouraged. 6. Admissions Office responsibilities should come under the Bed Manager. ***Capita recommends the following support structure for Group C Hospitals:*** 1. The role of the Bed Manager, where one is in place, should be primarily operational, with strategic functions performed depending on the requirements of the hospital. 2. The Bed Manager, where one is in place, should be supported by a Discharge Coordinator (at CNM3/Grade 7 level). This post is required even if a bed management function is not in place. A staffing standard of 2.0 professional bed management staff per 10,000 annual admissions can be used by hospitals to estimate staffing need. **For information:** Bed management, to be effective, requires access to and analysis of empirical data on historical/seasonal activity, patient status, A&E / bed management placement times, patient stay, patient discharge and consultant admission/discharge practices. We found that very little analysis or forecasting is being done by bed management departments. Most hospitals simply do not have the staffing within the bed management function to address anything but immediate operational issues. Information systems and analytical capabilities need to be given higher priority. Integrated bed management needs to be supported by accurate real time information. Data needs to be continuously collected, audited, analysed and disseminated to guide resource management and to optimise efficiency. Certain private insurance requirements encourage inappropriate bed utilisation, especially the lack of adequate coverage for outpatient or preventive procedures. For instance, VHI reportedly will not cover routine CAT scans on an outpatient basis; as a result, consultants admit private patients as inpatients, so the procedure can be paid for by private insurance.

Community healthcare (including GPs, and nursing homes)	**For information:** We believe that post-acute capacity is probably the key issue causing problems in bed management nationally, and the one whose resolution would provide the health services with the greatest potential to improve the bed management process quickly. Shortages of rehabilitation, step-down/intermediate care and nursing home/long term care facilities is a direct cause for the high levels of delayed discharge patients in major tertiary hospitals. In our view, this clearly points to a need for post-acute supply/demand capacity analyses to be conducted on a region to region basis across the country (a simple national analysis will not address the issues). In some locations, inadequate arrangements for service provision in primary care or community care meant that patients who might otherwise be treated without needing hospital admission were having to be admitted, reducing the availability of acute beds overall. Patient transfers between regions are sometimes not smooth and may delay discharge. The lack of community-based diagnostic services was also cited as a reason why A&E departments are very busy in many areas, leading to bed availability problems. Local Health Board was more concerned at finding convalescent places for people in its own acute hospitals In at least one region, some young chronically sick patients are kept in acute beds for very lengthy periods, as there is no dedicated facility in the region to cater for them; typically, these are patients with head injuries needing a higher level of care than is possible in nursing homes. This reduces bed utilisation substantially. Community services are not available beyond 9-5 Monday-Friday; outside those hours, there is nowhere to discharge patients to. Community services for the under 65 chronically ill are very underdeveloped in most parts of the country. Ambulatory or Urgent Care clinics, for urgent but non-emergency cases are almost non-existent. Limited access to specialty beds where ring-fencing occurs. Professional self-interest is prevalent nationally with regard to changing service delivery; even small changes in the status quo are opposed by one professional group or another. As one A&E consultant put it, "For every solution, there's a problem."
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** ***Capita recommends that the Bed Manager posts be graded at the following minimum grades:*** ▪ Group A Hospitals: Administrative Grade 8, with salary adjusted to be equivalent to the Assistant Director of Nursing grade. ▪ Group B Hospitals: Administrative Grade 7, with salary adjusted to be equivalent to the CNM-3 nursing grade. ▪ Group C Hospitals: Administrative Grade 6, with salary adjusted to be equivalent to the CNM-2 nursing grade. ***Capita recommends the following bed management coverage for Group A Hospitals:*** 1. Bed Management staff should provide coverage in the hospital between the hours of 8.00 am and 8.00 pm, seven days a week.

	2. Coverage for the night hours of 8.00 pm and 8.00 am, should continue to be the responsibility of the Night Superintendents on a seven day-a-week basis. ***Group B Hospitals:*** 1.Bed Management staff should provide coverage in the hospital between the hours of 8.00 am and 8.00 pm, Monday through Friday. 2.Coverage for 8.00 am to 4.00 pm Saturday should be determined by the needs of the specific hospital, and should be the responsibility of either Bed Management or Nursing Administration. 3.Coverage for 8.00 am to 4.00 pm Sunday should be the responsibility of Bed Management. 4.Coverage for 4.00 pm to 8.00 pm on Saturday and Sunday should be the responsibility of Nursing Administration. 5.Coverage for the night hours of 8.00 pm and 8.00 pm, should continue to be the responsibility of the Night Superintendents on a seven day-a-week basis. ***Group C Hospitals:*** 1.Bed Management staff (if a department is required) should provide coverage in the hospital between the hours of 8.00 am and 4.00 pm, seven days a week. 2.Coverage for 4.00 pm to 8.00 pm on Monday to Friday should be the responsibility of Nursing Administration. 3.Coverage for 8.00 am to 8.00 pm on Saturday and Sunday should be the responsibility of Nursing Administration. 4.Coverage for the night hours of 8.00 pm and 8.00 pm, should continue to be the responsibility of the Night Superintendents on a seven day-a-week basis. **For information:** Several hospitals reported that nursing staff in district hospitals and nursing homes are not trained or authorised to administer IV fluids, with the consequence that they receive many elderly patients who have to be admitted from a district hospital/nursing home bed and who simply need IV fluids or IV antibiotics. An ongoing series of national initiatives has added bed management-related posts (e.g., waiting list managers, discharge coordinators), but this has led to fragmentation of bed management functions as they were introduced with no relationship to bed management. In Capita's view, the Bed Manager should be the designated senior post, leading a team of persons involved in all aspects of admission, transfer and discharge of patients.
Funding	No information identified.
Other	No information identified.
Impact	Not information identified.

Table 10 Commission on Financial Management and Control Systems in the Health Service [2003]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Government of Ireland[10] Commission on Financial Management and Control Systems in the Health Service [2003] Report
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	No information identified.
Governance	**Recommendation/considerations:** High level recommendations below and followed by individual recommendations prefixed by R", for example, R3.1 <u>The Executive</u> A new Executive should be established outside the Department of Health and Children to assume management responsibility for the delivery of health care in Ireland and for planning and managing the application of the resources used by the health service in a comprehensive integrated way. ▪ The new Executive should operate under a board, whose Chairman should report to the Minister for Health and Children. ▪ A substantial number of existing executive agencies should be subsumed by the new Executive. ▪ Staff recruitment should be by open competition. ▪ The Chief Executive Officer (CEO) of the Executive should be accountable to the board of the Executive. ▪ The CEO of the Executive should be accountable for the performance of the CEOs of the regional health boards. ▪ The CEOs of regional health boards should retain their role as accounting officers. <u>Executive Functions</u> The new Executive should subsume the statutory functions of many existing executive agencies and be given any additional powers needed to manage the health service as a unified entity. These functions should include: ▪ Planning and managing the organisation of specialist services/hospitals. ▪ Deciding on the number and type of Consultant posts in each specialist service/hospital. ▪ Planning and organising the provision of primary medical services. ▪ Coordinating the management of the various interdependent functions necessary to run the health service as a

unified service e.g. manpower planning and recruitment, procurement, systems of funding and resource allocation.
- Ensuring that corporate governance meets the principles of best practice.

Executive Tasks

The following priority resource management issues should be addressed by the new Executive:
- Putting in place the new budgetary and accountability systems.
- Managing the investment in information systems which is necessary.
- Negotiating the changes necessary for the effective management of the health service with key stakeholders.
- Putting in place performance management and management development programmes.
- Eliminating the inappropriate use of expensive acute hospital beds by providing alternatives for the long stay patients who occupy them.
- Reorganising the Accident and Emergency services so as to keep more beds available for elective cases.
- Introducing more ambulatory day surgery to reduce waiting lists and increase throughput of patients.

Department of Health and Children

The creation and maintenance of the national policy framework within which the new Executive performs will place heavy demands on the Department of Health and Children. The work of the Department will require close interaction with the new Executive to ensure that the political and the executive systems for delivering the health service are kept closely aligned.

Regional Health Boards

The health board structure should be retained (although their number and functional areas should be reviewed) to safeguard the need for local democratic representation. The CEO of the Executive should be accountable for the performance of health board CEOs. The executive functions of health board CEOs should be expanded to include that of agreeing with the new Executive the Service Plan for the region, the implementation of national Service Plans/strategies within the region and the development of uniform financial planning, management and control systems for the health service.

Service Planning, Budgeting and Supplementary Estimates

A single comprehensive and standardised template for Service Plans should be adopted. Plans and budgets should derive from the individual plans of clinical Consultants and General Practitioners and from individual managers responsible for services not provided by clinically independent doctors. A three-year rolling indicative financial and service planning system should be introduced. Changes should be made in current arrangements for budgeting and for controlling expenditure on "demand-led" schemes.

	Accountability for Financial Management and Control in General Hospitals The accountability for managing resources and for financial control should be devolved to those persons with the authority to commit or expend resources. Such persons should be accountable for how those resources are used. Systems of clinical budgeting at the level of individual clinical practices should be developed. Budgets should focus on producing targeted outputs for patients in the most cost effective way. These systems should identify the true economic cost of treating private patients. Existing arrangements, which enable medical Consultants to combine their public hospital commitment with private practice, are inherently unsatisfactory from a management and control perspective. To address this, we recommend that all new public consultant appointments be on the basis of a commitment to work exclusively in the public sector. Accountability for Resource Management in the GMS and Drug Refund Schemes There should be a fundamental review of the General Medical Service with a view to agreeing with General Practitioners how budgets can be established to deliver agreed levels of service and treatment to patients which is in the interests of patients and of reducing unnecessary demands on expensive hospital services. Arrangements under the Drug Payment Scheme should also be reviewed. Accountability for Controlling Pay Costs There should be a detailed review of the drivers of pay costs including systems for control of numbers, for manpower planning and for work planning and scheduling which can control or reduce premium payments for non-emergency work outside core working hours. Financial Information Systems There needs to be an accelerated programme of investment in information systems to extend SAP (A fully integrated software package with available modules including financials, materials management, human resources, payroll, asset management and asset maintenance) and PPARS (Personnel, Pay, Attendance and Recruitment System - the human resource module of SAP) to all major spending agencies. This recommendation is contingent on the evidence of a detailed business case, parallel implementation of the organisational changes we recommend and the recruitment of certain key financial, human resource management and information technology personnel. Investment without the necessary other changes could be a waste of money. Other Systems We have also made recommendations on the development of governance structures such as internal and external audit, financial control, risk management and performance management. To ensure that the major changes we have recommended are implemented pending the establishment of the new Executive, we recommend that a National Implementation Committee under an independent Chairman be set up to drive the implementation process. Resources and skills in change management will be needed.

	Recommendations on the National Management of the Health Service **R3.1:** We recommend that the national management of the health service should be carried out by an "Executive" outside the Department of Health and Children. **R3.2:** Establishment of the Executive must involve the consolidation of many of the existing agencies within its functions. ***Recommendations on the Restructured Role of the Department of Health and Children*** **R3.6:** The role of the Department of Health and Children should include: (i) Acting as advisor to the Minister and the Government (ii) Developing and costing policy responses and strategies to achieve the necessary reform to address identified problems arising from existing policy (iii) Developing and costing policies for future service developments (iv) Dissemination and active sponsorship of best practice (v) The Estimates process (vi) Management of the legislative agenda as it relates to the health service (vii) Acting as "regulator" in respect of national health care standards (viii) International representation of the Irish health service (at the OECD, WHO etc.) (ix) Research and identification of ongoing developments in international best practice in the health area and consideration of the extent to which they may be adapted for implementation in an Irish context (x) Risk assessment/management; and (xi) Issues relating to public sector pay policy. ***Recommendations on the Role of the Executive*** **R3.7:** We recommend that the role of the Executive should include: (i) Strategic planning and management of change in the health system, including location of services, aimed at improved service delivery (ii) Managing the delivery of health services within budget (iii) Manpower planning and needs assessment (iv) Managing staff relations (v) The resource allocation process (vi) Analysing health spending annually by: (a) Programme/care group (childcare, hospital services, disability services etc.), (b) Health board region (vii) Under each of the headings at (vi)(a) and (vi)(b) above, the following actions should be undertaken: (a) A comparison of performance, productivity, quality of care and value for money, (b) Summary results of the comparative analysis undertaken at (vii)(a) above should be published, in a standardised format, within 6 months of the end of the relevant accounting period

	(viii) Identifying the problems and issues highlighted by the comparative analysis undertaken at (vi) and (vii) above (ix) Research and identification of ongoing developments in international best practice in the health area and consideration of the extent to which they may be adapted for implementation in an Irish context; and (x) Risk assessment/management. **R.3.8:** In regard to recommendation R3.7 (vii)(a), we recommend that the existing National Performance Indicators Project Team define appropriate measurable definitions and indicators of "performance", "productivity" and "value for money". This group should submit its recommendations to the Secretary General and Minister for Health and Children. ***Recommendations on the Role of the Executive Board, Chairman and CEO*** **R3.9:** The Executive board should be statutorily responsible for the execution of national health policy and should be formally accountable for its performance to the Minister for Health and Children. **R3.10:** The Executive board at R3.9 above should assume the functions associated with the management of the health service. These would be similar to the normal functions exercised by any corporate board and would include: (i) Implementing the overall strategic direction of national health policy for the health service (ii) Approval of the annual regional Service Plans (iii) Monitoring performance against objectives and ensuring that corrective action is taken when necessary (iv) Ensuring that services are delivered within budget/determination (v) Appointment of the chief executive officer (CEO) of the Executive (vi) Establishment of an audit committee (vii) Approval of the Annual Report and Financial Statements. **R3.11:** The board of the Executive should be accountable to the Minister for Health and Children. **R3.12:** The CEO of the Executive should be accountable to the board of the Executive. **R3.13:** The CEO of the Executive should be an accounting officer. **R3.14:** The CEO of the Executive should be responsible for the provision of financial and other information necessary to support the Secretary General of the Department of Health and Children in his/her role as accounting officer and policy advisor to the Government. ***Recommendations on Membership of the Executive Board*** **R3.15:** The Executive board should have not more than 12 members made up as follows: (i) An independent Chairman drawn from outside the health sector (ii) Ex-officio, the CEO of the Executive

	(iii) Ex-officio, the Director of Finance of the Executive (iv) A nominee of the Department of Health and Children (v) Not more than 8 non-executive members, reflecting the balance of expertise required, appointed by the Minister for Health and Children. **R3.16:** In appointing the non-executive members at R3.15(v) above, the Minister should have regard to the appropriateness of each candidate's skills and experience. ***Recommendations on Governance of Regional Health Boards*** **R3.17:** Functions of the regional health boards should include: (i) Advising on local and regional health service requirements (ii) Representing local community and professional interests in terms of regional service provision (iii) Advising and providing input in respect of the regions annual Service Plan (iv) Monitoring performance within the regional area against national health care objectives (v) Establishment of an audit committee (vi) Approval of the regional Annual Report and Annual Financial Statements. **R3.18:** CEOs of the regional health boards should be accountable to the CEO of the Executive for the execution of their functions, including delivery of services within budget/determination, in respect of national service provision. ***Recommendations on Accountability for Services Delivered in Regional Health Board Functional Areas*** **R3.19:** CEOs of regional health boards will be accountable to the CEO of the Executive for the performance of all staff, including the managers of health board hospitals, employed by their health board. **R3.20:** The CEOs of the major teaching hospitals providing national services would be accountable directly to the CEO of the Executive because of their role in the provision of national services and specialties. Recommendations on Implementation **R3.21:** The necessary changes to the Health Acts 1970 and 1996 and the Eastern Regional Health Authority Act 1999 should be brought forward by the Department of Health and Children to give effect to the above changes. Recommendations on a Code of Governance **R3.22:** The Department of Health and Children should produce a written Code of Governance for all agencies in the public health sector. This code should enshrine the principles contained in the Department of Finance Code of Practice for the Governance of State Bodies. **R3.23:** All Executive board members should be independent and act solely in the interest of the board.

	Recommendations on Service Planning **R4.1:** A single, comprehensive and standardised template for Service Plans should be adopted. This should cover Service Plans at all levels: clinical Consultants, hospitals and non-hospital General Managers at sub-health board level, as well as regional health boards and the Executive. Higher level Service Plans should be derived from lower level Service Plans (for example, hospital from the aggregate of individual Consultants). **R4.2:** Pending establishment of the Executive, a working group, including representation from the Department of Health and Children, Department of Finance and the regional health boards, should be established to devise an appropriate standard template and to make recommendations to the Secretary General and Minister for Health and Children. **R4.3:** The terms of reference for the working group recommended at R4.2 above should, having regard to the data improvements afforded by the investment in information technology recommended in Chapter 10, include consideration of how best the Service Plans could be structured to provide: (i) Clear statements of projected service provision analysed by the main care groups (including each specialty in hospitals), linked to funding (both pay and non-pay elements); (ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost (approved determination) and activity (level of service being provided); and (iii) Pay and employment data. **R4.4:** The working group at R4.2 above should also consider how existing reporting arrangements might be restructured to provide, again in a standardised format, an ongoing report on progress against targets and objectives set out in the Service Plan (see also Chapter 9 recommendations in this regard). In particular: (i) Monthly Integrated Management Reports should be closely linked to the Service Plan. (ii) Quarterly Performance Indicator Reports should continue to be explicit on delivery of targets and should also be linked to the Service Plan. (iii) Annual Reports and Financial Statements should specifically link back to financial and activity performance envisaged in the Service Plan. This would provide the final link between the Letter of Determination, Service Plan, Integrated Management Reports, Annual Financial Statement and Annual Report. **R4.5:** Service Plans of the Executive and the health boards should ideally be agreed and in place before the commencement of the year to which they relate. ***Recommendations on of Hospital Management Structures*** <u>Executive Management Committee</u> **R5.4:** Where they do not already exist, chief executive officers in all hospitals should immediately establish an Executive Management Committee. **R5.5:** The role of the Executive Management Committee should include: (i) Agree the Hospital Service Plan

	(ii) Monitor performance against budget (iii) Agree corrective measures (iv) Advise on policy matters that may arise from time to time. **R5.6:** The membership of the Executive Management Committee should include, at a minimum: (i) The hospital CEO/manager (as Chairman) (ii) The head of the hospital's finance function (iii) A clinical Consultant (iv) The Director of Nursing. ***Recommendations on Service Planning in the General Hospitals Programme*** **R5.7:** In the case of admitting Consultants who assume clinical care for a patient, the following steps should be taken: (i) Hospital/health board CEO, as appropriate, identify all individual clinical practices within each specialty; (ii) Hospital/health board CEO, as appropriate, identify a lead clinician as Head of Specialty; (iii) Hospital/health board CEO, as appropriate, should agree with the Head of Specialty the assignment of a member of staff as business manager to prepare cost and activity budgets, practice profiles and monthly expenditure reports for the specialty and each individual clinical Consultant's practice within the specialty. **R5.8:** In the case of non-admitting Consultants (e.g. radiology, pathology, etc.), the following steps should be taken: (i) Hospital/health board CEO, as appropriate, identify all non-admitting hospital departments; (ii) Hospital/health board CEO, as appropriate, identify for each department a Head of Department; (iii) Hospital/health board CEO, as appropriate, should agree with the Head of Department the assignment of a member of staff as business manager to prepare cost and activity budgets, practice profiles and monthly expenditure for the department. **R5.9:** All costs incurred by the non-admitting hospital departments identified at R5.8(i) above should be allocated back to the admitting specialties identified at R5.7(i) above in order to allow the calculation of full costs incurred by specialty and patient. **R5.10:** A working group, under the aegis of the Department of Health and Children, should be set up to agree a common national methodology to be applied to the allocation of the indirect costs referred to at R5.9 above. **R5.11:** The business managers recommended at R5.7(iii) and R5.8(iii) above: (i) May cover more than one specialty/department, depending on the particular needs and demands of that specialty/department (ii) Should be made available from within existing resources as part of a reorganisation by hospital/health board CEOs of existing duties and responsibilities **R5.12:** The annual practice/specialty/department Service Plan should include: (i) Clear statements of projected activity, linked to funding (both pay and non-pay elements)

	(ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost and activity (iii) A clear analysis between public and private patients in respect of (i) and (ii) above. **R5.13:** Clear reporting arrangements and responsibilities must be put in place such that: (i) Business managers are responsible for gathering and presenting management data on costs and activities (ii) Clinical Consultants/Heads of Department are responsible for providing explanations to the hospital/health board CEO of variances from budget and how such variances will be brought back into line. **R5.14:** Routine reports (monthly, quarterly, annual) should be submitted in the format and within the timescales envisaged in recommendation R9.1 ***Recommendations on Implementation in the General Hospitals Programme*** **R5.15:** Business managers should receive continuous relevant training to ensure they have the requisite skills, training and experience in medical and clinical work as well as finance and management to perform their duties. **R5.16:** The health board/hospital CEO should be responsible for determining the appropriate level and quantum of training and for putting in place the mechanisms necessary to ensure that training is delivered. **R5.17:** The Executive should liaise with educators to prepare/train clinical Consultants/Heads of Department on an ongoing basis to understand and to work with new financial management information systems. **R5.18:** The Department of Health and Children should liaise with the Higher Education Authority to introduce a requirement for medical schools to develop programmes to ensure that every medical student receives at least one module on health economics, technology assessment and financial management and control issues. **R5.19:** A working group under the aegis of the Executive, in consultation with the Department of Health and Children, should examine and make recommendations on appropriate incentives for those clinical Consultants/departments that successfully implement recommendations above. ***Recommendations on Public/Private Mix in Public Hospitals*** **R5.20:** All Service Plans, Practice Plans and monthly, quarterly and annual reports should include a clear breakdown between public and private costs and activities. **R5.21:** A coding system should be put in place in all cases (e.g. outpatient activity, private patients having tests in a public hospital etc.) and in all hospitals to explicitly identify all activity as relating to public or private patients, as appropriate. **R5.22:** The coding system referred to at R5.21 above should allow for allocating of general overheads incurred by hospitals between public and private patients so that the full cost of treating public and private patients can be calculated. The objective should be to identify the costs of treating individual patients. **R5.23:** The Executive should publish in its Annual Report a comprehensive analysis of the amount of public resources8 consumed by private patients within the public hospital sector.

	R5.24: Recognising that implementation of the information systems recommended in Chapter 10 will be necessary to produce accurate information in respect of R5.23 above and the lead in time for the establishment of the Executive, the Department of Health and Children should, on an interim basis, publish such information using the best estimates that are available to it. **R5.25:** The provisions of Consultants' existing common contract should be enforced to ensure that the following is undertaken: (i) The setting of core times when a Consultant must be available to patients in the public hospital (ii) Formal active monitoring of work commitment in respect of public patients. **R5.26:** The health board/hospital CEO should put mechanisms in place to ensure (i) Consultants' sessional contractual commitments to the public hospital are met (ii) The cap on private activity in public hospitals is observed both with respect to inpatients and day-cases (as in, agree with Consultants on the number of private patients to be treated in public hospitals). ***Recommendations on Other (i.e. Non-Hospital) Programmes*** **R5.27:** In all other areas of the health service (i.e. non-hospital), the individual responsible for the budget (whether clinical or non-clinical personnel) should be held formally accountable for financial performance. **R5.28:** The CEO of the Executive and the health board CEOs should analyse the totality of non-hospital related health board activities into clearly defined care groups (e.g. community care, mental health etc.) that are consistent throughout the system. **R5.29:** The health board CEO should identify a General Manager with responsibility for each care group identified at R5.28 above. **R5.30:** Each General Manager should prepare an annual Service Plan and budget for their area of responsibility. **R5.31:** Each General Manager's Service Plan should include: (i) Clear statements of projected service provision, linked to funding (both pay and non-pay elements); and (ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost and activity. **R5.32:** General Managers should submit routine reports (monthly, quarterly, annual) to the CEO of their regional health board within the format and the timeframe envisaged in recommendation R9.2., ***Implementation*** R5.33: The Health (Amendment) (No. 3) Act, 1996 should be amended, as necessary, to permit the health board CEO to formally assign duties to the General Managers making them accountable to the CEO/line management for their financial decisions. (The health board CEO should remain the accounting officer for all health board expenditure and nothing in our recommendations is intended to change or undermine this accountability.) **For information:**

	The main problems we have identified in the areas of financial management and control are: ▪ Management and control of services and resources is too fragmented; there is no one person or agency with managerial accountability for how the overall system performs on a day-to-day basis. ▪ Those who make decisions (mainly Consultants and other medical practitioners) which commit resources are not accountable for that expenditure and the outputs to be delivered. ▪ Systems of governance, financial control, risk management and performance management need to be developed further. ▪ The capacity of existing systems to provide relevant, timely and reliable information for linking resources to outputs/outcomes is severely limited. ▪ There is insufficient evaluation of existing expenditure and too much focus on obtaining funding for new developments. ▪ The capacity of existing systems to develop cost consciousness and provide incentives to manage costs is severely constrained by the under-development of systems such as activity based costing. ▪ The usefulness of data for resource management and for strategic planning purposes is limited because the data is not being interpreted by the clinicians treating the patients (Consultants and GPs). ▪ Patient cost information is not available. Such data is essential to any review of the system of allocating funds or in deciding where the most cost effective treatment can be obtained for various conditions. We have identified four core principles on which the recommendations of this report are based: ▪ The health service should be managed as a single national system. ▪ Accountability should rest with those who have the authority to commit the expenditure. ▪ All costs incurred should be capable of being allocated to individual patients. ▪ Good financial management and control should not be seen solely as a finance function.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** **R3.3:** There should be no net increase in staffing levels within the health service to give effect to recommendation R3.1. **R3.4:** Staff of the Executive should be recruited by way of open competition and not restricted to the civil or public service. **R3.5:** Recruitment of the CEO of the Executive should be by means of an international search and selection process. ***Recommendation on Contract for New Consultant Appointments*** **R5.3:** All new Consultant appointments, covering new posts and the replacement of existing Consultants, should be on the basis of contracting the Consultants to work exclusively in the public sector.

	Recommendations on Employment Information and Reports Responsibilities for provision of Employment Information **R7.3:** The CEO of each health board should be responsible for the provision of employment information both for their own direct employees and for employees of all agencies funded by the health board. **R7.4:** Health boards should afford appropriate priority and resources to ensure the compilation of timely, accurate and verifiable employment data. Employment Information to be included in Monthly Reports **R7.5:** Health board CEOs should report employee numbers and pay cost data to the Executive on a monthly basis within the revised Integrated Management Reporting structure recommended at R9.3. **R7.6:** The specific details of the pay and employment data to be provided in the health boards' Monthly Integrated Management Reports should be determined by the working group referred to in recommendation R4.4. At a minimum, these should include: (i) Detailed information on gross pay costs, by grade code; (ii) Details on the elements comprising pay (i.e. basic pay, overtime, shift allowances etc.), by grade code; (iii) Details on costs of agency working; (iv) Identification of approved vacancies and progress in filling new posts to support service development as set out in the annual Service Plans; (v) Comprehensive listing of voluntary bodies/agencies funded by each health board; and (vi) Similar detail as at (i) to (iv) above in respect of these voluntary bodies/agencies. **R7.7:** National employment data should be reported by the Executive to the Department of Health and Children within the revised Consolidated Integrated Management Reporting structure referred to at recommendations R9.4 and R9.5
Funding	**Recommendation/considerations** ***Recommendations on Rebalancing Financial Allocations*** **R4.6:** Funding of regional health boards should be evidence based and prioritised across identified needs. In particular, in allocating budgets between health boards, the Executive should take account of a number of nationally agreed key factors, as they apply across health board regions, such as: ▪ Demographics Specialities Client Profile Capacity ▪ Services Activity Infrastructure Socio-economic profiles **R4.7:** Pending establishment of the Executive, a working group representative of the Department of Health and Children, the Department of Finance and the regional health boards should be established: (i) To conduct advance development work on defining the appropriate factors under R4.6 above (ii) To determine the relative weighting which should be ascribed to each factor in determining each health board's allocation

	(iii) To examine the phasing arrangements that are appropriate to ensure a smooth transition to the new arrangement. ***Recommendation on Multi-Annual Budgeting*** **R4.8:** Service Plans should be framed on a 3 year multi-annual basis. ***Recommendation on Supplementary Estimates*** **R4.9:** If, notwithstanding the statement of the Minister for Finance in his Budget speech delivered in December 2002 that Ministers and their Management Committees will be required to manage strictly within the allocations given to them, there are to be supplementary estimates in the future, we recommend that the Department of Finance and the Department of Health and Children should: (i) Review the appropriateness and coverage of "allowable supplementaries" (ii) Make recommendations to the Minister for Finance in this regard (iii) Thereafter conduct biennial reviews by reference to the volume and content of supplementary estimates allowed in the intervening period. ***Recommendation on defining Units of Accountability*** **R5.1:** We recommend that clinical Consultants and their practices in individual clinical specialties be designated as the primary unit of accountability in the general hospital programme. ***Recommendation on the existing Consultants' Common Contract*** **R5.2:** The Consultants' common contract should be reviewed, for existing Consultants, to ensure that the following principles are explicitly reflected in the contract: ▪ Formal recognition and agreement by Consultants, as the key decision makers, of their responsibility to manage resources to which they are entitled to conduct their practice3 within agreed budgets at department, specialty and individual Consultant level. ▪ Participation in arrangements for collective representation of Consultants at hospital management committee level. ▪ Agreement of core hours of attendance. ▪ Active management and optimisation by Consultants of resource allocation against agreed practice, specialty and department Service Plans and budgets. ▪ Cooperation with arrangements for measurable and transparent systems of continuously monitoring adherence to public and private practice contractual commitments. ▪ Where there are competing public and private practice demands on Consultants' time and resources, the former should have priority call on such time and resources at all times.

	Recommendations in respect of the General Medical Service **R6.1:** The health board CEO should, in consultation with the GP, draw up, consistent with national guidelines established by the Executive, a Practice Budget for each GP covering his/her patients registered as medical cardholders. **R6.2:** The Practice Budget at R6.1 above should be broken down between: (i) Medical treatments (ii) Drug prescriptions. **R6.3:** The Practice Budget at R6.1 above should be based on treatment costs having regard to: (i) The demographic profile of each GP's medical card patients (ii) Attendance, treatment and prescribing patterns (iii) Attendance of patients at Accident and Emergency clinics (iv) Referral patterns to general hospitals. **R6.4:** In the event that a GP requires funding above the budget agreed at the start of the year, it should be necessary for him/her to submit a request for same to his/her health board CEO citing the clinical factors which have given rise to the overspend. **R6.5:** Health boards should monitor individual versus normative patterns of referral of patients to hospitals. (This can be facilitated by appropriate identification of patients by source within the hospital coding systems recommended at R5.21.) ***Implementation*** **R6.6:** The Secretary General of the Department of Health and Children should take immediate steps to agree with GPs' representatives the necessary changes to GPs' Contract for Service to give effect to recommendations R6.1 to R6.5 above. **R6.7:** The Secretary General of the Department of Health and Children should take immediate steps to devise a standard template for annual Practice Plans. **R6.8:** GPs should be assigned responsibility for reporting to the health board on the accuracy of their list of registered medical cardholders annually. **R6.9:** Health boards should introduce new verification and audit procedures to ensure their lists of medical cardholders are accurate. **R6.10:** Based on an evaluation of the reports at R6.8 by the health board, overpayments made in a previous year (for example, where a patient dies or moves to another GP) should be automatically netted off by the health board against that GP's Practice Budget for the following year. ***Recommendations relating to the Drugs Payment Scheme***

	R6.11: Current arrangements for reimbursing pharmacists under the medical card scheme – i.e. reimbursement on a cost of ingredients basis (without mark-up) plus a flat-rate prescription fee – should be extended to the Drugs Payment Scheme. **R6.12:** The operation of the Drugs Payment Scheme should be reviewed immediately by the Department of Health and Children, in consultation with the Department of Finance, the GMS (Payments) Board and the health boards. The review should actively examine: (i) Introducing a system whereby health boards would actively monitor and evaluate prescribing patterns by individual GPs, Consultants or Dentists and reimbursement patterns by individual pharmacists, having regard to relevant demographic and epidemiological factors (ii) Introducing incentive schemes for reducing levels of prescribing and drugs costs (iii) In recognition of the influence of hospital generated prescribing on community drugs budgets, each health board/hospital CEO should immediately establish Drugs and Therapeutics Committees, comprising Consultants, GPs from the hospital catchment area, supported by pharmacy and financial management expertise, to agree clinically cost-effective common drug formulary (iv) Relevant international experience and the lessons from this in containing drug costs and the rate of growth. **R6.13:** The existing agreement between the Department of Health and Children and the Irish Pharmaceutical Healthcare Association should be evaluated against international experience with similar agreements (particularly in countries of the European Union). The results of this evaluation should be used in the negotiation of any further agreement so as to assure value for money.
Other	**Recommendation/considerations:** *Recommendations on Information Systems* **R10.1:** The information systems necessary to support financial management and control systems recommended in this report should be built around SAP and PPARS. **R10.2:** This investment should be subject to: (i) Prior arrangements being put in place to ensure that appropriate use can and will be made of new systems as evidenced in a detailed business case as outlined in the text above (ii) Parallel implementation of the wider organisational changes we recommend throughout this report (iii) The recruitment of certain key financial, human resource management and information technology personnel, necessary to the successful implementation of the recommendations of this report, should be by means of open competition i.e. from outside the Common Recruitment Pool (see also recommendation R7.10). **R10.3:** There should be an acceleration in investment so as to achieve the early implementation of the following: (i) SAP financials installed in all health boards and the major teaching hospitals (ii) PPARS (Phase 1) fully implemented in the outstanding sites (South Eastern Health Board, Southern Health Board, Beaumont, Mater, St Vincent's and Tallaght hospitals) (iii) PPARS (Phase 2) implemented in the health boards and the major teaching hospitals.

	R10.4: Roll out of PPARS should continue to be driven by the National PPARS Office, to ensure a consistent and uniform national approach, and that Office should liaise on a monthly basis with the Implementation Committee referred to at R11.2. **R10.5:** Hospital information systems which provide information on patients and their procedures (i.e. number of tests, x-ray, lab time, theatre, drugs etc.) be rolled out to all acute hospitals and integrated with the financial and HR systems at R10.3 above. **R10.6:** Funding for the IT strategy should be ring-fenced to ensure that: (i) The funding is solely for specified IT investment (ii) There is increased transparency of where the investment occurs (iii) There is clear measurement of the improvements in management information resulting from such investments. **R10.7:** Pending establishment of the Executive, the Department of Health and Children should have full control over how this funding will be allocated and should report the results of such investments to the Implementation Committee recommended at R11.2. ***Recommendations relating to Drugs Assessment*** **R6.14:** The Irish Medicines Board should have its remit extended to not just examine new drugs for their efficacy and effectiveness, but also to: (i) Assess their cost effectiveness (ii) Approve the drug product for reimbursement under the community drugs schemes (including specifying the conditions under which it may be made available, for example restricted to named patients or in respect of defined clinical treatment regimes). **R6.15:** The Irish Medicines Board should also be charged with the responsibility to monitor the continuing effectiveness of existing drugs and to delist those which are no longer considered appropriate or clinically cost-effective. **R6.16:** Where the Irish Medicines Board determines that a cheaper, but equally effective, alternative exists, only the cost of the cheaper drug should be reimbursed by the GMS (Payments) Board. Where a GP prescribes the more expensive branded drug, the cost difference arising should be regarded as entirely private prescribing.
Impact	No information identified.

Table 11 Report of the National Task Force on Medical Staffing (Hanly Report) [2003]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Minister for Health and Children[11] Report of the National Task Force on Medical Staffing (Hanly Report) [2003] Report
The health service system (including health service reform)	**Recommendation/considerations:** ▪ The priority must be to provide a safe, high quality service to all patients at all times. The current organisation, structure and staffing of the hospital system is failing to deliver the care, that at its best, the Irish system is capable of giving. ▪ All of the measures proposed above should be done in a way that maximises value for money. There must be no unnecessary duplication of services. **Mid-Western Health Board region: proposed organisation of hospital services** **The Task Force recommends that:** ▪ Each hospital and acute unit in the MWHB should function as part of a single, integrated network. ▪ The Mid-Western Regional Hospital, Limerick should function as the Major Hospital for the MWHB. ▪ Ennis General Hospital, St Joseph's Hospital, Nenagh and St John's Hospital should function as Local Hospitals. ▪ Ideally and in the long term, a number of specialties currently provided in single specialty hospitals should ultimately be provided on the site of the Mid-Western Regional Hospital, Limerick. These include acute psychiatric care, acute obstetric and gynaecological care and protected facilities for regional workload in elective orthopaedics. ▪ Consideration should be given to the long-term transfer of St John's Hospital to a protected elective facility on the Regional Hospital campus. **Actions are set out in the short term: to 1 August 2004, the medium term: to 1 August 2009 and in the longer term: after 2009. Some of the medium to longer term dates are necessarily approximate, but those identified for action before August 2004 require immediate attention.** **Five immediate steps for implementation** **Action 1:** Government decision to implement Task Force report **Date:** Immediate **Action 2:** Establishment of national implementation group **Date:** Immediate **Action 3:** Establishment of hospital implementation groups in pilot regions **Date:** Immediate **Action 4:** Negotiations begin on NCHD and consultant contracts in light of report **Date:** Immediate **Action 5:** Negotiations on relevant issues for other health professionals **Date:** Immediate **Short Term: by 1st August 2004**

Key Requirements	Section	Action	Date
Reducing NCHD Hours	**5.2**	- Establishment of hospital working groups in pilot regions	Immediate
	5.2	- Establishment of industrial relations process to reduce hours involving employers, unions and others	Immediate
	3.2	- Establishment of hospital working groups in pilot regions	Immediate
	3.2	**-** Evaluation of extent to which on-call can be moved off-site	Immediate
	3.2	**-** Each hospital to evaluate potential for reduction in tiers of on-call cover	Immediate
	3.2	**-** Establishment of phlebotomy and cannulation teams	Immediate
	3.2	**-** Introduction of 'bleep policies'	Immediate
	3.2	**-** Introduction of new cross over arrangements	November
	3.2	**-** Introduction of data recording system on NCHD working hours	November 2003
	3.2	**-** Submission of first statistics from data system	December 2003
	3.2	**-** Renegotiation of NCHD contract	December 2003
	3.2	**-** Establishment of phlebotomy and cannulation teams	December 2003
	3.2	**-** Centralisation of rostering arrangements in each hospital	March 2024
	3.2	**-** Introduction of new working patterns	April 2004
	5.2	**-** Review NCHS numbers required in light of Phase 2 report	April 2004
	3.2	**-** Meet EWTD targets	June 2004
	4.2	**-** Employment/redistribution of dedicated frontline clerical/admin staff	2004-2009
Consultant-Provided Service	**4.3 & 3.4**	**-** Regulation of all hospital medical posts through a single agency and approval of NCHD post by central training authority	As soon as possible
	3.3	**-** Commence renegotiation of consultant contract in context of Task Force report	Immediate
	5.2	**-** Review consultant numbers required as part of Phase II report	January 2004
	4.1	**-** Commence increase in consultant numbers and commensurate decrease in NCHD numbers (subject to agreement)	January 2004
	App 4	**-** Specific wider increases in pilot regions	January 2004
	3.3	**-** New working patterns in place	April 2004

Key Requirements	Section	Action	Date
Medical education and training	**3.4**	**-** Commence phasing out of all non-training NCHD posts	Immediate
	3.4	- No new non-training NCHD posts	Immediate
	3.4	**-** All NCHD post advertisements to clarify	

			whether post is recognised for training	Immediate
		3.4	**-** Initiate legislative process required to establish central training authority	Immediate
		App 6	**-** Discontinue 'parallel' training schemes not leading to CSCST	Immediate
		3.4	**-** Adoption of National Flexible Training Strategy	September 2003
		3.4	**-** Initiate dialogue on international co-operation on training	January 2004
		3.4	**-** Introduction of innovative schemes for entry on the specialist register	March 2004
		3.4	**-** Develop career counselling/mentoring plan	October 2004
		3.4	**-** Develop training programme for skills complementary to clinical practice including up-skilling for existing specialists site	October 2004
		3.4	**-** Protected training time structures in place for trainers and trainees nationally	2004 – 2009
	Reorganising Hospital services	**5.2**	**-** Establish Group to prepare Phase II Report	Immediate
		3.5	**-** Initiate measures to improve patient management	Immediate
		3.5	**-** Evaluation of bed capacity review in relation to pilot regions	October 2003
		5.2	**-** Complete Phase II review	January 2004
		4.3	**-** New hospital management structures in place in pilot regions	June 20004
		3.5	**-** Development of protocols for the delivery of acute hospital care	October 2003
			- Outline timetable for changes in other regions	January 2004
			- Ongoing implementation of changes in pilot regions	April 2004
			Medium Term: by 1st August 2009	
	Key Requirements	**Section**	**Action**	**Date**
	Reducing NCHD Hours	**3.4**	- Graduated reduction in NCHD posts	2004 - 2009
		3.2	- Expansion of hospital information systems to support pathology, radiology and other departments	2005
		3.2	- Implementation of national guidelines for pathology and radiology requests	
		3.2 & 4.2	- Creation and training of new grade of operating department assistant	2005
		3.2	- National medication protocols in place in emergency departments	2006
		4.2	- Expanded decision-making role for nursing staff	2005
		4.2	- Review potential role for physician assistants	2008
	Consultant-Provided Service	**4.1 & App 3**	- Ongoing increases in certain specialities	2004 - 2009
		3.3	- Ongoing implementation of changed work patterns	2004 -2009

		5.2	- Review of consultant contract in light of information from pilot regions	2007
		5.2 & App 3	- Meet consultant targets set by Phase II report	2009
	Medical education and training	**3.4**	**-** Report on recommendations on outstanding MET issues	2004
		3.4	- Graduated reductions in NCHD numbers in line with increases in consultant posts	2004 - 2009
		App 6	- Ongoing implementation of Flexible Training Strategy	2004 - 2009
		3.4	- Full roll-out of central training authority functions	2004 - 2007
		3.4	- No replacement of non-training NCHD posts	2005
		3.4	- Ongoing implementation of mentoring/career counselling plan	2005 - 2009
		3.4	- Rollout of training programme for skills complementary to clinical training	2005 - 2009
		3.4	- Rollout of programme for up-skilling existing specialists	2005 -2009
	Reorganising Hospital services	**3.5**	- Training of EMT-As	Currently Underway
		3.5	- Implementation of bed capacity review for acute and non-acute beds	2004 - 2009
		3.5	- Implementation of primary care strategy	Current
		3.5	- Ongoing transfer of elective services to local hospitals	2004 - 2009
		3.5	- National and regional trauma management protocols in place	2005
		5.2	- Revise regional management arrangements	2007
		3.5	- Ambulance service staffed by sufficient emergency medical technicians	2009
			Longer Term: After 2009	
	Key Requirements	**Section**	**Action**	**Date**
	Reducing NCHD Hours	**3.2**	- Ongoing national monitoring of NCHD hours to ensure compliance with ETWD and other relevant legislation	2009 …..
	Consultant-Provided Service	**3. 4**	**-** Full achievement of consultant-provided service	2013
	Medical education and training	**3.4**	**-** Ongoing review of all medical education and training recommendations	2009 …...
		3.4	- Full implementation of medical education and training recommendations	2013
	Reorganising Hospital services	**3.5**	- Ongoing implementation of hospital reconfiguration set out in Phase II report	2009…….
		3.5	- Ongoing implementation of Primary Care Strategy	2009…...
		3.5	- Full implementation of bed capacity reports	2011

Pilot Regions

Section	Action	Date
5.2	- Establishment of implementation groups	Immediate
3.5	- Commence identification of capital needs for Local & Major hospitals	Immediate
4.1 & App 4	- Commence recruitment of additional consultants	Immediate
3.2, 3.3 & 4.2	- Identification of immediate industrial relations issues	Immediate
3.5	- Identification of immediate infra-structural needs	Immediate
3.2	- Initiate data recording system	Immediate
3.5	- Review and revise provision of out-patient services	Immediate
3.5	- Identify Local hospitals developed as key link with resource for GPs, primary care and community services and access point to hospital services	Immediate
3.5	- Initiate development of regional trauma management and ambulance bypass protocols	Immediate
3.5	- Initiate schedule of relocation of elective procedures to Local hospitals	Immediate
3.5	- Continuing implementation of Primary Care Strategy	Current
3.2	- Submission of first statistics from data system	December 2003
3.4	- Identify and assess safeguarded time for medical trainers and trainees	January 2004
5.2	- Begin establishment of clinical directorates and regional management structure	January 2005
3.5	- Establish medical and surgical admission and assessment units	January 2005

For information:

A number of critical national recommendations, including measures to reduce NCHD working hours, should be implemented immediately throughout the country, with appropriate negotiation and consultation. Others, such as the proposals for reorganising hospital services, should be applied to the two pilot regions in the first instance. The Task Force believes that a radical reorganisation of acute hospital services will be required nationally in order to implement the EWTD in full and to ensure a high quality service for patients. The Task Force proposes that in Phase II of its work it should prepare a second report as soon as possible on the organisation of hospital services outside the pilot regions. Implementation of the reforms in medical education and training necessary for compliance with the EWTD and development of a consultant-provided service should proceed as a matter of urgency.

Messages from the consultation process

Common themes included:

- problems with equity of access to public hospital care for public patients, with poor linkages between hospitals, general practitioners and community health services;
- inadequate data and information systems;
- intra-professional obstacles and a lack of multi-disciplinary team-working;

	▪ claims that some specialties are not adequately equipped to provide the full range of tests and support they need; ▪ while staff working in some settings encounter a wide variety of illness, a low volume of patients in some of these areas makes it difficult for them to keep the required range of skills up to date; ▪ problems in the choice of location for delivery of care to trauma and emergency patients; ▪ significant inappropriate or avoidable use of acute hospital beds; ▪ shortages of service alternatives to acute hospital care; ▪ lack of integration in the management of hospitals within a region and, in some instances, problems with the capacity of management to plan effectively and deal with current service issues; and ▪ consistent criticism of local pressure which is focused on 'safeguarding' local facilities without regard to the best way for providing safe and effective care. A failure to deal with difficult decisions affecting the location of services was also cited. These problems can and must be addressed. Implementation of the EWTD and the **introduction of a consultant-provided service** is, effectively, a driver for a significant change in the hospital system. Learning from previous reviews The Task Force had regard to the substantial analysis carried out over many years on the provision and organisation of acute hospital services in Ireland. Most recently, the Value for Money Audit of the Irish Health System (VFM) (Deloitte and Touche, 2001) and the Health Strategy Quality and Fairness: A Health System for You (2001) set out the context for re-organisation of acute hospital services. Following the Bed Capacity Review (2002) the Health Strategy announced the provision of an additional 3,000 beds by 2011 and the VFM audit argued for hospital networks, noting that current lack of integration poses difficulties for the provision of an effective service. A consistent message from previous analyses has been the need for clarity of hospital roles, genuine integration of services and the provision of high quality care. The record in implementing a number of previous reports has been disappointing, but this should not take from their central messages, many of which are strongly reflected in the Task Force's recommendations.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** ▪ Considerations about capacity, workload and a critical mass of patients must influence where hospital services can be safely provided. Patients have better outcomes when treated in units with appropriate numbers of specialist staff, high volumes of activity and access to the right diagnostic and treatment facilities. ▪ In the pilot regions studied, acute hospital services should be delivered by an integrated network of hospitals, currently serving populations of about 350,000. A small number of more specialist services should continue to be provided on a supra-regional or national basis. **Stream 1: Emergency care**

	At present many hospitals, including some smaller facilities, try to provide a large range of emergency, often complex, services. The current situation is not sustainable, either from the viewpoint of patient safety or staffing. Consistent expert advice, both national and international, is clear. While patients who present without serious or life-threatening conditions can be dealt with in minor injury and illness units, emergency care is best provided in a fully equipped Accident and Emergency Department, supported on-site by a full range of medical and surgical services and by well-trained ambulance staff. The Royal College of Surgeons (London) offer a concise description of the requirements for an efficient, high quality emergency service: An Accident and Emergency Department led by an A&E specialist; ▪ Enough consultants in trauma and orthopaedics, general surgery, anaesthetics and radiology to provide a dedicated emergency service ▪ Around-the-clock availability of high technology equipment such as CT scanners ▪ Emergency operating theatres for general surgery and trauma surgery ▪ A full range of specialist surgical, medical, paediatric, pathology and radiology services Intensive care; and ▪ Ready access to burns units, cardio-thoracic surgery, transplant surgery, neonatal surgery and neurosurgery'. It is clear that such a wide range of services can only be provided in a fully staffed and equipped Major Hospital. In summary, therefore, the emergency care stream should have the following characteristics: ▪ It should be focused on the Major Hospital, with central co-ordination of emergency services, including ambulance services; ▪ There should be rapid access to emergency services via 999/112 calls, emergency medical technicians and primary care; ▪ Seriously ill or injured patients should be brought directly to the accident and emergency unit of a Major Hospital; ▪ All ambulance personnel should be trained to EMT-A level and be capable of decisions about what level of service the patient requires. 'Nearest hospital' protocols should then be set aside, with patients triaged to the appropriate service immediately. **Stream 2: Elective care** Elective care should be provided in both Major Hospitals and Local Hospitals. While Major Hospitals must take the lead in relation to emergency care, the Task Force believes that an increasing proportion of elective work, primarily in the area of surgical and medical day procedures, should be carried out in Local Hospitals. These would be provided within agreed protocols and would be supported by the necessary diagnostic and treatment facilities. There would be scope for an enhanced role for Local Hospitals in performing this key role by delivering day services to an extended geographic area beyond its immediate local catchment area. Elective care should be co-ordinated between all acute hospitals in the region, with consultant teams, including NCHDs and certain nursing staff, rotating on a planned basis between the Major Hospital and Local Hospitals to provide the service. Elective work should be provided on the basis of an extended day, in which theatres, OPD, diagnostics and support services would be run for a twelve or thirteen-hour day, perhaps from 7 am to 8

	pm for up to six days a week, depending on volume. This would help reduce waiting lists, and ensure the most efficient use of capital, including expensive theatres and equipment, in line with need and resources. It would also offer patients greater flexibility in choosing the most convenient time for receiving services. **Stream 3: Out-patient and day care** Out-patient services should be delivered under clear regional protocols designed to facilitate the safe and effective throughput of patients through the hospital, primary and community care systems. Out-patient services should function as an interface between hospital, primary and community care and allow both consultants and GPs to share patient care, for example, in the management of diabetes or certain cardiovascular conditions. These systems should preclude inappropriate retention of chronic patients for long periods of time. Day care can be described as hospital-based care delivered within the 24-hour period, after which the patient is no longer in need of acute hospital care. Increasingly, large numbers of surgical and medical procedures and investigations are carried out on a 'day' basis. Often, the patient will not require an overnight stay. Both outpatient and day care should be: ▪ delivered locally on the basis of agreed protocols in Local Hospitals and Major Hospitals ▪ provided by consultant teams, including NCHDs and certain nursing staff, rotating on a planned basis between the Major Hospital and Local Hospitals ▪ co-ordinated within the integrated network of acute hospitals for the region ▪ available on an extended-hours basis, as in the case of elective care ▪ supported by diagnostic, treatment and other facilities.
Governance	**Recommendation/considerations:** • The management structure of acute hospitals should be strengthened to establish clear lines of accountability and ensure appropriate availability in the context of a 24-hour service. In the pilot regions, an integrated network of hospitals should be managed by a chief executive. There should be a single national hospitals authority to which the network chief executives should report. However, service integration must be ensured, in particular with primary care, community care and long term/continuing care services. The Task Force recommends that employers should record data under the following headings: grade of NCHD; point on pay scale; specialty and sub-specialty; hours worked on-site including the first 39 hours, overtime, those hours when the NCHD is (i) rostered for duty and (ii) rostered on-call; hours worked off-site on-call; hours spent in training (on-site and off-site); study leave; flexible training requirements, annual leave and other leave. The Task Force recommends that in the pilot regions, NCHDs should be appointed to work in a regional network as a whole (as discussed in section 3.5).

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Primary care services, including community care, should be an integral part of this network.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** ▪ NCHD working hours must be reduced in line with the European Working Time Directive. Appropriately implemented, this will help improve patient care and introduce safer working conditions for doctors. ▪ Health agencies should not attempt to meet the terms of the EWTD by recruiting more NCHDs. This would actually worsen the situation for both patients and doctors. ▪ Substantially more consultants should be appointed as part of a move to a team-based consultant-provided service. This would give patients improved access to senior clinical decision-makers. ▪ The organisation and staffing of acute hospitals must be restructured to allow for the safe provision of emergency and elective care. The safe provision of specialist services, reductions in NCHD hours and the appointment of additional consultants will require significant changes to service provision. It is also important to ensure that all patients, whether public or private, have equal access to services based on clinical need. ▪ Health professionals should work as part of a multi-disciplinary team, centred on delivering quality patient care over the full 24-hour period within an integrated network of hospitals. This will entail revised working arrangements for consultants and NCHDs. It will also have implications for other health professionals and will involve the appointment of some new grades of staff. ▪ Medical education and training systems must attract and train doctors to provide high quality patient care. NCHD training can only be delivered in recognised, accredited institutions with appropriate staff and facilities. All non-training NCHD posts must be phased out. ▪ The number of hospital doctors should be regulated nationally through a single agency. Each NCHD post should also be subject to approval by a central training authority. While the number of consultant, specialist registrar and intern posts are regulated at present, uncontrolled growth in the number of registrars and senior house officers is very undesirable. It can have implications for the quality of service to patients, and has affected the ability of individual doctors to access further training and achieve specialist registration. It has also hampered the efficient deployment of finite resources. ▪ The number of hospital doctors should be regulated nationally through a single agency. Each NCHD post should also be subject to approval by a central training authority. While the number of consultant, specialist registrar and intern posts are regulated at present, uncontrolled growth in the number of registrars and senior house officers is very undesirable. It can have implications for the quality of service to patients, and has affected the ability of individual doctors to access further training and achieve specialist registration. It has also hampered the efficient deployment of finite resources. ▪ Reductions in NCHD hours, the appointment of more consultants working in teams, reorganisation of the acute hospital system and the provision of high quality medical education and training are all part of the implementation process. Compliance with the EWTD and the provision of a sustainable acute hospital service are possible only if measures are taken to meet each of these goals.

	The Task Force recommends that the first tier of on-call should be appropriate to patient needs. This necessitates patient referral to, and in many cases on-site availability of, senior clinical decision makers. F: Changes in skill-mix and practice The major areas of recommended change are as follows: **Radiology** ▪ Increased use of emerging and developed IT systems such as Picture Archiving and Communications Systems13 (PACS) to create 'filmless hospitals' should improve efficiency ▪ Use of IT to order or review test results remotely from terminals on hospital wards ▪ The introduction of clinical protocols in radiology to help inform the appropriate use and delivery of diagnostic procedures ▪ Dedicated radiology facilities in emergency departments ▪ An extended working day for the radiology department. **Phlebotomy** ▪ Dedicated phlebotomy staff should perform venepuncture rounds on a consistent basis over the course of the 24-hour day. They could also take blood cultures and possibly perform cannulation ▪ Measures to ensure that developing dedicated phlebotomy services do not lead to inappropriate referrals for laboratory tests. Pathology ▪ The electronic management of requests for laboratory tests, including test ordering capability and reporting of results; ▪ Availability of routine diagnostic services for extended hours rather than the current narrow 9 am to 5 pm arrangement with a very limited repertoire of tests available out of hours. **Pharmacy** ▪ Pharmacists can play a key advisory and consultative role in emergency departments, medical assessment units and other areas of the hospital where initial assessment and treatment of patients is taking place ▪ Pharmacists should assist, in partnership with lead consultants, in the development of medication protocols for common conditions, particularly those presenting in the emergency department. **Surgery** ▪ The employment of, for example, operating department assistants, as discussed in section 4.2, will ensure that tasks previously performed by NCHDs in the early stages of their training can safely be delivered by other personnel. ▪ Expanded decision-making and enhanced role for nursing staff

3.8.5 Consultant Staffing of hospital services: pilot regions. In summary, the Task Force's proposals involve an additional 80 consultants in the East Coast Area Health Board by 2009, rising to an extra 129 by 2013, in the Mid-Western region there would be an additional 146 consultants by 2009 rising to an extra 195 consultants by 2013.

	Consultant staffing 1st January '03	Proposed 2009	Proposed 2013
ECAHB region	178	258 (+45%)	307 (+72%)
MWHB region	109	255 (+134%)	304 (+178%)

Recommended consultant staffing for Emergency medicine for the ECAHB and MWHB regions is set out in the table below. Other specialities are available on page 160 onwards

Consultant Staffing Requirements – Pilot sites

Specialty:	East Coast Area Health Board			Mid-Western Health Board		
	2003 Consultant staffing At 01.01.03	2009 Projected 350,000 population	2013 Projected 350,000 population	2003 Consultant staffing At 01.01.03	2009 Projected 350,000 population	2013 Projected 350,000 population
Anaesthesia	23.6	27	NA	18	27	NA
Intensive Care	1	7	NA	1	7	NA
Paediatric Anaesthesia	0.4	3	NA	NA	3	NA
Pain Management	NA	1	NA	NA	1	NA
Total Specialty	*25*	*38*	42	19	38	42
Emergency Medicine:	3	8	9	1	9	9

Compliance with the EWTD and the move to a consultant-provided service will require major changes in medical education and training. In particular it will require phasing out all non-training NCHD posts, safeguarding training time (protected time) for NCHDs and their trainers and ensuring that additional posts are not created purely to meet service needs. The Task Force proposes the establishment of an independent statutory central training authority with key functions including a role in controlling training numbers through the approval of each NCHD post and lead responsibility for co-ordinating the strategic development of medical education and training in Ireland

For information:

Consultant-provided service

A fourth option is to employ a much larger number of consultants, working in teams, with revised working patterns, and a significantly reduced number of NCHDs. Important clinical decisions would be made faster and at a higher level and the ratio of consultants to NCHDs would be balanced. Acute hospital medical services would be consultant-provided, rather than consultant-led. This is in line with the recommendations of a number of reports on hospital medical staffing over the past two decades. It is also the only solution that simultaneously addresses the need to improve patient care, reform

	medical education and training and support the continued provision of safe, high quality acute hospital care 24 hours a day, 7 days a week. It contrasts with the present reliance on large numbers of NCHDs who work excessively long hours and have limited access to formal training. The implications of a maximum 48 hour working week (including a maximum 13 hour day on-site) by 1 August 2009, together with annual leave entitlements and other EWTD requirements, are that at least five doctors must be employed to allow one to be present on the hospital site, 24 hours a day, 7 days a week. This, however, represents the absolute minimum level of emergency cover. Doctors must also provide cover for routine, elective and outpatient services, as well as teaching, research and participation in continuing medical education and quality assurance. In order to do this and provide emergency cover, a minimum of seven doctors will be required. Hospitals without sufficient volumes of patients and activity cannot sustain large numbers of consultants. Without sufficient consultants, hospitals will not be able to provide quality care, nor will they be able to train NCHDs. Sufficient critical mass will be required to achieve expertise across a range of specialties1 and to provide satisfactory medical education and training. All hospitals providing emergency care must have acute medicine, surgery and anaesthesia on-site. This means that an irreducible minimum of 21 doctors — 7 doctors in each of medicine, surgery and anaesthesia — will be needed to provide basic on-site medical cover within a 48-hour working week. This is an absolute minimum for modelling purposes. In practice, many more specialties would be needed to provide comprehensive acute care, requiring a minimum of some 45 to 50 consultants. *The Task Force's recommendations are centred on three key elements:* ▪ Reducing NCHD hours in line with the European Working Time Directive ▪ Introducing a consultant-provided service ▪ Reforming medical education and training structures. The Task Force has devised detailed proposals for the staffing and organisation of hospitals in the two pilot areas which it studied, i.e. the East Coast Area Health Board and Mid-Western Health Board regions, and a set of key recommendations that it considers applicable to the country as a whole. These proposals are based on a population of about 350,000 and the principle that all appropriate specialist services should be provided as much as possible within that region. For reasons of volume, safety and quality, some services will continue to be provided at a supra-regional or national level. A number of critical national recommendations, including measures to reduce NCHD working hours, should be implemented immediately throughout the country, with appropriate negotiation and consultation. The purpose of utilising pilot regions was: ▪ to understand the present system fully ▪ to explore alternative models of delivery, with particular emphasis on the work patterns of medical and other staff

	▪ to estimate the likely cost of adopting a specific model.
Funding	**Recommendation/considerations:** The Task Force recommends that the current fragmentation in the coordination, management, regulation, inspection, control and funding of postgraduate medical training should be addressed by vesting in a central, independent, statutory postgraduate training authority a wide range of specified executive powers.
Other	No information identified.
Impact	Repeated attempts have been made over the last twenty years to reduce the working hours of NCHDs. As part of the preparation for implementing the EWTD, a National Joint Steering Group on the Working Hours of NCHDs was established in June 1999 and reported in January 2001. Known as the Hanly report, it recommended that: ▪ fundamental changes should be introduced in the working conditions and training of all hospital doctors for the benefit of patients and improvement of services ▪ appropriate consultants should be on duty to provide a better quality service with greater continuity in patient care delivery 24 hours a day. They should be supported by rostered NCHD staff working appropriate shift patterns ▪ flexible working arrangements and more family-friendly policies should be introduced ▪ a re-designation or reconfiguration of services may have to be considered in some hospitals because of the reduced working hours commitment by NCHDs ▪ more structured and flexible training should be provided.

Table 12 Acute Medical Units [2004]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Comhairle na nOspidéal[12] Acute Medical Units [2004] Report
The health service system (including health service reform)	**For information:** **<u>Limitations of Current Pathway</u>** ▪ Shortage of acute medical inpatient beds. ▪ Inability of local GPs to directly access hospital services thereby causing them to instruct their patients to present themselves at A&E departments. ▪ Repeat inappropriate re-assessment by emergency department staff of acutely seen and referred by GPs for admission. ▪ Majority of care in A&E is delivered by junior doctors, many of whom are relatively inexperienced. Due to the nature of their complaint, many medical patients can be left waiting for long periods of time in A&E departments before being assessed or treated as other more "urgent" cases are continually prioritised ahead of them. Delays associated with waiting for the relevant on-call medical team to assess an acute medical patient in A&E. ▪ Delays in admitting patients until relevant medical team agrees. ▪ Patients with similar conditions who are being treated by the one consultant and their NCHD team being scattered throughout the hospital rather than located in one designated section/ward of the hospital. ▪ Admission of medical patients to inappropriate wards including surgical wards. ▪ Pressure in A&E departments to admit patients to any bed that is unoccupied in any part of the hospital in order to get patients off trolleys and chairs and free up much needed space in A&E departments. **<u>Consequences</u>** ▪ Significant delays, sometimes up to a few days before an acute medical patient can be admitted to an inpatient bed. ▪ No incentive for patients to attend their GP in the first instance, and no benefits for the patient if they have attended a GP and where further medical assessment is required. Perception among GPs that they have little support from their local hospitals. Increased workload in A&E departments for all patients. ▪ Delays by hospitals in treating patients who have been diagnosed by their GPs as needing inpatient treatment and/or urgently required investigations. ▪ Decision making pathway slowed due to lateral referrals and insufficient senior clinical decision makers. ▪ Significant delays in treating and diagnosing acute medical patients and in identifying and implementing optimal care pathways. ▪ Patients' and relatives' perceptions of experiencing an unsatisfactory hospital service.

	▪ A&E department playing the role of a holding facility with respect to emergency medical patients. ▪ Chaotic ward rounds for medical teams, commonly referred to in international literature and in the hospital consulted as "safari" rounds. In certain circumstances, patients may be overlooked for a considerable period as the relevant teams may not have been informed of their precise locations. ▪ Patients can undergo a number of bed-to-bed transfers, as inappropriately placed patients are alter moved to the appropriate wards as beds become available. Issue of the ability of surgical ward staff to look after medical patients. ▪ Increased interruption and cancellation of elective activity and urgent inpatient investigations in both medical and surgical specialties.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendations:** **ACUTE MEDICAL UNITS** Arising from its consultation process, the committee examined and considered a wide variety of alternative ways of dealing with emergency medical admissions and presentations. Though the facilities reviewed differed across a number of areas including size and staffing arrangements, the impact of these facilities on the relevant hospitals, with very few exceptions, was reported as having been positive from the perspective of the patient, the staff and the hospital. There exists good reason and real scope to effectively manage and streamline the process of assessment and/or admission of acute medical emergencies from General Practitioners/Primary Care, A&E, and hospitals' OPDs. Taking into consideration the strengths and weaknesses of the units reviewed, and in light of the rapidly developing area of acute medicine, Comhairle na nOspidéal makes recommendations below regarding how it believes such units could best be developed, organised, staffed and integrated within the acute hospital system. The widely varying terms in place to describe the functioning of existing units was noted. It is recommended by Comhairle na nOspidéal that, in the interests of consistency, the dedicated area in hospitals used to manage acutely ill medical patients be called the Acute Medical Unit. Accordingly, Comhairle na nOspidéal recommends the development of Acute Medical Units (AMUs) in all acute general hospitals receiving acutely ill medical patients. These AMUs should treat patients referred for urgent medical assessment and/or admission. The AMU, a centrally located facility in the hospital, should provide rapid assessment, diagnosis and treatment of acute medically ill patients referred from General Practitioners, the A&E department, and the hospital's OPD. Each AMU should be staffed by a multidisciplinary acute care team led by a designated consultant physician with appropriate training. When on AMU duty, the consultant physician should have no other fixed/scheduled commitments so as to ensure the immediate availability of senior clinical decision making for patients during their assessment, on-going care and management in the unit. Pathways available to AMU patients should include discharge directly home, provision of continuing care in the AMU in cases where a short length of stay is envisaged, transfer to a specialty/general ward within the hospital or referral to an outpatient clinic. The AMU must have priority access to acute investigative facilities and inpatient beds within the hospital. **KEY COMPONENTS** In order to ensure the success of any Acute Medical Unit, the following key components have been

identified as essential:
- strong management and clinical support for the AMU
- clear and agreed protocols and guidelines for access to and discharge from the AMU
- designated consultant leadership of the unit
- consultant physicians with the appropriate training having a dedicated commitment to the AMU
- all consultant physicians in the hospital being involved in providing designated services to the unit
- evidence-based protocols for the management, diagnosis and treatment of patients in the AMU which would be reviewed and updated on a regular basis
- fast-track access to the full range of diagnostic services for AMU patients
- provision of high level multidisciplinary services in AMUs including medical staffing (consultant physicians and NCHDs), specialist nursing, occupational therapy, physiotherapy and access to rehabilitation and community based services
- effective communication systems in place between the AMU, the A&E, general practitioners, the hospital bed manager and the hospital's OPD.

A number of factors will influence the exact structure and organisation of Acute Medical Units within each acute general hospital. These factors include:
- size of hospital
- population served by hospital
- role of the hospital within its region
- the specialty mix within the hospital
- bed capacity of hospital vis-à-vis population served
- staffing of hospital
- level of provision of primary care in region
- number of long-stay beds available for population served
- access to rehabilitation beds.

Assessment and Admission
Any general hospital receiving acutely ill medical patients should have an Acute Medical Unit. The AMU should combine the functions of acute medical assessment and medical admission. It is envisaged that the units will provide services to two broad categories of patients. These are:
1) patients who are acutely medically ill and need immediate assessment and treatment
2) medical patients where there exists clinical uncertainty, who may be potentially acutely ill and who require further assessment and treatment.

Following assessment and treatment, some patients will be discharged directly from the unit on the same day as being referred. Other patients will be identified as requiring admission to hospital for ongoing inpatient care. Of these patients,

	those with an anticipated short length of stay should remain in the AMU for their entire inpatient episode. Others in need of specialist inpatient medical care and/or with an anticipated greater length of inpatient stay should be admitted to a specialty/general ward via the AMU, as the appropriate beds become available in the hospital. It is acknowledged that the exact proportion between assessment and admission within any given AMU will be influenced by local circumstances and need, including the size of the hospital, bed capacity and average daily clinical intake of acute medical patients. Some AMUs may focus primarily on acute assessment and in this context will transfer all patients identified as needing inpatient care after assessment directly to the relevant wards within the hospitals. Other AMUs will provide both assessment services and admission services i.e. inpatient care. In hospitals with AMUs of this kind, all medical admissions not planned for (with the exception of those directed to ICU, CCU and other specialised services allowed under agreed protocols), should be directed to and admitted via the AMU. All AMUs, regardless of the exact mix of assessment and admission, must retain a protected assessment component, as not all patients referred to the unit will require admission. **Hours of Operation** The opening hours of an Acute Medical Unit will be influenced by the balance of assessment and admission functions provided and the role of the hospital. If providing both assessment and admission, the unit should be open 24 hours a day, seven days a week. If providing an assessment function only, local circumstances will best inform the ideal opening hours of the unit. **Access to Unit** Access to the AMU should be based on clear patient-driven protocols and guidelines which have been agreed by all the relevant parties. Access to the AMU should be provided to the following: ▪ General Practitioners ▪ Accident & Emergency Department ▪ Hospital OPD **Size and Location of Unit** A variety of factors will each play a role in determining the size of unit, including the balance between the assessment and admission functions of the unit, the catchment population of the hospital, the average daily clinical intake of acute medical patients and available resources. It is recommended that where feasible, the Acute Medical Unit should be sited near the A&E department within the hospital and close to diagnostic facilities. **Bed Capacity Requirements** The manner in which the beds for the acute medical unit are sourced will vary from hospital to hospital. In some hospitals, a process of re-designation of existing beds may be possible. In others, it may be that additional beds will have to be provided.

Bed availability outside the hospital in the form of rehabilitation and community service beds will also need to be considered and taken into account, as these influence the patient-flow through all hospitals. A shortage of community-based beds can present a serious exit block in hospitals, and will impact negatively upon the effective functioning of the AMU.

Access to Diagnostics
All AMUs should have dedicated "fast-track" diagnostic services available to them from the range of diagnostic facilities in the hospital including laboratory, radiology and cardiology.

Ward Rounds
Consultant-led ward rounds should take place at least twice daily in an AMU, once in the morning and once in the afternoon/evening. This will ensure that patients requiring transfer to a specialty bed or discharge home are identified on a regular basis throughout the day. It is envisaged by Comhairle na nOspidéal that in the major hospitals with large AMUs, these will be joint ward rounds, involving one of the consultant physicians appointed to and based in the unit and the relevant consultant physician on-call.

Length of Stay
Each Acute Medical Unit will estimate its ideal length of patient stay. For those units focussing solely on medical assessments this will be in the 8-12 hours range. For those AMUs with the ability to provide inpatient care, i.e. those with an admission function, the maximum length of stay is likely to be from 3 – 5 days. Patients with an anticipated short length of stay could spend their entire inpatient episode in the unit. Patients identified as in need of specialist inpatient medical care or with an anticipated greater length of stay may have to remain in the unit until the appropriate inpatient bed in the hospital becomes available. No patient should remain in the unit beyond the pre-determined maximum length of stay. Local circumstances will guide the appropriate length of time to be set for each unit. It is important that these time objectives are met and sustained, because if they break down, the AMU will be in danger of functioning sub-optimally and not meeting its objectives.

Discharge from Unit
The routes of discharge from an Acute Medical Unit include

- discharge home from the unit with a letter for the GP and/or an appointment to a relevant out-patient clinic or other specialist service
- admission to a specialty/general ward within the hospital for further inpatient treatment.

Patients from the AMU needing hospital admission should be given priority access for beds in the hospital. To function smoothly, it is essential that AMUs become an integral part of the bed management policy of all hospitals and that clear and continuous communication takes place between the AMU and the Hospital Bed Manager.

For information:

	Mid-Western Regional Hospital, Limerick A medical initiative, termed the Medical Day Ward (MDW), was introduced in Limerick by the Mid Western Health Board as a strategic investment to provide rapid access for GP services, avoid unnecessary admissions and reduce the average length of stay for certain defined diagnostic categories. The operation of the MDW relies on the use of evidence-based diagnostic-driven integrated care pathways. The MDW provides an alternative assessment pathway for defined medical patients and helps bridge the gap between outpatient clinics and A&E. The MDW is staffed by one consultant physician, NCHDs, nurses and administrative staff. The consultant with overall responsibility for the MDW is a specialist in general internal medicine and geriatric medicine. The ward also receives further consultant input from various other specialties. The MDW currently has 5 beds and 14 treatment couches (i.e. 19 treatment slots) and has close links with rehabilitation services. The opening hours of the MDW are from 9.00 to 17.00, Monday to Friday, with patients being received up to 16.30. At the time of the committee's visit the MDW was looking to extend its opening hours. The workload of the MDW is based primarily around the following diagnostic pathways: deep vein thrombosis (DVT), syncope, transient ischaemic attack (TIA), stroke, asthma/chronic obstructive pulmonary disease (COPD), shortness of breath (SOB), falls, atrial fibrillation/congestive cardiac failure (CCF), anaemia, bronchoscopy and non-orthopaedic fractures. If a patient does not fit into any of the identified clinical care pathways, then the patient is directed to the general medicine pathway. The MDW provides open referral from A&E for certain diagnostic categories and provides a priority service to GPs, with a response time of two working days for the latter. The MDW also provides services in certain pre-designated medical procedures including for example blood transfusions. The MDW receives approximately 20 patients per day (at least 5 new and 10 review patients) and on average sees 360 patients a month. 40% are referrals from GPs, 40% from A&E and 15% from other consultants. The committee were informed that the introduction of the Medical Day Ward in Limerick has resulted in a 1.2 day reduction in the average length of stay for patients over 75 years of age.
Governance	**Recommendation/considerations:** **Leadership of AMU** Clear consultant leadership of the AMU is a crucial issue. With respect to the variety of units visited by the committee, a major determinant of the success or failure of the units was the presence or absence of a designated consultant physician leader for the unit, and the management skills of this consultant physician. In this context, Comhairle na nOspidéal recommends that one consultant general physician should be clearly identified by both management and medical staff, as having a lead role to play in the management, running, auditing and development of the AMU. It is recommended that this lead consultant physician would have a major interest in and commitment to the unit and have the appropriate management skills to undertake satisfactorily the leadership role envisaged. This lead role in the AMU could be a renewable appointment with the additional option of a rotation among interested consultant physicians involved in the unit. In line with the recommendations contained in the Comhairle na nOspidéal report on A&E Services, the lead clinician in the AMU should be a member of the Hospital Emergency Service Committee. The establishment of such a committee in each acute hospital was proposed in the Comhairle A&E Report to aid the co-ordination of emergency services within hospitals. The Report envisaged that the membership of the committee would be comprised of a range of staff including acute medical,

	surgical, paediatric, obstetric, psychiatric, anaesthetic, radiology and pathology medical staff, together with nursing, health and social care professionals, ambulance staff and general practitioners.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** **Staffing of Acute Medical Unit** All Acute Medical Units should have dedicated staff to ensure the provision of a high quality service. The success of any unit will be dependent on the provision of adequate staffing levels and senior experienced medical and nursing staff to treat patients and make decisions. **CONSULTANT STAFFING OF THE ACUTE MEDICAL UNIT** ▪ Acute medical units should be staffed at all times by a consultant physician who has designated responsibility for the unit for a particular time period. ▪ The number of consultant physicians working in the AMU will vary from unit to unit depending on the hospital's workload, size, consultant staffing and other local circumstances. ▪ In Acute Medical Units in major hospitals i.e. those that provide both an assessment and admission service and which experience a busy daily clinical intake of acutely ill medical patients, it is recommended that additional consultant physicians with appropriate training in acute medical care be appointed to and based in the AMU. ▪ It is envisaged that a minimum of two such consultant physicians' posts will be needed in AMUs in the major hospitals. ▪ It is recommended that, in the first instance, these posts be structured with 8-9 sessions to the AMU for acute medicine and 2-3 protected sessions to maintain and facilitate a special interest. ▪ The commitment to the AMU by these consultants should involve providing assessment, diagnosis and treatment of patients referred to the AMU and participation in the acute on-call rota in association with their fellow consultant physicians. These consultants should also lead the development of protocols for the AMU and be involved in teaching, research and audit centred on the AMU. ▪ In all hospitals, the day-to-day consultant staffing and responsibility for the AMU could rotate amongst consultant physicians based on the 24-hour general medical on-call rota. ▪ Comhairle na nOspidéal recommends that all consultant physicians leading on-call teams should ensure that their principal responsibility when on AMU call is to the evaluation and management of acutely ill medical patients presenting to the AMU. This is essential given the requirement for their instant availability and the need for at least twice daily consultant-led major ward rounds in the AMU. In major hospitals with larger AMUs, where consultant physicians with the appropriate training in acute medical care will be appointed to and based in the AMU, it is envisaged by Comhairle na nOspidéal that these consultants will cover the AMU and

	the medical patients referred to it during working hours, Monday to Friday. The 24 hour general medical on-call rota, which would still be in operation in these hospitals, would de facto be supplanted during office hours by this arrangement with respect to consultant staffing of the AMU. The general medical on-call rota would determine which consultant physician and medical team would be responsible for acute medical patients and the AMU outside of core working hours and at the weekends. This on-call rota would include the consultant physicians based in the unit. ▪ Comhairle na nOspidéal wishes to stress the importance of every hospital with an AMU putting in place clear, precise and agreed protocolised arrangements which will cover such issues as the shared care of patients, assumption of care of patients, continuity of care of patients and transfer of care of patients in the AMU. These protocols will clarify the roles and relationships between the different consultant physician teams involved in staffing the unit and the interaction of the unit with other services in the hospital. ▪ All medical patients admitted via the AMU should be admitted under the designated on-call physician for that day unless there exists agreed protocols for specific groups of patients to be directed or transferred onto other pathways of care. ▪ There is scope in the future for the development of consultant physician posts which would be dedicated full-time to acute medicine. It is expected that these individuals would be based full-time in the AMU. ▪ As all AMUs will need on-going input from the range of medical specialties, it is fundamental to a unit's success that all consultant physicians, including those who may not partake in the general medical on-call rota, are involved in providing their specialised services to the AMU. It is important therefore that agreed protocols are drawn up regarding how such inputs will be accessed and provided to the unit, and how transfer of care between different specialties, if deemed appropriate, will operate. **NCHD STAFFING OF THE ACUTE MEDICAL UNIT** It is expected that the medical team of the consultant physician on-call will identify the AMU as their principal responsibility for that period. It is recommended that all Acute Medical Units be staffed on the floor, at all times, by at least one senior experienced NCHD with appropriate skills in acute medicine. This doctor should be at Registrar/Specialist Registrar level at the minimum. In AMUs in the major hospitals it is envisaged that a team of dedicated NCHDs will be attached full time to the unit, akin to the arrangement within Accident and Emergency Departments, and be under the supervision of the acute medicine consultant physicians appointed to and based in the AMU. In such large units, it is envisaged by Comhairle na nOspidéal that the NCHD staffing of the unit will be a blend of NCHDs based full-time in the unit and NCHDs from the consultant physician on-call team. Clear protocols will need to be worked out in each hospital regarding the NCHD staffing of AMUs, as the number of NCHDs and extent of coverage needed will vary from hospital to hospital. Comhairle na nOspidéal wishes to stress the training potential that the development of AMU could have for medical NCHDs in the future. It is recommended that training programmes be considered and developed by the Irish Committee on Higher Medical Training (ICHMT, RCPI) to include structured rotation of trainees through AMUs supervised by recognised trainers in Acute Medicine. **NURSE STAFFING OF THE ACUTE MEDICAL UNIT**

	An AMU will require a higher nurse-patient ratio than in general medical wards due to the nature of the work and the rapid turnover of patients in these units. It is recommended that an AMU would be staffed by the appropriate level of senior nursing staff with high level of skills and competencies to aid the efficient and effective care and streamlining of patients through the units. **ALLIED HEALTH PROFESSIONALS** The committee observed from the consultation process that the medical units which had the greatest positive impact on patients and their well-being were those that had the dedicated on-site services of allied health professionals including occupational therapists, physiotherapists and direct access to community services. The ability of patients to access these services when most needed i.e. after an acute medical episode, allowed these units to provide a comprehensive service. Care followed the patient into the community immediately after discharge, particularly in situations where joint appointments between hospitals and community care existed. In this context, it is recommended by Comhairle na nOspidéal that employing authorities make arrangements for the provision of, or timely access to, such support services for patients attending AMUs. **ADMINISTRATIVE & CLERICAL STAFF** All AMUs should have sufficient dedicated administrative and clerical staff to deal with the volume of activity and the maintenance of patient records.
Funding	No information identified.
Other	**For information:** Previous reports: **Quality & Fairness - A Health System for You. Department of Health & Children** The Government's Health Strategy, Quality & Fairness, A Health System for You, was launched in November 2001. This strategy outlines the principles, values, goals and objectives which will underpin and guide the development and direction of health service delivery in Ireland over a 10-year period. Among the weaknesses identified within the current health system were inadequate bed capacity and unequal access to services. It was noted that despite considerable reductions in acute hospital bed numbers since the 1980s, hospital activity had increased significantly in the subsequent 20 years. This has imposed serious strain on hospital staff, facilities and services. In addressing these issues the Strategy states that "systems in hospitals will be reviewed to enhance clinical pathways. This will be aimed at improving the flow of patients through A&E departments, diagnostic services and the hospital generally." Actions identified in the Strategy include commissioning an additional 3,000 acute hospital beds for patients over the ten years to 2011, as well as initiatives to be undertaken to improve the operation of accident and emergency departments by directing patients to the most appropriate location of care, thus ensuring that patients are seen as quickly as possible and in the most appropriate facility. **Acute Hospital Bed Capacity – A National Review. Department of Health & Children**

	This review, carried out by the Department of Health and Children as part of The Programme for Prosperity and Fairness, focused on bed capacity in publicly-funded acute hospitals in Ireland. This was carried out with the aim of examining the need for change to the current acute bed complement and utilisation patterns, taking account of factors which impact on demand for acute hospital beds now and in the future. The review took into consideration strategies with the potential to reduce the need for additional beds, including substitution of elective inpatient surgery with day surgery. The review recommended that 2,840 additional inpatient acute hospital beds were required in Ireland by 2011. This figure was deemed sufficient to address goals such as reducing average bed occupancy in major hospitals while meeting projected demographic changes and coping with increased demand for healthcare. Assessing and measuring current acute hospital activity in Ireland the review concluded that, "in short, current acute hospital bed capacity is unable to respond adequately to the demands to which it is subjected." Making its recommendations regarding additional beds, the review group noted however "that adding beds is only part of the solution to the difficulties being experienced in the acute hospital system… Examining ways in which current capacity could be used more effectively and efficiently is another. It is unlikely that one solution can be found for such a complex problem. More likely is that a combination of measures will be required." **Report of the Committee on Accident & Emergency Services. Comhairle na nOspidéal** In February 2001, Comhairle na nOspidéal established a committee to undertake a review of the structure, operation and staffing of A&E Services and Departments. In its report, published in February 2002, Comhairle na nOspidéal noted that many of those consulted stated that "significant improvements in emergency services, including reduced waiting times, would not happen without changes in the organisation of emergency care, better use of care pathways, increased and more timely access to diagnostics and better access to and management of inpatient beds". The report further noted that "improvements in patient flow in the Emergency Department are limited by difficulties in accessing inpatient beds and the congestion caused by being unable to move patients to a ward." In making its recommendations Comhairle na nOspidéal concurred with the view expressed to it during its consultation process that a "whole system" approach to hospital care was required in order to ensure that hospital emergency services can be delivered effectively. In this context, Comhairle na nOspidéal recommended "that hospital services are explicitly organised in 3 distinct but interdependent streams or services: *1. Emergency care* Organised so that patients, depending on their needs, can move smoothly between Emergency Departments, assessment beds, intensive care, coronary care, the best inpatient medical and surgical care and have rapid access to appropriate diagnostic services and primary care. *2. In-patient Elective Care* Encompassing inpatient beds in clinical specialities, diagnostic facilities and services as well as strong links to outpatients and day care facilities.

3. Day and Outpatient care
Addressing the needs of patients who require non-urgent care in a hospital setting but who do not need admission to the hospital. These include out-patients appointments, many diagnostic investigations, day surgery and various therapies."

The report noted that the above reconfiguration of services would require a range of designated beds including emergency department observation beds, intensive care beds, coronary care beds, rehabilitation beds and beds in acute admission wards for short duration inpatient stay. Making its recommendations regarding hospital emergency services, Comhairle na nOspidéal proposed that for "emergency care to work efficiently, the hospital emergency service must be organised so that patients, depending on their need, can move smoothly between Emergency Departments, minor injury and illness areas, primary care, assessment beds, intensive care, coronary care, the best inpatient medical and surgical care and have rapid access to diagnostic services."

Report of the National Task Force on Medical Staffing
The National Task Force on Medical Staffing was established in February 2002 by the then Minister of Health and Children, Mr. Micheál Martin. The Task Force was asked to devise an implementation plan for reducing substantially the working hours of NCHDs to meet the requirements of the European Working Time Directive (EWTD), to plan for the implementation of a consultant-provided service and to address the medical education and training needs associated with the EWTD and the move to a consultant-provided service. The report of the Task Force, adopted as Government policy in October 2003, made a number of recommendations regarding the configuration and staffing of the Irish hospital system. During the formulation of its report, the Task Force considered whether there was a role for doctors termed "hospitalists" or "generalists" within the Irish Health System, "who could provide a considerable level of frontline clinical service in hospitals before referring patients to the appropriate specialists". The Task Force concluded that it would not be desirable to develop the hospitalist or generalist model extensively in Ireland. Rather the Task Force believed "that it would be valuable to have a number of consultants concentrating mainly on general internal medicine but with an interest in another medical specialty. Such consultants would have an 80/20 or 70/30 commitment to general internal medicine and a subspecialty and share on-call rotas with consultants in the sub-specialties of general internal medicine". The Task Force felt that this approach would combine some of the efficiencies offered by a generalist model with the important benefits of sufficient links with specialist work.

The Task Force recommended that Medical Assessment Units and Medical Admission Units play a key role in the effective management of emergency department attendees with medical problems. The report defined Medical Assessment Units as providing "a short stay area for assessing medical patients who need further investigations before a decision on the most appropriate care can be made" and Medical Admission Units as facilities that provide "rapid assessment, diagnosis, observation and early treatment to patients with medical problems who are referred for admission to hospital. Patients could be referred to the Medical Admission Unit by the hospital emergency department, directly from GPs or from outpatient clinics."

	Admission and Discharge Guidelines, Health Strategy Implementation Project. **The Health Boards Executive** These guidelines were produced by the Health Boards Executive in response to specific commitments made in the Government's Health Strategy 2001. These commitments related to enhancing the discharge function in each acute hospital to ensure that patients do not have to stay in hospital any longer than is necessary and to ensure emergency patients will be the only group admitted to hospitals via A&E departments. The report makes a number of recommendations regarding best practice, protocols and policies for improving emergency and elective admissions and discharges within the hospital system. In addressing the issue of admitting patients from emergency departments, it is noted in the report that more rigorous assessment of patients is needed to ensure the appropriateness of hospital admission and to maximise the number of beds available for elective admission. A number of factors, which are considered important in admitting patients from the emergency departments, are identified. These include: ▪ extended access to rapid assessment clinics and outpatient radiology and pathology services ▪ rapid assessment and extended access to diagnostics ▪ early senior medical decision-making available at the point of admission ▪ close multidisciplinary team work ▪ patients being streamlined into a number of categories, including resuscitation, minor illness and injury and specialised medical/surgical team assessment for patients who may require admission and ▪ rapid access facilities such as MAUs requiring robust, specific and auditable operational policies. Concluding its recommendations, the report notes the essential need for a "whole systems approach" to admission planning, underpinned by high quality communication and information systems.
Impact	No information identified.

Table 13 Emergency Department Task Force Report [2007]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Health Service Executive (HSE) Emergency Department Task Force[13] Emergency Department Task Force Report [2007] Report
The health service system (including health service reform)	**Recommendation/considerations:** Recommendations: *Capability* Chronic Disease Management ▪ Expand and mainstream chronic disease management programmes with the development of shared care models and integrated care pathways. ▪ Exploit the opportunities offered by a national system for developing common protocols and care pathways to facilitate chronic disease management in line with the established evidence base (see sections under international evidence and recommendations)
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** International evidence suggests that reducing variations in capacity can be achieved by moving away from ring-fencing of beds, smoothing elective activity, redesigning internal processing to reduce complexity and the number of steps needed to manage the patient effectively. **Recommendations:** *Capacity* ▪ Ensure access to existing capacity using targeted initiatives in relation to issues such as diagnostics and long term care. The development of improved care pathways for specific groups such as chronic disease, paediatrics, geriatrics and mental health patients should also be considered as a matter of priority. ▪ Manage capacity according to prioritised need – Ensuring that capacity freed by initiatives such as the movement of patients to long-term care or improved diagnostics is appropriately balanced between emergency and elective admissions. ▪ Introduce or enhancing management control processes to ensure capacity freed by reductions in delayed discharges is used in line with emergency need is only one part of the solution. Hospitals must re-examine and re-configure their approach to overall bed capacity management in all settings if change is to be effective. ▪ Implement effective additional capacity initiatives to allow timely admission. ▪ Identify the capacity requirement associated with emergency and elective admissions. ▪ Reduce variation in the level of elective activity. ▪ Implement appropriate escalation measures in response to rising emergency admission demand

	▪ Create new capacity through initiatives aimed at diverting or fast tracking patients for example, AMAUs and rapid access clinics. ▪ Develop specific solutions to meet the continuing care requirements of Young Chronic Sick patients. ▪ Develop alternative community solutions to presentation to ED particularly for older patients (see section Elderly patients in the ED). *Capability* <u>Appropriate ED avoidance</u> ▪ Create additional and alternative access routes to urgent care thereby obviating the need for Emergency Department attendance. ▪ Ensure that all initiatives aimed at supporting rapid access to Consultant opinion are underpinned by dedicated up skilled teams, supported by adequate diagnostic capability and robust clinical protocols. ▪ The availability of additional community professionals, especially Community nursing, on a seven day basis to match changed hospital service provision and discharge policies should be immediately pursued. <u>Rapid Access to inpatient care</u> ▪ Fast track Clinics: The Taskforce endorses such clinics as likely to be effective in reducing the volumes and wait times in EDs, provided they are delivered and overseen by senior decision makers and underpinned by robust clinical protocols. ▪ Hospitals can improve existing inpatient bed capacity usage through specific non-elective 'medical' patient orientated capability initiatives, particularly the creation of Acute Medical Admission Units. The creation of short stay (less than 5 days), high intensity capacity can result in the following benefits: ß Reduced ED 'trolley' waits / prompt admission ß 'Pull' to accommodation within appropriate ward ß Focused condition specific protocols, rather than individualistic approach ß Shorter average length of stay (approximately 2 day reduction) ß Prompt effective discharge – with no adverse increased readmission. <u>Access to Diagnostics</u> ▪ Develop rapid routine diagnostic reporting on an extended 12 hour, 7 day basis – linking diagnostic reporting capacity to ED attendance patterns and patient need over the 24 hour period. ▪ In the short term, the option of out-sourcing diagnostics should be considered particularly for GP workloads in order to improve overall bed utilisation and patient flow. Also, the potential for delivering an extended day through the use of overtime should be supported. It is vital that safeguards are in place to ensure quality assurance, shared access to results, and avoidance of test duplication should the patient require hospital attendance. ▪ Any short-term initiatives should be carefully selected and evaluated in terms of overall impact on volumes and wait times in ED and control.

	▪ In this context, work practice issues must be addressed urgently in relation to diagnostic and support services within the context of a national IR environment. <u>Effective Discharge of patients</u> ▪ Patients placed directly under the care of the appropriate specialist will have a streamlined investigation process; early diagnosis and treatment and earlier discharge. *Control* <u>Acute hospitals</u> ▪ Hospitals should set specific volume targets relating to the patient groups on a day- to- day basis on the premise that. ED and Elective generated bed base volume requirements are largely predictable; this should be done on a daily, weekly, and monthly basis. ▪ Establish a single bed management control function within hospitals to manage the requirements of all patient cohorts efficiently. ▪ Strengthen discharge management functions as an immediate priority. incorporating two key elements- (Planned) date of discharge to be identified on admission and individual patient information to be used at a macro hospital level to predict overall ongoing bed availability / capacity. **For information:** At the current time, hospitals routinely do not have beds available to meet patient need. This results in those patients who require admission to hospital spending significant periods in the Emergency Department (ED). Such patients are sometimes referred to as 'boarded inpatients'. Variation is a key cause of delay The key cause of delays for patients in ED are variations in the hospitals and community's capacity and capability and control processes. These variations include: ▪ Variation in bed capacity ▪ Variation in the level and availability of clinical decision-making ▪ Variation in the availability of diagnostics, senior in-house specialty assessment and other ED supports ▪ Variation in internal control processes ▪ Variation in community and continuing care capacity and processes. Such variations result in admitted patients being accommodated inappropriately with in the ED while awaiting transfer to an inpatient bed. At the current time, a significant number of hospitals examined by the Task Force are operating at close to 100% capacity against a well-established international evidence base that states that the optimum level is approximately 85% occupancy.

	Findings: ▪ At least 7 of the Emergency Departments are unfit for purpose. This militates against effective management of patient volumes and wait times within Emergency Departments. ▪ A number of other hospitals are less than optimal in terms of space and overall design which does not enable effective streaming of patient cohorts. This points to the need for a national ED planning framework within the overall capital planning process that ensures there is adequate space provision within new builds to enable effective streaming and fast-tracking and / or diversion of attendees. ▪ The supporting infrastructure within EDs to address the resuscitation needs of patients and dignity and privacy requirements of specific groups such as paediatric and obstetric patients is inadequate on a number of sites. ▪ A number of the hospitals examined by the Task Force are operating at close to 100% capacity and the majority at 95%. This results in sub-optimal management of elective and emergency workloads. ▪ It is vital that hospitals have full access to their existing beds. For the Dublin hospitals, issues relating to delayed discharges have meant that up to 20% of their current bed capacity is not available to each hospital. There is insufficient access to long-term beds and an ad hoc approach to the allocation of such beds. A similar trend is emerging in Cork, Galway, Drogheda, Cavan and Limerick. ▪ In Dublin, there is an ongoing requirement for 46 long-stay beds per week to meet the needs of post-acute patients. The HSE has estimated that, nationally, there is a requirement for 2,472 long stay places over the next 12 months, with similar numbers recurring in future years. ▪ In terms of optimising existing capacity, issues have also been identified in relation to lack of consistent availability of diagnostics and reporting availability – in real time – in response to emergency and inpatient needs. *Effective Management of Patients within ED* ▪ The Task Force identified a number of initiatives as having the potential to improve patient processing and overall management within the ED. These include streaming, "See and Treat", Clinical Decision Units (CDUs) and fast-track specialist consultant clinics. Key issues identified are as follows: o There is a need to ensure that attempts to optimise the efficient management of high volumes of less urgent patients does not compromise the care of the more acutely or seriously ill patients. ▪ In a number of the hospitals visited, the existing space and design would not enable such processes to be implemented efficiently. ▪ Evidence of the efficacy of the CDU and Fast-Track Specialist Consultant Clinics is growing, if they are provided by Senior Clinical Decision Makers and adequately supported. ▪ Accordingly, the success of each of the initiatives is dependent on there being sufficient availability of senior clinical decision-makers and adequate support from diagnostic services.

Governance	**Recommendation/considerations:** Recommendations: *Control* <u>Acute Hospitals</u> ▪ Ensure that the Hospital Manager is accountable and responsible for overall operational management of hospital including target settings and effecting changes in work practices. ▪ Develop an overall pan-hospital control structure that recognises the need to accommodate emergency, urgent elective and less urgent patient groups within the bed base. ▪ Support hospitals to develop solutions tailored to specific local needs. Robust clinical and business processes and mechanisms to assess the impact on overall patient flow should underpin such solutions. ▪ Develop Clinical Treatment / Care pathways, whereby predetermined optimal pathways are developed for specific illnesses and used to effect control of work practises and enable achievement of desired performance metrics. Apply control mechanisms to the totality of the patient care pathway. ***Recommendations regarding implementation:*** In summary, the Task Force recommends that: a. The HSE moves immediately to a target of 12 hours or less wait time from decision to admit; b. The HSE sets a date by the 1st February 2007 from which hospitals will meet a target of 6-hours or less wait time after decision to admit; and in this context takes account of the timeframe for implementation of infrastructural and other measures identified above: c. The HSE sets a date by 1st February 2007, to have determined the timeframe from which a total maximum wait time of 6 hours from arrival at the Emergency Department to admission or discharge will apply and have detailed the measures to be undertaken to enable each hospital to meet this target.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** The international evidence from Australia, UK and USA indicates that the key change requirement for effective chronic disease management is a move from existing predominantly hospital focus to a more pro-active, integrated, population-focussed model incorporating the hospital, community and GP services. Recommendations: *Capacity* ▪ Develop sustained solutions to meet the long- term care requirements of those patients who no longer require acute hospital beds (see section Meeting Future Long-Term Care Requirements). ▪ Ensure capacity released by the discharge of patients to long-term care is used to appropriately balance emergency and elective activity requirements. *Control* <u>Primary Community and Continuing Care (PCCC)</u>

	▪ Ensure that Community bed volume, other community service provisions and wait times for assessment and access to community and continuing service should form an integral part of the PCCC annual service plan agreement. ▪ Targets linked to service volumes and wait times should be developed with immediate effect for PCCC ▪ Provide placements and services on a proactive assessment of overall hospital need, rather than a delayed reactive response to demand based on actual inappropriate acute bed occupancy. ▪ Design Control structures within PCCC to enable and support discharge in a timely manner – avoiding duplication of assessment and in securing services. ▪ Each Hospital and local PCCC area should jointly develop and effect discharge and community maintenance requirements, supported by joint performance metrics. Recommendations regarding implementation: *Targets for Primary Community and Continuing Care (PCCC)* ▪ the Taskforce recommends the introduction of targets for the delivery of continuing care (community or institutionally based) by the HSE PCCC Directorate. Such targets are intended to be a realistic and deliverable mechanism to positively affect the flow of patients through the acute hospital setting and minimise wait-time in the ED. **For information:** Findings: ▪ The development and impact of community responses to address patient requirements at both primary and continuing care levels has been very variable. Specifically, the availability of and impact of out-of-hours services on ED volumes is variable. ▪ The development of appropriate home care supports outside of Dublin has been limited. As a result, their impact on addressing the continuing care needs of patients has been sub-optimal. ▪ There is a need for standardisation of processes to optimise the use of home care as an alternative to long-term care. *Appropriate ED avoidance* ▪ Initiatives aimed at linking GP and PCCC services with acute hospitals have not been sufficiently targeted at supporting improvements in the volumes, or wait times of patients presenting in ED. ▪ There are no formal structures providing ongoing links between GP's, hospitals and community and continuing care services. ▪ In relation to the impact of out of hours and GP cooperatives on ED services, the following should be noted: The period of highest demand and self-referrals to Emergency Departments is between 8 am and 8 pm, largely times when GP's are available in their surgeries.

	▪ While the development of GP out of hour cooperatives will provide more accessible and structured primary care services out of hours, such services do not act to reduce the number of patients inappropriately accommodated in EDs after a decision to admit to an inpatient bed. Instead, if utilised correctly by patients and properly supported by diagnostic capability, they will provide alternative rapid access for patients who have non-life threatening illness or injury, and who currently use the ED for these services.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Recommendations: *Capability* <u>Effective Management of Patients within the ED</u> ▪ Increase the level of senior clinical decision making in ED ▪ The Task Force recommends that the role of each on-call admitting Consultant in the hospital includes a specific commitment to respond to ED activity. This includes: Daily specialist Consultant ward rounds in the acute specialties. Daily handover of admitted patients to the relevant Consultant or specialty in that hospital. Participation of the on call admitting team in escalation measures. The availability of specialist Consultants to admit, discharge, or refer patients to fast-track clinics. The workforce implications of these measures will need to be quantified. <u>Senior Decision-Making</u> ▪ There is a need for additional consultant workforce levels in the admitting specialties and in Emergency Medicine and the introduction of an extended working day within a National IR framework to facilitate such changes to ensure the 2007 target of Emergency Department Registration to Disposition of 6 hours is achieved and maintained. ▪ There is an imperative to ensure that those attending Emergency Departments for admission are assessed by a senior clinician in the admitting team as soon as possible after arrival. ▪ Supporting improved access to early Senior Clinical Decision making by admitting consultants – in relation to inpatients and patients within ED – including those patients who do not require admission from ED (including diversion by specialists to Rapid Access / OPD / Clinics / Diagnostics or Social Worker – depending on circumstance).
Funding	No information identified.

Other	**Recommendation/considerations:** Recommendations: *Control* Measurement ▪ Introduce system wide definitions that apply to all Hospitals and Emergency Departments, to allow for better comparative analysis of performance (including paediatric beds/ paediatric hospitals). ▪ Develop dedicated IT systems to measure agreed variables. There is a requirement for enhanced National and Local IT and information availability. ▪ Develop National Frameworks to establish norms on issues such as Triage, supporting Infrastructure, Staffing levels, Transport and Treatment; o Measure wait time for all patients from time of arrival at Emergency Department or AMAU. This will require significant effort and resources but will build a more accurate picture of clinical need and demand volumes. ▪ Agree on the targets to be applied for the balance of 2006 and for 2007. At a very minimum there is a need to introduce a maximum target waiting time of 12 hours with immediate effect, with a six hour total maximum target wait time to be set by the HSE. The above innovations must be implemented in an integrated manner to maximise the impact on the volumes and wait times in ED. The Role of Incentivisation ▪ The Task Force acknowledges the effect of the introduction by the HSE of ED targets linked to financial allocation in providing a whole hospital focus in tackling the problems that manifest themselves in the Emergency Department. ▪ The Task Force observations in relation to the role of incentivisation can be summarised as follows; ß There is a need for positive incentives aimed at rewarding performance and/or enabling whole system focus on the emergency admission issues manifesting in ED. ß Targets also need to be set for hospital avoidance measures at community level. ß There is a need to balance the merits of incentivisation against the requirement to enable improved performance in those hospitals that have infrastructural deficits.
Impact	No information identified.

Table 14 Acute hospital bed review. A review of acute hospital bed use in hospitals in the Republic of Ireland with an Emergency Department (summary, conclusions and recommendations) [2007]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	PA Consulting Group and Balance of Care Group[14] Acute hospital bed review: a review of acute hospital bed use in hospitals in the Republic of Ireland with an Emergency Department (summary, conclusions and recommendations) [2007] Review [NOTE: This is a data focused review and therefore extraction is focused on the conclusions and recommendations].
The health service system (including health service reform)	**Recommendation/considerations:** ***Conclusion 1:*** This review concludes that the most influential factor determining appropriateness of bed utilisation is how the care system in place manages the patient, rather than the characteristics of the individual patient. ***Recommendation:*** The recommended changes to service configuration and care delivery in this report to increase appropriate placement of patients should be taken forward as part of the HSE Transformation Programme. **For information:** The review was undertaken using the Appropriateness Evaluation Protocol (AEP) tool, one of a number of tools designed to assess bed utilisation. The AEP is a validated tool for utilisation review which was originally developed in the US but has also been widely used in Europe. The AEP determines whether a particular patient: ▪ was appropriately admitted to an acute bed in the first place and ▪ was appropriately occupying an acute bed on the day of the survey (or should have been discharged to an alternative setting).
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *Conclusion 2:* The data confirm that additional and different capacity is needed if patients are to be more appropriately placed. In particular, the data support the shift towards a wide spectrum of home and community based care, and away from the acute, inpatient setting. Acute hospital admissions and acute length of stay could be reduced if access to the following alternatives was improved: ▪ Assessment / diagnostics ▪ Non-acute beds with therapy support ▪ Home-based patient care including GP support, therapy, specialist nursing, community nursing and home care packages.

	Recommendation: 1: Increase provision of a broad spectrum of community and home-based care to avoid admissions, facilitate timely discharge and ensure convenient, patient-centred care. These care options include: ▪ Improved access to specialist nursing e.g. to support management of chronic diseases outside of the acute hospital ▪ Resources to support provision of i/v therapy in the home ▪ Improved access to home care packages and community nursing to support self-care, anticipatory care and co-ordinate access to services. 2: Increase access to diagnostics and assessment without admission to the acute hospital setting. Based on the survey data, this includes: ▪ Extended hours access to diagnostics and assessment ▪ Creation of community based diagnostic capacity ▪ Roll-out of MAUs to facilitate assessment without admissions where clinically appropriate and protocol based access to diagnostics ▪ Improved GP access to hospital and community diagnostics to reduce delays and avoid unnecessary admissions. 3: Increase the range of non-acute bed-based alternatives available. ▪ Confirm the scale of the capacity gap for long-term care and other non-acute beds at Hospital Network level ▪ Identify opportunities to improve access to non-acute beds through better utilisation ▪ Increase non-acute bed capacity in the context of the role of the non-acute bed as one aspect of the spectrum of non-acute care. *Conclusion 3:* The survey confirms there is significant opportunity to use the current complement of acute beds more efficiently through changes in hospital practice. The review highlighted the need to improve the internal hospital organisational factors that influence length of stay, bed occupancy and bed utilisation. This includes the configuration of ward rounds, introduction of discharge planning and management and multi-disciplinary working to reduce delay in assessment and discharge. *Recommendation:* 1: Implement protocol-based discharge planning and use of estimated dates of discharge. Based on the findings of this review, this should include: ▪ Implementing protocol-led discharge

	▪ Early involvement of PCCC in the planning of patient discharge and transition to non-acute care. ▪ Identifying lead-in times required, e.g. test, and test result availability, medicines, transport, social services and planning around the lead-in times. ▪ Multi-disciplinary, team-based working to reduce delay during care and at discharge. ▪ Establishing regular decision making ward rounds at least once a day. ▪ Matching time of discharge with time beds are required on an hourly basis. 2: Review internal hospital processes to reduce patient delay. ▪ Revising processes for patient assessment and review to ensure timely access to senior decision-making. ▪ Support the provision of timely access to assessment and diagnostics. *Conclusion 5:* There is a need to increase the focus on illness prevention and management. Greater identification and management of high-risk populations and those with chronic disease is necessary to minimise admissions and optimise use of additional home and community based support. *Recommendation:* Accelerate the implementation of the National Chronic Disease Management Strategy. *Conclusion 6:* The HSE now has the trained staff, tools and supporting materials necessary to undertaken acute bed utilisation review. Such review should become an integral part of HSE business as usual activity. *Recommendation:* Undertake the survey at hospital level to inform detailed local planning and performance improvement and to assess the impact of changes made as a result of this study.
Governance	No information identified.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Conclusion 4:* The review signals a need for the re-orientation of services to ensure more appropriate placement of patients, which demands far greater integration of care delivery across health providers at a local level. Optimising any one aspect of the patient pathway in isolation will not deliver optimum care across the whole system as all of the above factors interact with each other in a systematic way. These interactions are often complex, but they can be predicted and managed. *Recommendation:* Adopt an approach of joint-working across providers within and outside of the acute setting to implement the recommendations of this review at local level.
Staffing (including workforce planning, recruitment and retention)	No information identified.
Funding	No information identified.

Other	No information identified.
Impact	No information identified.

Table 15 Review of Acute Hospital Services in HSE Mid-West: An action plan for acute and community health services [2008]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Health Service Executive (HSE)[15] Review of Acute Hospital Services in HSE Mid-West: An action plan for acute and community health services [2008] Review
The health service system (including health service reform)	**Recommendation/considerations:** **Of Note: Specifically, unless full and effective pre-hospital services are put in place, down to the most local level, and proven to be effective by all objective measures of performance, the HSE will not achieve its intention to implement international standards of acute care, as it will find itself unable to proceed to the next step, the planned acute service.** **The over-riding principle is that no acute service will be withdrawn from the current general hospitals until the regional 'centre of excellence' is resourced and ready to deliver that service with reference to international quality standards.** **Reconfiguration.** *Review findings:* **1. Too many patients are being admitted unnecessarily to hospital.** We found a wide variation in non-elective hospitalisation rates by county even after adjusting for age and sex, in medicine ranging from 571 to 1,203 per 10,000, in surgery from 347 to 688, suggesting different clinical practices and criteria for admission. This is in keeping with the findings of the recent national bed utilisation review that found that some 10% of acute admissions were inappropriate. **2. Too many patients are staying too long in hospital.** If the acute services in the Mid-West were to make efficiency improvements, benchmarked to national and international comparators, then this would mean that the 50,000 or so patients admitted each year would reduce their use of inpatient beds from some 938 to 642, a reduction of 296 (32%). Again, this is supported by the national bed utilisation review which found that 40% of inpatients in the Mid-West were considered to be inappropriate for acute hospital services. An illustration of our findings and our concern about quality of service and patient safety. We have selected the Accident & Emergency service (A&E) to illustrate how the present service configuration, and corresponding consultant deployment, leads to the conclusion that the fragmentation of the current services generate an increased clinical risk to patient safety, are unsustainable and need to be reconfigured if they are to deliver to international standards. A&E should be delivered as a 'consultant-led' emergency 'round the clock service',

	with continuous consultant supervision and direct clinical input as necessary to provide systematic, high quality care at all times. There are presently 4 discrete A&E units (Dooradoyle, the main A&E and regional trauma centre, and 3 others, at St. John's, Nenagh and Ennis) serving the Mid-West population. There are only 3 A&E consultants to cover these 4 units, providing a total of only 99 contracted hours of work per week (33 sessions, each of 3 hours). The consultant sessions are distributed as 29 to Dooradoyle, 3 to Ennis, 1 to St. Johns and none to Nenagh i.e. there is only nominal cover at Ennis and St. John's and no consultant cover at all at Nenagh. Allowing for leave, on-call and non-clinical activities, the 3 consultants are able to provide direct clinical care for a total of around 50 hours per week across the standard working week – to cover the four units – to provide consultant supervision – to respond to emergencies during Monday to Friday during working hours. It is therefore just not possible for patients attending A&E across the 4 sites to routinely receive direct consultant care as and when clinically required, with obvious consequences for the quality of clinical decision making and emergency patient management. The service is largely delivered in reality by non-consultant and junior doctors without enough supervision. In terms of critical mass: ▪ The total consultant staffing is insufficient for the Mid-West population and also too dispersed to be fully effective at current staffing levels ▪ In terms of the populations served by Nenagh, Ennis and St. John's, they are too small to generate sufficient A&E workload for these units to qualify as viable, stand-alone A&E services and justify further local investment. It can also be argued that the dispersal of A&E resources has compromised the service requirements needed at Dooradoyle, which is the main A&E and regional trauma centre for the Mid-West e.g. the low level of consultant input and the lack of essential facilities, especially decontamination and isolation. For A&E services, we have, therefore, made the following recommendations: ▪ The HSE should direct the peripheral units and their staff to sensibly limit the 'unfiltered' emergencies that presently come to these small A&E units by: - Informing the public of the safety issues and announcing new access criteria and levels of treatment available; - Insisting that the ambulance service comply with current protocols to by-pass these small A&E units, and to update these protocols as necessary according to the new access criteria; - Announcing a programme of immediate, short and medium term actions to improve current services, pending full service reconfiguration.

	▪ Confirm one regional A&E 'centre of excellence' at Dooradoyle, focused on managing the more major emergencies, and with a consultant recruitment plan to eventually establish a team of A&E Consultants sufficient for the provision of a 'consultant-led' 24 hour, 7 day a week service and compliant with the European Working Time Directive. ▪ Establish an Emergency Care Network for Adults and Children for the Mid-West, providing an integrated, seamless service, connecting all the professionals on emergency duty, whether General Practitioner, Advanced Nurse Practitioner, Community Nurse, the Advanced Paramedic and all the duty teams in the acute hospital specialties. ▪ Develop Nenagh, Ennis, and St. John's, and possibly other sites, into key elements of the Emergency Care Network. They need to both relieve and complement the regional A&E centre by providing all the services for minor injuries and illness (Urgent Care, with access 12 hours per day, 7 days per week) across the Mid-West. Each would be led by an Advanced Nurse Practitioner and professionally accountable, as part of the Network, to the regional A&E Consultant team ▪ And in the meantime, until implementation of the new service configuration is completed, put in place additional temporary medical staffing, to improve the levels of patient safety of current services at Nenagh and Ennis. ***Our overall recommendations:*** We have set out our recommendations for action in a practical, 'patient centred' implementation plan, aligned with the HSE Transformation Programme and designed to achieve consultant-led, clinically safe, sustainable, high quality acute and related primary and community services. We have identified the risks and pre-conditions which the action plan needs to address, in particular, immediate actions to improve patient safety and transitional investments to maintain basic standards in the current acute core services, pending full implementation of the Transformation Programme. We estimate that such a programme would largely achieve its objectives within 3 to 4 years, once the detailed project planning has been completed and subject to major capital builds. In overall terms, providing high quality, safe and sustainable services, built upon a 'best practice' foundation, across the Mid-West means: ▪ Each hospital and specialty taking prompt action to: remove excessive variations in clinical and organisational practices (by standardising clinical management according to Integrated Care Pathways); and improve their current levels of efficiency and effectiveness to avoid unnecessary hospital admissions and reduce the length of stay in hospital. ▪ Reconfiguring services into clinical networks, operating across three local 'centres of excellence' providing a wide range of routine out-patient, diagnostic and treatment services, and one regional 'centre of excellence' in Limerick City providing all specialist acute care.

	▪ Identifying what additional acute and community resources are needed to ensure that no patient is admitted unnecessarily to the acute hospital, and that all patients have access to supported earlier discharge. ▪ Undertaking detailed workforce planning, training, restructuring and development in line with future service objectives. ▪ Revisiting the Mid-West acute and PCCC capital build programme to confirm that the buildings and design enable the delivery of the new clinical strategies. • Confirming that local 'centres of excellence' offer a fully integrated service profile and easy patient access to: primary care teams; out-patient clinics; urgent care; diagnostics; day surgery; endoscopy; rehabilitation; and therapy beds. • Ensuring the ambulance strategy to deploy the Advanced Paramedic emergency workforce is in place. • Introducing new, complementary clinical and corporate governance structures to support the concept of integrated working practices and clinical networks, which will also incorporate the university / academic organisations to ensure that service planning and delivery can benefit from academic leadership and clinical best practice. • Persuading all HSE staff and other providers to engage in challenging the 'status quo' and committing to support implementation of the HSE Transformation Programme across the Mid-West for the benefit of all patients, carers, resident population and the staff themselves. The changes recommended in this report present major challenges, but, in terms of patient safety, the availability of high quality care and clinical sustainability, the continuation of the present configuration of services is not acceptable. The benefits will be profound: much better patient experience and interaction with health care services; patients accessing more care at home and in their community setting; fewer patients spending unnecessary time visiting or being an in-patient in hospital; and safe and sustainable local and regional hospital services for patients, the population of the Mid-West, and for staff. **<u>Patient benefits in the current acute service configuration</u>** In the Mid-West, patients are already benefiting from the move towards centralisation and previous regionalisation of some specialties, an important step in the provision of better, safer and more sustainable services. For example: ▪ Obstetrics & midwifery services are centralised in the Mid-Western Regional Maternity Hospital (St. Munchin's). However, there are well recognised residual risks to mothers as the hospital is not co-located with adult critical care support services. Furthermore, there is no on-site paediatric cover for babies which poses further risks. Plans are now agreed for a final move of the service to the Regional Hospital Dooradoyle. ▪ Orthopaedics operates a regional trauma centre at Dooradoyle and a regional elective centre at St. Nessan's Orthopaedic Hospital, Croom.

	▪ And the regional hospital, Dooradoyle, is also recognised as providing regional services for paediatrics, urology and a range of tertiary services, including nephrology, haematology and cancer / oncology, as one of eight major specialist cancer centres. **<u>The current system for acute services generates substantial risks to patients and staff</u>** In essence, the present system means that the resources for four of the core acute specialties in the Mid West - A&E, general medicine, general surgery and critical care, are too fragmented. Presently, the resources are too diluted, dispersed across four hospitals and providing four small independent services. This circumstance is not satisfactory for staff and exposes patients to unnecessarily increased levels of clinical risk. By and large, and with the specific exception of A&E, there are already enough consultants in the system. If grouped together on one site, they could provide systematic, safe, continuous, sustainable, high quality care to recognised international standards. In relation to assessing clinical performance and checking upon the quality of patient care, there is presently no system of peer review or monitoring or reporting upon performance through clinical audit and clinical governance. Particular concern was expressed about increased risks to trauma patients due to unnecessary delays in ambulance transfers to the regional trauma centre. We recommend that consultants are invited to conduct regular peer review within their specialty and that the HSE develops a Clinical Governance strategy to openly and transparently assess the degree of compliance of service quality and patient outcomes against international standards and practice. However, the present service configuration can no longer deliver today's quality standards and needs to change fundamentally in order to be able to deliver international best practice. In other words, the present health system as delivered today is itself a key source of increased patient risks. These risk factors are not new, they are not subtle, and are already well known. They create circumstances that: ▪ Leave patients exposed to an environment where there is an increased risk of something going wrong ▪ Leave staff exposed to lack of consultant supervision ▪ Leave the quality of clinical performance unchallenged, in the absence of any system of ▪ regular audit, peer review and clinical governance.

	▪ In essence, acute emergency care in the Mid-West is too fragmented, such that the clinical resources, consultants, nurses and on-call staff, probably sufficient if grouped together on one site, are too diluted and overstretched across the four sites to provide safe, continuous, sustainable, high quality care to international standards. Consultants and hospital managers, individually working hard to deliver a satisfactory quality of acute care, are exposed by this fragmentation, as are the patients, who rightly expect to receive high quality care in hospital. Consultants are routinely working in very small teams, or even single-handedly, patently inadequate to sustain an acute 24/7 service. There is not enough workload within and between the four sites to justify more consultants. These circumstances place excessive stress upon the staff, and expose patients to an unacceptable level of clinical risk. **<u>Accident and Emergency Care</u>** The bottom line is that the current services in the Mid-West have major practical difficulties in meeting basic standards, let alone international best practice standards. *Recommendations* We strongly recommend that the HSE takes prompt action to develop a specific programme to address these unsatisfactory arrangements, including: ▪ It would be prudent for the HSE to direct the affected units and their staff to sensibly limit the unfiltered emergencies that presently come to these small A&E units by: - Informing the public of the safety issues and announcing new access criteria and levels of treatment available; - Insisting that the ambulance service comply with current by-pass protocols to avoid these small A&E units, and to update the protocols as necessary according to the new access criteria. ▪ Announcing a programme of immediate, short and medium term actions to improve current services, pending full service reconfiguration. ▪ Confirm one regional A&E 'centre of excellence' at Dooradoyle, focused on managing the more major emergencies, and with a consultant recruitment plan to eventually establish a team of A&E Consultants sufficient for the provision of a 'consultant-led' 24 hour, 7 day a week service and compliant with the European Working Time Directive. ▪ Establish an Emergency Care Network for Adults and Children for the Mid-West, providing an integrated, seamless service, connecting all the professionals on emergency duty, whether General Practitioner, Advanced Nurse Practitioner, Community Nurse, the Advanced Paramedic and all the duty teams in the acute hospital specialties. ▪ Establish local Urgent Care Centres at Nenagh, Ennis, and St. John's, and possibly other sites, as the key local services of the Emergency Care Network. The Urgent Care Centres need to both relieve and complement the regional A&E centre by providing all the services across the Mid-West for minor injuries, minor illness and urgent assessment/observation to determine whether patients need to be referred to services at the regional centre.

Access to Urgent Care should be at least available 12 hours per day, 7 days per week. Each UCC is led by an Advanced Nurse Practitioner and professionally accountable, as part of the Network, to the regional A&E Consultant team.

- In the meantime, until implementation of the new service configuration is completed, put in place transitional support arrangements, in the form of additional temporary medical staffing for Ennis and Nenagh in particular to improve the quality of current services.

Limerick Locality

Given the concentration of residents in and around Limerick City, it is reasonable to expect that there would be a need for a 'local' hospital providing a standard range of services as described in the model within the locality boundary. In Limerick, there is the MWRH Dooradoyle, Mid-Western Regional Orthopaedic Hospital, Mid-Western Regional Obstetric Hospital, and St. John's Hospital. It is already agreed in principle for the obstetric hospital to be rebuilt, located on the Dooradoyle site. As will be seen later on in this section, we also recommend that the elective orthopaedic service be similarly relocated to a ring fenced service to the Dooradoyle campus. This leaves the St. John's Hospital as the potential location for a local 'centre of excellence'. From the site visit, our observation would be that many areas of the St. John's Hospital have undergone recent refurbishment. One drawback to this is the small footprint and the lack of access for patients and staff by car. However, any city centre location would face a similar issue. This site already has 106 inpatient and day case beds available. Significant development plans are proposed for a 94 bed 'tower block' development to replace this existing patient accommodation.
Based on our site familiarisation review, we recommend that St. John's Hospital be considered as a potential location for a local 'centre of excellence' for Limerick City and County, providing a whole suite of local non-acute services.

Clare Locality

The population of Clare is 106,000. The Mid-West Regional Hospital, Ennis was built in the 1940s and has around 94 inpatient and day case beds. However, the hospital requires substantial backlog maintenance and, therefore, its role and function as a local 'centre of excellence' needs to be considered carefully. Although the location is ideally suited to be a local 'centre of excellence', the buildings and infrastructure require substantial investment to meet the service criteria as laid out for the emerging clinical model of care. We recommend that an estates review is undertaken with a view to refurbishment or new build to establish a standard local 'centre of excellence'.

North Tipperary/East Limerick Locality

The North Tipperary locality (60,000) on its own would fail to satisfy the minimum catchment for a local 'centre of excellence'. However, a third of its resident population is from the East Limerick area and therefore gives it a resident population of some 119,000 which is a viable population base to support and sustain a local centre. The Mid-West Regional Hospital, Nenagh is located in this area with a bed base of some 81 inpatient and day case beds. Over the years there has been some capital development to improve its facilities. A profile of the services and facilities that

could be provided in a local 'centre of excellence' at Nenagh Hospital is presented in Table 13. However, we recommend that an estates review is undertaken with a view to refurbishment or new build to establish a standard local 'centre of excellence'.

The Mid-West needs one regional 'centre of excellence' for acute care

Based on the international evidence of the minimum catchment population for a regional hospital of between 350,000 and 500,000, there is a clinical need for one regional 'centre of excellence' for the Mid-West.

As stated earlier, in terms of the organisation of services:

- There will be separation of planned care from emergency care workloads at the regional centre
- The clinical networks will require the regional 'centre of excellence' to deliver comprehensive outreach services to the local centres and the wider community; and
- The local 'centres of excellence' will meet all the out-patient, ambulatory care and routine diagnostic needs for the region. This system avoids patients having to travel to the regional centre for their routine outpatient care.
- Defining the clinical specification and estimating the bed requirements for the regional centre As described in the emerging model of care, the regional 'centre of excellence' will provide in-patient services and complex planned care in:
  - General medicine (including geriatric medicine, cardiology, respiratory medicine, gastroenterology, endocrinology, neurology, clinical haematology, renal medicine, rheumatology and dermatology)
  - General surgery (including upper gastrointestinal surgery, lower GI surgery, breast surgery, vascular surgery, endocrine surgery), orthopaedics, maxillo-facial surgery, urology, gynaecology, ENT, ophthalmology
- Major A&E, with a helipad for emergency air ambulance transfer
- Trauma
- Obstetrics, with co-located midwifery service, and level 3 neonatal unit
- Paediatrics, with high dependency unit
- Cancer services, in line with national cancer control strategy
- Anaesthesia and pain management service
- Level 3 adult critical care.

Cancer services are already provided on the Dooradoyle site in a joint public-private venture. The unit was built by the hospital's Trust and is operated by the Mater Private Hospital. The centre is privately operated in co-operation with the National Plan for Radiation Oncology. The level of tertiary activity undertaken in the acute regional 'centre of excellence' will be dictated by national strategies. For example, for paediatrics, we understand that all specialist tertiary work will be undertaken by the new national paediatric hospital in Dublin. We have forecast the number of patients to be treated in the acute regional 'centre of excellence' in 2010. This assumes that all residents are treated at the regional centre with recognition that some tertiary services may be provided outside of the Mid-West. This

	analysis also excludes any additional activity that the regional centre may attract from outside the counties of Limerick, Clare and North Tipperary. The methodology for modelling the anticipated volume of patients in 2010 includes the following assumptions: ▪ 2005 resident-based data has been used as the baseline for modelling the impact analysis ▪ Population growth is based on Central Statistical Office forecasts which has been included for 2010 ▪ All planned day cases will be treated at local 'centres of excellence' ▪ Bed capacity modelling assumes occupancy levels of 85% and takes account of trends in hospital design for best practice in the management of infection control. **Site configuration** The regional 'centre of excellence' would need to have the capacity to accommodate 642 in-patient beds. The Dooradoyle site currently has 472 beds (375 in-patient and 97 day case beds), with development plans for transferring obstetrics, and for additional beds through the co-location project. This would significantly increase the site's bed base. **If sufficient accommodation could be provided and the current site could be reconfigured, then the Dooradoyle site should be designated as the regional 'centre of excellence' for the Mid-West.** However, consideration must be given to the economies of scale in developing the existing site to provide a modern, 'fit for purpose' facility, or whether a new purpose-built regional 'centre of excellence' should be developed. The list of reconfiguration/refurbishment (excluding any private co-location build programme), is substantial and includes: ▪ New obstetrics, midwifery and neonatal unit ▪ New elective orthopaedics unit ▪ New or refurbished A&E ▪ New or refurbished critical care unit ▪ Complete ward refurbishment to infection control standards ▪ New additional in-patient beds, totalling 135. Based on modelling, the Dooradoyle site would require 30141 (676 beds less 375 beds) additional in-patient beds to operate as the regional 'centre of excellence' for acute care. Assuming the relocation of obstetrics and orthopaedics, the net additional requirement would be 135 acute inpatient beds. **What the new acute hospital bed configuration looks like in the future**: Dooradoyle **Baseline 2005** Acute Inpatient: 375 Day Case:97

	Total (Beds): 472 **Emergency and ring-fenced elective inpatient centre at Dooradoyle** Non-elective: 508 Elective: 168 Day Case: - Total: 676 **Change in acute inpatient beds** Acute inpatient beds change: 301 Of which Obstetrics: 99 Orthopaedics: 67 Net additional acute beds: 135 **Including ` Required equivalent beds' for rehabilitation:** Acute IP bed baseline: 676 Day case: 0 Rehab beds: 0 Total beds: 676 <u>Ennis</u> **Baseline 2005** Acute Inpatient: 88 Day Case: 6 Total (Beds): 94 **Emergency and ring-fenced elective inpatient centre at Dooradoyle** Non-elective: - Elective: - Day Case: 29 Total: 29 **Change in acute inpatient beds** Acute inpatient beds change: -88 Of which

	Obstetrics: - Orthopaedics: - Net additional acute beds: - **Including ' Required equivalent beds' for rehabilitation:** Acute IP bed baseline: 0 Day case: 29 Rehab beds: 52 Total beds: 81 <u>Nenagh</u> **Baseline 2005** Acute Inpatient: 75 Day Case: 6 Total (Beds): 81 **Emergency and ring-fenced elective inpatient centre at Dooradoyle** Non-elective: - Elective: - Day Case: 30 Total: 30 **Change in acute inpatient beds** Acute inpatient beds change: -75 Of which Obstetrics: - Orthopaedics: - Net additional acute beds: - **Including ' Required equivalent beds' for rehabilitation:** Acute IP bed baseline: 0 Day case: 30 Rehab beds: 54 Total beds: 84 <u>Obstetrics</u>

	Baseline 2005 Acute Inpatient: 99 Day Case: 0 Total (Beds): 99 **Emergency and ring-fenced elective inpatient centre at Dooradoyle** Non-elective: - Elective: - Day Case: - Total: 0 **Change in acute inpatient beds** Acute inpatient beds change: -99 Of which Obstetrics: - Orthopaedics: - Net additional acute beds: - **Including ` Required equivalent beds' for rehabilitation:** Acute IP bed baseline: 0 Day case: 0 Rehab beds: 0 Total beds: 0 <u>Croom</u> **Baseline 2005** Acute Inpatient: 67 Day Case: 10 Total (Beds): 77 **Emergency and ring-fenced elective inpatient centre at Dooradoyle** Non-elective: - Elective: - Day Case: - Total: 0

	Change in acute inpatient beds Acute inpatient beds change: -67 Of which Obstetrics: - Orthopaedics: - Net additional acute beds: - **Including ' Required equivalent beds' for rehabilitation:** Acute IP bed baseline: 0 Day case: 0 Rehab beds: 0 Total beds: 0 <u>St. John's</u> **Baseline 2005** Acute Inpatient: 96 Day Case: 10 Total (Beds): 106 **Emergency and ring-fenced elective inpatient centre at Dooradoyle** Non-elective: - Elective: - Day Case: 38 Total: 38 **Change in acute inpatient beds** Acute inpatient beds change: -96 Of which Obstetrics: - Orthopaedics: - Net additional acute beds: - **Including ' Required equivalent beds' for rehabilitation:** Acute IP bed baseline: 0 Day case: 38 Rehab beds: 67

	Total beds: 105 <u>Total</u> **Baseline 2005** Acute Inpatient: 800 Day Case: 129 Total (Beds): 929 **Emergency and ring-fenced elective inpatient centre at Dooradoyle** Non-elective: 508 Elective: 168 Day Case: 97 Total: 773 **Change in acute inpatient beds** Acute inpatient beds change: -124 Of which Obstetrics: - Orthopaedics: - Net additional acute beds: - **Including ` Required equivalent beds' for rehabilitation:** Acute IP bed baseline: 676 Day case: 97 Rehab beds: 173 Total beds: 946 Note: Beds for non-elective and elective critical care dependent activity are modelled at an occupancy level of 80-% and all other bed requirements are modelled at an occupancy level of 85%. The above does not reflect the additional in-patient and day case bed capacity from the private hospital co-location programme, and to what extent this will contribute to the 135 in-patient beds at Dooradoyle, or to the overall 97 day case beds as indicated in the local 'centres of excellence'. Subject to the impact of the co-located private hospital, in overall terms, the total number of in-patient and day case beds at 946 will be virtually the same as in the 2005 baseline.

	This would include a significant increase at Dooradoyle, which reflects the assumption of transferring both obstetrics and orthopaedics. The analysis in Table 17 also indicates that the existing capacities at Ennis, Nenagh and St. John's are sufficient to accommodate future requirements. However, the usage and designation of the beds will be significantly different from the present arrangements for each site. The regional elements of the network: ▪ The A&E service at the regional 'centre of excellence' in Dooradoyle, with a multidisciplinary team, is led by a group of at least 8 consultants providing 24/7 supervision, input and specialist advice across the whole network ▪ The regional A&E centre will manage some 80,00043 A&E attendances per year ▪ Patients being transferred from the local Urgent Care Centre for more specialised care are triaged directly to the most appropriate emergency unit in the regional centre, for example, medical assessment, coronary care, trauma unit, or critical care. The organisational infrastructure: ▪ There is formal, 'real-time' integration across the whole workforce on duty i.e. GPs, APs, ANPs, CNSs, A&E staff, on-call hospital consultants, emergency assessment units, coronary care units, critical care, duty community nursing, social care and voluntary sector teams, etc. ▪ The smooth day-to-day running is the responsibility of the regional arm of the national ambulance service. It manages all staff deployment, and is supported by real-time monitoring of status, access to care and available acute beds ▪ There is a single point of entry into the emergency care system and a single assessment and triage process across the network ▪ All the frontline workforce rotate regularly through all the service elements of the network for wider experience and professional development ▪ The AP ambulance workforce is strategically deployed across the network to provide a local first response service for life-threatening patient events ▪ The network is technology-enabled to provide: - A system for staff 'in the field' to communicate across the whole network, seek urgent specialist advice, use telediagnostics, telemonitoring - Support for training and development through tele-education The emergency care network liaises closely on a daily basis with its 'partner' network responsible for critical care. **<u>Critical Care Network</u>** The local elements of the network: There is no provision of critical care at the 'local' centre

	The local 'centre of excellence' is still a key member of the critical care network. It provides a post-acute/step down/rehabilitation programme that: - Enables the safe, early transfer of the patient closer to home; and - Optimises the patient flow through the regional critical care service, ensuring the most effective use of these beds. *At the regional centre:* ▪ The critical care centre is a key service of the regional 'centre of excellence', co-located with those acute specialties most likely to need immediate access; ▪ There is a full multi-disciplinary critical care team, reflecting the complexity of patient illness, co-morbidities and management needs, led by consultant intensivists, with input from ANPs / CNSs in intensive care, physiotherapists, respiratory technicians, clinical laboratory medicine specialists, nutritionists, pharmacists, radiographers, speech and language therapists, occupational therapists, medical physicists and engineers and staff in training. The critical care centre delivers: - A 24/7 system of comprehensive Level 2 and Level 3 critical care support for seriously ill patients and for patients undergoing complex planned or emergency surgery - A 24/7 system of preventative critical care outreach surveillance to identify 'at risk' patients on the acute general wards - A critical care rehabilitation programme, delivered across the whole network. *Organisational infrastructure:* ▪ The regional critical care centre is at the heart of the regional 'centre of excellence'; ▪ The service is led by a consultant team of at least 8, providing 24/7 supervision and input across the clinical network, with some consultants working on a full-time basis for critical care only, and others also supporting the regional anaesthetic and pain management service ▪ There is a dedicated operational management structure to ensure the smooth day-to-day running and organisation of the clinical network ▪ There are dedicated robust triage, transfer and transport arrangements in place for both admission and transfer home of patients ▪ The intensivist team lead a system of critical care education and training for the whole network. *Planned care network* The local elements of the network: The local 'centres of excellence' will provide a wide range of services, including outpatient, day surgery and diagnostic testing. The benefits of these centres are the provision of local access, dedicated facilities, and the development of new models of care enhancing the quality of patient care.

	At the regional centre: ▪ All major planned care is undertaken in the regional centre ▪ There is separate streaming and bed provision for planned in-patient and for emergency admissions to ensure no interruptions of planned procedure activities. **Pre-conditions to delivering service reconfiguration** It is self-evident that a fully resourced, detailed implementation programme is required if the Mid-West is to secure international best practice quality for its acute and related PCCC services in terms of clinical standards, service configuration and working relationships. Such a plan needs to take account of: ▪ Putting in place an effective implementation group, one that commands respect, has all round support and has the capacity to deliver ▪ Taking urgent steps upfront to reduce clinical risk and improve patient safety in areas of the current services where the present quality of care needs to be addressed ▪ Maintaining the current service configuration and reducing deficiencies in capacity to meet today's demands, pending implementation of the new service configuration; ▪ Developing integrated locality working between NHO and PCCC services ▪ Ensuring that all the pre-conditions to delivering the optimal configuration for acute care are in place ▪ Ensuring that appropriate contingency plans are in place to manage the risks to success. The over-riding principle is that no acute service will be withdrawn from the current general hospitals until the regional 'centre of excellence' is resourced and ready to deliver that service with reference to international quality standards. In turn, these assumptions for acute care are based on the following assumptions for prehospital services: ▪ The PCCC service has been resourced, developed, and is working to recognised international best practice standards for the management of the anticipated future demand across the Mid-West, both during working hours and out-of-hours, for admissions avoidance and earlier discharge ▪ The ambulance service has fully developed its mobile emergency response capabilities, by developing its 'Advanced Paramedic' workforce and by deploying them to all areas of the Mid-West ▪ The Helicopter Emergency Medical Service is fully integrated into the emergency care system for Mid-West ▪ There is an 'Advanced Nurse Practitioner' and 'Clinical Nurse Specialist' workforce in place, leading the delivery of a Mid-West network of local nurse led Urgent Care Centres, integrated with local Advanced Paramedic and duty GP teams and the single central A&E service. There is effective partnership working across all elements of the pre-hospital and hospital systems. The future clinical model of acute care is designed around a robust infrastructure. Creating the circumstances for the provision of an assured quality of care is based upon the presence of:

	▪ Formal clinical teams/networks, responsible for managing and coordinating care for that specialty or category of acute care across the region (emergency care, planned care, cancer, critical care, obstetrics, paediatrics, radiology, etc.); ▪ An integrated network programme for education, teaching, training and research, developed in partnership with all local stakeholders, including the University of Limerick, the 'regional centre of excellence' and the local 'centres of excellence' as part of the academic network ▪ Clinically relevant information technology and communications (unique patient identification, electronic records, real time/store and forward transfer of clinical images, tele-consultation and so on). The action plan below sets out the major steps to achieving the necessary changes in service reconfiguration. We estimate, excluding the timescales for new builds and refurbishment, that the programme should be deliverable within 3-4 years, following completion of the detailed project planning stage. Actions have been identified in relation to the project management arrangements, improvements in operational efficiency, the regional 'centre of excellence', localities, and workforce development. The actions also identify the transitional arrangements necessary to make clinical services safer in the immediate future, pending the full transformation of services. **Areas for urgent action and implementation** **Taking action to reduce clinical risk and improve patient safety.** ▪ All major trauma patients must be taken directly to the regional trauma centre ▪ All sick children and pregnant mothers being conveyed by ambulance must be taken directly to the appropriate recognised service ▪ Establish a formal retrieval service for the transfer of critically ill patients between hospitals ▪ Establish a regional Level 3 adult critical care service at Dooradoyle as soon as possible ▪ Establish criteria to identify and exclude patients from increased risk as a result of undergoing complex orthopaedic surgery at Croom in the absence of onsite critical care support ▪ Establish a decontamination facility for the A&E service at Dooradoyle ▪ Establish an isolation facility within the critical care service at Dooradoyle. **Actions and objectives in the first six months** **Establishing a transitional support programme to improve current services.** ▪ Temporarily expanding the A&E medical staffing numbers to the level of being able to establish a suitable rotation out of the A&E service at Dooradoyle to serve both Ennis and Nenagh, until such time as nurse-led local Urgent Care Centres are established as part of the Emergency Care Network ▪ Specifically linking the general medicine duty teams across the Mid-West with the duty team at Dooradoyle, with clear responsibilities for providing urgent advice and patient transfer to the centre

	▪ Establishing an effective Medical Assessment Unit/Clinical Decision Unit at Dooradoyle to overcome the present interdepartmental bottlenecks between the A&E, acute medicine and emergency surgery services. **<u>Developing new governance structures to support the overall implementation plan.</u>** The HSE needs to lead the joint development of: • A Clinical Governance strategy, designed to manage the clinical governance dimensions of clinical networks and integrated care being delivered by multi-disciplinary teams. The strategy therefore needs to primarily cover the acute services but also reflect shared care arrangements with PCCC and include the academic dimensions, through the University of Limerick medical faculty • A Corporate Governance strategy and code of practice, aligned with managing the inherent complexities and accountabilities in the funding, devolving and delivering of integrated models of care across a number of key stakeholders and organisations. **<u>Establishing a regional 'best practice' programme to reduce the overall acute bed needs through improved service efficiencies, in preparation for full transformation.</u>** A 'best practice' team, composed of acute, PCCC and HSE support staff, need to get on with a programme that effectively reduces unnecessary admissions to an acute bed and makes sure that patients are discharged in a timely manner, including: ▪ Optimising access to community services and expanding their influence to keep patients safely out of hospital or to plan their discharge better ▪ Developing more Hospital at Home services ▪ Ensuring more consultant input into rapid clinical decision making and safe immediate discharge for urgent general medicine referrals ▪ Proactive discharge planning from Day One of admission, having joint acute / PCCC input to discharge planning, agreeing standard lengths of stay for common, routine, uncomplicated conditions, effective discharge arrangements at weekends and so on ▪ All in-patients, both planned and emergency, have a date of intended discharge recorded in their notes at pre-admission or day of admission ▪ Establishing a robust pre-operative assessment process to avoid inpatient 'work up' immediately prior to surgery ▪ Agreeing to the admission of elective surgical patients on the day of surgery. **<u>Establishing a robust project management infrastructure and detailed project plan.</u>** A Programme Director with executive responsibility is required to manage and troubleshoot the Mid-West implementation programme. One of the first tasks will be to confirm that other relevant national policy programmes, upon which the success of the Mid-West programme is dependent, are delivering on time, including confirming that:

	▪ The current PCCC development programme is delivering according to expectation with reference to today's acute care support needs and that planned developments have the capacity needed to make sure that no patient is admitted unnecessarily to an acute bed or has a delayed discharge. ▪ The current ambulance programme for the training and operational deployment of APs to emergency front line business, starting in the most 'need' areas of the Mid-West, is delivering according to plan. ▪ The professional development programme for ANPs and CNSs is proceeding and is aligned with the service plan for nurse led Urgent Care Centres. ▪ The national recommendations for the future of laboratory medicine service are in line with the implementation programme. The HSE senior management team will need to be appraised if remedial action is considered necessary if any of the above programmes are not delivering to expectation, or lack the future capacity to achieve optimal service transformation. Other steps that the HSE will need to take include: ▪ Establishing a Mid-West Steering Group and Terms of Reference for overseeing the whole implementation programme ▪ Establishing a project implementation team with day to day responsibility ▪ Appointing a clinical programme director / lead to oversee and advise upon the clinical dimensions of the implementation plan ▪ Establishing an HR group to address the workforce requirements that underpin the implementation programme ▪ Establishing a technology group to develop the necessary clinical information a communication infrastructure to link the clinical networks and 'centres of excellence'. **Completing a detailed project plan for transforming services across the Mid-West.** At this stage, it is possible only to describe the definitive high level actions needed for implementation. Each action will need a detailed work programme for its delivery. The implementation plan needs to cover: The full implementation of the interim transition programme within the first 12 months, in order to ensure that current services continue to be supported and receive on-going investment to make them as safe as possible within their present circumstances Preparing the Dooradoyle site to fulfil its new role as the regional 'centre of excellence' for acute emergency and complex planned care, including: ▪ Releasing acute bed capacity through efficiency and best practice improvements and a programme of progressive transfer of day surgery and other workload e.g. minor injuries, to the local 'centres of excellence' ▪ Confirming the planned acute bed capacities to cope with the peaks of acute inpatient demands from across the region, with the development of plans for bed expansion as required ▪ Preparing Dooradoyle for the transfer of obstetrics and elective orthopaedics

	▪ Preparing Dooradoyle to become the regional emergency general surgery service ▪ Developing a workforce programme to make sure that all the acute emergency specialties are up to 'full strength' for the provision of 24/7 senior and junior 'round the clock' cover, working to rotas that are compliant with the European Working Time Directive ▪ Increasing the critical care capacity to meet the region's demands, with closure of capacity and transfer of resources from elsewhere ▪ Refurbishing hospital facilities as necessary to become the regional 'centre of excellence' and in keeping with infection control protocols ▪ Ensuring functional, preferably also physical, separation of planned activity from emergency clinical business. Preparing a commissioning strategy for the cessation of acute in-patient services from St. John's, Ennis and Nenagh Hospitals and their conversion to new local 'centres of excellence' for the comprehensive delivery of all non-acute services ▪ Preparing Ennis and Nenagh hospitals for their new roles as local 'centres of excellence' including: - Rapidly expanding their position as key providers of day surgery - Ensuring that the AP emergency ambulance service is deployed to the most appropriate points in the region - Transferring all current emergency general surgery services to Dooradoyle as soon as it can be safely arranged - Reshaping local services in line with the needs of the local population - Ensuring, through new capital build/refurbishment if necessary, that Ennis and Nenagh are 'fit for purpose' as new local 'centres of excellence' ▪ Supporting HSE to achieve its objectives, including: - Ensuring that the PCTs and Home Care support services are enabled / resourced to maximise admissions avoidance and early supported discharge, in line with acute initiatives to achieve best practice - Ensuring that the HSE undertakes a fresh study on equity of access in relation to how many local 'centres of excellence' are needed, where they should be sited, what their capacities should be, and what range of services should be offered - Ensuring that local HSE services are aligned so that the optimal configuration of the regional 'centre of excellence' can be achieved i.e. that no patient is admitted to the regional 'centre of excellence', except when active acute clinical management is needed - Charging each Local Health Office with revising/developing a fresh locality plan in line with the new acute strategy, general practice opportunities and the HSE Transformation Programme for the integration of PCCC services - Ensuring that the HSE capital build programme enables both the functional and physical integration of services around the local 'centre of excellence' - Ensuring that the HSE diagnostics programme means that no out-patient needs to go to the regional 'centre of excellence' for tests, except specialised ones

	▪ Establishing a clinical network development group, with a clinical lead for each network46 to prepare for the new service configuration ▪ Establishing a public relations programme to inform the staff and public about the Mid-West implementation programme and its intended benefits and outcomes ▪ Establishing a secure and effective platform for partnership planning and working between the acute services and the PCCC services ▪ Assisting PCCC in securing integrated services across the pre-hospital sector, namely the ambulance service, general practice, primary care, community care, social care and voluntary services. **For information:** International evidence highlights that there is a critical mass relationship between medical workforce and workload for the systematic delivery of high quality 24/7 acute hospital care. This means matching the size of the consultant team with the size of the catchment population, i.e. having the right numbers on the team to ensure senior supervision of patient management at all times and the right size of clinical workload to produce the best clinical outcomes. Although there has been good progress in some areas, there are still clear and substantial shortcomings in the way core acute hospital services are presently planned and provided, compared to international best practice. Substantial reconfiguration is required to move the acute services in HSE Mid- West towards the systematic delivery of safe, high quality patient care. This service reconfiguration is about reallocating existing HSE resources. The consultant resources for acute care are already largely sufficient but they are presently too dispersed across units that are too small to meet the critical mass criteria of workforce and population, such that it is not possible for staff to systematically deliver consistent high quality acute care. **<u>Impact of previous strategies</u>** **The HSE approach** Since its inception, the HSE has embarked upon a nationwide programme of health reforms to move the current health and social services towards international standards of care: ▪ The PCCC strategy pre-dated the HSE and was launched in 2001. There is a national implementation programme to provide on average one new primary care team for every 10,000 of the resident population. In reality, due to the different catchment populations and communities for which PCCC services would be provided, this would result in putting in place some 600-1,000 primary care teams by 2011. ▪ The ambulance service is now being reorganised into a national service. A new cadre of Advanced Paramedics is being developed, who are skilled in urgent assessment and resuscitation. This development overcomes the problem of the traditional 'golden hour', the time within which a patient in a critical condition needs to reach an

	A&E service and start the resuscitation to save their life. In effect, resuscitation will start immediately, in the home or at the roadside. ▪ The HSE strategy for acute services was developed in 2006, following Teamwork's independent review of acute hospital services in the North East. The new strategy specifically uses recognised international best practice standards in acute and community care as its foundation. The HSE has also described a clear pathway to implementation for these and other related strategies through its 2007-2010 Transformation Programme. This sets out the HSE's purpose 'to enable people to live healthier and more fulfilled lives'. The vision is that by 2010 'everybody will have easy access to high quality care and services that they have confidence in and staff are proud to provide'. Six service transformation priorities have been identified which encompass 13 different transformation programmes. The six service transformation priorities are to: ▪ Develop integrated services across all stages of the care journey so that people can easily get into, through and out of the health and social care system. ▪ Configure PCCC services so that they deliver optimal and cost effective results, and in so doing make it easy for people to access a broad spectrum of services through their local primary care teams. ▪ Configure hospital services to deliver optimal and cost effective results so that people will be able to easily and rapidly access high quality acute care through designated centres of excellence. ▪ Implement a model for the prevention and management of chronic illness so that people receive high quality care and positive clinical outcomes from comprehensive and integrated care in their communities and designated care centres. ▪ Implement standards-based performance measurement and management throughout the HSE so that people can be confident that they will receive high quality care measured against transparent standards. ▪ Ensure all staff engage in transforming health and social care in Ireland and ensure their work has a direct impact on, and contributes to, the overall transformation of health and social services. In summary, these national transformation priorities are setting a direction of travel in which more care is provided at home or as close to home as possible, and that when patients do need acute hospital services, they will receive high quality care that is integrated with local services and provides best value.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Key Gaps identified in the Mid West: *Standard 1: Acute emergency and complex planned care is provided in a single regional 'centre of excellence', serving a minimum population of 350,000 to 500,000.*

	Not met - the present system has 3 HSE hospitals and 1 voluntary hospital providing acute general care for the Mid-West population of 360,000.2 **Planned Care** Major planned surgery should not be undertaken on an occasional basis or dispersed across multiple sites. It is recognised that the best clinical outcomes are achieved by such surgery being undertaken regularly, by teams specialising in that aspect of surgery. We recommend, in the interest of patients having the best clinical outcomes that major planned surgery is delivered as one regional service. With the present fragmentation of surgical services across four sites, one of the other issues is where major planned surgery is undertaken. It is generally acknowledged that individual units carrying out low numbers of major operations i.e. not undertaking such surgery on a regular weekly basis, are associated with poorer quality clinical outcomes. Cancer surgery is a good indicator of this critical mass argument. Table 3 below summarises the 2005 experience, which indicates that many cancer operations were undertaken on an occasional basis on all sites. Overall, there were 812 cancer procedures undertaken across the four acute hospital sites equating to some 16 procedures a week across the Mid-West. It is our understanding that since 2005, with the consolidation of cancer/oncology services at the Dooradoyle site, cancer surgery is increasingly centralised e.g. all breast surgery in the Mid-West is now centred on two sites, namely Dooradoyle and St. John's. This is a welcome trend in line with other cancer strategies. Finally, the generally low volumes of planned inpatient surgery carried out across the sites in 2005 raises questions about clinical viability and quality of outcomes. This is particularly relevant to Ennis (292 procedures in the year) and Nenagh (266 procedures in the year). Recommendation: We recommend that the HSE formally requires the centralisation of all major planned surgery in the appropriate sub-specialty regional service. **Adult Critical Care** There is only one full time intensivist for adult critical care in the Mid-West and four units undertaking adult critical care. It is not possible to maintain the appropriate level of trained staff needed to provide a satisfactory quality of critical care across all sites and at all times. This exposes patients to unnecessarily increased clinical risks. We strongly recommend, in the interests of patient safety, that prompt action is taken to ensure that all adult critical care is delivered from one regional adult critical care unit and one regional coronary care unit. Analysing the information for 2005 against the criteria for the emerging clinical model of care

	leads to the following conclusions: ▪ Operating four stand-alone critical care units inevitably means that each is competing for scarce critical care staffing, expertise and resources, an arrangement that is inherently unsatisfactory, unsustainable and exposes patients to increased clinical risk. ▪ Three of the four units are small, with 6, 5 and 3 critical care beds in Ennis, Nenagh and St. John's, respectively. ▪ There is a dedicated coronary care unit consisting of 7 beds on the Dooradoyle site with Ennis and Nenagh also accessing this facility. *Conclusion:* The present fragmented arrangements for adult critical care is unsatisfactory, with patients exposed to increased clinical risks due to the dispersed nature of the service. Recommendation: ▪ There should be only one regional, well resourced, general adult critical care service for the Mid-West. ▪ Similarly, only one regional, well resourced, coronary care unit. **Accident & Emergency** ▪ There are only three A&E consultants across the Mid-West. ▪ There are four stand-alone A&E services, mostly delivered without any consultant supervision. In addition, the A&E services at Ennis and Nenagh are staffed by external, non-HSE, non-specialist doctors recruited from overseas, with no particular qualification in A&E medicine. ▪ The three services at Ennis, Nenagh and St. John's are not viable, cannot be considered as true A&E services and lack any critical mass criteria for them to become sustainable A&E services in the future. ▪ The present system is unsustainable and we strongly recommend the HSE to take prompt action to reduce the current levels of clinical risk and improve patient safety. ▪ Emergency A&E care should be provided from one regional centre for the Mid- West, appropriately resourced. Urgent care, for minor injuries and illness, should be provided by the network of local 'centres of excellence'.
Governance	**Recommendation/considerations:** Clinical Governance recommendations: *Recommendations* We recommend that the consultants across the Mid-West are invited to set aside a regular session each month for the team to undertake internal peer review, examine the quality of care across the specialty, review compliance with agreed care pathways and agree further quality improvements in patient outcomes. We recommend that the HSE develops a Clinical Governance strategy, designed to openly and transparently monitor that service quality and patient outcomes across both the local and regional 'centres of excellence' are satisfactory

	and meet international standards of best practice. The strategy also needs to accommodate the concept of networks and of integrated care being delivered in teams. It needs to work across organisations and individuals. Effective clinical governance, ensuring that patient outcomes are optimised, depends therefore, for example, on the effective interaction between clinicians in different organisational units, some of them being HSE employees and others being GPs in private practice. In making these recommendations, we naturally respect the need for the consultant's clinical autonomy to be protected. We also respect the need for: ▪ The patients to be much better informed and reassured that the service they are accessing has an effective system for measuring quality, that performance is objectively measured, that it is confirmed to be satisfactory and that any shortcomings are quickly identified and action is taken accordingly. ▪ The organisation to know that clinical risk management is being effectively and proactively managed and that there is optimal use of resources. ▪ Therefore, there is a need for consultants, at the same time as citing clinical autonomy as acting in the best interests of their patients, also to contribute to performance review, checking that the overall quality of their clinical and organisational working practices are in line with international best practice. ***Project Management for implementation*** The project management arrangements need to include: ▪ A small HSE steering group to oversee the programme and take executive action as necessary to keep the programme on track. ▪ A Mid West project board comprising representatives from NHO, PCCC, Population Health, University of Limerick and a nomination from the consultant body, supported by: - HR, Finance (inc. Procurement), and Estates directorates - Consultative panels of clinicians and other local stakeholders ▪ A full-time programme director with overall responsibility for leadership and managing the programme team ▪ Project manager/s or seconded personnel within PCCC and NHO to manage and coordinate the phasing of the actions ▪ Clinical directors responsible for leading the development of the managed clinical networks: emergency care; planned care; critical care; cancer; pathology; radiology; etc. ▪ Service change leads to support the service programme changes within the networks, including the clinical support services of pathology and radiology. ▪ Workforce director to lead the workforce planning, education and development#. ▪ Undertaking an estates review to assess compliance of the current programme with the new model of acute and community care and managing any future capital investment and disinvestment in the Mid-West. ▪ Ensuring resources are identified and made available to support the transitional arrangements and any capital and revenue implications of the Mid-West transformation programme.

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Integrating Primary, Community & Continuing Care (PCCC) services with the acute services* To complement the regional and local 'centres of excellence', there needs to be a comprehensive range of primary and community services, which can support the changes in acute hospital care. Most importantly will be health promotion and the prevention of ill health, the avoidance of hospital admissions and supporting earlier discharge from the acute care setting. Most of this support will be provided by the development of: ▪ Self-care, promoted through education of patients and carers and telemedicine ▪ Home care packages, PCTs and PSCNs to support patient management in the home ▪ Community chronic disease management programmes ▪ More PCCC services to cover out-of-hours and week-end requirements ▪ An Advanced Paramedic service; and ▪ Community facilities to provide an Urgent Care Centre, nurse and therapy managed beds for rehabilitation, access to enhanced diagnostics and a base for staff. The recent national Acute Hospital Bed Review32 identified a significant proportion of inpatients who could have been cared for in more appropriate care settings, both at admission and during their stay in hospital. At a national level the review found that 13% of patients were unnecessarily admitted to hospital and that 39% of patients in hospital could have been treated in an alternative setting on the day of care, if appropriate alternatives were available. The national review also identifies the appropriate alternatives to acute hospital care that would be required, and the proportion of patients occupying an inpatient bed that would satisfy these alternatives. For the Mid-West, these alternatives and their proportions are below: **Alternative Care Setting:** None or not specified **Proportion of inappropriate admissions:** 18% **Proportion of patients whose length of stay could have been reduced:** 17% **Alternative Care Setting:** General Practitioner **Proportion of inappropriate admissions:** 12% **Proportion of patients whose length of stay could have been reduced:** 11% **Alternative Care Setting:** Home with support **Proportion of inappropriate admissions:** 19% **Proportion of patients whose length of stay could have been reduced:** 22%

	Alternative Care Setting: Home Care Packages **Proportion of inappropriate admissions:** 3% **Proportion of patients whose length of stay could have been reduced:** 0.3% **Alternative Care Setting:** Non Acute Bed **Proportion of inappropriate admissions:** 3% **Proportion of patients whose length of stay could have been reduced:** 7% **Alternative Care Setting:** Non Acute Bed & Therapy **Proportion of inappropriate admissions:** 9% **Proportion of patients whose length of stay could have been reduced:** 21% **Alternative Care Setting:** Hospice **Proportion of inappropriate admissions:** 3% **Proportion of patients whose length of stay could have been reduced:** 0.3% **Alternative Care Setting:** Mental Health Bed **Proportion of inappropriate admissions:** 0% **Proportion of patients whose length of stay could have been reduced:** 1% **Alternative Care Setting:** Diagnostics/Assessment **Proportion of inappropriate admissions:** 33% **Proportion of patients whose length of stay could have been reduced:** 21% **Total** **Proportion of inappropriate admissions:** 100% **Proportion of patients whose length of stay could have been reduced:** 100% For inappropriate admissions, 18% required no alternative service and a further 12% required access to the normal services of a GP. A third of inappropriate admissions required access to diagnostics and assessment outside of the acute hospital setting, with the remainder of patients requiring alternative bed based support or home care support. For those patients whose length of stay in an acute hospital could have been reduced, 17% required no support and could have been discharged immediately, and a further 11% only required access to the normal services of a GP. For those patients who required additional support following discharge from the acute hospital, 28% required access to a non-acute bed either with or without therapy services, just over 22% required home care support or a Home

	Care Package, and 21% required access to diagnostics and assessment outside of the acute care setting. We have taken these findings of the alternative care settings from the Acute Hospital Bed Review and applied them to the number of patients that we identified for admission avoidance and earlier supported discharge, (modelled to 2010), by applying our best practice assumptions. Our analysis has identified 4,586 patients whose admission to an acute hospital could have been avoided, and 8,717 patients whose care could qualify for earlier supported discharge. Having identified the number of patients requiring access to services in primary and community settings, we have converted this into appropriate capacity requirements for avoidable admissions and earlier supported discharge. The outcomes have been subsequently reviewed and agreed with Local Health Managers of the Primary, Community and Continuing Care Directorate of the HSE Mid-West. Key findings from the analysis are: ▪ 33% (1,513 patients) of avoided admissions and 21% (1,831 patients) of supported earlier discharges requiring access to diagnostic services through primary care services ▪ 3% of patients (138) avoiding admission to regional hospital services requiring home care packages ▪ Less than 1% of patients (29) being discharged earlier from regional hospital services requiring a home care package ▪ The remainder of patients avoiding admission to, or being discharged earlier from, regional hospital services requiring support either through the specialist skills of the Primary Care Teams and wider network support, or a stay in a rehabilitation/community support bed ▪ On average, the length of stay for rehabilitation/community support would be up to four weeks, given the range in intensity of care required. *Admission avoidance* The estimated impact of the additional home care packages, patients supported by PCTs and rehabilitation/community support beds relating to admission avoidance. **2010 impact on PCCC from admission avoidance (4,586 patients)** **Resource type:** None or not specified **Proportion:** 18% **Patients:** 825 **Assumption:** None **Resource quantum:** 0 **Resource currency:** -

	Resource type: GP **Proportion:** 12% **Patients:** 550 **Assumption:** None **Resource quantum:** 0 **Resource currency:** - **Resource type:** Home with support **Proportion:** 19% **Patients:** 871 **Assumption:** 10 WTE supporting 1,000 referrals **Resource quantum:** 9 **Resource currency:** WTE **Resource type:** Home Care Packages **Proportion:** 3% **Patients:** 138 **Assumption:** Patients **Resource quantum:** 138 **Resource currency:** Patients **Resource type:** Non Acute Bed **Proportion:** 3% **Patients:** 138 **Assumption:** Extended Care **Resource quantum:** 138 **Resource currency:** Patients **Resource type:** Non Acute Bed & Therapy **Proportion:** 9% **Patients:** 413 **Assumption:** LoS of 4 weeks **Resource quantum:** 32 **Resource currency:** Bed equivalents

	Resource type: Hospice **Proportion:** 3% **Patients:** 138 **Assumption:** LoS of 4 weeks **Resource quantum:** 11 **Resource currency:** Beds **Resource type:** Mental Health Bed **Proportion:** 0% **Patients:** 0 **Assumption:** LoS of 2 weeks **Resource quantum:** 0 **Resource currency:** Beds **Resource type:** Diagnostics **Proportion:** 33% **Patients:** 1,513 **Assumption:** Patients **Resource quantum:** 1,513 **Resource currency:** Patients Total: 100% Patients: 4,586 This analysis shows that some 30% of patients (1,375) admitted did not require any further resources over and above those already available to them in the community. A further 33% of patients (1,513) were admitted for diagnostic purposes. *Earlier supported discharge* The analysis relating to supported earlier discharge from the acute regional hospital and its impact on PCCC services shows that 28% of patients (2,383) were in a hospital bed that required no other resource than the normal support of their GP. Furthermore, 22% (1,889) would require some additional support at home and 21% (1,831) a diagnostic test to enable earlier discharge. **Additional estimated PCCC services by LHO locality area for 2010**

	Local Health Office locality area: Limerick **Patients requiring access to diagnostics:** 1,304 **Additional Home Care Packages:** 65 **Additional referrals supported by PCTs:** 1,076 **Additional Rehabilitation bed equivalents:** 67 **Local Health Office locality area:** Clare **Patients requiring access to diagnostics:** 1,003 **Additional Home Care Packages:** 50 **Additional referrals supported by PCTs:** 828 **Additional Rehabilitation bed equivalents:** 52 **Local Health Office locality area:** North Tipperary/ East Limerick **Patients requiring access to diagnostics:** 1,037 **Additional Home Care Packages:** 52 **Additional referrals supported by PCTs:** 856 **Additional Rehabilitation bed equivalents:** 54 **Total** **Patients requiring access to diagnostics:** 3,344 **Additional Home Care Packages:** 167 **Additional referrals supported by PCTs:** 2,760 **Additional Rehabilitation bed equivalents:** 173 Based on the assumptions derived at the PCCC workshops, there is a significant requirement for additional diagnostic, home care packages and PCT support. As part of the on-going transformation of services by the HSE, an investment in additional resources to provide fully functioning PCTs and PSCNs and to deliver additional home care packages has already been identified for the coming years. This shows that for the Mid- West, there is to be an additional 111 wte personnel to support the PCTs. Approximately 30 wtes are already in place with a further 81 to be in place by December 2010. However, it must be noted at this point that there are other major shortfalls in PCCC resources that were identified during the workshop programme, shortfalls not yet accounted for in the investment planning. In summary these are: ▪ The year on year wte core deficits, incurred as a result of the national headcount policy ▪ The fact that PCCC does not provide 24/7 hours across the relevant family of programmes

	▪ The fact that current PCCC resources have budgets designated for supporting the elderly over 65 population, failing to recognise that, in reality, there is a substantial requirement for supporting the under 65 population as well, such that this cohort of patients is not being looked after ▪ Developing comprehensive community chronic disease management programmes ▪ Addressing the need for aggressive preventative programmes, particularly for the elderly. Evidence is available from the UK which gives a comparison of community teams providing both rapid response and re-ablement services in order to avoid admissions to hospital and support earlier discharge. This shows that a multidisciplinary team of 10 wtes can support 1,000 referrals per annum. On this basis, then the additional 2,760 referrals to the PCTs would require an additional 27 wtes. If it is assumed that the existing plans for PCTs and the additional recruitment make no contribution to admissions avoidance or earlier discharge, this requirement of some 27 wte PCT staff would be in addition to the 111 wtes already planned to be in place by 2010. It is more realistic to discount the extra 27 wte that we have calculated as necessary, by say 20%, to acknowledge some contribution from existing plans. The additional 173 rehabilitation beds (see Table 10 above) makes no allowance for the preferred way forward, for fewer beds and more staff to take rehabilitation into the home. The bed needs could be largely accommodated over time through the release of acute beds as the current acute hospitals transform their functions. Investment will be required in relation to additional home care packages. Patients avoiding admission are largely those with chronic diseases, therefore, they will need access to a range of CNSs in the community, including respiratory, cardiac and diabetes. Some of these CNSs are already in post in the acute general hospitals and, therefore, there may need to be a realignment of duties between community and hospital based care, for example, more in reach and outreach services, as well as some further investment in specialist nurse training. **<u>Emergency Care Network (Adult and Children)</u>** The local elements of the network: ▪ The Advanced Paramedic workforce will be at the front line of the local emergency response for all major, life-threatening events, strategically deployed to be accessed locally by the whole population. They will immediately assess, resuscitate, stabilise, triage and transfer the patient directly to the appropriate emergency service. They will be in constant clinical communication, including real-time remote physiological monitoring as necessary with the appropriate duty team at the regional centre. This approach helps solve the perennial argument about travel times to the nearest A&E and the concern about accessing appropriate treatment interventions within the 'golden hour' ▪ The mobile emergency response is tailored to fit the urgency of the patient's needs. Definitive emergency management begins in the home, and, if clinically safe, the patient remains at home, with arrangements for follow up assessment and care being delivered as necessary by the general practitioner, public health nurse, local

	community health and social service staff. Experience to date from the UK national pilot sites indicates that Emergency Care Practitioners already substantially reduce the rate of conveyance to hospital of patients accessing the ambulance service as an emergency ▪ The mobile emergency service is complemented by a network of Urgent Care Centres based in the local 'centres of excellence' • These Urgent Care Centres: - Are nurse led by Advanced Nurse Practitioners, professionally accountable to the regional hospital A&E team for the quality of service; they will progressively extend their range of skills and competencies under the aegis of the regional A&E centre, for example to include the management of simple fractures - Treat both adults and children and are normally open 12 hours per day, 7 days a week - Manage minor injuries and illnesses - Undertake observation and assessment, to decide whether patients need to access the regional centre or not - Are supported by 'Point-of-Care' laboratory facilities, plain X-ray, and 24/7 telemedicine and tele diagnostic links to the regional A&E duty team or other appropriate service ▪ The services provided by both the Advanced Paramedic and Advanced Nurse Practitioners are formally integrated with the GP emergency service, with routine consultation to optimise each individual emergency response ▪ The local GPs have an enhanced range of resuscitation skills, competencies and equipment to complement those of the AP and ANP ▪ All the above services are integrated with, and have 24/7 access to, local community nursing, social care, and voluntary sector teams.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Key gaps identified in the Mid West: *Standard 2: Acute care in core medical and surgical services is delivered in teams of at least 8 consultants in order to provide patients with access to safe, high quality 'round the clock' care.* Not met – the present system of running 4 acute hospitals means that each team in each hospital lacks the critical mass of workforce and workload needed to meet international quality standards. **General Medicine: consultants, non-elective activity and catchment population** **<u>Dooradoyle</u>** **Baseline**

	Population: 183,863 **Beds:** 117 **Consultants** **Full time (General):** 4 **Full time (Elderly Medicine):** 1 **Full time split site (WTE):** 2.0 **Part time posts (WTE):** 1.4 **Total (WTE):** 8.4 **Number of consultant sessions:** 92 **Non-elective inpatient activity** **Admissions:** 6,164 **Average length of stay:** 8.4 **Daily average admissions:** 16.9 **St. John's** **Baseline** **Population:** 183,863 **Beds:** 43 **Consultants** **Full time (General):** 0 **Full time (Elderly Medicine):** 0 **Full time split site (WTE):** 2.2 **Part time posts (WTE):** 0.2 **Total (WTE):** 2.4 **Number of consultant sessions:** 26 **Non-elective inpatient activity** **Admissions:** 1,168 **Average length of stay:** 9.3 **Daily average admissions:** 4.7

	Ennis **Baseline** **Population:** 110,800 **Beds:** 58 **Consultants** **Full time (General):** 2 **Full time (Elderly Medicine):** 0 **Full time split site (WTE):** 0.6 **Part time posts (WTE):** 0.2 **Total (WTE):** 2.8 **Number of consultant sessions:** 31 **Non-elective inpatient activity** **Admissions:** 3,644 **Average length of stay:** 6.8 **Daily average admissions:** 10.0 **Nenagh** **Baseline** **Population:** 65,988 **Beds:** 44 **Consultants** **Full time (General):** 3 **Full time (Elderly Medicine):** 0 **Full time split site (WTE):** 1.5 **Part time posts (WTE):** 0.2 **Total (WTE):** 4.6 **Number of consultant sessions:** 5.1 **Non-elective inpatient activity** **Admissions:** 2,718 **Average length of stay:** 6.8

	Daily average admissions: 7.4 **<u>Total</u>** **Baseline** **Population:** 360,651 **Beds:** 262 **Consultants** **Full time (General):** 9 **Full time (Elderly Medicine):** 1 **Full time split site (WTE):** 6.3 **Part time posts (WTE):** 1.9 **Total (WTE):** 18.2 **Number of consultant sessions:** 200 **Non-elective inpatient activity** **Admissions:** 13,694 **Average length of stay:** 7.7 **Daily average admissions:** 39.0 Analysing the information for 2005 against the criteria for the emerging clinical model of care leads to the following conclusions: ▪ None of the hospitals, on their own, has a catchment population large enough to qualify as an acute regional centre ▪ However, if there had been one acute regional general medicine service, there would have been more than enough consultants (10 full time + 8.2 part time) to manage an average of 39 patients per day, from a population of 360,000, and the consultant workforce and workload would meet the critical mass criteria for high quality standards of care ▪ High quality care is also based upon consultant availability, with no other commitments when on emergency duty and continuity of care. The common approach of consultants having either split site or part-time appointments (8.2 wte out of 18.2 across the Mid- West) is satisfactory for delivering planned care sessions, but substantially compromises the sustainable provision of continuous consultant emergency care ▪ The present services at Ennis, Nenagh and St John's are not sustainable, either in terms of the number of consultants or volume of workload: - St. John's hospital has no full time consultant and only 2.4 visiting wte to run the service

- Ennis has only 2.0 wte full time consultants and admits an average of only 10 patients per day
- Nenagh has only 3 wte full time consultants and admits an average of only 7.4 patients per day

▪ At Dooradoyle, although there are 8.4 wte consultants, only 5 are full time on site, while 2.0 wte have split appointments, and 1.4 wte work part-time. As already stated, the element of consultant resources that are dispersed substantially detracts from consultant availability and continuity of consultant care needed for emergency patient management.

General Surgery

General surgery: consultants, non-elective activity and catchment population

Dooradoyle
Component
Population: 183,863
Beds: 80

Consultant Surgeons
Full time: 2
Full time split site (WTE): 3.4

Total (WTE) surgeons: 5.4
No. of consultant sessions: 59

Consultant Anaesthetists
Full time: 7
Full time split site (WTE): 6.2

Total (WTE) anaesthetists: 13.2
No. of consultant sessions: 145

Non-Elective inpatient activity
Admissions: 2,294
Average length of stay: 6.7
Daily average admissions: 6.3

St. John's

	Component Population: 183,863 Beds: 36 **Consultant Surgeons** Full time: 0 Full time split site (WTE): 2.3 **Total (WTE) surgeons: 2.3** No. of consultant sessions: 25 **Consultant Anaesthetists** Full time: 1 Full time split site (WTE): 1.7 **Total (WTE) anaesthetists: 2.7** No. of consultant sessions: 30 **Non-Elective inpatient activity** Admissions: 351 Average length of stay: 6.6 Daily average admissions: 1.4 ***Ennis*** **Component** Population: 110,800 Beds: 24 **Consultant Surgeons** Full time: 2 Full time split site (WTE): 0.4 **Total (WTE) surgeons: 2.4** No. of consultant sessions: 26 **Consultant Anaesthetists**

	Full time: 2 Full time split site (WTE): 0.7 **Total (WTE) anaesthetists: 2.7** No. of consultant sessions: 30 **Non-Elective inpatient activity** Admissions: 1,329 Average length of stay: 5.2 Daily average admissions: 3.6 ***Nenagh*** **Component** Population: 65,988 Beds: 26 **Consultant Surgeons** Full time: 1 Full time split site (WTE): 0.9 **Total (WTE) surgeons: 1.9** No. of consultant sessions: 21 **Consultant Anaesthetists** Full time: 2 Full time split site (WTE): 0.7 **Total (WTE) anaesthetists: 2.7** No. of consultant sessions: 30 **Non-Elective inpatient activity** Admissions: 1,249 Average length of stay: 4.8 Daily average admissions: 3.4 ***Total***

	Component Population: 360,651 Beds: 166 **Consultant Surgeons** Full time: 5 Full time split site (WTE): 6.9 **Total (WTE) surgeons: 11.9** No. of consultant sessions: 131 **Consultant Anaesthetists** Full time: 12 Full time split site (WTE): 9.4 **Total (WTE) anaesthetists: 21.4** No. of consultant sessions: 235 **Non-Elective inpatient activity** Admissions: 5,223 Average length of stay: 5.8 Daily average admissions: 14.8 **For Emergency Care** There are not enough consultant surgeons or anaesthetists to deliver sustainable 24/7 services in the present fragmented service arrangement: - Ennis has 2 full time consultant surgeons and 2 full time anaesthetists to run a 24/7 service - Nenagh has 1 full time consultant surgeon and 2 full time anaesthetists to run a 24/7 service - St. John's has no full time surgeon and 1 full time anaesthetist to cover its weekday service There are very low rates of daily average admissions: 6.3 at Dooradoyle, and only 3.6 at Ennis; 3.4 at Nenagh; and 1.4 at St John's (weekday service only). *Conclusions* ▪ Presently, the general surgery resources are dispersed, attempting to deliver 4 separate general surgery services across the Mid-West ▪ This fragmentation means that the 3 services at Ennis, Nenagh and St. John's do not have enough consultants to maintain a safe service for patients

	▪ The 3 services do not have enough workload to justify any more consultants ▪ The services at Ennis and Nenagh do not have enough workload to justify the HSE keeping these theatre services available on a 24/7 basis ▪ If there had been a single regional general surgery service, there would have been enough surgeons and anaesthetists (11.9 surgeons + 21.4 anaesthetists), enough to manage a daily average of 14.8 emergency surgical admissions and to meet the critical mass criteria for the delivery of high quality care to international standards. *Recommendations* ▪ We strongly recommend that the emergency surgery service is regionalised as soon as possible at Dooradoyle to reduce the risks to patients and raise the quality of care to international standards ▪ We strongly recommend the initial rationalisation of the emergency out-of-hours arrangements for theatres between Dooradoyle, Ennis and Nenagh. **Adult Critical Care** There are not enough intensivists, with only one single full-time intensivist in the Mid- West on the Dooradoyle site. Most of the critical care management and cover is provided by the consultant anaesthetists as part of their general duties **Accident and Emergency Care** **A&E Attendances and Consultant Staffing** **Hospital:** Dooradoyle **Total Attendances:** 53,551 **Consultant Sessions:** 29 **Consultant Staff (wte):** 2.63 **Hospital:** Ennis **Total Attendances:** 21,435 **Consultant Sessions:** 3 **Consultant Staff (wte):** 0.27 **Hospital:** Nenagh **Total Attendances:** 13,329 **Consultant Sessions:** 0 **Consultant Staff (wte):** 0.00

	Hospital: St. John's **Total Attendances:** 16,669 **Consultant Sessions:** 1 **Consultant Staff (wte):** 0.10 **Total** **Total Attendances:** 107,894 **Consultant Sessions:** 33 **Consultant Staff (wte):** 3.00 Analysing the information for 2005 (Table 5 above) against the criteria for the emerging clinical model of care for A&E services leads to the following conclusions: ▪ There are serious gaps in consultant staffing, with only 3 wte consultants for four A&E services, seeing an annual total of over 100,000 attendances [The BAEM recommends at least 9 consultants at that level of clinical activity, calculated on 1 consultant per 12,000 attendances to provide 24/7 cover] ▪ With over 50,000 annual attendances, only Dooradoyle meets the criteria for clinical viability, but has only 2.63 wte consultants ▪ The workloads at Ennis, Nenagh and St. John's, ranging from 13,000 to 21,000, are too low for them to qualify as true A&E services and to be staffed accordingly. Their workload levels would make them suitable to be developed as nurse led Urgent Care Centres, providing minor injuries & illness services [There is already a Minor Injuries Unit service operational at St. John's Hospital which treats some 9,000 of the total 19,000+ attendances a year] ▪ Moreover, Nenagh has no consultant input to its A&E at all, while Ennis and St. John's both have nominal consultant cover and support, which is not sustainable ▪ There are patently unsatisfactory A&E staffing arrangements at Ennis and Nenagh. The service is provided by external, non-HSE, non-consultant doctors, recruited from overseas on contract to a commercial medical recruitment agency. Concerns have been expressed in relation to the fact that although there is some consultant input to the services at Ennis, they operate independently, and there appears to be no measure of their quality of service delivery • Overall, there are not enough consultants, and they are spread too thinly across too many sites to provide a satisfactory level of consultant supervision anywhere in the present system.
Funding	**Recommendation/considerations:** *Potential scale of capital requirements* The areas where capital investment will be required for the implementation programme include:

	▪ Additional build and redevelopment at the Dooradoyle site to support its role as the regional 'centre of excellence' in the Mid-West; this includes providing for a net additional 135 inpatient beds, as well as the relocation of obstetrics and orthopaedics ▪ New build to replace the existing A&E, including decontamination and isolation facilities, at the Dooradoyle site to become the regional A&E centre for the Mid-West ▪ Redevelopment/refurbishment of the estate at Ennis, Nenagh and St. John's to undertake their role as local 'centres of excellence'. *Revenue costs of new service models* Areas where revenue costs and potential savings are likely to be incurred in the Mid-West include: ▪ Additional medical staff to reduce clinical risk and improve patient safety in the immediate future, for example, in A&E with the costs being offset by the existing external staff contract arrangements when no longer required ▪ Establishing an adult critical care retrieval team ▪ The clinical specification and workforce models for the regional and local 'centres of excellence' ▪ Network workforce models ▪ Academic training plans and access to research and development ▪ Additional PCCC staffing and home care costs partly covered from current HSE investment plans and partly by staff redeployment. Achieving the centralisation of acute inpatient services at the new 'centre of excellence' on the Dooradoyle site will result in sufficient consultant staff numbers across the core specialties without the need for further permanent appointments.
Other	**Recommendation/considerations:** The Health Service Executive has already laid out its future strategies for Ireland's Primary, Community & Continuing Care services, ambulance services and acute hospital services, and is currently developing a new programme to align laboratory medicine services with the new clinical strategies. These strategies are now proceeding to implementation through the 2007- 2010 HSE Transformation Programme4. They aim to substantially improve the care of all citizens by aligning the health services in Ireland with recognised international best practices. The HSE is now seeking to understand how these strategies should be rolled out to the health services across the Mid-West. [NOTE: Recommendations for obstetrics & midwifery, paediatrics, urology, ENT and ophthalmology are also made in the review, however these have not been extracted.]
Impact	No information identified.

Table 16 Report of the investigation into the quality and safety of services and supporting arrangements provided by the HSE at the Mid-Western Regional Hospital Ennis [2009]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Health Information and Quality Authority (HIQA)[16] Report of the investigation into the quality and safety of services and supporting arrangements provided by the HSE at the Mid-Western Regional Hospital Ennis [2009] Inspection report
The health service system (including health service reform)	**Recommendation/considerations:** International evidence also shows a move towards providing the greatest possible amount of safe and appropriate healthcare as close as possible to where people are living, such as enhanced diagnostic testing locally, non-emergency day case surgery and a range of outpatient services. Such services provided in MWRH Limerick could in fact migrate to centres such as MWRH Ennis. <u>Recommendation cluster 1: emergency department services</u> *Local* **1.3:** The Health Service Executive must take prompt action to review the role of the Mid-Western Regional Hospital Ennis emergency department as part of the development of an urgent care network across the Mid-Western Hospital Network. *National* **1.4:** The Health Service Executive should undertake a strategic review of configuration for emergency care services. This should lead to a prioritised programme of service development aimed at consolidating emergency services in regional centres with smaller hospitals (having a similar activity profile to Mid-Western Regional Hospital Ennis) re-designated for minor injuries. <u>Recommendation cluster 2: surgical treatment</u> *Local* **2.1:** The Mid-Western Regional Hospital Ennis should not provide acute, or elective inpatient surgical services. All acute and major surgery, including major elective and cancer surgery, should be transferred to the Mid-Western Regional Hospital Limerick. **2.2:** The Health Service Executive should review day surgery provision at Mid-Western Regional Hospital Ennis and consider the feasibility of a new regional surgical service based at Mid-Western Regional Hospital Limerick providing an outreach day-surgery and day-procedure service, including endoscope procedures, in the Mid-Western Regional Hospital Ennis using regionally agreed integrated protocols and care pathways. 2.3 In order to create maximum capacity at the regional centre in Limerick, the day surgery review should include

	consideration of an extended range of surgical specialties at the Mid-Western Regional Hospital Ennis to allow the transfer of some current elective day surgery activity from the Mid-Western Regional Hospital Limerick to create capacity on that site. Recommendation cluster 3: cancer services *Local* **3.1:** All women with symptoms of breast disease who present to the Mid-Western Regional Hospital Ennis should be referred immediately on to the designated symptomatic breast disease service at the Mid-Western Regional Hospital Limerick. The current breast review clinic at the Mid-Western Regional Hospital Ennis should cease. Recommendation cluster 4: critical care services *Local* **4.1:** The Mid-Western Regional Hospital Ennis should not care for patients requiring level 2/3 critical care services. Patients requiring level 2/3 critical care services should be taken directly to the Mid-Western Regional Hospital Limerick by the ambulance services. Where patients self-attend, or deteriorate at the Mid-Western Regional Hospital Ennis and require level 2/3 critical care services, they must be stabilised by appropriately trained staff and safely transferred as a priority to the Mid-Western Regional Hospital Limerick, or other appropriate centre with Level 2/3 critical care resources. Recommendation cluster 5: general medical services *Local* **5.2:** The Health Service Executive should seek to ensure that as wide a range of medical services as possible, including out-patients, day procedures, day patient facilities and inpatient services, are safely provided in the Mid-Western Regional Hospital Ennis. These should be fully networked with the Mid-Western Regional Hospital Limerick with clear patient pathways designed and implemented. Recommendation cluster 6: children's services *Local* **6.1:** Acutely ill children should not be cared for at the Mid-Western Regional Hospital Ennis. The ambulance service should take children directly to the paediatric services in Mid-Western Regional Hospital Limerick. Where children are brought to the Mid-Western Regional Hospital Ennis by other means, they must be stabilised and transferred to the regional paediatric services in the Mid-Western Regional Hospital Limerick. **6.3:** The Health Service Executive should consider the feasibility of the Mid-Western Regional Hospital Limerick paediatric services providing a paediatric outreach day-surgery service in the Mid-Western Regional Hospital Ennis with integrated regional protocols and care pathways. Any surgical and anaesthetic day-case services

	must be provided in a child appropriate environment by healthcare teams competent in the clinical care and resuscitation of children. Recommendation cluster 7: maternity services *Local* **7.1:** Women with pregnancy-related conditions should not be brought by the ambulance services to the Mid-Western Regional Hospital Ennis. These patients should be brought directly to the Mid-Western Maternity Hospital Limerick. Patients self-presenting to the hospital should be transferred as a priority to the regional centre at Mid-Western Maternity Hospital Limerick. **7.2:** The Mid-Western Maternity Hospital Limerick should review the provision of ultrasound scans for women attending its outreach service in the Mid-Western Regional Hospital Ennis to ensure it is consistent with the service provided at its regional centre. **7.3:** The Mid-Western Maternity Hospital Limerick should regularly audit its outreach services to ensure they are consistent with services at the regional centre. Recommendation cluster 8: diagnostic services *Local* **8.1:** The future role of diagnostic services in the Mid-Western Regional Hospital Ennis should be clearly defined. A strategic review of the radiology and laboratory services should be undertaken leading to these services being outreach services from the Mid-Western Regional Hospital Limerick with centrally agreed integrated protocols and care pathways that will be fit for purpose in supporting the changes in services outlined in this report.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Key findings in the area of the planning and provision of clinical services at MWRH Ennis include the following: ▪ Change for safety must happen. It is unsafe to keep the configuration of services at MWRH Ennis as they are and these changes must take place safely and effectively ▪ Acute, complex and specialist services are not sustainable at MWRH Ennis. This is because there are not sufficient numbers of patients presenting with these conditions to enable professional healthcare teams to maintain their clinical skills and expertise. Continuing these acute services, including acute and complex surgery, cancer surgery, level 2/3 critical care and 24-hour emergency department services, in their current structure, exposes patients to potential harm ▪ MWRH Ennis does not have sufficient volumes of patients attending out of hours to justify emergency department and operating theatre resources being available on a 24-hour basis ▪ In the course of the investigation, a number of patient safety issues were identified by the Authority. The HSE was notified and interim recommendations were made to address these issues. These recommendations must continue to be implemented as an immediate priority.

	▪ The provision of more staff and resources at MWRH Ennis will not address the fundamental issue of professional teams maintaining their clinical skills and expertise in the area of surgery, critical care, emergency care, children's and maternity services. This is dependent on sufficient numbers of patients attending MWRH Ennis with certain conditions. There are not enough patients presenting with acute, complex and or specialist conditions to allow healthcare teams to maintain their clinical skills and achieve the best outcomes for patients. Acute, complex, and specialist services should cease in MWRH Ennis **as soon as resources can be organised to safely provide centralised and better integrated services** for MWRH Ennis's catchment population. These services include: acute and complex surgery including cancer surgery level 2/3 critical care 24-hour emergency department maternity children's. The absence of acute surgery and critical care will mean that the provision of acute medicine at MWRH Ennis should be reviewed and a clear medical service model implemented. Recommendation cluster 1: emergency department services *Local* **1.1:** Patients with major or complex emergency conditions should not be treated in the emergency department in the Mid-Western Regional Hospital Ennis. In exceptional circumstances where such patients arrive in Mid-Western Regional Hospital Ennis they should be stabilised and transferred, as a priority, to a specialist centre. **1.2:** The current provision of a 24-hour emergency care service is unsustainable and should be discontinued. A day-time minor injury service, as indicated by current activity, operating as a satellite of the regional centre should be developed and introduced. Recommendation cluster 4: critical care services *Local* **4.2:** In the interim while acute medical and surgical services are provided at the Hospital, the level of care provided at the Mid-Western Regional Hospital Ennis should be consistent with level 0/1 only. Recommendation cluster 5: general medical services *Local* **5.1:** The range of general medical services provided at the Mid-Western Regional Hospital Ennis should be reviewed by the Health Service Executive in light of the changes recommended to the emergency department, surgical and critical care services. A clear protocol-driven medical service model should be implemented that specifies which conditions can (and cannot) be treated safely in Mid-Western Regional Hospital Ennis. These protocols should be subject to regular audit. **5.3:** For as long as the acute medical services remain on site, dedicated elderly care services should be re-established to provide an appropriate integrated approach by a multidisciplinary team.

	Recommendation cluster 6: children's services *Local* **6.2:** There should be immediate cessation of elective inpatient paediatric surgery. Recommendation cluster 8: diagnostic services *Local* **8.3:** The Mid-Western Regional Hospital Ennis should implement reliable mechanisms, e.g. multidisciplinary clinico-radiological meetings, whereby the referring clinician, including GPs, can discuss the imaging findings in complex cases in more detail with the radiologist or other individual who has reported the examination. **For information:** …the Investigation Team concluded that the MWRH Ennis will have an important part to play in providing high quality and safe services for its community. However, the Hospital will need to change the range and types of services it provides for its patients in the future. Change for safety must happen. Acute services are not sustainable at MWRH Ennis. It is unsafe to keep the configuration of services at MWRH Ennis as they are and these changes must take place safely and effectively. MWRH Ennis does not have sufficient volumes of patients attending out of hours to justify emergency department and operating theatre resources being available on a 24-hour basis.
Governance	**Recommendation/considerations:** Key findings in the area of corporate governance and leadership at MWRH Ennis include the following: ▪ The lack of clarity around local accountability and the authority to make decisions means that there is no single person at hospital level who is fully accountable for the quality and safety of services ▪ There were limited systems in place for effective clinical governance in order to provide the necessary assurance for patients ▪ Risk management processes were not pro-active. Adverse events, complaints and claims processes were not formally integrated within MWRH Ennis and therefore the outcomes from these processes are not patient focused. To do this safely and effectively will require experienced leadership and management skills; detailed planning; communication and coordination. It is important to ensure that the reassignment of existing resources and necessary changes to the infrastructure should take place before the services for patients are moved.

	The HSE should, as a priority, undertake a review of the clinical and non-clinical management, leadership and governance arrangements at Mid-Western Regional Hospital Limerick to ensure that the governance arrangements and organisational structure are fit for purpose, and that clinicians and managers in key positions have the capacity and capability to manage the new role of the Hospital. Recommendation cluster 2: surgical treatment *National* **2.5:** In order to make the best use of available in-patient beds, the Health Service Executive should work with the relevant professional bodies, using current international evidence, to identify a selection of suitable procedures to be undertaken as day surgery cases (in the absence of agreed contraindications). **2.6:** Having identified benchmark activity volumes and suitable day surgery procedures, these should be routinely monitored and reported publicly at facility level. They should then be considered as part of annual service planning at national and local levels. **2.7:** A focused review of acute surgical activity should be undertaken as a priority at hospitals with similar activity profiles to the Mid-Western Regional Hospital Ennis to determine whether they are safe according to international best practice. Recommendation cluster 3: cancer services *Local* **3.3:** The Health Service Executive should regularly audit the care pathways of patients with symptomatic breast disease, within the Mid-Western region, to ensure agreed best practice including access arrangements, is being complied with. *National* **3.4:** The National Cancer Control Programme Directorate of the Health Service Executive should ensure local service configuration and referral/access/ follow up pathways for each designated specialist cancer centre are communicated effectively to GPs and patients. Recommendation cluster 4: critical care services *Local* **4.2:** In the interim while acute medical and surgical services are provided at the Hospital, the level of care provided at the Mid-Western Regional Hospital Ennis should be consistent with level 0/1 only. **4.3:** The relevant transfer and bypass protocols must be regularly reviewed on a multidisciplinary basis, compliance audited and updated as necessary. **4.4:** The Mid-Western Hospital Network should review its provision of critical care services within the region to ensure safe patient services that comply with safe practice guidelines. *National*

	4.5: The Health Service Executive should review critical care provision in hospitals with a similar resource and activity profile to the Mid-Western Regional Hospital Ennis to ensure that services are being provided within safe practice guidelines. Where this is not the case, appropriate risk management measures, and the necessary service changes, should be implemented and managed to protect patients. <u>Recommendation cluster 5: general medical services</u> *National* **5.4:** The Health Service Executive should work with the relevant professional bodies to develop a national model for acute medicine that is stratified to allow centres to be designated as fit to provide services up to a certain level so it is clear which centres should provide which services. This acute medicine model should include taking into account the location of other acute services such as surgery, anaesthetics, maternity, children's and critical care at any one centre. **5.5:** In order to make the best use of in-patient beds, the Health Service Executive should work with relevant professional bodies to identify a "basket" of conditions suitable (in the absence of agreed contraindications) to ambulatory (non-inpatient) patients requiring medical services. **5.6:** Having identified conditions to be managed on an ambulatory basis, these should be monitored routinely and published on an institutional basis. They should then be considered as part of annual service planning at national and local levels. <u>Recommendation cluster 6: children's services</u> *National* **6.4:** The Health Service Executive should ensure that there is a clear national policy for the appropriate care setting for, and management of, acutely ill children and those requiring inpatient surgery. <u>Recommendation cluster 8: diagnostic services</u> *Local* **8.2:** A quality assurance system, which includes rigorous procedures and protocols for requesting, prioritising, reading and reporting radiology examinations, with defined timelines and volumes, should be implemented, regularly reviewed and compliance audited. **8.4:** A robust system for the safe, timely management and reporting of all tests, both at local and regional laboratory level, should be developed, implemented and regularly audited. This system should involve the prioritisation of test reporting and protocols for the follow up of the reports by the identified clinician. <u>Recommendation cluster 9: ambulance services</u> *Local*

	9.1: The bypass protocols for maternity and children must be fully implemented immediately and the Health Service Executive should systematically evaluate all of its bypass protocols through audit and, as required, identified improvements should be implemented. *National* **9.3:** The Health Service Executive should ensure that the ambulance service has a recognised call prioritisation and dispatch system in place nationally in order to prioritise emergency calls to ensure that the right patient receives the right care by the right professional at the right time. This should be implemented in the Mid West region as a priority. <u>Recommendation cluster 10: admission and discharge</u> *Local* **10.1:** The Mid-Western Hospital Network should systematically evaluate its bed management processes, through audit, with required improvements implemented and re-evaluated to confirm continuous quality improvement. This should incorporate a robust discharge planning policy, which commences on admission and states that appropriate and open information must be provided to the patient and or their family members and the receiving care provider to ensure transfer and ongoing patient care pathways are safe and of a high quality. **10.2:** The Health Service Executive should systematically evaluate all of its discharge protocols, through audit, and, as required, identified improvements should be implemented and the protocols re-evaluated to confirm continuous quality improvement. *National* **10.3:** The Health Service Executive nationally should further develop and implement an active bed management strategy with appropriate care pathways, access to diagnostics and integrated discharge planning. <u>Recommendation cluster 11: leadership and governance</u> *Local* **11.1:** All the acute hospitals contributing to the Mid West region acute care system should form a hospital group under an integrated operational governance and management structure, based at the Midwestern Regional Hospital Limerick. The group should be led by a management board with executive accountability and the appropriate skills and experience to discharge these responsibilities and to manage the changes required in the transition of patient services across the areas. Satellite centres should have clear and appropriate day-to-day on-site operational management arrangements. **11.2:** This hospital group should be led by a chief executive, who is ultimately accountable for the provision and management of the services provided by the group, and who is accountable to the Network Manager. The chief executive should lead an executive management board consisting of directors, who have the appropriate

	skills and experience to discharge their responsibilities and who are accountable to the chief executive. This board will be responsible for the provision of all services and implementation and management of the transition of patient services across the area. The smaller hospitals in the group should have clear and appropriate day to day operational management arrangements reporting to the group management board. **11.3:** A code of governance should be established that sets out the management board's roles and responsibilities including an oversight role in respect of safety and quality of health services provided. This must include clear lines of accountability and devolved decision-making. **11.4:** The regional management tier at Network level, in conjunction with the executive management board of the hospital group should focus on strategic governance of the region, stakeholder engagement and performance management and monitoring of the hospitals. **11.5:** The HSE should establish an active programme to address historical anomalies in reporting arrangements, in order to achieve clearer lines of accountability for clinicians and managers at hospital level. This should include all clinical consulting teams being appointed to, and organised from, the Mid-Western Regional Acute Hospital Group as part of a regional service. **11.6:** Clinical teams in the Mid-Western Regional Acute Hospital Group should come under a unified clinical governance system led by regional clinical specialty groupings based in the regional centre in Limerick. This should incorporate the development of agreed patient pathways owned by the regional clinical departments each under the leadership of a clinical director. **11.7:** For as long as an emergency service continues to be provided at the Mid-Western Regional Hospital Ennis, formal clinical accountability and reporting arrangements must be established immediately for emergency care physicians working in the emergency department. <u>Recommendation cluster 13: managing change and transition</u> *Local* **13.1:** The local change programme should be led by an experienced senior manager and the implementation programme must incorporate significant engagement with service user and clinical stakeholders. **13.2:** A comprehensive programme of change that is effectively led and managed, needs to be undertaken. This will take time to implement, and the HSE needs to ensure that appropriate facilities, resources and staff are in place throughout the current Mid-Western Acute Hospital Network in order that changes in the location of patient care can be safely accommodated. **13.3:** The Health Service Executive should, as a priority, undertake a review of the clinical and non-clinical management, leadership and governance arrangements at Mid-Western Regional Hospital Limerick to ensure that the governance arrangements and organisational structure are fit for purpose, and that clinicians and managers in key positions have the capacity and capability to manage the new role of the Hospital. *National*

	13.4: The corporate HSE executive management team should nominate a specific Director accountable for ensuring the development of an implementation plan for these recommendations. This should include a clear timeframe with milestones. Progress against the implementation plan should be made public and reported to the Board of the Health Service Executive. **13.5:** There should be regular progress reports to the Minister for Health and Children.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Recommendation cluster 3: cancer services *Local* **3.2:** Tailored awareness and education programmes for general practitioners (GPs), community services and the public in the Mid West about new regional referral pathways and protocols, in particular for breast disease, should be developed and implemented. Recommendation cluster 9: ambulance services *National* **9.4:** The Health Service Executive should ensure that the ambulance service develops and implements arrangements to ensure that emergency ambulance crews are not providing transport for patients who do not require emergency care and that appropriate resources are established to better meet the needs for patients requiring non-emergency transportation.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Recommendation cluster 9: ambulance services *Local* **9.2:** The Health Service Executive must ensure that there are appropriate numbers of suitably qualified ambulance staff to provide a safe emergency and non-emergency patient transport service in the Mid West region within an established duty rota that does not rely on an on-call rota for the basic provision of the service. **For information:** The Investigation Team, following review of staffing levels and HIPE data, found that there were insufficient numbers of consultant staff in surgery, anaesthetic and emergency medicine to provide a sustainable, safe, 24-hour service for surgical patients attending MWRH Ennis. Access to safe surgery depends as much on anaesthetic care as surgical skills.
Funding	No information identified.

Other	**Recommendation/considerations:** <u>Recommendation cluster 12: responding to concerns and learning from adverse incidents</u> *Local* **12.1:** The Mid-Western Regional Hospital Ennis should ensure that a proactive patient-centred approach to risk management is taken and implemented throughout the Hospital according to national policies. This should include improving integration between its risk management, complaints, and Freedom of Information systems to facilitate timely, patient-focused responses and to enable shared learning. **12.2:** The Mid-Western Regional Hospital Ennis should undertake a regular audit of the views of complainants to ascertain how the Hospitals approach to complaints and concerns can be improved and the necessary changes identified in such audits should be implemented. **12.3:** As recommended by the Authority in a previous investigation report (25), the MWRH Ennis should ensure that an effective independent advocacy service for patients is in place in the hospital. These advocacy services should support and facilitate patients coming forward to raise concerns and have them addressed. **12.4:** The Health Service Executive should ensure that the new regional risk management structures, in the Mid West, have clearly defined lines of responsibility and levels of accountability. The processes must be transparent, patient-focused and have clear learning pathways. **12.5:** At a regional level the risk management process should be regularly monitored and audited with the outcomes reported through the national risk management structure to the Chief Executive Officer of the Health Service Executive. **12.6:** The Health Service Executive should identify a suitable independent person or organisation, agreed with individuals/persons that request it, to offer mediation with a view to discussing in detail and resolving any residual concerns in the way with which their complaint was dealt. *National* **12.7:** Risk management and complaints processes in the Health Service Executive and health services generally must include a stage in the process to establish, understand and document the outcomes desired by affected patients/relatives before any investigation or review is undertaken. **12.8:** The Health Service Executive should ensure the planned implementation of its new Quality and Risk Framework takes account of the lessons from this investigation and that an appropriate training programme on risk management and feedback is delivered that emphasises the importance of communication and outcomes as well as process. **12.9:** The role of the Office of the Ombudsman for public services should be publicised more effectively by the Health Service Executive in relation to the handling of complaints in the health service to ensure complainants understand they can have the handling of complaints reviewed and national learning can be applied throughout the health service.

Impact	No information identified.

Table 17 HSE emergency departments: Technical Report [2009]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Comptroller and Auditor General[17] HSE emergency departments: Technical Report [2009] Technical report
The health service system (including health service reform)	**Recommendation/considerations:** From an operational viewpoint, the streaming of emergency cases and the routing of appropriate cases through special clinics has the potential to improve emergency department efficiency and effectiveness. In addition, it would be worth evaluating the contribution of rapid access initiatives which hold the prospect of allowing quicker access to diagnostics and treatment. As part of its Transformation Programme the HSE plans to reconfigure its acute services and concentrate emergency, urgent and complex acute care into regional centres with skilled clinicians. The intention is that regional centres will be supported by a network of minor injury units in outlying facilities. The report findings suggest that considerable work remains to be done to bring about change consistent with these objectives and align current service provision with the objectives of the desired reconfiguration. **For information:** Since April 2009, the opening hours of the emergency departments at Ennis and Nenagh General Hospitals were changed to a twelve-hour service. Patients requiring emergency care are treated in Limerick Regional Hospital outside these hours. **Implementation of Rapid Access Initiatives:** Mid West: Number of Hospitals: 4 Fast Track Clinics: 1 Medical Registrars (rostered only to the ED): 1 Same Day Endoscopies: - Dedicated Diagnostics (available to the ED): 1 Advanced Nurse Practitioners (in Cardiology/Emergency Medicine available within the ED): -

Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** The examination found that the provision of appropriate care in all types of emergency cases within a reasonable timeframe is adversely affected by the restricted availability of key resources. A factor that will fall to be addressed in attempting to improve access to diagnostic services is the restricted working arrangements in the diagnostic disciplines. Current arrangements limit access to services at night and at weekends. Standards and norms in the provision of diagnostic services and the organisation of work in diagnostic disciplines need to be developed. The examination noted some potential to improve emergency department effectiveness through: ▪ better planning of discharges and finding alternative lower cost accommodation for patients whose acute care needs have been dealt with ▪ improving hospital capacity through a combination of day care, same day admission and, where necessary, increased bed numbers. The examination concluded that the length of stay of patients could be better managed through: ▪ a wider use of early discharge planning based on standard targets for each condition ▪ more even discharging across the week ▪ discharge of patients earlier in the day which could favourably impact on bed availability since attendance in EDs tends to increase in the afternoon. A dedicated bed management function operating on the basis of norms established in an evidence-based way could provide coordination of these functions. Many hospitals have begun initiatives to improve patient flows and establish patient pathways through the hospital and some good practice opportunities were identified during the course of the examination. However, a systematic mechanism to provide for the sharing of these good practice initiatives is needed to facilitate replication on a wider basis. Some of the pressure on emergency departments could be ameliorated by more streamlined hospital processes particularly in managing discharges and increasing the volume of work completed on a day case basis. **For information:** ▪ In most cases, there was considerable scope to improve the timeliness of diagnostic support and four departments had unsatisfactory access to those services. ▪ The waiting time for bed accommodation following decisions to hospitalise emergency patients was unsatisfactorily long in most cases

	▪ The examination found that there were considerable differences in emergency department capacity and that cost per attendance also varied significantly across the service. **Relative Performance of EDs** **Hospital:** Limerick **Attendances 2008:** 59,356 **Direct Cost per Attendance:** 163 **Decision Capacity:** Inadequate **Speciality Access:** Satisfactory **Diagnostics:** Satisfactory **Bed Waiting Time:** Inadequate **Existence and Type of Streaming:** MAU **Hospital:** Ennis **Attendances 2008:** 19,662 **Direct Cost per Attendance:** 141 **Decision Capacity:** Inadequate **Speciality Access:** Inadequate **Diagnostics:** Satisfactory **Bed Waiting Time:** Inadequate **Existence and Type of Streaming: -** **Hospital:** Nenagh **Attendances 2008:** 16,257 **Direct Cost per Attendance:** 107 **Decision Capacity:** Inadequate **Speciality Access:** Inadequate **Diagnostics:** Inadequate **Bed Waiting Time:** Satisfactory **Existence and Type of Streaming: -** **Hospital:** St. John's **Attendances 2008:** 18,552 **Direct Cost per Attendance:** 85 **Decision Capacity:** Inadequate **Speciality Access:** Inadequate

	Diagnostics: Inadequate **Bed Waiting Time:** Satisfactory **Existence and Type of Streaming:** MAU
Governance	**Recommendation/considerations:** Overall, the introduction of a comprehensive set of performance measures that are applicable to all emergency departments would help to drive performance and allow for comparability across hospitals. The Health Information and Quality Authority is developing such a suite of indicators including quality of care indicators. A pilot project is proposed for early 2010. When developed, the feedback should help emergency departments and the HSE to better manage the emergency services. **For information:** The HSE is pursuing changes to services including emergency care under a Transformation Programme (2007-2010). This Programme encompasses more than 100 interlinked projects, designed to change the way patients access health and social care services. The programme sets out a number of key priority areas which directly relate to service delivery and include the development of integrated services, the configuration of hospital, primary and continuing care services and the implementation of a model for the prevention and management of chronic illness.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** As the cost of step-down beds is considerably lower than the cost of acute beds there may be scope for cost efficiencies through development of a strategy to provide more beds in the community. The provision of alternatives to acute hospital care through strengthening primary and community care services could reduce reliance on the acute hospital services and demand on emergency departments. The inadequate and fragmented arrangements for the management of chronic illnesses has been recognised for some time and both the Department of Health and Children and the HSE have been working to re-orient the related services towards a primary care setting and bring about a more integrated approach between hospital and primary care services. Bringing this re-orientation to completion will require the development of a robust change management programme, the setting of standards of care and clinical guidelines, as well as developing a framework for implementation at local level. The HSE has developed a number of hospital avoidance measures such as home help and home care packages for older people who might otherwise occupy an acute hospital bed. An evaluation of home care packages is being finalised by consultants on behalf of the Department.

	In 2008, there were nearly one million attendances at out-of-hours GP services which are provided to 90% of the population. This service should be evaluated to assess its cost effectiveness and whether it has the potential to impact on reducing demand in emergency departments. In addition, in order to assess the scope for savings from the further development of community intervention teams and community based rapid access clinics, a full overall costing exercise taking account of all overheads should be completed. Community initiatives need to be evaluated to determine their relative cost effectiveness and, to the extent that they are found to be more economic and effective, integrated into the primary care team model. This could also help reduce recourse to the emergency services. **For information:** Community intervention teams provide a rapid response to patients who are deemed medically suitable for treatment in the home. Four teams are in operation two of which are in Dublin and one each in Cork and Limerick. These services have the potential to generate significant efficiency savings relative to hospital care as well as better patient care. In November 2006, a rapid access clinic in the community was opened in Smithfield in Dublin to provide care for older people with urgent but non-emergency care on the basis of referrals by their GPs or by emergency departments. A review of the clinic by the HSE found that 42% of new patients had avoided hospital admission through an emergency department. It is likely that the clinic has provided significant savings by comparison with the cost of acute hospital care. Community Intervention Teams 5.4 Community Intervention Teams (CITs) were first established in 2006 to provide a rapid response from the community services to patients who are deemed medically suitable for treatment in the home. This should prevent unnecessary referrals to the emergency department and facilitate early discharge from hospital. A team of nurses and home help services provide immediate supports until mainstream community services can take over – usually within 72 hours. The main source of referrals to CITs are emergency departments, hospital consultants, Public Health Nurses and GPs. 5.5 Four teams are in operation, one in Cork City, one in Limerick City and two in Dublin, serving a population of approximately 850,000.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Fundamental prerequisites to the care of patients in emergency situations include on-site availability of senior clinical decision makers and prompt access to other specialist consultants. The recently negotiated contract with medical consultants which provides for increased working hours should extend the time decision makers are available and reduce patient waiting times. However, the HSE will need to put procedures in place to confirm that the service gain envisaged under the new arrangements is achieved. **For information:** ▪ 23 of the 33 emergency departments had delays in accessing senior decision-makers.

	▪ access to consultations from specialities within the wider hospital was rated as unsatisfactory in most cases. **Resource application by ED:** Hospital: Limerick Attendance: 59,356 Medical Staff: 17.00 Nursing Staff: 54.50 Attendance per Medical Staff per Day: 17.12 Attendance per Nursing Staff per Day: 4.88 Hospital: Ennis Attendance: 19,662 Medical Staff: 4.00 Nursing Staff: 11.00 Attendance per Medical Staff per Day: 24.10 Attendance per Nursing Staff per Day: 8.02 Hospital: St. John's Attendance: 18,552 Medical Staff: 4.75 Nursing Staff: 11.18 Attendance per Medical Staff per Day: 19.15 Attendance per Nursing Staff per Day: 7.44 Hospital: Nenagh Attendance: 16,257 Medical Staff: 4.00 Nursing Staff: 8.00 Attendance per Medical Staff per Day: 19.92 Attendance per Nursing Staff per Day: 9.11 **3.12:** The restricted availability of key SDMs contributes to delays in the patient journey and to prolonged waits within the system. This militates against best practice patient care and service delivery. **3.13:** According to the HSE, there were 56 Consultants in Emergency Medicine in August 2009 working in the 33 emergency departments. 28 of these are available on a whole time basis in the eight major hospitals.

	Consequently, the other 28 cover 25 hospitals. The Royal College of Surgeons in Ireland (RCSI) are of the view that because emergency medicine is a specialised discipline, all emergency departments should be under the direction and leadership of a Consultant in Emergency Medicine as other specialists would not necessarily have a corresponding required range of training and experience.
Funding	**For information:** While the direct cost of emergency departments before taking account of overheads is estimated at €196 million, ultimately in the hospitals examined, care for those patients who had to be admitted cost an additional €1.5 billion in 2008. **Cost of Community Intervention Teams 2008** Limerick Direct Costs (including pay and non-pay costs): €400,739 Number of Patients Treated: 924 Cost per Patient Treated: €434
Other	No information identified.
Impact	No information identified.

Table 18 Report of the national acute medicine programme [2010]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Royal College of Physicians of Ireland, Irish Association of Directors of Nursing Midwifery, Therapy Professions Committee, Quality and Clinical Care Directorate (HSE)[18] Report of the national acute medicine programme [2010] Report Note: key data extracted from executive summary.
The health service system (including health service reform)	**Recommendation/considerations:** Retrieval service: critical to the success of the programme is the concept of guaranteed streaming and reverse streaming of patients to appropriate sites of care across the ISA with appropriate senior clinical input, by the case managers. To facilitate this further and to improve safety, the programme recommends the establishment of a retrieval service and associated transfer protocols. **For information:** The acute medicine programme is a clinician-led initiative between the Royal College of Physicians of Ireland (RCPI), the Irish Association of Directors of Nursing and Midwifery (IADNAM), the Therapy Professions Committee (TPC), the Irish College of General Practitioners (ICGP) and the Quality and Clinical Care Directorate (QCCD), HSE. The programme recognises the essential role of large and small hospitals, general practitioners (GPs) and community services. It provides a framework for the delivery of acute medical services which seeks to substantially improve patient care. The acute medicine programme provides a strong framework for provision of acute medical care because it: • Is driven by a quality agenda...Has benefited from its integration with other national clinical programmes to facilitate the development of an integrated solution development e.g. links between emergency medicine, critical care, surgery and other national programmes.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** As a result of these emerging models of healthcare delivery and the ageing population the total volume of activity in local hospitals will need to grow substantially for the successful implementation of this programme. Acute floor: the development of an acute floor concept (in model 3 and 4 hospitals) comprising a co-located emergency department, acute medical unit, coronary care unit, acute stroke unit, intensive care unit, high dependency unit, interventional cardiology suite, acute surgical assessment unit and clinical decision unit is proposed.

	The acute medicine programme recommends that in the Irish context, acute medical presentations to hospitals are best managed in dedicated medical facilities, staffed by physicians and a dedicated multidisciplinary team. These facilities will be stratified by patient acuity and structured as follows: • acute medical unit (AMU) • acute medical assessment unit (AMAU) • medical assessment unit (MAU)
Governance	**Recommendation/considerations:** Benefits: ▪ Standardised, evidence-based care pathways and protocols developed through the Quality and Clinical Care Directorate (QCCD) to ensure that every patient receives the most appropriate care. ▪ The general manager/CEO, director of nursing, clinical director, clinical services manager are the leadership team responsible for ensuring the effective implementation of the programme. ▪ The programme will ensure the standardisation of quality, safety and access to care and identify and correct variations in the delivery of services.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Primary care: general practitioners (GPs) will be supported by their hospital colleagues in the provision of clinical discussion, assessment and treatment for patients with acute medical problems about whom the GP is concerned. Benefits: ▪ The relationship between hospital staff and GPs will be a two way process based on mutual respect. ▪ GPs will have direct methods of communication with consultants, case manager, nurse managers and therapy leads and be able to select the most appropriate patient pathway from a wider range of assessment, diagnostic and treatment options. ▪ In addition to direct methods of communication, GPs will have accessible appropriate advice, assessment and treatment for patients with acute medical problems about whom the GP is concerned. ▪ GPs will have direct access to diagnostic services (e.g. radiology, endoscopy) as per agreed protocols. ▪ GPs will be members of the governance structure for the AMUs/AMAUs/MAUs. ▪ GPs may wish to work within the hospital models in addition to their primary care role.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** New working practices/continuous presence: the programme sets out recommended enhancements to clinical work practices in order to ensure patients receive timely care from a senior medical doctor working within a dedicated multidisciplinary team and are discharged appropriately New approach to education, training and development: the programme recommends the development of acute medicine as a specialty and the establishment of a cadre of acute medicine physicians (i.e. physicians with acute medicine as their primary specialty and physicians with a 50/50 acute medicine/other specialty interest).

	Benefits: ▪ All key decisions will be reviewed by a consultant. ▪ Nurses will have an expanded role in the delivery of patient care including discharge planning and X-rays and medication prescribing. ▪ Doctors will not have competing responsibilities which will conflict with the provision of acute medical care. ▪ Doctors will have protected time when off service to develop additional specialty/management interests. ▪ The programme is a clinician-led initiative involving wide spread clinician consultation. ▪ The programme recommends that authority should be delegated to clinicians to affect change locally ▪ There will be structured weekend work in accordance with the consultant contract 2008 ▪ Therapists will have an expanded role in the delivery of patient care including discharge planning, NIV and arterial blood gas sampling.
Funding	No information identified.
Other	No information identified.
Impact	No information identified.

Table 19 HSE Regional Service Plan Area West [2011]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource**	Health Service Executive (HSE)[19] HSE Regional Service Plan Area West [2011] [NOTE: Area West here covers both the West and Mid West] Service Plan
The health service system (including health service reform)	**Recommendation/considerations:** Overall Mid West Priorities for 2011: ▪ Maintain the overall levels of service provided in 2010 ▪ Deliver the cost reduction and restructuring programmes to enable the maintenance of these service levels on a ▪ reduced budget ▪ Ensure the delivery of high quality and safe services ▪ Accelerate our reform programme to reconfigure core services and in line with our strategy, deliver an appropriate ▪ balance between hospital and community services as well as best care models in childcare, disability, mental health and older person's services, and ▪ Implement the national clinical change programmes and new service developments. A major initiative in 2011 is the implementation of the national clinical programmes. The focus will be on standardising care and implementing proven solutions to save lives, prevent complications, remove waiting lists and save money. The clinical programmes that will be introduced this year include: ▪ Acute Medicine Programme ▪ Emergency Medicine Programme ▪ Elective Surgery Programmme ▪ Diabetes Programme ▪ Heart Failure Programme ▪ Stroke Programme ▪ Epilepsy Programme ▪ Chronic Obstruction Pulmonary Disease (COPD) Programme, and ▪ A range of initiatives to address outpatient waiting lists including neurology, dermatology and rheumatology. Aim for 2011 in regards to reconfiguration of the health system: ▪ Complete centralisation of cardiology in 2011 and the development of the implementation plan for the Acute Medicine Programme in the Mid West (Q1 – to be completed by RDO/Hospital Managers/Clinical Directors).

	▪ Develop implementation plan and have work streams in place (Q3-4. To be completed by RDO/Hospital Managers/Clinical Directors). **Emergency Presentations / Admissions:** The AMP will involve the implementation of a range of clinical led initiatives aimed at emergency admission avoidance and will also focus on a number of areas which will lead to improvements in EDs. There will be a continued focus on the development of acute medical and surgical assessment units and the use of MAUs for emergency admissions. Improvements within hospitals will be achieved through the focus on bed utilisation and improvements in admitting surgical patients on the day of surgery; proactive discharge planning; senior clinical decision-making particularly at weekends; and better access to assessment / diagnostics. [NOTE: Data for inpatient and day cases, emergency presentations and admission for 2010 and projected 2011 are provided however not extracted]. **Specific tasks requiring capital to be completed in 2011:** **Mid West Hospital Network** **Redeployment** ▪ HR, IR and Finance functions across the Mid West ISA will be integrated ▪ Catering departments across Limerick Acute Services will be integrated and a plated meal service will be introduced ▪ Corporate office staff will be redeployed to frontline services. **Reconfiguration and Restructuring:** ▪ OT, Speech and Language, Social Work, Audiology, Physiotherapy and Pharmacy will be integrated across the Mid West ▪ Outpatient Department referrals at the Hospitals will be centralised ▪ Restructuring Nursing rosters in Theatres, OPD and ED will be restructured ▪ Reconfiguration of Nursing and HCA grades ▪ Restructure of skill mix/grade within non-frontline nursing offices for example nursing staff carrying out clerical/administration work in allocations. **Extension of Working Day 8-8 5/7:** ▪ Extension of working day to 8pm and 5/7 roster for Lab/Mortuary, Radiology, ECG, Physiotherapy, Maintenance, Clinical Engineering, Pharmacy, porters, medical staff, finance, IT and patient services. ▪ Outpatient clinics will be extended to 8 pm ▪ Surgical day ward opening. **Mid West Regional Hospital** ▪ Commission an additional 4 ICU/HDU beds by March 2011 ▪ Centralise Acute Cardiology

	▪ Develop a dedicated rapid retrieval advanced paramedic service in Limerick ▪ Appoint three ambulatory care physicians for the Region for the Acute Medicine Programme. **St. John's Hospital, Limerick** ▪ Implement the acute medicine programme particularly the Acute Medicine Unit ▪ Participate in the development of a Regional nursing bank in Q1 ▪ Appoint an ambulatory Care Physician in 2011, under the Acute Medicine Programme ▪ Develop the Advanced Nurse Practitioner role in Accident and Emergency. **Ennis General Hospital** ▪ Commission new endoscopy unit and enhance bed capacity ▪ Develop dermatology services. **For information:** Challenging service level targets have been set for 2011, notwithstanding the budgetary reductions and the impact of the recruitment moratorium. In order to do this in a sustainable way we need to change, reconfigure and develop services in accordance with best practice both nationally and internationally. In this area there are 3 reconfiguration programmes underway in 2011; Mid West (Clare, Limerick, North Tipperary); West (Galway, Roscommon, Mayo); North West (Donegal, Sligo/Leitrim). The Mid West project has been running for a number of years and has already reconfigured emergency and surgical services across the three counties of the Mid-West. The HSE organisational structure, implemented in 2005, comprised of a hospital pillar and community pillar. While initially providing a focus on acute hospitals and community services it did not enable sufficient integration between hospital and community services to improve our health and social care system. As a result in 2009 the HSE took the first steps towards a more integrated organisation when it established four HSE regions, including HSE West. In 2010 the priority was to design the structure below regional management team level. This has been finalised and the implementation of Integrated Service Areas is now proceeding. The intention is to devolve decision making to the next level of organisational management and delivery to be called Integrated Service Areas (ISA). The ISAs will continue to operate within national standards and frameworks for services i.e. best practice for specific service settings. These areas are based on primary care team and acute hospital catchment areas. In HSE West ISAs have been established for Donegal, Mayo, Mid West, Sligo/Leitrim and Galway/Roscommon.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Targets for 2011: Acute hospitals will target a 2% reduction in inpatient activity but coincided with a 3% increase in day cases. The implementation of a number of national programmes such as the acute medicine and surgical programmes

	will be needed to support the delivery of these targets in 2011. The quality improvement agenda for cancer services under the National Cancer Control Programme will also continue, as will the outpatient service improvement programme. **Acute Hospital services:** Key Result Area: Medicine (Acute Medicine Programme) Deliverable Output 2011: Finalised implementation plans under the Acute Medicine Programme in all sites. Target Completion: Q2. Lead Responsibility: RDO/ISA Managers. Key Result Area: Critical Care Programme Deliverable Output 2011: Audit process for critical care. Target Completion: Q3. Lead Responsibility: Acute Lead. Key Result Area: Emergency Care (Emergency Medicine Programme) Deliverable Output 2011: Introduce Emergency Medicine Programme; Finalise Patient Experience Time (PET) data set. Target Completion: Q3; Q4. Lead Responsibility: Hospital Managers/Clinical Directors; Hospital Managers/Clinical Directors. Key Result Area: Surgical Care (Elective Surgery Programme). Deliverable Output 2011: Increase day case surgery and improve day of surgery rates to meet national standards; Increase use of pre-admission assessment clinics. Target Completion: Q1-Q4; Q1-Q4. Lead Responsibility: Hospital Managers/Clinical Directors; Hospital Managers/Clinical Directors **For information:** In 2010: Acute inpatient and day case activity exceeded target
Governance	No information identified.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Our HSE West priorities for 2011 are: 1. Increase the number of Primary Care Teams (PCT) from 87 to 118 2. Improve disease management in both primary and ambulatory care services in line with prioritised QCCD programmes 3. Implement Phase 1 of National Audiology Review recommendations and preparation for rollout of new-born hearing screening 4. implement the recommendations of General Practice Co-op review

	5. Implement the Independent Strategic Review of the Delivery and Management of HSE Dental Services. 6. Deliver the Human Papilloma Virus (HPV) to the 1st year cohort of young women LHO: Clare Actual No. of PCTs in Operation Y/E 2010: 12 Target No. of PCTs in Operation Y/E 2010: 12 % of 2010 Target Achieved: 100% Target No. full rollout Y/E 2011: 12 HSE Staff working to PCT: 99 LHO: Limerick Actual No. of PCTs in Operation Y/E 2010: 14 Target No. of PCTs in Operation Y/E 2010: 14 % of 2010 Target Achieved: 100% Target No. full rollout Y/E 2011: 18 HSE Staff working to PCT: 107 LHO: Tipp/East Limerick Actual No. of PCTs in Operation Y/E 2010: 9 Target No. of PCTs in Operation Y/E 2010: 9 % of 2010 Target Achieved: 100% Target No. full rollout Y/E 2011: 12 HSE Staff working to PCT: 56 **For 2011:** ▪ Establish new Primary Care Areas to give effect to the Mid West ISA (from three Local Health Office Areas to two areas). ▪ Redeployment of staff to provide administrative support to each Primary Care Team so that all services are delivered though a Team or Network. ▪ Reconfigure core Primary Care Team resources across the Mid West ISA area to enable the development of the remaining six Primary Care Teams. ***Older People*** Additional funding has been identified to support developments in 2011: ▪ €6m has been allocated for Fair Deal nationally ▪ €2m has been allocated for HSE West for the continued roll-out of Home Care Packages

	▪ €0.3m has been allocated for a national awareness campaign on elder abuse. ***Current Service Deliverables and Quantum*** Services for older people in HSE West supports the provision of the following services: ▪ Home Help - 3.5 million hours provided - The average number of people in receipt of Home Help per month is 15,159. ▪ Home Care Packages - Total number of clients in receipt of home care packages (HCP) was 2,133 as at 31st December 2010 - Total number of people benefiting from a home care package in 2010 was 3,234. ▪ Day Care Places - 2,660 (Clare x 7 facilities; Limerick x 10 facilities; North Tipperary x 9 facilities; Galway x 7 facilities; Mayo x 5 facilities; Sligo/Leitrim x 16 facilities; Roscommon x 2 facilities and Donegal x 42 facilities). ▪ Residential Care - 2,656 Public Residential care beds; of which approximately 789 are community support beds, (including respite, rehab, convalescent, palliative care and assessment) and 1,867 are long term care. - 876 people, as at 31st December 2010, are benefitting from Nursing Home Subvention in private nursing homes in the HSE West. 4,762 applications for the Nursing Homes Support Scheme received since the introduction of the scheme (as at the 30th November 2010). - 247 contracted beds in private Nursing Homes - Replacement and Additional Beds (See Below). **For information:** In 2010: Community based Home Care Packages for older persons.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** ***Employment Control Framework and 2011 Approved Employment Ceiling*** The 2010 revised employment control framework for the HSE has devolved to each of the four regions the day-to-day operation of the general moratorium on recruitment and promotion and delegated sanction to recruit specific grades and exceptions. The West operated within the approved reducing employment ceiling throughout 2010. Service Function: Acute Hospitals Services Ceiling Dec 2010: 10,896 Actual WTE Dec 2010: 10,954

	Variance with Dec 2010 Ceiling: 57 % Variance with Dec 2010 Ceiling: 0.53% Service Function: Ambulance Services Ceiling Dec 2010: 437 Actual WTE Dec 2010: 449 Variance with Dec 2010 Ceiling: 12 % Variance with Dec 2010 Ceiling: 2.68% Service Function: Primary and Community Services Ceiling Dec 2010: 14,334 Actual WTE Dec 2010: 13,840 Variance with Dec 2010 Ceiling: -494 % Variance with Dec 2010 Ceiling: -3.45% Service Function: Total ISD West Ceiling Dec 2010: 25,667 Actual WTE Dec 2010: 25,242 Variance with Dec 2010 Ceiling: -425 % Variance with Dec 2010 Ceiling: -1.66% Service Function: Corporate Ceiling Dec 2010: 867 Actual WTE Dec 2010: 797 Variance with Dec 2010 Ceiling: -70 % Variance with Dec 2010 Ceiling: -8.12% Service Function: Population Health Ceiling Dec 2010: 246 Actual WTE Dec 2010: 232 Variance with Dec 2010 Ceiling: -14 % Variance with Dec 2010 Ceiling: -5.78% Service Function: Total HSE West Ceiling Dec 2010: 26,780 Actual WTE Dec 2010: 26,271

	Variance with Dec 2010 Ceiling: -509 % Variance with Dec 2010 Ceiling: -1.90% The opening 2011 WTE ceiling is 26,780. The employment control environment in 2011 will demand even more for less in terms of employment numbers and costs. The national public sector moratorium on recruitment and promotions will continue in 2011, with the continuing exception of a number of specific grades and services. The framework will provide flexibility to recruit additional psychiatric nurses, advanced nurse practitioners, clinical specialists and interns. Robust and responsive employment control, with the accountability at regional and service manager level, continues to be a key driver for 2011. Reconfiguration and integration of services, reorganisation of existing work and redeployment of current staff will underpin the employment control framework in order to deliver government policy on public service numbers and costs and within budgetary allocations. A detailed workforce plan will be required to scope out the implementation of the approved employment ceiling for 2011. ***Recruitment Activity and Priorities for 2011*** In 2011, the moratorium on recruitment may, because of its unstructured nature, cause challenges to the maintenance of the volume, quality and safety of services. Prioritisation of recruitment in 2011 will be targeted at minimising these service risks. In addition, the focus of recruitment activity will primarily be in respect of the posts which have been prioritised because of their service impact and will be accommodated within the employment ceiling in 2011. Recruitment will also focus on grades with delegated sanction in order to ensure that employment levels are maintained in line with agreed growth targets. Continuing centralisation of recruitment to the National Recruitment Service (NRS) will be further implemented in 2011. HSE and HSE-funded agencies are experiencing significant challenges maintaining NCHD staffing in certain specialties and locations. In 2011, the HSE will be recruiting all service posts on the basis of a 2 year contract which includes placement in a large regional centre or major hospital, participation in a professional development scheme and access to a range of supports to meet registration, visa and other costs. A new Framework Agreement for the provision of agency NCHD staff will be in operation from 1st January. The HSE will also introduce a minimum English language competency requirement and ensure that common standards and processes are applied to recruitment of NCHDs through Initial and Higher Specialist Trainings schemes. The HSE will also be working closely with the Medical Council to ensure doctors are registered appropriately and efficiently and a centralised database of all NCHD posts will be rolled out nationally in 2011 to assist in same. Centralised recruitment of NCHDs to non-training posts will be implemented by NRS in 2011. ***Further HR actions to support organisational priorities include:*** Performance Management: The implementation of a health sector wide performance management system, in 2011 and beyond as set out in the PSA. Active engagement with Unions is ongoing at Frontline Service level across the West. The Area Management Team will monitor the implementation of the PSA initiatives on a weekly basis.

	Medical Education, Training and Research: In response to its legislative responsibilities under the Health Act 2004 and the Medical Practitioners Act 2007 and to Government Policy, the HSE is implementing its strategy and implementation plan for medical education, training and research (METR) and the improved integration of education, training and research across the various health service disciplines. In 2011, we will continue the implementation of planned developments such as academic clinician posts, integrated clinician scientist training pathways, sponsored training abroad for doctors in higher specialist training, competence based training and generic training for doctors. The HSE will review posts for doctors in specialist training and make proposals to the Medical Council in line with our statutory responsibilities under the Medical Practitioners Act. In addition, the METR Unit will focus on key strategic areas of development including the reform of the intern year, achieving optimum benefit from funding for medical education and training, the establishment of explicit contractual agreements with training bodies for the provision of postgraduate specialist medical training, the development of medical workforce database and the implementation of aspects of the NCHD contract related to education and training. Leadership, Education and Development: Continued implementation of the policy position set out in the report HSE Principles and Recommendations for Education, Training and Research will guide initiatives in 2011. Development of additional skills and competencies and capacity building becomes more critical to the provision of quality patient care in the context of reduced staffing, significant redeployment and challenging budgetary parameters. **For information:** [In 2011] The Government moratorium on the recruitment of public service staff (with the exception of some clinical grades) and ongoing financial challenges will put pressure on our ability to deliver the ambitious targets set for 2011. Employment Control: the 2010 outturn shows a positive variance of 509 below ceiling. Key appointments were made in Frontline Services during 2010 (Social Workers, Psychologists, Physiotherapists, Occupational Therapists and Nursing). Figures show a continuous downward trend on staff numbers from December 2008 to December 2010 with an overall 4.25% reduction in WTEs. Absenteeism Management: during 2010 the overall absenteeism rate dropped from 5.54% to 4.83% (12.8% improvement). This was enabled by continued support focus for Frontline Management by HR/Performance and Development Unit and Employee Relations. This resulted in an overall reduction in absenteeism of: ▪ 5.67% to 4.96% (12.5% improvement) in Acute Services ▪ 5.42% to 4.70% (13.3% improvement) in community services
Funding	**Recommendation/considerations:** The gross allocation for the West in 2011 is €1,990.3bn. This reflects a net reduction of €104.1m (5%). **Considerations:**

	The financial constraints in 2011 and the continuing public sector recruitment moratorium will challenge our ability to recruit certain categories of staff – significant flexibility in relation to change and redeployment will therefore be needed in order to maintain frontline services. ▪ The 2010 closing deficit of €22m will add to the financial challenges ▪ Delivery on the cost reduction and service restructuring programmes is crucial for 2011 in order to maintain services at current levels with reduced resources. ▪ The continuing NCHD recruitment difficulties in many of our hospitals will pose challenges in the delivery of acute services. **The National Funding Position** The gross current Estimate for the HSE is €13.456bn as set out in the published Estimates for the Public Services 2011. This reflects a net reduction of €683m (4.8%). The total reduction to the HSE is €962m (6.7%) which is being offset by the return of €279m for additional expenditure relating primarily to medical cards, new services, pensions costs and the Clinical Indemnity Scheme. The table below sets out the budget reduction framework for 2011: **Area West Finance** It is important to state at the outset that a significant effort has been made this year at national level to ensure that cost reduction measures are implemented in a way which minimises the impact on front line services at regional and local level. The focus of our efforts this year is to reduce costs without reducing services. The 2011 Financial Allocation for the West is €1,990.3bn which reflects a net reduction of €104.1m (5%) on 2010. Last year's allocation was adjusted for the various items set out in the table below. In relation to public hospital charges for private and semi-private accommodation an increased income collection target of €20.7m has been set and the charges have been increased by an average of 21%. Certain allocations are made annually on a once off basis and these relate primarily to cancer, innovation funding, NCHD training grants and health and safety allocations. These total €16.9m. The reduction of €19.2m in relation to the staff Moratorium is based on the actual salaries of staff that left. These staff have not been replaced and the workload must be reorganised / redistributed. The most significant target of €38.8m relates to cost reductions to be achieved through the procurement process. These are nationally led projects in the areas of procurement and contracts management, logistics and inventory management, estates and maintenance, training and education, agency, laboratory and a further reduction in all areas of discretionary spending. These cost reduction projects are not expected to impact on front line service delivery. The strategic priorities adjustment of €6.6m is to provide a funding stream for critical national priorities in relation to patient quality and safety. This programme is being driven by the National Quality and Clinical Care Directorate through

	the implementation of various care improvement programmes nationwide and outlined elsewhere in this report. The extraction of €4.6m is to allow the newly established national legal services department to centrally manage and control all legal costs going forward. The additional €2.7m is for the full year cost of the CAMHS Unit in Merlin Park, Galway. Notwithstanding these challenging targets, an additional €56m has been provided nationally in 2011 for further service improvements. The funding priorities are the National Cancer Care Programme for radiation oncology of €10m, Children and Family Services for implementation of the Ryan Report €9m, Disability Services for day, residential, respite, personal assistance and home support services €10m, Older Persons Fair Deal, home care packages and long stay repayment scheme €26m and Mental Health Suicide Prevention services €1m. The 2010 closing deficit of €22m in the West area will require local cost containment measures which will add to the foregoing challenges. A further budget reduction in relation to Management / Admin and Support staff who left through the VRS/VER exit schemes is also awaited. **Cost Containment Measures 2011** The area West plan is based on savings in non-pay of €38.8m, details of which are summarised in the table below. This is an aggressive savings target which will require strong focus across all service areas and which will also require significant engagement and negotiation with the supplier base to the HSE in seeking to reduce prices and control volumes of stock of supplies and services used by the HSE and the voluntary sector. Expenditure Category: Procurements and Contracts Management National (€m): 78.7 Mid West (€m): 13.3 Expenditure Category: Logistics and Inventory Management National (€m): 20.0 Mid West (€m): 5.6 Expenditure Category: Reduce Discretionary Spend National (€m): 41.7 Mid West (€m): 7.8 Expenditure Category: Agency services National (€m): 7.0 Mid West (€m): 0.9 Expenditure Category: Medical and Nurse Training

	National (€m): 2.6 Mid West (€m): 0.0 Expenditure Category: Laboratory services National (€m): 5.0 Mid West (€m): 1.1 Expenditure Category: Review of Rent/Lease Renewals National (€m): 5.0 Mid West (€m): 1.0 Expenditure Category: Further non-services impacting initiatives (to be identified) National (€m): 40.0 Mid West (€m): 9.1 Expenditure Category: Total National (€m): 200.0 Mid West (€m): 38.8 Acute Hospital: St. John's Hospital, Limerick Budget 2010 €'000's: 19,471 Budget 2011 €'000's: 17,853 Acute Hospital: Limerick Regional Hospital Budget 2010 €'000's: 148,175 Budget 2011 €'000's: 131,032 Acute Hospital: Limerick Maternity Hospital Budget 2010 €'000's: 17,653 Budget 2011 €'000's: 15,442 Acute Hospital: Croom Orthopaedic Hospital Budget 2010 €'000's: 10,429 Budget 2011 €'000's: 8,250 Acute Hospital: Nenagh Hospital

	Budget 2010 €'000's: 18,553 Budget 2011 €'000's: 17,704 Acute Hospital: Ennis Hospital Budget 2010 €'000's: 20,496 Budget 2011 €'000's: 19,655 Acute Hospital: ISA/Orthodontic Budget 2010 €'000's: 3,133 Budget 2011 €'000's: 3,229 **MidWest Hospitals Sub Total** Budget 2010 €'000's: 237,910 Budget 2011 €'000's: 213,164 **Acute Sub Total** Budget 2010 €'000's: 861,303 Budget 2011 €'000's: 793,240 Primary, Community and Continuing Care: Clare Budget 2010 €'000's: 110,179 Budget 2011 €'000's: 106,226 Primary, Community and Continuing Care: Limerick Budget 2010 €'000's: 174,793 Budget 2011 €'000's: 168,774 Primary, Community and Continuing Care: Tipperary Budget 2010 €'000's: 124,481 Budget 2011 €'000's: 119,481

Other	**Recommendation/considerations:** Priorities in regards to quality and safety in 2011: Our priorities for 2011 are to: ▪ Further develop and implement the Quality, Safety and Risk Management Framework ▪ Strengthen accountability arrangements ▪ Increase service user input into planning and delivery of services ▪ Strengthen our healthcare audit, progress clinical audit, strengthen clinical effectiveness and develop health ▪ technology assessment capacity ▪ Comply with Health Information and Quality Authority (HIQA) report recommendations ▪ Enhance our management of serious incidents and complaints ▪ Improve preparedness for major emergencies ▪ Strengthen research and development, and ▪ Enforce statutory functions in relation to environmental health services. **For information:** [NOTE: a number of sections including children and families, disability services, mental health, social inclusion, older people, acute hospital services and the NCCP were outlined in the service plan. Only older people and acute hospital services were extracted as most relevant to the report, however the others can be reviewed as required].
Impact	The document outlines the implementation of the National Service Plan 2011 (NSP2011) was in HSE West. A major initiative in 2011 is the implementation of the national clinical programmes, focus will be on standardising care and implementing proven solutions to save lives, prevent complications, remove waiting lists and save money. The clinical programmes that will be introduced this year include: ▪ Acute Medicine Programme ▪ Emergency Medicine Programme ▪ Elective Surgery Programme ▪ Diabetes Programme ▪ Heart Failure Programme ▪ Stroke Programme ▪ Epilepsy Programme ▪ Chronic Obstruction Pulmonary Disease (COPD) Programme, and ▪ A range of initiatives to address outpatient waiting lists including neurology, dermatology and rheumatology.

Table 20 Health Service Executive (HSE) West service plan [2012]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Health Service Executive (HSE)[20] Health Service Executive (HSE) West service plan [2012] [NOTE: the West in this case includes all of the West and not just the Mid West] Service Plan
The health service system (including health service reform)	**Recommendation/considerations:** Key principles underpinning the way we deliver services in 2012 include: ▪ Providing a safe and quality service is a key objective. ▪ Improving access to services and ensuring that the patient will be at the centre of everything we do. ▪ Delivering efficient and effective use of resources to ensure best value for money is achieved. The focus this year will be on reshaping and remodelling health services in line with the 'Programme for Government' including the development of hospital networks with new governance structures, and stronger more integrated primary and social care sectors. HSE West is leading the way on this with the two new management structures already underway in the Galway/Roscommon acute hospitals group and the Mid West acute hospitals group, and further development is on the way in relation to the Northwest Acute Hospitals. Putting the Patient First The focus in 2012 will also be on standardising care and implementing proven solutions consistently, to prevent complications, reduce waiting lists and maximize the use of resources. This includes initiatives such as: ▪ Introduction of the Acute Medicine and associated Programmes. ▪ The productive operating theatre programme. ▪ The productive ward programme. ▪ Introduction of Surgical assessment units. ▪ Implementation of a range of initiatives to address inpatient and outpatient waiting lists. **For information:** In 2011 HSE West delivered major change programmes in both acute and community services, for example: ▪ The reconfiguration of services in Roscommon County Hospital (and previously in Ennis and Nenagh Hospitals) has seen the benefits of the centralisation of acute medical, surgical and emergency medical services into larger hospitals, with the smaller hospitals moving to the provision of locally accessible planned services, diagnostics and day patient care. ▪ The implementation of the Clinical Care Programmes has commenced with the rollout of Acute Medicine, Emergency Medicine and Stroke Care Programmes across HSE West.

	▪ Executive Clinical Directorates were established in Mental Health. ▪ The formation of the five service areas in the region has facilitated more integrated and responsive services for patients and service users. Three hospitals in particular, namely Galway, Limerick and Letterkenny face major financial challenges in 2012 due to the carry forward of significant overspends. Further efficiencies will be pursued through the reorganisation of rostering, reduction in overtime and agency, improving of skill mix and other measures such as improved procurement and income collection to limit the impact on frontline services. While every effort will be made to ensure that the impact on services is minimised, it is recognised that it will prove very challenging to maintain existing levels of service provision.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** In 2012 we will: - ▪ Focus on improving timely and equitable access to services and work with the Special Delivery Unit (SDU) to improve waiting times for emergency services and scheduled/planned care. ▪ Provide for 144,077 inpatient discharges and 170,210 day case discharges, - total combined 314,287. ▪ Provide for 15,969 births. ▪ Provide 521 dialysis treatments (haemodialysis and home therapies), an increase of 44 treatments on the outturn 2011. ▪ Prioritise unscheduled care (ED trolley waits) particularly in the peak capacity pressure periods. ▪ Comply with the new nine-month target for scheduled care. ▪ Prioritise urgent elective/planned cases including relevant cancer cases in gynaecology and other specialities to ensure they are not negatively impacted. **Priorities for 2012** ▪ Improve Access performance and comply with the SDU targets for both scheduled and unscheduled care. ▪ Implement the clinical care programmes, particularly acute medicine, emergency medicine and the elective surgery programmes. ▪ Implement Phase 2 of the smaller hospitals framework. This will involve a rationalisation and review of beds and activity across the region. ▪ Develop and implement a regional plan for the reconfiguration of elective and day case surgery. ▪ Implement the productive theatre model to generate more efficient utilisation of theatres. ▪ Prioritize waiting list OPD targets in rheumatology, dermatology and neurology. ▪ Consolidate orthopaedic elective activity in the region. ▪ Enhance stroke teams across the West and develop rehabilitation units in Galway and Roscommon. ▪ Implement the average length of stay (AvLOS) programme in Galway and Limerick by Q2 and all other hospitals in HSE West by end of 2012.

	▪ Roll out the colorectal cancer screening programme in Sligo, Ennis, Letterkenny and Mayo. ▪ Review medical physics and clinical engineering services to identify more efficient ways of working across the region. ▪ Maximise income generation throughout all hospitals in HSE West. **Unscheduled care** ▪ Ensure that 95% of all attendees at EDs are discharged or admitted within 6 hours of registration, and that those who need to be admitted through ED wait no more than 9 hours from registration. ▪ An average length of stay (ALOS) of 5.8 days or less. ▪ A reduction in bed days lost through delayed discharges. **Scheduled care** ▪ Ensure that nobody is waiting more than 9 months for planned surgery. ▪ Ensure that nobody is waiting more than 20 weeks for paediatric elective inpatient or day case surgery Ensure that nobody is waiting more than 4 weeks for an urgent colonoscopy. ▪ Ensure that nobody is waiting more than 13 weeks for routine GI endoscopy (colonoscopy/gastroscopy). ▪ The focus is to ensure long term sustainability to the ongoing service improvements and to be satisfied that there is a sufficient degree of flexibility across unscheduled and scheduled care service delivery in the region. In addition to the specific targets set out above the Region is committed to working with the SDU in relation to delivering on the priorities set by the Minister for Health and ensuring that integrated plans addressing the balance of capacity, demand, resources and associated risks across the region are in place during the implementation of any changes to how services are delivered e.g. service reorganisation, cost containment, ongoing financial monitoring, implementation of the "Framework for Smaller Hospitals" and the impact of staff retirements. Detailed site plans will follow from the individual hospital groups in due course. Key Result Area: Acute Medicine Deliverable Output 2012: Acute Medicine Model fully operation in Limerick; Implement MEWS in all sites. Target Completion Quarter: Q1; Q1. Key Result Area: Critical Care Programme (Improving safety and quality of care for patients) Deliverable Output 2012: Appointment of CNS in Limerick to facilitate the implementation of the national Critical Care Audit; Commissioning of Critical Care Block in Limerick on bases of existing level of service. Target Completion Quarter: Q1; Q3. Key Result Area: Emergency Medicine Programme

	Deliverable Output 2012: Working with the SDU to implement the emergency management programme across all acute hospital sites and compliance with unscheduled care targets; Establish Emergency Care networks and implement national standards. Target Completion Quarter: Q1-Q3; Q2. **Mental Health** In 2012 we will: - ▪ Reduce acute bed capacity at Ballinasloe (15 beds), Sligo (10 beds), Galway (8 beds) and Clare (19 beds) on a phased basis as recommended in Vision for Change. ▪ Review and rationalise long stay beds in Limerick (St. Joseph's Hospital) and supervised residential facilities in Sligo, Limerick, Galway, Mayo and Clare. ▪ Provide 3,700 inpatient hospital places.
Governance	**Recommendation/considerations:** *Priorities for 2012* ▪ Implement a strong system of corporate and clinical governance. ▪ Ensure there is a system-wide co-ordinated approach to the quality agenda that spans the spectrum of service provision and covers regulatory standards, recommended practices, and quality and safety issues. ▪ Implement national and international standards and recommended policies / guidelines developed both by government and other regulatory bodies / HSE. ▪ Strengthen patient and service user input through developing and implementing best practice models of customer care and service user involvement. ▪ Further embed integrated risk management across all services. Utilise the risk register mechanism as part of the HSE control framework. Learning from the HSE incident experience will inform the work and set the priorities for the risk register and controls assurance. ▪ Provide transparency and accountability to the public about quality and safety of care by: - Responding to, reporting on, and learning from incidents and adverse events. - Implementing learning from report and review recommendations, risk analysis, serious incidents, audits, complaints, surveys, and ensure that best practice is shared and distilled. This will help to prevent and minimise avoidable repeat incidents. - Enhancing quality, clinical and social care audit and assurance. ▪ Improve prevention, control, and management of healthcare-associated infections and improve antimicrobial stewardship. ▪ Provide assurance to the organisation on the implementation, monitoring, and evaluation of the above priorities.

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** In 2012 we will: ▪ Operate within a budget of €231.3m. ▪ In order to deal with the budget reduction outlined above and the embedded deficit, HSE West is required to reduce costs by €5.1m, which represents approx 2% of 2011 allocated resources. ▪ Provide 238,415 GP Out of Hour contacts. ▪ Maintain the number of orthodontic patients receiving active treatment at 2011 levels – 3,745. ▪ Improve Child Health Immunisation Programmes as recommended by the national programme. ▪ Continue Child Health Screening and Development Programmes, prioritising children less than 1 year and vulnerable families. ▪ Provide 115 Primary Care Teams (PCTs). ▪ Progress the development of Health and Social Care Networks (HSCN) necessary to support the PCTs in the ▪ Provision of specialist community based services and care groups services. This will include services such as social inclusion, mental health, disability, older people and child protection amongst others. ▪ Continue training on GP Training Schemes. ▪ Continue health promotion development in schools, the workforce and the community. ▪ Continue to provide funding for the GP Out of Hours cooperatives NoWDOC, ShannonDoc and Westdoc - albeit at reduced funding levels compared to 2011. We will continue to review with a view to creating greater efficiencies between the three services. ▪ The recommendations of the National Review of the Public Health Nursing Service will inform and assist HSE Areas to allocate resources, maximising nursing staff allocation, supervision and skills mix across PCTs and specialist HSCN teams. ▪ Continue implementation of the National Audiology Review, including establishing a Regional Audiology Service and roll out of the National Newborn Hearing Screening programme within HSE West. ▪ Work is underway nationally and regionally to clarify community supports including aids and appliances administered by local regions and areas and charged to PCRS. This plan assumes that any adjustments resulting from this work will be cost and service neutral during 2012. Priorities for 2012 [NOTE: A number of specific actions in relation to primary care are outlined in the document] ▪ Improve the management of chronic diseases in community settings ▪ Identifying new processes and efficiencies in delivering primary care / community services ▪ Consolidating services provided by existing Community Intervention Teams ▪ Improving audiology services ▪ Implement the recommendations of the National Review of the GP Out of Hours Services report. **Older People Services**

	In line with national policy, our aim is to maintain older people in their own homes for as long as possible and where this is not possible, to provide high quality residential care, appropriate intermediate rehabilitation and respite beds. In HSE West we will maintain and where possible enhance (by means of reconfiguration of public long term care capacity) the provision of intermediate care beds (complex discharge, respite, rehabilitation, step-down and so on). We are committed to keeping as many of our public long term care beds open as far as practical during 2012. However, given the scale of the financial challenge and our ability to deliver safe services due to the reduction in staff, the closure of some beds may be necessary. We propose to safely and appropriately limit the closure to a maximum of 132 long term beds. The number of bed closures will be determined based on service viability and client choice which will be reflected by bed occupancy levels and continued funding at current cost of care rates. Currently two of our public units are being considered for cessation of residential care. Day and respite services may continue at these locations subject to sustainable staffing levels. A decision to close units will only be made following a process which will involve consultation with residents and their families. There will be a requirement of 6 months' notice to HIQA before unit closure. In 2012 we will: ▪ Operate within a budget of €172.5m. ▪ Reduce costs by €8m which represents approx 3% of 2011 allocated resources. ▪ Deliver 5,715 beds/places under NHSS in 2012 (Fair Deal). ▪ Significantly reduce the level of Agency/Over Time from 2011 levels. ▪ Provide home help services for 13,460 clients – 3.1m home help hours. ▪ Provide home care packages to 2,238 clients. ▪ Enhance assessment and decision making process for long term residential care placements, to ensure the full range of support options (home care/respite/rehabilitation/intermediate care) are explored before long term care is deemed necessary. ▪ Maintain and where possible increase intermediate care bed capacity (step up/step down, respite and rehabilitation). ▪ Provide day care services at 141 centres. ▪ Work with the National Clinical Programme for Older People to move towards an improved and more integrated model of care. ▪ Participate in the National Review of Home Support. ***Priorities for 2012*** ▪ Administer the Nursing Homes Support Scheme within the resources allocated to meet the HSE's strategic objective of maintaining older people at home for as long as possible and only providing long term residential care when all other reasonable alternatives have been exhausted. In addition, we will establish one HSE West Area

Office for the administration of the Nursing Homes Support Scheme in order to increase efficiencies and standardisation of the Scheme.

- Provide quality residential care through the attainment of the standards outlined in the National Quality Standards for Residential Care Settings for Older People and engagement with the Health Information and Quality Authority.
- Improve the quality of home care services being delivered by implementing the National Quality Guidelines for Home Care Support Services. Following the completion of the national tender for Enhanced Home Care Packages, ensure standard implementation and monitoring of the approved providers across HSE West.
- Provide the supports required for older persons to live independently in their own homes for as long as possible through the use of high quality home support services targeted at those in need of support for personal care.
- Respond to referrals of allegations of elder abuse in a timely and appropriate manner, in line with Protecting Our Future.
- Support the development of a Single Assessment Tool to determine patient / client need and ensure equitable access to services based on this need.
- Encourage and support older people to remain living within their communities though health promotion initiatives such as falls prevention, positive ageing, Community Intervention Teams, meals on Wheels, etc. Promote 2012 as the European Year of Active Ageing and Solidarity between Generations.
- Deliver 5,715 beds/places under NHSS in 2012 (Fair Deal).
- Provide home help services for 13,460 clients in receipt of home help services.
- Provide home care packages to 2,238 clients - maintain projected outturn 2011.

Public facilities scheduled for services reductions include (in the Mid West):

Nursing Home	**Beds**
St. Camillus, Limerick	13 of 134
St. Ita's	10 of 102

Intermediate care is underdeveloped in many parts of the West and has been identified as a critical element of the older persons' care pathway. The HSE is committed to working with the DoH in allocating funding from long-term residential care and other potential sources, such as acute hospitals, to increase intermediate care capacity, e.g., step-up / stepdown beds, and to provide additional community services such as Home Care Packages. This should reduce demand on acute hospital services and assist in the prevention of inappropriate admissions to long-term residential care. As part of this process, HSE West will review its short term bed capacity and service need.

Service Improvements

- Roll out of Home Care Package approved provider list of voluntary and private home care providers, which will introduce national minimal standards for the delivery of home care services as part of a home care package.

	▪ Establish a regional office for the processing of applications for the Nursing Home Support Scheme – this will assist applicants for the scheme through the provision of information, update on progress of the application process etc. ▪ Implement National Home Help Guidelines which will introduce a standardised and consistent approach to the delivery of home help services. Mental Health In 2012 we will: ▪ Provide 14 Child and Adolescent Community Mental Health Teams. ▪ Provide accommodation for clients in more appropriate care settings within the level of available resource. Staff released through inpatient bed reductions will be redeployed to support the development of community-based services including the filling of vacancies to agreed levels.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *Employment Control Framework and Estimated Ceiling 2012* ▪ The Employment Control Framework (ECF) will remain in place during 2012 as a key element of the National Recovery Plan and Public Service Reform Plan. The purpose of the ECF is to reduce public service numbers, maximise efficiency and support the transformation of services in line with Government Policy in response to the economic climate. The employment control environment in 2012 will demand even more for less in terms of employment numbers and costs. HSE Area West operated within the approved reducing employment ceiling throughout 2011 with a year-end out-turn of 24,815 - 338 within ceiling. The 2012 employment target reduction is 784. This will require robust and responsive employment control, with accountability from all Services Managers. Reconfiguration and integration of services, reorganisation of existing work and redeployment of current staff as provided for under the PSA through a consultative process will be required to achieve the employment control target and deliver on government policy on public service numbers within the current budgetary allocation. The employment control framework is being broadened to address workforce issues such as overtime, agency usage and costs, and cost of allowances. *Consultant Employment* ▪ Since 2009, there has been an increase in employment levels for Medical Consultants (up 34 on 2009 baseline) and these increases will further accelerate as a result of the number of Consultants approved posts under the Clinical Programmes. There will be a need to offset this growth in both employment terms and pay costs in 2012 by rebalancing NCHD numbers and through reductions on medical overtime and agency/locum. *Overtime and Agency Usage Policy*

	▪ The transposition of the EU Temporary Agency Directive into Irish law will have a significant potential cost implication on the usage of agency staff across the Health Services. In adhering to the Directive, there will be a particular focus to reduce the overall expenditure on agency staff in 2012 (50% reduction target). Careful monitoring of the employment ceiling will continue and if there is scope to substitute through recruitment and employment of staff at lower than agency costs this will be considered. In 2012, there will be a continued emphasis on reducing volumes of overtime and agency usage across all staff functions. Agency staff should only be utilised if there is sufficient funding and on a short term basis. Overtime and agency staff are not to be used to support service levels beyond those agreed in this Plan or to substitute for staff losses as a result of the need to reduce Health Sector employment. *Absence Management* ▪ This is a key priority issue for Human Resources. The Area West average absence rate of 5.65% is slightly higher than the National average of 5.41%. A National benchmark of 3.5% has been established as a target. A HR and Senior Management Task Group combined with Frontline Services Management has been formed. The purpose of the Task Force will be to manage and reduce absenteeism in HSE West to: ▪ Focus on locations/staff categories where the absence rate % is significantly higher than average absence rates. ▪ Implement a multi-disciplinary, cross-functional, 'per site' interventions targeted at specific groups, managers and categories of staff to lead to a decreased absences rate. ▪ Support local managers to manage absence more effectively ▪ Identify, plan and develop organisational supports required for the management of attendance in the workplace. ▪ Specific targets are set to be reached within a specific timeframe with action plans agreed with Local Management. *Performance Management System (PMS)* The Public Service Reform Plan places emphasis on organisational performance, leadership and individual /team performance. Performance management requires clarity about accountability, direction and leadership. Effective performance management is essential to implementing this Plan, identifying strengths and weaknesses of our workforce, developing stronger and more effective team performance management and supporting staff to up skill/retrain to meet the needs of the service. A robust PMS commencing with senior management grades across all disciplines will be implemented during 2012 to cascade down into the future to ensure that there is a single shared context within which performance is appraised and improved. **For information:** ***Public Sector Agreement (Croke Park)*** The Public Service Agreement provides the framework for delivering on the significant change programmes across the health sector during the course of 2012. It continues to provide an opportunity to further transform and

	modernise the health services by facilitating efficiency and productivity, reducing costs and improving quality. We will work closely with staff and staff associations to build on the work already undertaken in 2011. An outline of the range of planned changes is set out in the service plan. ***Human Resource and Workforce Management (HR)*** The 2011 year-end employment control position was within ceiling by 338 WTE with an out-turn of 24,815 WTE. The employment control framework will remain in place during 2012 as a key element of the National Recovery Plan. The 2012 plan provides for a further reduction of 784 WTE (3%). The present position is that 683 staff (615 WTE) are expected to retire by the end of February 2012 under the End of Grace period retirement option. Therefore, there is a requirement for a further reduction of 169 WTE by the end of 2012. In addition there is a requirement to reduce Agency costs by 50%. However, additional staff will be recruited in 2012 in the areas of Mental Health, the filling of key vacancies in Primary Care and continued recruitment to support the HSE National Clinical Programme in Acute Hospitals. HSE West has worked closely with staff and staff organisations to deliver the necessary changes required during 2011 and will continue to build on this in 2012. With a permanent reduction in the overall levels employed in our services, staff will be required to prioritise to ensure that the impact on front-line services is kept to a minimum. Such an approach will require redeployment and reassignment across all our services.
Funding	**Recommendation/considerations:** The 2011 final allocation of €1997.4m is reduced by €4.3m in respect of funding given annually or on a once off basis which will be returned during the year. Under the pay heading there is a Moratorium reduction of €34.7m in respect of an estimated 784 staff - 680 are expected to retire during January and February of 2012 to avail of the public service pension reduction exemption. These staff will not be replaced and workload will have to be reorganised and redistributed to a restructured workforce in accordance with the Croke Park Agreement. A sum of €3.5m has been returned to provide funding for the filling of posts in the exempt medical and para medical grades. A premium pay savings target of €8.0m has been set for reductions in Agency, Overtime, Premium payments and sick leave etc. Under the non-pay heading there is a general efficiency savings target of €11.2m, the bulk of which is expected to be achieved through the National Procurement Process of contract price reductions, logistics and inventory management. These cost saving measures are not expected to impact on front line services. In addition there are further efficiency savings targets set for Mental Health (€3.7m), Childcare (€1.9m), Hospitals (€6.8m) and multicare (€1.9m). There is also a net top slice of €20.7m towards funding for the new national Children and Family Support Agency and the national Nursing Home Support Scheme (Fair Deal). On the income side there are three measures outlined in respect of private patient charges. First there is a €4.2m target set for an increase in charges. A further target of €14.9m has been set for accelerated collection of existing charges which will result in an improved cash flow position. This is not a budget

	reduction. The Government also propose to introduce legislation to allow the HSE charge for all patients who opt for private treatment irrespective of which bed they occupy. At present the HSE can only charge for patients in designated private beds. The budget transfer for Fair Deal of €105.1m is in respect of the transfer of all funding in respect of long term elderly residential care beds to the National Fair Deal budget. This figure remains under discussion at the present time. Preparations are also underway for the transfer of the Childcare budget to the proposed new Agency. At national level the Government have provided an additional €35m for mental health services in line with the Programme for Government commitment. We also await the final allocation in respect of the national Clinical Programmes and we will review the resource allocation issue in February. **Mid West Hospitals** St. John's Hospital, Limerick: Budget 2010 €'000's: 17,626 Budget 2011 €'000's: 15,849 Limerick Regional Hospital: Budget 2010 €'000's: 138,059 Budget 2011 €'000's: 123,188 Mid-Western Regional Maternity Hospital, Limerick: Budget 2010 €'000's: 15,705 Budget 2011 €'000's: 13,646 Mid-Western Regional Orthopaedic Hospital, Croom: Budget 2010 €'000's: 9,824 Budget 2011 €'000's: 9,083 Mid-Western Regional Hospital, Nenagh: Budget 2010 €'000's: 17,976 Budget 2011 €'000's: 16,715 Mid-Western Regional Hospital, Ennis: Budget 2010 €'000's: 19,652 Budget 2011 €'000's: 18,678 Network Manager/Orthodontic: Budget 2010 €'000's: 3,571 Budget 2011 €'000's: 3,490 MidWest Hospitals Sub Total: Budget 2010 €'000's: 222,414 Budget 2011 €'000's: 200,649

	Acute Sub Total: Budget 2010 €'000's: 844,586 Budget 2011 €'000's: 750,010 **Primary, Community and Continuing Care** **Clare** Budget 2011 €'000's: 99,300 Budget 2012 €'000's: 85,218 **Limerick** Budget 2011 €'000's: 170,699 Budget 2012 €'000's: 145,494 **Tipperary** Budget 2011 €'000's: 122,263 Budget 2012 €'000's: 108,980 ***Resources for 2012*** The focus is on reducing costs while maintaining services. The budget reduction for HSE West amounts to €104.8m or 5.2% of the 2011 base budget. This excludes the reductions associated with staff retirements and the public sector moratorium. A significant challenge in 2012 will be managing the reductions of staff arising from the early retirement schemes across all grades and locations. A full review will be undertaken in March to ensure that the effects of the retirement schemes are fully reflected and the contingency arrangements are in place and operating effectively. Significantly increased income targets have also been set for 2012 and are a key part of the HSE West budgetary plan for the year. The financial constraints in 2012 and the continuing public sector recruitment moratorium will challenge our ability to recruit certain categories of staff – significant flexibility in relation to reconfiguration and redeployment will therefore be needed in order to maintain frontline services. The continuing NCHD recruitment difficulties in many of our hospitals will pose challenges in the delivery of acute services. The 2011 deficits carried forward will add to the financial challenges in certain areas. Delivery on the cost reduction and service restructuring programmes is crucial for 2012 in order to maintain services at current levels with reduced resources.

	The budgetary challenge for HSE West in 2012 amounts to €104m and a staffing reduction of 784 WTEs by the end of the year. In recent years the service impact of budget reductions was offset by reductions in the rate of pay for staff. In 2011, reduced overhead, procurement, drug costs and a change to demand led schemes again reduced the impact on services. However in 2012 the cost reductions will primarily focus on our pay costs and on significant reductions in staffing levels. Health is very much a service provided by people to people, and consequently as our staffing levels reduce our capacity to provide services is coming under increasing pressure. **Key Investments in HSE West 2012:** Despite the budget reductions affecting all services, HSE WEST is in a position to advance priority investments in maintaining and improving services during 2012 including: ▪ Investment in Clinical Programmes, including Stroke and Acute Medicine and the appointment of new Consultant Physician posts in Acute and Emergency Medicine, Geriatrics, Cardiology and Rheumatology. ▪ Additional long term care beds via the national €55m Fair Deal investment. ▪ Ring-fenced investment in Mental Health Services (from €35m national fund) ▪ Disability Services - priority in autism services. €1m (national). ▪ The opening of the new Critical Care facility in the Mid Western Regional Hospital. **In 2012 we will: -** ▪ Operate within a budget of €750m, which is €61.5m less than the 2011 budget. This is an average across all of the acute services; for individual figures please refer to the Resource Framework chapter. ▪ In order to deal with the budget reduction outlined above and the embedded deficit, Acute hospitals will need to reduce costs by €81m in 2012, which represents approx 10% of 2011 allocated resources. ▪ Significantly reduce the level of agency/overtime from 2011 levels. ▪ Invest €5.9m in National Clinical Care Programmes. ▪ Roll out phase 2 of the smaller hospitals framework. **Capital Projects Planned for completion in 2012** **Care Group:** Critical Care **Facility:** Mid West Regional Hospital, Limerick **Project Details:** Provision of a new critical care block linked directly to the main theatre block. Includes two floors (shell only) and car parking underneath. **Care Group:** Ambulance **Facility:** Tipperary North (Thurles and Nenagh)

	Project Details: New ambulance station. **Care Group:** Primary Care **Facility:** Limerick **Project Details:** New Primary Care Centre.
Other	**For information:** *Quality and Patient Safety* At a time of sustained reduction in resources it is essential that we maintain and, in fact, increase our focus and investment on quality and patient safety (QPS). In 2012 this will include improving governance and investing in maintaining and enhancing support at regional, area, and local level to assist staff to meet their responsibilities in providing safe services. [NOTE: Information is provided on areas such as children and families, disability services, social inclusion services, cancer services, mental health services however these were not extracted. Please refer to the larger document for full information].
Impact	No information identified.

Table 21 The National Emergency Medicine Programme: A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland [2012]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Clinical Strategy Programmes Directorate, (HSE) Quality Patient Safety Directorate, Irish Committee for Emergency Medicine, Irish Association for Emergency Medicine, National Board for Ireland, the College of Emergency Medicine, Therapy Professions Committee[21] The National Emergency Medicine Programme: A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland [2012] Report [Note: Data primarily extracted from key recommendations]
The health service system (including health service reform)	**Recommendation/considerations:** <u>Objectives:</u> Develop models of care to improve patient access to high quality emergency care: ▪ Define a National Emergency Care System comprising networks of EDs fully integrated with pre-hospital and hospital-based services, ensuring a standardised approach to the delivery of high quality emergency care. *Key recommendations:* ▪ Emergency Care Networks (ECNs) should be established. These will be formed by a number of collaborating emergency units, closely aligned with local pre-hospital and primary care services and operating within a shared governance framework. The role of each unit within the network will be defined. ▪ Effective operational links with pre-hospital services will be established in each network and ambulance service representatives will participate in ECN operational meeting. ▪ The EMP will work with the National Ambulance Service, the Pre-hospital Emergency Care Council and the National Transport Medicine Programme to support pre-hospital services. ▪ The key interface between EM and Acute Medicine (AM) will be developed to ensure the provision of high-quality patient care for patients accessing both services. **For information:** The term "Emergency Care" (EC) includes all emergency medicine services, pre-hospital care, EDs and the initial stages of hospital-based management of patients who present in need of emergency or urgent care. It also includes ED Clinical Decision Units (CDUs) which are inpatient services led by Consultants in Emergency Medicine. Voluntary organisations and General Practitioners (GPs) who provide immediate care for communities are also contributors to emergency care.

Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Ensure continuous quality improvement across the emergency care system: ▪ Roll-out the development of, and optimise the work of, Clinical Decision Units ▪ AMUs/AMAUs and EDs should not compete for resources. *Key recommendations:* ▪ ED resources should not be used for the provision of non-EM work and any such work should be redirected to more appropriate care settings. ▪ CDUs should be developed in all 24/7 EDs. ▪ The Acute Floor concept that sites the ED, Critical Care facilities, Diagnostic Imaging and acute speciality assessment areas in proximity to each other should be realised in future acute hospital infrastructure development. ▪ All EM patients who require ICU admission should be admitted to an ICU bed within six hours of ED arrival. ▪ All ECN units should have service level agreements with specialties providing this diagnostic support to ensure optimal patient access. ▪ Emergency diagnostics should be routinely available from 08:00 to 20:00 seven days a week and emergency on-call services must be responsive to service need. ▪ Key Performance Indicators are necessary to drive quality improvement in EC. The key access KPIs are: - Episodes of EM care should be completed within 6 hours - Ambulance-borne patients should be handed over to EM staff within 20 minutes - Fewer than 5% of patients should leave an ED before completion of treatment.
Governance	**Recommendation/considerations:** Develop models of care to improve patient access to high quality emergency care: ▪ Implement new clinical governance structures and processes to ensure clear authority, accountability and responsibility across the emergency care system. *Key recommendations:* ▪ A National Emergency Care System Steering Group should be established. ▪ A governance hierarchy should be established with a National Emergency Care System Coordinating Forum ensuring implementation of the strategic recommendations of the NECS Steering Group and driving implementation of the EMP plan. It will oversee the work of ECN Operational Groups. ▪ Governance activity across the NECS must be adequately resourced. This includes clinical audit, guideline implementation, measurement of KPIs and related governance meetings. ▪ CDU care should be audited and CDU effectiveness should be monitored through ED Clinical Operational meetings. ▪ There should be planning for routine and surge capacity across the ED/AMU/AMAU interface to prevent

	overcrowding. **For information:** The Programme is led by a multidisciplinary working group that includes Consultants in Emergency Medicine, Emergency Nurses, representatives of Pre-hospital Care and the Therapy Professions. It is supported by the Irish Committee for Emergency Medicine Training, the Irish Association for Emergency Medicine, the National Board for Ireland of the College of Emergency Medicine, the Office of the Nursing and Midwifery Services Director, the Therapies Professions Committee and National Emergency Medicine Programme Report Overview and Key Recommendations 2 the Clinical Strategy and Programmes Directorate (CSPD) of the Health Service Executive (HSE). The Programme working group is also supported by an advisory group drawn from the relevant training bodies and other stakeholders, a Nurse Reference Group and a Primary Care consultation group.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Ensure continuous quality improvement across the emergency care system: ▪ develop new roles for GPs in EDs and enhance links with Primary Care. *Key recommendations:* ▪ The EMP will work with the DoH, the HSE, the ICGP and other Primary Care organisations to develop new and sustainable roles for GPs who may wish to work on a sessional basis in EDs and other ECN units. ▪ The EMP will explore the potential for collaborative service and training development between Emergency Medicine, Pre-hospital Care and Primary Care, with the aim of improving the quality of patient care across this interface. ▪ The EMP recommends that a new paradigm of care is developed for older patients within ECNs. It will support and nurture the development of Geriatric EM throughout all networks and improve care to this increasingly complex group of patients. The EMP will implement the following proposals: • Closer collaboration with the Primary Care, Medicine for the Elderly and Acute Medicine Programmes in providing education and training in core geriatric competencies and recognition of atypical presentations within EDs. • Improve the integration of Geriatric Care at the hospital/community/public health nursing/General Practice interface with safe hospital avoidance and timely discharge.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Develop models of care to improve patient access to high quality emergency care: ▪ Increase patient access to Consultant-provided care through increased Consultant numbers and expanded hours of Consultant presence in EDs. ▪ Develop roles for nurses including Staff Nurses, Clinical Nurse Specialists and Advanced Nurse Practitioners, for Therapy Professionals, Medical Social Workers and other members of the multidisciplinary team. Maximise value in Emergency Care: ▪ Enhance senior staffing and improve the quality and timeliness of care to reduce admission rates and decrease length of stay for inpatients referred from ED.

	Key recommendations: ▪ EDs must be staffed by full-time Consultants in EM and must operate under the governance of EM. ▪ Pre-hospital care medical support staffing should be included in future workforce planning for EM and Intensive Care Medicine. ▪ There will be ongoing comprehensive workforce planning for EM, including all components of the multidisciplinary team and supporting services, because appropriate staffing of the ED is the single most important factor in providing a prompt, timely and clinically effective service to patients. ▪ Standardised staffing models will be developed to ensure the equitable and appropriate staffing of all EDs and ECN units. ▪ There needs to be a phased and sustained enhancement of Consultant staffing levels in EM to achieve levels comparable to international norms. ▪ Enhanced Consultant in EM staffing levels will support expanded hours of Consultant working and, in parallel with an expansion of the normal working day in other hospital specialties and supporting services, will improve the quality, access and cost-effectiveness of patient care in ECNs.
Funding	**Recommendation/considerations:** The EMP Plan will include implementation actions that: ▪ are ED-based initiatives that are cost-neutral and deliverable through the reorganisation of existing work practices ▪ the Programme recommends standardising nursing roles and job descriptions across the NECS. Workforce planning and the use of an appropriate patient dependency and acuity measurement tools will support the standardisation of staffing levels, grade and skill mix which match with each type of emergency service throughout the system. *Key recommendations:* ▪ The EMP will advance the development of cost-measurement and resource allocation systems to enable the cost-effectiveness of emergency care to be measured and improved. ▪ The EMP will standardise care to assist in reducing the variance in ED patient costs identified in the Comptroller and Auditor General Special Report, Emergency Departments, November 2009.
Other	No information identified.
Impact	No information identified.

Table 22 Future of Health: Strategic Framework for Reform of the Health Service [2012 – 2015]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Department of Health (DoH)[22] Future of Health: Strategic Framework for Reform of the Health Service [2012 – 2015] Strategic Framework [Note: Extraction is focused on the actions outlined]
The health service system (including health service reform)	**Recommendation/considerations:** Future Health is built on four key inter dependent pillars of reform. *(i) Health and Wellbeing:* There will be a new focus on the need to move away from simply treating ill people, to a new concentration on keeping people healthy. The health and wellbeing pillar recognises the need for a whole of government approach to addressing health issues and commits to the development of a comprehensive health and wellbeing policy framework and the establishment of a Health and Wellbeing Agency. *(ii) Service Reform:* The service reform pillar will move us away from the current hospital centric model of care towards a new model of integrated care which treats patients at the lowest level of complexity that is safe, timely, efficient, and as close to home as possible. This will help to reduce costs, improve access and move from the existing emphasis on episodic reactive care towards preventative, planned and well-coordinated care. *(iii) Structural Reform:* We recognise that structural reform of the health service will be key to addressing the problems with our current health system, and will also be critical in the journey to UHI. The first phase of the process will deliver a greater degree of accountability for the HSE to the Minister. It includes abolition of the Board of the HSE, establishment of a Directorate and a new management structure in the HSE. Hospital groups will be established on an administrative basis, with Group Chief Executives having budgetary and staff responsibility for both the HSE and voluntary hospitals in their group. Smaller hospitals will be developed in tandem with the establishment of hospital groups. There will be a review of Integrated Service Areas which will (i) ensure maximum alignment between all service providers at the local level; (ii) review executive management and governance arrangements; and (iii) inform new structures for the delivery of primary care. The second phase will involve the development of a formal purchaser/provider split and, effectively, the dissolution of the HSE. The third phase, to be implemented as we move to UHI, will move us from a tax funded system to a combination of UHI and tax funding. *Reform Initiative:*

	(ii) Hospitals: Future Health identifies three main areas of reform for the hospital system. We will deliver more responsive and equitable access to scheduled and unscheduled care for all patients through continued implementation of the Special Delivery Unit's initiatives in this area. Public hospitals will be reorganised into more efficient and accountable hospital groups that will harness the benefits of increased independence and a greater control at local level. The introduction of hospital groups and the development of smaller hospitals are interrelated. A Framework for the Development of Smaller Hospitals will be published shortly which will ensure that smaller hospitals will play a vital role in service delivery. **Action 1:** The Department of Health will publish a White Paper on Universal Health Insurance in 2013. A preliminary document will be produced by end 2012. *Structural reform* **Action 14:** The Department of Health will make recommendations by Q4 2012 on (i) the composition of hospital groups; (ii) the criteria for the formation of hospitals groups and (iii) the first wave of new hospital groups to be established immediately thereafter. **Action 15:** The Department of Health in conjunction with the HSE will conduct a review of Integrated Service Areas in Q2 2013. **Action 16:** The Department of Health will work with the HSE to develop Sectoral Plans for Shared Services and External Service Delivery by Q4 2012**.** **Action 17:** The Department of Health in conjunction with the HSE will conduct a review in 2013 of corporate functions and resources (staff and budget) of the various corporate/support/shared services as they currently exist within the HSE and make recommendations for the future. *Reforming our hospitals* **Action 30:** The Department of Health will work with the HSE on an on-going basis to drive implementation of the programmes aimed at reducing waiting times for scheduled and unscheduled care in hospitals. **Action 31:** The Department of Health will work with the HSE to oversee the establishment of administrative hospital groups during Q1 2013 as a first in a series of steps leading to the introduction of independent hospital trusts for all hospitals by December 2015.

	Action 32: The Department of Health in conjunction with the HSE will publish in Q4 2012 a framework to address the development of smaller hospitals, setting out what services can be delivered safely by these hospitals in the interest of better outcomes for patients. **Action 33:** The Department of Health will work with the HSE to ensure that the Ambulance Service is reconfigured by Q1 2014 to ensure a clinically driven, nationally co-ordinated system, supported by improved technology, which will also encompass the National Aeromedical Co-ordination Centre. *Reforming social and continuing care* **Action 34:** The Department of Health will develop policy in relation to the introduction of financial assessment, contribution and charges for certain social and continuing care services by 2015. **Action 35:** The Department of Health will support the HSE to roll out a Single Assessment Tool for older people services in 2013. **Action 36:** The Department of Health will commence work on a national standard assessment tool for people with disabilities as part of a resource allocation framework in 2013. **Action 37:** The Department of Health will extend the HIQA regulatory regime to residential services for people with disabilities in 2013 and to other social and continuing care settings by 2016. **Action 38:** The Department of Health will commence a review of the Fair Deal scheme to assess its sustainability by Q4 2012 and will further review the scheme to assess its applicability to other sectors such as the disability and mental health residential sectors by Q4 2013. **Action 39:** The Department of Health will develop a high level implementation plan for the Value for Money and Policy Review of Disability Services by Q4 2012. **Action 40:** The Department of Health will work with the HSE to move towards a person-centred model of services and supports for disability services, through the initiation of demonstration projects as "proof of concept" in 2013. **Action 41:** The Department of Health will work with the HSE to complete a prospective funding model for palliative care in 2013.

Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *Tackling the capacity deficit* **Action 42:** The Department of Health will develop an eHealth Strategy in conjunction with the HSE by Q1 2013. This will serve as a blueprint for the design and implementation of eHealth systems to support and enable the delivery of integrated patient care under the reform agenda. **Action 43:** The Department of Health will ensure that the necessary preparatory work is undertaken to allow publication of the Health Information Bill by end Q2 2013. **Action 44:** The Department of Health in conjunction with the HSE will establish an Information and ICT Strategy Unit, led by a Chief Information Officer in Q1 2013, to ensure that the necessary information, technical and governance infrastructure is in place. **Action 45:** The Department of Health and the HSE will continue to use the Public Service Agreement to the fullest extent possible between 2012 and 2014 to protect health services and to facilitate implementation of the reform programme. **Action 46:** The Department of Health will work with the HSE from 2012 to implement an approach to workforce planning and development that includes recruiting and retaining the right mix of staff, training and upskilling the workforce, providing for professional and career development and creating supportive and healthy workplaces. **Action 47:** The Department of Health will work with the HSE and relevant experts to develop a series of leadership and learning sets in relation to governance, quality and safety of health care delivery to meet the requirements set out in the HIQA report on Tallaght hospital.. **Action 48:** The Department of Health, with the HSE, will further develop an approach to address both short-term and long-term succession requirements at senior management level from 2012.
Governance	**Recommendation/considerations:** **Action 2:** The Department of Health will establish a robust governance structure to oversee the health reform programme by Q1 2013. **Action 3:** The Department of Health will establish an appropriately resourced Programme Management Office in Q1 2013 to drive, co-ordinate and monitor the reform process.

	Action 4: The Department of Health will develop a proactive Consultation, Collaboration and Communication Plan for the reform programme by Q4 2012. Consideration will be given to the introduction of a system of primary care accreditation. Such a system of accreditation will drive improvements in quality as well as facilitating integration between services within primary care and between primary care and secondary care.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Reform initiatives: *Primary Care:* Our vision for primary care is one where: no one must pay fees for GP care; GPs work in teams with other primary care professionals; the focus is on the prevent ion of illness and structured care for people with chronic conditions; primary care teams work from dedicated facilities; and staffing and resourcing of primary care is allocated rationally to meet regularly assessed needs. Primary care teams will provide the foundation medical and non-medical care that people need, whether it is for health or social needs. Patients will be referred from primary care only when their needs for care are sufficiently complex; otherwise they will be managed through primary care. Registration with a primary care team will be compulsory once the Universal Primary Care system is fully implemented. We will retain the community ethos of primary care, in which the patient's needs are the first concern. *(iii) Social and Continuing Care:* Future Health commits to the development of a social and continuing care system that maximises independence and achieves value for the resources invested. The measures include a reform of the Fair Deal scheme to allow many more people to continue living at home as they would wish. Consideration will also be given to the extension of the Fair Deal model to the disability and mental health sectors. Disability services will be reformed in line with the findings of the recent Value for Money and Policy Review of Disability Service s. Future Health also reaffirms our support for the move from the traditional institutional based model of mental health care, towards a patient centred, flexible community based service. Other important measures identified include the introduction of: a standardised framework to commission services from both public and non-public providers; individualised budgeting to bring about a closer alignment between funding and the outcomes of individuals; and a robust regulatory regime to ensure quality and safety. *Health and wellbeing* **Action 9:** The Department of Health will produce a comprehensive Health and Wellbeing Policy Framework by end 2012. **Action 10:** The Department of Health will establish a Health and Wellbeing Agency in Q1 2015.

	Action 11: The Department of Health will work with the HSE to ensure that the age range extension of BreastCheck to 65-69 year old women will commence in 2014. **Action 12:** The Department of Health will work with the HSE to ensure that the national colorectal screening programme will have completed the first round of screening for 60-69 year old men and women by end 2015. **Action 13:** The Department of Health will work with the HSE to ensure the delivery of the targets for routine and urgent endoscopy procedures by end Q4 2012. *Reforming primary care* **Action 26:** The Department of Health will introduce legislation to extend GP care without fees on a phased basis. **Action 27:** The Department of Health will work with the HSE to ensure that chronic disease management programmes will be introduced between 2013 and 2015. **Action 28:** The Department of Health will work with the HSE to increase the numbers of health care professionals working in primary care from 2013. **Action 29:** The Department of Health will work with the HSE to implement a programme of investment in primary care centres between 2012 and 2015.
Staffing (including workforce planning, recruitment and retention)	No information identified.
Funding	**Recommendation/considerations:** (iv) Financial Reform: The financial challenges facing the health system are immense. Demand is increasing on an annual basis while the amount of funding available to provide services has decreased significantly and will continue to reduce in the years ahead. The financial reforms envisaged under Future Health are designed to ensure that the financing system is based on incentives that are aligned to fairness and efficiency, while reducing costs, improving control and also improving quality. Measures aimed at addressing financial control issues to be implemented under the reform programme include the return of the Vote to the Department of Health from the HSE; the introduction of programme based budgeting; implementation of the recommendations set out in the Reviews of Financial Management Systems in the Irish Health Service; and the development and roll out of a comprehensive financial management system as a matter of priority. A new Money Follows the Patient (MFTP) funding model will be introduced in order to create incentives that encourage treatment at the lowest level of complexity that is safe, timely, efficient, and is delivered as close to home as possible. This shift

	will be used as an opportunity to use money as a lever to achieve quality and safety objectives rather than simply being a means of paying for activity. Ultimately, the MFTP system will be designed so that money can follow the patient out of the hospital setting to primary care and related services. This, along with other initiatives such as the introduction of integrated payment systems, will help to support integration between primary, community and hospital care. Important reforms of the private health insurance market are also planned, including a new permanent scheme of risk equalisation from 1 January next, an emphasis on cost control and an examination of the options in relation to the future status of the VHI. In the context of UHI, the Programme for Government envisages a statutory system of health insurance, guaranteed by the State, in which the system would not be subject to European or national competition law. Future Health recognises that the legal and practical requirements to achieve this are likely to be very complex, and are being explored at present. Any decision on the exact way forward will take full account of the Government's previous commitment to address an important European Court of Justice judgement in relation to the regulatory status of the VHI by the end of 2013. *Financial reform* **Action 18:** Funding for the health service will be provided through the Vote of the Office of the Minister for Health from Q1 2014. The Department of Health will work closely with the HSE and the Department of Public Expenditure & Reform on the detailed arrangements that are required to bring about this change. **Action 19:** The Department of Health will work with the HSE and the Department of Public Expenditure and Reform to develop Programme Based Budgeting in 2013 within the confines of the existing financial systems. **Action 20:** The Department of Health and the HSE will oversee implementation of the recommendations contained in the 2012 Reviews of Financial Management Systems in the Irish Health Service from Q4 2012. **Action 21:** The Department of Health will work with the HSE to ensure the development and roll-out of a comprehensive financial management system as a matter of priority. **Action 22:** The Department of Health will develop time-bound plans for the implementation of Money Follows the Patient by end 2012. **Action 23:** The Department of Health will pursue cost control in the private health insurance market in particular through the Consultative Forum on Health Insurance and through the external review in 2012 of the VHI's claims costs. Implementation of these initiatives will continue through 2013 and beyond.

	Action 24: The Department of Health will introduce a permanent scheme of risk equalisation to support the principle of community rating from Q1 2013. **Action 25:** The Department of Health will address the regulatory status of the VHI, in line with the European Court of Justice ruling, by no later than the end of 2013.
Other	**Recommendation/considerations:** *Patient safety and quality* **Action 5:** The Department of Health will establish a new Patient Safety Agency on an administrative basis in 2013. **Action 6:** The Department of Health will develop a licensing system initially focussed on hospitals and specialist service providers to commence in Q1 2015. **Action 7:** The Department of Health will work with the HSE and the State Claims Agency to develop a risk based approach to provision of indemnity to services and professionals by end 2013. **Action 8:** The Department of Health will establish a National Task Force on Prescribing and Dispensing Practice by end Q4 2012.
Impact	No information identified.

Table 23 Mid-Western Regional Hospitals Group Service Plan [2013]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Health Service Executive (HSE)[23] Mid-Western Regional Hospitals Group Service Plan [2013] Plan
The health service system (including health service reform)	**Recommendation/considerations:** Key priorities 2013: Implement the Small Hospitals Framework when published which will ensure that patients receive high quality care in the most appropriate setting resulting in best possible outcomes.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *Key priorities 2013:* Improve access to services by reducing waiting times for emergency or unscheduled care and elective or scheduled care. This includes improved access to out-patient and diagnostic services. Specific targets will include: ▪ No adult will wait more than 8 months for an elective procedure (either inpatient or day case) ▪ No child will wait more than 20 weeks for an elective procedure (either inpatient or day case) ▪ No person will wait longer than 52 weeks for an OPD appointment ▪ No person will wait more than four weeks for an urgent colonoscopy and no person will wait more than 13 weeks following a referral for routine colonoscopy or OGD ▪ 95% of all attendees at Emergency Departments will be discharged or admitted within 6 hours of registration ▪ Our expected activity for 2013 is 45,800 inpatient and 41,729 day cases Continued commitment to delivering the optimal care pathway for differing clinical needs by implementation of the Clinical Programmes. Implementation of the National Clinical Programmes will align with the newly established Corporate and Clinical Directorate Governance structure in the Mid-Western Regional Hospitals Group in 2013. The six hospitals within the Group will operate in a mutually supportive way across a one hospital system. The impetus of change in the Clinical Programmes is at both macro and micro levels of multi-disciplinary clinical practice and organisation. The focus of the Medicine Directorate in 2013 will be to plan for and manage scheduled and non-scheduled care under the direction of the Emergency Medicine and Acute Medicine Programmes. Optimal care pathways for unscheduled care will continue to be developed. Hospital admission avoidance strategies will be expanded in the areas of GP/ED rapid referral access clinics, and specialist nursing care. Increasing OPD care capacity for Neurology and Dermatology will be looked at.

	Improvements in scheduled and non-scheduled care delivery will be of particular importance to the patient with a chronic illness such heart disease, respiratory disease, diabetes, renal disease, neurovascular and neurological diseases, and diseases of the skin. The recognised bed capacity issues at the Model 4 Mid-Western Regional Hospital Limerick will be the significant challenge in implementing the umbrella Programmes of Acute Medicine and Emergency Care. Under the Peri-operative Directorate, the Elective Surgery Programme will be progressed with the emphasis on increasing Day Cases and Day of Procedure Cases, expanding Pre-operative Assessment, decreasing admissions for elective surgery, reducing waiting times for elective procedures, and improving the effectiveness of the workings of theatre. The protection of beds for booked surgery patients will come under pressure from the need to address the urgent bed needs of people in ED. The Diagnostics Directorate will strive to deliver imaging and laboratory services that are important catalysts to decision making along the Clinical Programmes' unscheduled and scheduled pathways. **2013 Actions** **Priority Area:** Emergency Medicine Programme **Action:** Review work practices and develop an improvement plan as required to ensure PET targets can be attained; Develop LIUs at St. John's Hospital and MWRHE; Promote and develop the role of the ANP on all sites; Design team in place for new ED and commence construction; Implement Programme targets to further reduce waiting times for patients. **End Q:** Q2; Q3; Q1-Q4; Q1; Ongoing. **Priority Area:** Acute Medicine Programme **Action:** Appoint Acute Physicians; AMU to function 24/7 at MWRHL; MAUs operational in JEN hospitals; Implement selected take at MWRHE; Open short stay unit at MWRHL; Increase capacity at MWRHL site be opening additional capacity released when critical care block opens (will needs this in place for Ward 3B going out of commissioning in April 2013); Achieve the AMP target of ALOS of 5.8 days through pathway processes and discharge planning; Review operation of MAU in Nenagh; Progress appointment of 5th AMU Physician. **End Q:** Q1; Q1; Q1; Q1; Q1; Q3; Ongoing; Q3; Q3. **Priority Area:** Anaesthetics/Critical Care

	Action: Move to new critical care block opening 10 ITU and 8HDU beds; integrate the governance of ICU and HDU; Appoint a staff nurse to ICU to facilitate Limerick's participation in the National ICU Audit Programme; Develop single Department of Anaesthetics. **End Q:** Q1/Q4; Q1; Q2; Ongoing. **[A number of targets for 2013 for average length of stay, in-patient discharges, day cases, ED presentations, emergency admissions and births are also outlined in the plan – these have not been extracted].** **For information:** During 2012: ▪ We continued to make progress in decreasing the trolley waits despite an increase in ED admissions and a real deficit in capacity which has been examined in detail through the bed utilisation study and capacity planning work that we have undertaken. ▪ Average length of stay (ALOS) across the group for both Medicine and Surgical services is at the high end of national performance yet, the Hospital Group continues to maintain a re-admission rate below the national standard. ▪ The Department of Health set a target that no adult should wait more than 9 months and no child should wait more than 20 weeks for scheduled treatment. We achieved both these targets in 2012.
Governance	**Recommendation/considerations:** *Focus in 2013:* Continue strengthening governance **Governance & Accountability** The Interim Board of the Mid-Western Regional Hospitals Group was appointed in February 2013 with the first Board meeting scheduled for 28th February 2013. Reporting to the Board is the Executive Management Team (EMT) through the Chief Executive Officer (CEO). Since 21 January 2013, a new system of governance and management has been introduced across the single hospital system with the creation of four clinical directorates. Each directorate is responsible for all services within the directorate across the different sites. The four Clinical Directorates are: ▪ Medicine ▪ Peri-operative ▪ Diagnostic ▪ Maternal & Child Health Each Directorate is led by a Clinical Director with a Directorate Manager and Directorate Nurse Manager. Each

	Directorate Management Team is supported by specialist personnel in patient safety and quality, business management, Financial and HR. Supporting our Service Plan, each directorate has a detailed business plan that is monitored on a monthly basis. Each directorate also has its own score cards that form the basis of management conversations throughout the directorate and between the directorates. St John's Hospital, whilst a member of the MWRHG, remains under the governance of its own Board of Management, but is financially accountable by way of Service Level Agreement (SLA) to the CEO of the MWRHG. It is committed to the reform project within the MWRHG but until a legislative solution is enacted, it is legally bound to operate independently. It is envisaged that the publication of the report to the Minister of Health on the establishment of Hospital Groups will provide a roadmap to how this might occur. St John's works constructively with their MWRHG colleagues to ensure success of the new governance arrangements. The SLA with St John's will dovetail with the priority areas of the 2013 Service Plan. **2013 Actions** Priority Area: Quality and Safety Clinical Governance Development Action 2013: Support the development, implementation and monitoring of clinical governance structures within the MWRHG; Priorities include: Drive the Quality Risk and Customer Care agenda through the MWRHG's Directorates and Clinical Governance Committees; Assist and support Clinical Care Programmes for example the AMP, Effective Patient Flow Management Process within the Group. End Q: Q1-Q4. Priority Area: Governance Action 2013: Develop Hospital Board; Appoint remaining leadership roles at Executive and Directorate level; embed new organisational structures and strengthen clinical governance by the establishment of a Clinical Governance Framework; Continue to foster and promote the concept of the one hospital. End Q: Q1; Q1; Q1; Ongoing. **For information:** The primary focus in 2012 was on strengthening governance. This was achieved through the establishment of Clinical Directorates and a new model of corporate and clinical governance. Key areas of patient safety concerns were focused on and a change in how business was done driving efficiency through the creation of a single hospital system, breaking down traditional barriers and the utilisation of the total capacity of the organisation to progress the delivery of targets for scheduled and unscheduled care, implementation of commitments as set out by the National Cancer Control Programme (NCCP) and the National Clinical Care Programmes.

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Key priority 2013:* Ensure alignment between hospital and pre-hospital, primary and community services at both a strategy and operational level. **GP Forum** In an effort to improve communications with the GPs of the region, a GP Forum is proposed as a joint initiative between the Clinical Directors and GP representatives. This forum will provide a platform where service initiatives and issues can be addressed in a meaningful manner that will be mutually beneficial.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *Priorities for 2013 include:* ▪ Implement the EWTD in respect of interns ▪ Implement revised rosters for Senior House Officers (SHOs), Registrars and Specialist Registrars that maximise EWTD compliance ▪ Issue guidance regarding measures to reduce hours and standards which should be met in terms of hours worked and rostering practices in place **Workforce Position** The Employment Control Framework 2013 requires us to maintain the general moratorium on recruitment and promotion in place since 2009. All recruitment decisions to fill vacancies are to be by exception and subject to rigorous assessment, control and compliance requirements and will be devolved nationally to the Executive Management Team to allow for employment decisions to be made as close as possible to the point of care. The Employment Control Framework 2013 requires a reduction of approx. 4% which includes an allowance for the recruitment of new service developments. The workforce will have to continue to undergo major overhaul, downsizing and has to be reconfigured to deliver more for less in terms of employment levels and costs during 2013. **Public Service Agreement (2010-2014)** The single hospital and its management by directorates require a new level of flexibility that has not been required or experienced in the hospitals heretofore. During 2012, the Group used the PSA process to achieve a number of its objectives, e.g. staff from St John's Hospital transferred to the MWRHL as part of the rationalisation of services. These opportunities will be critical in 2013 along with the progression of the restructuring plan and the appropriate redeployment of resources to best meet the needs of the group. **Recruitment Policy** A Director of HR was appointed in November 2012 and we are in the process of setting out the organisational and functional structures for the HR service. While we must retain and develop local recruitment staffing expertise to

	ensure we retain flexibility to respond to our business needs, the Group will continue to utilise the services of the national recruitment service (NRS) as appropriate. An Internal Employment Control Group has been developed to decide on HR issues including the approval/non approval of posts, and decisions on training and development requirements. This is considered the most appropriate mechanism for the control of WTEs within the Group whilst considering the difficult balance between patient safety and risk versus financial management. Recruitment will be confined to new service developments and the filling of vacancies by exception. **Management of Absenteeism** During 2012 we have invested in staff development in the management of attendance. We have also had independent audits of our processes so that we can learn from what is working and what needs further improvement. These efforts have proved successful in 2012 with a reduction in the percentage of absenteeism in each hospital within the group, the most significant reduction being from a high of 8.3% down to 3.69% in one area. In 2013 we will continue to manage absenteeism aggressively and reduce the level of absence to assist us in moving closer to the national target of 3.5%. This will be achieved through further training of managers, closer monitoring and regular audits to ensure compliance with the Managing Attendance Policy. **Agency & Overtime Policy** Greater controls on agency and overtime are being introduced which will focus on reducing the level of both overtime and agency being utilised across all areas within the hospital group. A policy for the hospital group has been developed to create greater awareness on this issue and clearly outline the controls to limit the use of agency & overtime. This will result in agency and overtime only being used where no alternative exists for short term need in situations of critical service/safety need. **Performance Management** The implementation of an individual and team based performance management system is a key objective for 2013. This will be achieved through the Directorate structures. **European Working Time Directive** A NCHD workforce plan will be developed to address areas such as overtime, agency, EWTD compliance, rostering, skill mix and training. In particular, a management action plan will be developed and the recently published National Standards for reducing NCHD hours will be used to benchmark our performance on implementation. This work will be led by the Medical Manpower Unit on behalf of the Directorates. **Education Training and Development** The attainment of the standards as a university teaching hospital is very important to the MWRHG. We will be working closely with the University of Limerick during 2013 on a number of existing and new ventures, these include

	the development of new academic posts in Nursing and Radiology and new research ventures. It is tempting to ignore the important areas of education and development when resources are scarce. We will be prioritising statutory and mandatory training, and will be exploring more innovative delivery mechanisms. We will also focus on areas where training needs have been identified that are associated with patient safety concerns. A training plan to address the service needs of all grades of staff across the group will be developed in response to the needs of the Directorates. This will be rolled out in 2013 and evaluated to ensure that the training meets the needs of the service and provide a return for the group. **For information:** During 2012: They operated within the Groups' employment ceiling.
Funding	**Recommendation/considerations:** Our outturn for 2012 was €250.445m. Our projected costs for 2013 are €260.103m. The difference between our outturn 2012 and our projected costs for 2013 is €9.658m. The reason for the additional costs is accounted for as follows:- ▪ full year effects of 2011/2012 clinical developments ▪ historical liabilities to St John's Hospital ▪ new revenue costs of the critical care facility ▪ Provision for adjustments in pay costs associated with national agreements and entitlements As set out above our budget allocation for 2013 is €238.344m which represents an uplift of €21.739m on our 2012 budget but against out projected costs for 2013 this leave a financial challenge of €21.759m. **For information:** During 2012: We have retained our financial position in 2012 despite a number of unfunded cost pressures and a significant increase on activity. **For 2013: Resource Framework** The NSP 2013 seeks to address legacy issues and give the hospital group a more realistic allocation for 2013 with an increased emphasis on performance management and accountability. This is very much welcomed by the group. Despite this budget adjustment, 2013 will be a very challenging year for us due to the historical scale of our deficit and the elements of the cost base that need to be addressed. We have developed a cost containment plan that is aimed at breaking even. This plan is based on a number of assumptions and like all assumptions there are risks that these assumptions may not be realised, e.g. if our assumptions on income are not realised or demand growth is required to maintain our targets, we will then have to find other measures to address this shortfall. There is a degree of uncertainty at this point regarding our work force as we do not have good visibility on the impacts of the

	proposed schemes aimed at reducing headcount and the impacts these will have on our services and financial plan. This will be monitored closely so that remedial action can be taken quickly if required.
Other	**Recommendation/considerations:** **Improving Quality and Delivering Safe Services** Quality & Safety is about delivering effective care to patients, improving quality and protecting people from harm and is all our responsibility and a priority for the MWRHG. Integrated corporate and clinical governance enables us to deliver the leadership and accountability systems to achieve this. The MWRHG Patient Safety and Quality Directorate will support the Clinical Directorates to manage quality and safety within their directorates. We are focusing on the development of the provision of healthcare where service users attending our services receive high quality treatment at all times, are treated as individuals with respect and dignity, are involved in their own care, have their individual needs taken into account, are kept fully informed, have their concerns addressed, and are treated / cared for in a safe environment based on best international practice. The National Standards for Safer Better Healthcare, were launched in 2012, and will drive improvements for patients by creating a common understanding of what makes a good, safe, health service. The National Standards for Safer Better Healthcare will be implemented and will support frontline services to drive quality improvement in response to these standards. ***Priorities for 2013*** ▪ Outline a robust quality and safety management structure to include accountability arrangements with clear lines of responsibility for quality and safety within the MWRHG. ▪ Ensure core processes for quality and safety management are defined, communicated, implemented and monitored in a sustainable manner in all areas within the hospitals group (e.g. risk registers, incident management (including the management of serious incidents), serious incident escalation, compliance with relevant standards/legislation EU Directives and continuous quality improvement (CQI). ▪ Provide mechanisms to support the professional development and networking of quality and safety within the MWRHG to assure adequate capacity and capability. ▪ Promote best practice and share learning to improve Quality and Patient Safety within the MWRHG ▪ Provide the CEO and the Executive Management Team with assurance in relation to the progress and performance of the Quality & Safety priorities. **For information:** *Focus in 2013:* ▪ Address patient safety and quality issues

	▪ Pursue efficiencies to ensure we maximise available resources to progress the delivery of targets for scheduled and unscheduled care ▪ Control HCAI and ensure our hospitals meet hygiene standards ▪ Implementation of commitments as set out by the National Cancer Control Programme (NCCP) and the National Clinical Care Programmes. A number of ICT priorities are outlined for 2013 [refer to document for further information].
Impact	The Health Service Executives (HSE) National Service Plan (NSP) for 2013 was approved by the Minister for Health, Dr James Reilly TD on 9th January 2013. The NSP sets out the type and volume of services the HSE will provide directly and through a range of funded agencies, during 2013. These health and social care services must be delivered within the funding provided by Government and within the stipulated employment levels and is informed by the Department of Health's (DoH) Statement of Strategy 2011 – 2014 and Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015, both of which set out the Government's priorities for the health services.

Table 24 Securing the future of smaller Hospitals: A framework for development [2013]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE and DoH[24] Securing the future of smaller Hospitals: A framework for development [2013] Framework
The health service system (including health service reform)	**Recommendation/considerations:** Under the Programme for Government 2011-2016, we are committed to developing a universal, single-tier health service, which guarantees access to medical care based on need, not income. The Government will introduce a system of Universal Health Insurance which will end the present unfair two-tier service. A key part of the new system will be to develop independent not-for-profit hospital trusts in which all hospitals will function as part of an integrated group. Already, the Minister for Health has announced his intention to establish hospital groups as a first step towards hospital trusts. Each Group will have a management team headed by a Group Chief Executive, with responsibility for performance and outcomes, operating within clearly defined budgets and employment limits. We believe that the best way forward will be for smaller hospitals to operate initially within Hospital Groups and ultimately within the proposed new system of independent hospital trusts. This will be a locally effective way of ensuring that hospitals deliver on the access requirements set by the Special Delivery Unit, within the budgets set by Government and the safety and quality requirements set by Health Information Quality Authority. There is much work to be done on organising our acute hospital services appropriately, to ensure that they are safe, of high quality and efficient. In this Framework we focus in particular on the role of nine smaller hospitals which have been the subject of particular attention from the HIQA: ▪ Dublin North East: - Our Lady's Hospital Navan - Louth County Hospital Dundalk ▪ Dublin Mid Leinster: - St. Colmcille's Loughlinstown ▪ South: - Mallow - Bantry ▪ West: - Ennis

	- Nenagh - St. John's Limerick - Roscommon County Hospital **Characteristics of a Model 2 Hospital** The future growth in healthcare will be in the services such as ambulatory care (including chronic disease management and day surgery), diagnostics and rehabilitation which will be based in model 2 hospitals. As a result of these emerging models of healthcare delivery and the ageing population, the total volume of activity of the model 2 hospitals will grow substantially. Model 2 hospitals will be part of a network of hospitals operating as single departments such that: 1. linked specialist services to these units will be under the governance of a single directorate embracing the model 2 Hospital with linked model 3 or model 4 hospital(s); 2. this single governance will be reflected in the appointment of Clinical Directors across the Hospital group and make provision for staff to move between sites, as appropriate; and for care to be provided on two sites there must be access to the full records on each site, including letters, clinical notes, operating notes, laboratory and other data. **For information:** The successful implementation of the Framework for Smaller Hospitals, within the context of Hospital Groups, provides the opportunity to deliver safe and effective care at the lowest level of complexity and closest to the patient's home. It also provides the opportunity for smaller hospitals to have a sustainable and central role into the future.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** <u>Developing the role of smaller hospitals</u> We can and will expand the services delivered in smaller hospitals, especially in services such as : ▪ day surgery (e.g. cataracts, hernia repairs, gynaecological procedures, and other surgeries that can safely be done in a day-based environment) ▪ ambulatory care (including chronic disease management and assessment for older persons) ▪ medical services (including cardiac failure clinics, cardiac rehabilitation, COPD outreach and clinics, rheumatology, dermatology, diabetic day centre, rehabilitation, and a range of others depending on local policies and protocols) ▪ diagnostics (including blood tests, X-rays, endoscopy, bronchoscopy and sigmoidoscopy). Much of this type of work is still carried out largely in the bigger hospitals, despite the other pressures facing them. It makes little sense to retain all of these services in bigger hospitals when they can safely be carried out in the smaller facilities. Transferring even some of this work frees the larger units to concentrate on the

	treatments that only they can provide. It also brings more services closer to local communities, since they will not have to travel to the larger hospital for them. We also recognise that some services cannot safely be provided in smaller hospitals, and that they need to be moved in a planned way to the larger hospitals best placed to provide them. Again however, we will not assume that larger hospitals are automatically safer. They must be properly organised and all hospitals will ultimately be subject to licensing requirements for quality and safety. ***Overview of services at a Model 2 Hospital*** ▪ The hospital will have a daytime Urgent Care Centre comprising a Medical Assessment Unit and Local Injuries Unit which will be open where feasible 7 days a week. ▪ Subject to local consultation consideration should be given to supporting the provision of onsite GP out of hours services as already exists in a number of locations. Pre hospital care needs to be developed with appropriate linkages to primary care, especially GP out of hours services in rural areas. GPs will refer selected medical patients (i.e. unlikely to require high intensity cardiopulmonary and/or neurological support) for assessment in the MAU during daytime hours. ▪ Patients will self-refer to the daytime Local Injury Unit or co-located GP OOH services. ▪ The hospital will see and admit medical patients on a 24 hour basis. It will provide in-patient and out-patient care for low risk differentiated medical patients who are not likely to require full resuscitation. All patients will have an appropriate care plan. ▪ The hospital will provide day surgery and will have the capacity to admit some of these patients overnight based on pre agreed criteria (as discussed below in relation to surgery). ▪ The hospital will be able to provide the vast majority of outpatient services. ▪ Patient flow will be enhanced by expanded nursing and therapy practice (e.g. nurse prescribing of medicinal products and ionising radiation/X-rays and therapy facilitated discharge). These services will be developed in response to service need. ▪ All model 2 hospitals must have an in-house clinical pharmacy service or formal access to, and reporting relationship with, the service in a model 3 or model 4 hospital. ▪ The Hospital Group must have a person trained and responsible for infection prevention and control on site and formal access to advice from a consultant microbiologist/infectious disease physician. ▪ Medical and Critical Care Services for a Model 2 Hospital ▪ This hospital will not have an ICU, so the patient will be assessed and tracked using the national early warning score and where appropriate, this score will prompt an acute medicine response and if necessary, transfer to the associated model 3 or model 4 hospital. ▪ The following applies to anaesthesia/ critical care requirements of Model 2 Hospitals

	- An adequate retrieval service needs to be in place to allow model 2 hospitals accept low risk medical inpatients due to the potential that these patients may deteriorate and require urgent critical care and transfer into the associated model 3 or 4 hospitals. - Medical staff who are providing inpatient and walk-in treatment within the model 2 hospital need to be Advanced Cardiac Life Support certified and have completed the BASIC (Basic Assessment and Skills in Intensive Care) course or equivalent. - Medical staff who are training in acute medicine support should ideally rotate through critical care rotations and such rotations should be developed and implemented. - The implementation of the new roles for model 2 hospitals will require a plan for managing anaesthetic/critical care requirements of patients in each location. The redeployment of anaesthetic staff to cover the enhanced critical care activity in the model 3 and 4 locations should not occur until on site medical staff in the Model 2 hospitals are Advanced Cardiac Life Support certified and have completed the Basic Assessment and Skills in Intensive Care or equivalent, and that the retrieval service to the associated model 3 or 4 hospital is in place. A patient's condition may deteriorate and after treatment, patients with acuity of ICS Level 2 unstable or Level 3 will require critical care retrieval and transfer to ICU in a model 3 or model 4 hospital. ▪ There will be guaranteed acceptance of transfer of all patients who deteriorate by the associated model 3 or model 4 hospital (bi-directional patient flow must also occur as required). ▪ Patients requiring palliative care, respite, rehabilitation and pre-discharge care and low risk differentiated patients with direct GP to consultant referral (via MAU) can be admitted to this hospital. ▪ Patients will be admitted from the MAU under the care of a named consultant, and out-of-hours selected medical patients can be admitted by agreement between the G.P. and the on-call medical team/consultant. ▪ The medical department and medical staff need to be part of a wider rotation under the governance of the acute medicine service in the linked model 3 or model 4 hospital. During the day there will be appropriate NCHD presence in the MAU and wards. ▪ The medical staffing at night will be a resident medical registrar/SpR +/- a senior house officer (both of whom are advanced cardiac life support [ACLS] certified with formal assessed training in airway management). In addition there will be a consultant on-call. ▪ Nurse staffing at night will include a nurse manager/supervisor for the nursing services. ▪ Therapy staffing will be senior grade to staffing complement managed across hospital group to ensure appropriate expertise and supervision on model 2 sites. Clinical specialists in model 3 and model 4 hospitals will provide advice and/or support as required. ▪ Standards of care should be measured and should be comparable to those delivered in model 3 and model 4 hospitals. ▪ The following day services are appropriate based on local need and capacity:

	– Day services/ambulatory care assessment for older persons – Antenatal care/postnatal care – Gynaecology Clinics – Full range of Endoscopy (Bronchoscopy, Cystoscopy, Colonoscopy, OGD, Sigmoidoscopy), – PEG tube insertion – Non-invasive cardiology – Cardiac failure clinic – Cardiac rehabilitation service – Venesection, infusion and transfusion therapy – Bone marrow aspiration and trephine biopsy – Abdominal paracentesis and thoracentesis – Lumbar puncture – Diabetic day centre including foot care and eye care – Rheumatology day services/Clinics – Dermatology day services/Clinics – Oncology/haematology day ward/Clinics – Mental health day services/Clinics – COPD outreach/Clinics – Pulmonary rehabilitation/Clinics – Hepatology day services/Clinics – Diagnostic imaging – Rehabilitation day services/Clinics – General Rehabilitation medicine – Prosthetic and Orthotic clinic – Other services, depending on local policies and protocols. The following additional services apply to Model 2 hospitals: ▪ **Acute Cardiology:** Patients should be managed according to referral guidelines and clinical protocols. An out-patient clinic session should be provided by a visiting cardiologist one day per week to review the results of non-invasive tests. Patients with acute presentations should be transferred to a model 3 or model 4 hospital according to protocol. ▪ **Ambulance Services:** Ambulance services will develop protocols for ambulance transfer to and between hospitals in consultation with GPs and Hospital staff. ▪ **COPD:** In-patients will have care up to, and including, non-invasive ventilation (NIV) where appropriate based on careful patient selection.

	▪ **Diagnostic imaging:** Plain film X-ray, ultrasound and CT-scanning including CT or US guided procedures. The diagnostic imaging service should provide at a minimum timely and direct access to GPs for plain film X-ray and ultrasound. There will be an on-call diagnostic imaging service with access to 24-hour reporting for specific modalities from the model 4 hospital. The on-call diagnostic imaging service on site will support GP OOH services. ▪ **Heart failure:** A heart failure services will be established under the governance of a lead consultant physician. Selected heart failure patients with a clearly defined care plan who develop decompensated heart failure may be admitted. There will be a rapid access clinic for out-patient IV therapy to stabilise patients with deteriorating hear failure. A full out-patient service for diagnosis and specialist review will be provided. ▪ **Palliative Care:** Patients with palliative care needs may be managed in model 2 hospitals with appropriate support from the specialist palliative care services as required. Services provided in model 2 hospitals should be sufficiently flexible and integrated with specialist palliative care services to allow rapid and efficient movement of patients from one care setting to another depending on their clinical needs and personal preferences. Admission criteria, discharge protocols and interface with specialist palliative care services will be according to agreed national palliative care services will be according to agreed national palliative care programme protocols. Specialist Palliative Care services may be developed locally and linked to Model 2 hospitals. ▪ **Rehabilitation:** The Model 2 hospitals can function as a regional centre for specialist rehabilitation. Patients will be treated by a local specialist rehabilitation team which may be led by consultants in specialities other than Rehabilitative Medicine and staffed by therapy and nursing teams with specialist expertise in the target condition with support from specialist rehabilitation medicine services. Patient goals are typically focused on restoration of function/independence and co-ordinated discharge planning with a view to continuing rehablilitation the community. ***Emergency Medicine Services*** A Local Injury Unit (LIU) will be located in a model 2 Hospital and will aim to provide unscheduled emergency care for patients with non-life threatening or limb threatening injuries, as conveniently as possible, while ensuring patient safety and equitable standards of care within an Emergency Care Network. LIUs will be open to new patients where feasible 0800 – 20:00 hrs (or 18:00hrs) followed by two-hours of ongoing clinical work for the completion of patient care. ***General issues relating to Local Injury Units*** ▪ A Local Injury Unit will be located in a model 2 hospital and will be part of an emergency care network and linked to a lead Emergency Department within each network. ▪ The Local Injury Units will operate under the clinical governance of the Network Coordinator for Emergency Medicine.

	▪ There will be no Clinical Decision Unit on site. ▪ Administrative functions will be centralised within the network and only direct patient contact administrative function (i.e. reception) will be based at the Local Injury Unit. ▪ Telemedicine may contribute to clinical care in the Local Injury Unit. ▪ The unit will be open to new patients for limited hours' access, followed by two hours of ongoing clinical work for the completion of patient care . ▪ Patients may self-present or be referred by GPs with non-life-threatening or non-limb- threatening injuries. ▪ Patients whose care needs cannot be met at these units will be transferred directly to networked Emergency Department. ▪ Paediatric patients (i.e. aged under 16 years) may attend, according to network protocols. The Network Co-ordinator in EM and the PEM Lead Clinician will develop protocols and procedures to ensure the safe management of children who access care at Local Injury Unit. All clinical staff in units accepting children will be trained in paediatric life support and in the recognition of non-accidental injury. These units will be integrated into regional and national PEM networks. ***Surgery*** From a surgical perspective Model 2 Hospitals can be further divided into: ▪ Those that only perform Day Surgery – Model 2D ▪ Those that perform Stay Surgery (as well as Day Surgery) – Model 2S ▪ Those that are more than 60 kilometres (Remote/Rural) from the nearest Level 3 or 4 hospital – Model 2R Surgical services in Model 2D and Model 2R hospitals Surgical services and activity planned in Model 2 hospitals should take account of and complement the nature of Medical services which exist in their unit. Good management of surgical services demand that: ▪ The Department of Surgery should be managed under the governance of a single unit including the Model 2 hospital and the linked Model 3 or 4 hospital(s). ▪ This governance structure should be overseen by a single Clinical Director, with surgical (Consultants, NCHDS, Nursing) and other staff moving between sites, as appropriate. It is important for the department to be able to 3.5 Surgery1 From a surgical perspective Model 2 Hospitals can be further divided into: ▪ Those that only perform Day Surgery – Model 2D ▪ Those that perform Stay Surgery (as well as Day Surgery) – Model 2S ▪ Those that are more than 60 kilometres (Remote/Rural) from the nearest Level 3 or 4 hospital – Model 2R Surgical services in Model 2D and Model 2R hospitals Surgical services and activity planned in Model 2 hospitals should take account of and complement the nature of Medical services which exist in their unit. Good management of surgical services demand that: ▪ The Department of Surgery should be managed under the governance of a single unit including the Model 2 hospital and the linked Model 3 or 4 hospital(s).

	▪ This governance structure should be overseen by a single Clinical Director, with surgical (Consultants, NCHDS, Nursing) and other staff moving between sites, as appropriate. It is important for the department to be able to rehabilitation and pre-discharge care. ▪ The hospital Minor Injuries Unit will require surgical consultation from time to time. Patients requiring acute surgery should be transferred to the local Model 3 or 4 hospitals. Protocols for management of minor urgent procedures (for example, those requiring relatively minor procedures under GA such as suturing or abscess drainage) should be developed and defined at a local level. It would be hoped that there would be scope to deal with these minor. ▪ emergencies on site, rather than transfer to local Model 3 or 4 unit. Consideration might be given to the reservation of an emergency theatre slot on one list on a daily basis. ***Surgical Services in a Model 2S Hospital*** The Model 2S Hospital is proposed for use in certain circumstances. These would be Model 2 Hospitals which work geographically close to and administratively part of a group or network with a Model 3 or 4 hospitals. The purpose of a Model 2S hospital would be to provide additional designated capacity for elective surgery for the parent Level 3 or 4 Hospital. A Model 2S hospital would have all the features of a regular Model 2 hospital undertaking the agreed basket of day case procedures. In addition, it would seek to expand its workload to include more complex elective surgical procedures in otherwise relatively fit patients. This would be subject to local agreement between management and clinicians (anaesthesia, surgery & nursing) as to what could be safely delivered within the context of local staffing, capacity and peri-operative care. A Model 2S hospital, from a surgical perspective, is an elective hospital which, as with all Model 2 hospitals, receives no unscheduled, undifferentiated medical or surgical patients. From a medical perspective the service that is delivered should be identical to that described above for a standard Model 2 hospital except for the presence of a Surgical Observation Unit which would be exclusively required for surgical patients. The concept behind a Model 2 hospital is to provide an elective surgical unit with designated or protected beds - beds that may be otherwise difficult to rely on in the neighbouring Model 3 or 4 hospitals. The surgery and anaesthesia programmes support the good practice principle that elective surgical services should be separated from emergency admissions whenever possible. In addition, a physical separation of services may help in dealing with differences in clinical management that arise between elective and emergency care, as well as facilitating the fixed designation of beds. Finally, MRSA-protected elective wards avoid admissions from the emergency department and transfers from within/outside the hospital. As well as separating elective from emergency care, elective surgical procedures can be divided into minor, intermediate and complex. Most minor and intermediate surgery should be performed as day procedures. This activity can and should be performed in a Model 2S hospital, in the same manner as planned for Models 2 and

	2R hospitals. Model 2S hospital will have the potential to locally decide on the feasibility and capability of their unit to carry out intermediate and complex surgery, which could not be carried out on a day case basis and would require in-patient stay and accommodation. These patients would still be worked up as for day care, with a planned admission on the day of surgery (DOSA admissions). ***Surgical Services in a Model 2S Hospital:*** ▪ The Department of Surgery should be managed under the governance of a single unit including the Model 2 hospital and the linked Model 3 or 4 hospital.(s) ▪ This governance structure should be overseen by a single Clinical Director, with surgical (Consultants, NCHDS, Nursing) and other staff moving between sites, as appropriate. It is important for the department to be able to communicate and work as a single unit. In addition, clinical staff must have sufficient working time in the larger unit so that they don't deskill in the management of more complex cases. ▪ For patient care to be provided on more than one site, a robust mechanism needs to be planned and delivered such that full patient records, including letters, clinical notes, operating notes, laboratory and other data are available in a timely manner, in order to deliver a safe service9 ▪ Out-patient, pre- and post-operative care and Pre-admission Assessment should be provided at either site for all patients requiring surgery. ▪ All surgery should be supported by a Pre-operative Assessment Clinic. ▪ Less than '5-day care' surgical procedures could include intermediate or complex operations carried out by a variety of surgical specialties including General, Gynaecology, Maxillofacial, Otolaryngology Ophthalmic, Plastics, Vascular and Urology. They should be appropriate to less than 5-day stay surgery in a Model 2S hospital, not anticipating admission to HDU or ICU post-operatively. ▪ Local implementation teams should, following multi-disciplinary collaboration, develop the capacity, policies and protocols to manage post-operative overnight admission on a planned basis, taking into account their specific situation and service configuration. All plans should deliver best practice in relation to patient safety and clinical risk management. ▪ No patient should have a planned, anticipated need for HDU or ICU care post-operatively. ▪ Patients requiring specific fluid management or analgesic requirements (PCA, Patient controlled Anaesthesia or, if decided upon and justified locally, a nurse provided epidural service) should be managed in a Surgical Observation Unit (SOU - 3-4 bedded). ▪ The NEWS "Emergency Response System" will facilitate post-operative patient assessment and tracking. There should be a defined response to a critical event (surgical complication/ deterioration in respiratory function, GSC etc.) with early transfer and mandatory acceptance to Critical Care in the associated model 3 or 4 hospital. This should be protocol driven with transfer facilitated by the regional Critical Care retrieval service.

	▪ Out of hours staffing should include an appropriately qualified senior nurse (COMPASS certified in NEWS) and an experienced, resident NCHD (SHO at >BST 2 or Registrar), surgical or medical or equivalent doctor – provided he/she is working with appropriately trained nurse in post-operative care. In the case of non-surgical cover there should be clear protocols for communication and escalation. ▪ A senior on-call Surgical or Anaesthetic opinion should be available as needed (Consultant or SpR in last their 2 years of training). This should be provided by the on-call team at the neighbouring Model 3 or 4 hospital and this needs to be protocol driven and managed locally assuring a rapid, safe and appropriate response. Patients who have a surgical complication out of hours that cannot be managed on the ward of the Model 2S hospital should be transferred without delay to the neighbouring Model 3 or 4 Hospital where there should be access to specialist services. ▪ All patients should have a discharge plan developed from the outset of their surgical journey. ▪ Care will be provided for surgical patients requiring palliative, respite, rehabilitation and pre-discharge care. The Hospital Minor Injuries Unit will require surgical consultation from time to time. Patients requiring acute surgery should be transferred to the local Model 3 or 4 hospitals. Protocols for management of minor urgent procedures (for example, those requiring relatively minor procedures under GA such as suturing or abscess drainage) should be developed and defined at a local level. It would be hoped that there would be scope to deal with these minor emergencies on site, rather than transfer to local Model 3 or 4 unit. Consideration might be given to the reservation of an emergency theatre slot on one list on a daily basis.
Governance	**Recommendation/considerations:** Overall governance ▪ All hospitals (ranging from model 2 to model 4 hospitals) must operate within single Hospital Groups. ▪ Smaller hospitals provide a unique and essential opportunity for the undergraduate and post graduate training of all our healthcare professionals. To ensure these benefits are realised, education and training should be organised on a network basis across the Hospital Group. In addition staff working within smaller hospitals need to be full participants in network-based continuous professional development programmes. ▪ Smaller hospitals need to be full participants in a comprehensive clinical governance infrastructure for the Hospital Group. ▪ Doctors (including consultants and junior doctors) should be appointed to single departments which operate across the Hospital Group. Junior doctors should rotate across the Hospital Group as part of their training. ▪ A single executive structure and function should be implemented across the Hospital Group to ensure that the hospitals operate as effectively and efficiently as possible. There should be GP representation in the governance structures.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** All hospitals, irrespective of size, as well as associated GP and community services, must work together in an integrated way. Co-operative working is key to success, and hospitals in each area will need to work all the more closely to meet the needs of patients. This must happen nationwide and within regions with:

	▪ improved speedier communications (to be certain everyone clearly understands their own and each other's roles and how they interact) ▪ better emergency patient transport and improved access to diagnostic services including direct access for GPs to key diagnostic services ▪ improved staff flexibility (with more rotation between hospitals of key staff to allow staff to gain more experience and to provide more services locally in smaller hospitals). **The Critical Links with Primary Care** It is well recognised that primary care can safely manage locally the majority of patients who require only a routine, straightforward level of urgent or planned care. Treatment can be delivered at home or as close to home as possible. The aim of developing primary care is to provide up to 90% of the health and social care in local communities. This will be achieved through an increase of activity in a primary care setting and the redirection of health services away from acute hospitals to the community. Key to service integration is the promotion of capacity building in the community. This includes the use of smaller hospitals in a local community where appropriate. Patients in an integrated system are more likely to receive the type and quality of care they need, when they need it, in the most appropriate setting and from the most appropriate health professional. Effective integration of care is easier to achieve where primary care team professionals assume key significance in the healthcare system through their role as gatekeepers to specialist referral. Out-reach clinics in primary care will be an important means of developing more effective patient care. For example, at least a proportion of the return visits to outpatient departments are for the purpose of monitoring, which could be just as effectively and much more cheaply carried out in primary care. Anti-coagulant therapy is one example of a treatment currently confined to outpatient departments in Irish hospitals at present but which could be carried out in the more appropriate setting of primary care. A number of other areas of primary care can benefit both primary care teams and the smaller hospitals working together more effectively. These include: ▪ more structured chronic disease management interactions that are better planned and managed ▪ more opportunities for patient education and self-management classes in the hospital with shared primary care responsibilities for providing this education service ▪ opportunities for GPs and other primary care professionals to work in the Urgent Care Centres and as part of out-reach teams ▪ better opportunities for GPs to refer to low complexity day procedures and access beds for procedures ▪ enhanced opportunities for primary care professionals to play a role in palliative, rehab and pre-discharge care ▪ IV therapy provision ▪ minor Surgery provision

	▪ nebuliser treatment in the case of acute asthmatic attack ▪ specialist therapy treatment. In addition, the management of chronic diseases is a clear example where close cooperation between primary care and smaller hospitals can bring very positive results. Chronic disease forms the backbone of much workload in general practice, making the extension of primary care work into a smaller hospital a logical step. Many patients with a chronic disease do not require the high technology of higher level hospitals and engagement in smaller hospitals can promote innovation and enhanced service delivery more easily than in larger settings with huge benefit both to patients and hospitals alike. Finally, it is important to acknowledge the existing links that already exist between primary care and smaller hospitals. We want to cultivate and increase these links to the benefit of all patients. The strengths of existing arrangements, which we will seek to develop further, include: ▪ local services: smaller hospitals provide more convenient services and less costly access for their local population. The theme of patient choice is welcomed and at the heart of general practice. direct and timely access to key diagnostic services ▪ appropriate services: smaller hospitals will provide a range of safe and appropriate services often with considerable cost benefits. The range of services can evolve to meet local needs and will not require the large capital outlay essential for many larger hospitals; ▪ modern staffing structures: smaller hospitals could link with out-of–hours primary care services based in these hospitals ▪ improved skill mix: GPs working with smaller hospitals value the close relationship they can develop with visiting consultants, and may be able to work alongside those consultants as GPs with special interests. Long before this role was conceived, most GPs used their smaller hospitals to carry out many minor operations; and- ▪ extended outpatient services: these can benefit patients as there is often easier access at a convenient location (especially for older people), and peripheral clinics reduce the pressure and congestion at the larger hospitals. For medical staff, the contact and communication is improved between GP and consultant.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *Workforce issues for Local Injury Units* ▪ Local Injury Units will be under the governance of Consultants in EM from the lead ED in the Hospital Group. There will be at minimum two half-day sessions of Consultant presence in any week, provided by one or more Consultants. ▪ Network Consultant staffing arrangements will include this commitment to Local Injury Units. ▪ NCHDs, primarily middle-grade doctors, will contribute to patient care and a middle grade doctor will be present on site at all times. Medical staff may rotate to EDs in the Group, according to local arrangements.

	▪ The recruitment and clinical supervision medical staff working in Local Injury Units will come under the governance of the Coordinator for Emergency Medicine in the Hospital Group. ▪ Teams of Advanced Nurse Practitioners (ANP) will provide most of the clinical care in these units and will work within the network clinical governance structures. Highly skilled, experienced ANPs will be needed to work in these units as there will not be a Consultant in Emergency Medicine on-site. ▪ Nursing staff will provide a supporting role for ANP and medical staff. ▪ Dedicated administrative staffing for patient reception and registration will be required for the duration of hours of opening of the unit, seven days a week. ▪ There are potential benefits to Local Injury Units being developed in partnership with the local General Practice community. In addition, there is an opportunity for GPs who wish to do so to work in Local Injury Units. The governance, training and work practice details will be developed in consultation with the relevant stakeholders. ▪ Staff will rotate through networked units for education and CPD. CPD and education will be provided within the Emergency Care Network and through eLearning and other linked supports. All staff will rotate from the Local Injury Unit to the network centre for mandatory training, education and CPD.
Funding	No information identified.
Other	No information identified.
Impact	No information identified.

Table 25 University of Limerick Hospitals Group (ULHG) Operational Plan [2014]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	University of Limerick Hospitals Group (ULHG)[25] University of Limerick Hospitals Group (ULHG) Operational Plan [2014] Plan
The health service system (including health service reform)	**Recommendation/considerations:** In 2013 (adoption of recommendations/considerations): Achieved full Implementation of the Small Hospitals Framework across all three Model 2 Hospitals. Implemented a new model of care for acute medicine with the development of Acute Medical assessment Unit and Medical Assessment Units in each of the JEN hospitals. *Strategic plan 2013-2016 priority:* To develop a functioning single hospital across multiple sites and implement a development plan for new and existing physical facilities to ensure a better patient experience across UL Hospitals. **Public Service Reform** The single hospital and its management by directorates require a new level of flexibility that has not been required or experienced in the hospitals heretofore. During 2013, the Group used the PSA process to achieve a number of its objectives: ▪ The development of a single nursing structure across the hospital group, the redeployment of staff from Ennis and Nenagh hospitals. ▪ The introduction of the recommendations of the Smaller Hospital Framework in both Ennis Hospital and St. John's Hospital. ▪ As part of our single hospital laboratory aim the laboratory staff in Nenagh were redeployed to University Hospital Limerick. ▪ Further reorganisation of the support functions is also ongoing with the unions under the PSA. ▪ The commencement of the reorganisation of the clerical/admin resources, including a central referrals office. ▪ The Haddington Road Agreement came into effect in July 2013, this has brought additional hours for a number of staff grades within the hospital, including Medical, Nursing, Clerical/Admin and Health & Social Care Professional into the system. Both the Public Service Agreement and the Haddington Road Agreement continues to have an overarching impact on Human Resources and Workforce Management across Health Services. Along with reducing staffing resources in UL Hospitals, the challenge will be to maintain access, quality and safety of services, to meet the increase in demand for services.

	▪ Maintaining staffing levels at the approved WTE ceiling is also subject to financial affordability. This will require robust employment control, with accountability from all services managers. Further reconfiguration and reorganisation of existing work and redeployment of current staff as provided for under the PSA through a consultative process will continue to achieve the employment control framework and deliver on government policy on public service numbers within the current budgetary allocation. **For information:** The Minster for Health Dr. James Reilly T.D. established the Mid Western Regional Hospitals Group in January 2012 bringing together the six acute hospitals in the Mid West under a single leadership with the appointment of a CEO. UHL is the only hospital site that has a full 24/7 emergency service and critical care service. There are three Model 2 hospitals2 in the Group EH, NH, and St John's Hospital, collectively referred to as the JEN Hospitals. All three hospitals have being reconfigured to provide service in line with the Small Hospitals Framework published by government in July 2013. **In 2013:** Commissioned our new Intensive Care Unit at UHL Progressed the development of our infrastructure through an aggressive capital programme.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** We are developing a new Emergency Department and additional bed capacity on the site of UHL however, by the nature of capital development this will not all happen in 2014. We have developed and continue to refine our acute medical assessment services in an effort to address the issues that manifest themselves in the emergency department. This coupled with timely sub speciality access to outpatient services and the maximum usage of our beds at Ennis, Nenagh and St John's Hospitals will assist with our delays in ED. **Key priorities 2014:** Improve access to services by reducing waiting times for emergency or unscheduled care and elective or scheduled care. This includes continuing to improve access to out-patient and diagnostic services. Specific targets include: ▪ No adult will wait more than 8 months for an elective procedure (either inpatient or day case) ▪ No child will wait more than 20 weeks for an elective procedure (either inpatient or day case) ▪ No person will wait longer than 52 weeks for an OPD appointment ▪ No person will wait more than 4 weeks for an urgent colonoscopy and no person will wait more than 13 weeks following a referral for routine colonoscopy or OGD ▪ 95% of all attendees at Emergency Departments will be discharged or admitted within 6 hours of registration

	Continue to develop optimal care pathway for differing clinical needs by implementation of the National Clinical Programmes and standards set by the National Cancer Control Programme. Pursue efficiencies to ensure we maximise available resources. ***Planned Actions 2014:*** ULH has an ambitious capital programme. Major development work is currently underway at UHL, NH and EH. In 2014 we will be: ▪ Commissioning new theatres at Nenagh Hospital ▪ Opening additional beds at UHL ▪ Opening interim Paediatric ED ▪ Progressing the current developments underway - New ED – 2016 - Dialysis – 2016 - New Parkinson, Stroke, Breast and Dermatology building – 2015 - Education and research facility in partnership with UL 2016 ▪ Secure capital for the development of a maternity hospital on site at UHL ▪ Implement Single Patient Administration System across six sites (iPIMS). ***Specific priority areas and actions for 2014 [only Acute Medical Programme and Emergency Medicine extracted]*** Priority Area: Acute Medicine Programme Action: Extend AMU function to operate 7/7; Progress the appointment of additional AMP physicians in partnership with national clinical programme; Implement short stay unit to complement the AMU; Develop and expand the MAUs at JEN hospitals; Monitor and achieve AMP targets across the group. Quarter: Q1; ongoing; Q2; Ongoing; Q1 – Q4. Priority Area: Emergency Medicine Action: Continue to streamline patient flow process in the ED; Establish an ambulance handover area; Monitor and improve PET times; Further development of the ICT infrastructure within the ED; Finalised the new paediatric ED area; Progress development of Paediatric Assessment Unit; Finalise plans for the opening of the new ED (2016). Quarter: Q1-Q4; ongoing; Q2; Q1; Q3; Q3; Q3. **For information:**

	2014 is going to be an extremely challenging year for UL hospital as it will be for the entire Health Delivery system. Our challenge may be different to other areas as we are an organisation in a growth and development phase whilst we continue to struggle with inadequate capacity and facilities to meet all the needs of our patients. This manifests itself predominately at the University Hospital Limerick where patients attending our emergency department, regrettably, can experience unacceptable delays in accessing our services. This is something that we are acutely aware of and remain concerned that the solutions to fully address this are not realisable in the short term. **In 2013:** ▪ Improved patient flow between UHL and the JEN hospitals maximising utilisation of all our capacity. ▪ Average length of stay (ALOS) across the group for both Medicine and Surgical was reduced. ▪ National targets of no adult should wait more than 9 months and no child should wait more than 20 weeks for scheduled treatment by end of 2013 were achieved.
Governance	**Recommendation/considerations:** *Strategic plan 2013-2016 priority:* To achieve a well-governed, quality, safe, efficient service; support a common understanding of healthcare quality amongst stakeholders; and promote the health and wellbeing of our staff. **Key Priority 2014:** Continue to review and strengthen our governance especially in relation to QPS **Planned actions:** The UL Hospitals Quality and Patient Safety Department will support the four Clinical Directorates in the delivery of quality and patient safety goals. For 2014 we will build on the work commenced in 2013 to focus on the implementation of the national standards for safer and better healthcare through a programme of ongoing self-assessment and the development and implementation of associated quality improvement plans. **Priorities for 2014** ***[broken down further into specific actions if required]*** ▪ Support implementation of the standards for Safer and Better Healthcare ▪ Strengthen the system of integrated corporate and clinical governance ▪ Build capacity and provide support to all staff to improve quality and patient safety ▪ Promote an integrated risk management system including feedback from patients and service users ▪ Promote an organizational culture of learning to achieve better outcomes and experiences for patients/service users and staff ▪ Continue initiatives enabling optimum standards of infection prevention and control and hygiene. **For information:**

	The primary focus in 2013 was on strengthening governance. This was achieved through the full implementation of Clinical Directorates and the new model of corporate and clinical governance. Key areas of patient safety concerns were focused on and a change in how business was done driving efficiency through the creation of a single hospital system, breaking down traditional barriers and the utilisation of the total capacity of the organisation to progress the delivery of targets for scheduled and unscheduled care, implementation of commitments as set out by the National Cancer Control Programme (NCCP) and the National Clinical Care Programmes. **In 2013:** Further development of our Board – Launched UL Hospitals interim board and developed board sub committees **Control Systems** A number of control systems have been developed during 2013 and they will continue to form part of our governance and assurance arrangements for 2014. These include: ▪ Vacancy Approval Committee ▪ Drugs and Therapeutics Committee ▪ Medical and Surgical Supplies Committee ▪ Medical Equipment and Devices Committee ▪ Accommodation Committee ▪ Clinical Governance Committees ▪ Corporate Risk register ▪ ICT Governance Committee.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *Key priority 2014:* Progress the recruitment of staff to improve our services **Employment Control** The Employment Control Framework requires the health sector to maintain the general moratorium on recruitment and promotion in place since 2009. All recruitment decisions to fill vacancies are the subject to rigorous assessment, control and compliance requirements which have now been devolved to the Hospital Group to allow for employment decisions being made as close as possible to the point of service. The ECF required the workforce in the UL Hospitals to reduce in 2013 with an approved WTE Ceiling in December 2013 of 2943. This number will be adjusted to take account of the additional 30 WTE set out in the 2013 National Service Plan. The requirement to reduce our WTE's will continue in 2014 with a requirement for a further reduction to meet the targets on public sector numbers. We are currently awaiting

	clarification on the exact reduction for 2014. Over the past year the reduction in our WTE has seen us reduce from a WTE outturn figures of 3021 to an outturn figure of 2974 in December 2013. Our normal retirements for 2013 were significantly reduced mainly due to the accelerated retirements in early 2012 and previous exit schemes over the past years. For 2014 a reduction of out WTE will need a strategy to focus on creating further efficiencies that will in turn provide us with an opportunity to offer staff the Voluntary Redundancy Facility. The primary focus has to remain on redeployment, restructuring and reorganisation of the current workforce to deliver services within the budgetary and workforce constraints. **Absence Management** The national target for absence management remains at 3.5%. Over the past 12 months managers and staff have worked to improve attendance at work across all staff grades. Every effort has been made to continue the focus on all measures to enhance the health sectors capacity to address and manage more effectively absenteeism levels, support people managers in better managing the issue, whilst also supporting staff to regain fitness to work and resume work in a positive and supporting environment. Using the independent audits of our processes which had taken place our focus of attention in 2013 was on those areas with the highest levels in 2012. This has resulted in training with managers on how to conduct return to work meetings and where necessary when to invoke the disciplinary procedure. Our efforts in 2013 proved successful in some areas however other areas were challenged with serious illnesses which hampered their progress. In 2014 we will continue to manage absenteeism aggressively with the aim of achieving the national target of 3.5%. This will be achieved through a change in the delivery of training of managers, ongoing support, closer monitoring and regular audits to ensure compliance with the Managing Attendance Policy. In 2014 we also plan to provide training for managers on how to deal with staff presenting with stress which will be run in conjunction with Occupational Health, Employee Support Services and the Psychology services. **Agency and Overtime Policy** Greater controls on agency and overtime were introduced in 2013 which have focused on reducing the level of both overtime and agency being utilised across all areas within the hospital group. A policy for the hospital group was developed to create greater awareness on this issue and clearly outline the controls to limit the use of agency & overtime. This will result in agency and overtime only being used where no alternative exists for short term need in situation of critical service/safety need. However, in 2013 due to significant gaps in the recruitment of NCHD's and in order to ensure that safe levels of care are maintained UL Hospitals have had to rely on agency and or overtime in certain areas. This will continue pose a challenge in 2014 with many NCHD's positions remaining unfilled thus forcing the service to resort to agency cover. **EWTD** UL Hospitals continues to be committed to the implementation of the European Working Time Directive for Non Consultant Hospital Doctors (NCHDs). An EWTD Steering Group is in place and chaired at Executive Management Team Level and the

	work of this group will continue to progress and develop the required changes to bring about full EWTD compliance by the end of 2014. Considerable progress was achieved in 2013 with the elimination of 24 hour working across all specialities. As part of the UL Hospitals commitment to achieving full compliance, the following key priorities for 2014 will include: ▪ Review of workforce plan across all specialities to support full implementation of EWTD by the end of 2014. ▪ Establishment and development of the Lead NCHD role to provide formal linkages with NCHDs and Hospital Management. ▪ Implementation of verification processes on time and attendance patterns as a means of validating compliance within Directorates ▪ Facilitation and integration of an electronic time and attendance recording system as a means of supporting this validation process. ***Risks to EWTD implementation*** One of the major barriers to successful implementation of EWTD compliance for UL Hospitals is the multi-site nature of the services that we deliver. Our services are delivered across 6 sites. Attainment of full compliance will require the recruitment of additional NCHD'S which is both dependant on securing new resources and WTE's to support this. **For information:** In 2103: We operated within our employment ceiling.
Funding	**Recommendation/considerations:** *Money Follows the Patient* From the 1st January 2014, phase one of the Money Follows the Patient (MFTP) approach to hospital funding will be implemented in the 38 hospitals in the country participating in the Case Mix system. This program will be implemented over a number of years. A baseline exercise has been undertaken for a number of selected hospitals to compare actual 2013 activity against target activity and assess variance. University Hospital Limerick is the designated hospital within UL Hospitals to participate at this level. There are a number of limitations for UL Hospitals participating fully in this initiative, mainly, our ICT systems are not of a type and standard to allow full participation in Money Follows the Patient exercises in 2014. Despite this UL Hospitals remains very engaged in discussions regarding the development of Money Follows the Patient and will be in a better position to participate more actively with the introduction and development of our ICT capabilities. UL Hospitals in 2014 is projecting actual net expenditure to be €263.600m versus a current year budget allocation of €235.600m resulting in financial shortfall of €28m. This projected shortfall will be a significant challenge for UL Hospitals in the year ahead. **Financial Challenge** **UL Hospitals**

	2013 Run Rate (€'000): 255,600 **2014 Requirement(€'000):** 263,600 **2014 Allocation(€'000):** 235,600 **Challenge(€'000):** 28,000 **%:** 11.9 **Cost Reduction Measures:** A UL Hospitals Cost Containment Plan has been developed to determine how the projected shortfall of €28m can be potentially bridged. This cost containment plan is not without significant risk and a number of the items included in the plan require National enablers to facilitate delivery. **For information:** ***In 2013:*** Despite a number of unfunded cost pressures and a significant increase in activity our closing balance is at 4.1% variance on budget. The financial outturn for 2013 was €255.6m for UL Hospitals. Our projected outturn for 2014 equates to €263.6m. The difference between our 2013 outturn and our projected costs for 2014 is €8.0m. The main items which are contributing to our additional costs in 2014 are primarily attributable to full year costs for continuation of 2013 service developments and provisions for the implementation of a replacement Patient Administration System. The budget allocation assigned to UL Hospitals for 2014 is €235.6m, which reflects a decrease of €9.877m or 4% on our 2013 outturn budget allocation. The 2014 current budget allocation of €235.6m against our 2014 projected outturn of €263.6m results in a financial challenge of €28m which is an 11.9% deficit on the allocation for 2014. **Income** In 2014, National HSE has a target for increased revenues from private inpatients in public hospitals through revised billing arrangements for private patients, which has been facilitated through the Health Amendment Act 2013. An increased income budgetary target of €4.9m has been set for UL Hospitals. The ability to realise any of this additional income is significantly dependant on private insurance levels remaining at current levels. **Pay and Pay Related Expenditure** In July, 2013 the Haddington Road Agreement came into effect for UL Hospitals staff. A total budgetary saving of €8.2m has been applied to the UL Hospitals in respect of this public service agreement for 2014. Delivering against these budgetary target is a central component of UL Hospitals overall budget plan for 2014. In addition to this public sector agreement, payroll budgetary savings of €585,000 and €417,000 have also been applied in respect of Employment Control Framework (ECF) and Incentivised Career Break (ICB). The hospitals ability to deliver on these budgetary targets is highly dependent on National HSE Schemes being implemented to facilitate these anticipated reductions whilst also ensuring that

	staffing levels remain at adequate levels to provide safe and professional care and services with UL Hospitals. These budgetary targets will be a significant challenge for UL Hospitals.
Other	**Recommendation/considerations:** *Strategic plan 2013-2016 priority:* ▪ To **develop our ICT systems** to significantly enhance the efficient delivery of high quality healthcare. ▪ In collaboration with our academic partner, The University of Limerick, to **promote clinical education and research** within all disciplines and across UL hospitals such that we become a major international centre for education and research**.** **Key priorities 2014:** ▪ Patient safety and quality across our hospitals is at the centre of all decisions and actions ▪ Progress the implementation of standards for safer and better healthcare ▪ Progress the implementation of our ICT Strategy with the deployment of a new Patient Information System ▪ Progress our agenda with the University of Limerick with the ongoing development of joint Professorial appointments particularly in Pathology, Radiology and Nursing services.
Impact	Related policies: The Health Service National Service Plan 2014 (NSP2014) was approved by the Minister for Health, Dr James Reilly TD on December 16th 2013. The NSP2014 sets out the type and volume of services that the Heath Service will provide directly and through a range of funded agencies, during 2014. These health and social care services must be delivered within the funding provided by Government and within the stipulated employment levels and is informed by the Department of Health's (DoH) Statement of Strategy 2011 – 2014 and Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015, both of which set out the Government's priorities for the health services. In addition and of significance is that NSP2014 is the first plan published by the Health Services following the publication of the Francis Report (February 2013) and the Keogh Report (July 2013) both of which identified weaknesses in the safety of care delivered to patients in hospitals in the UK. Similar findings were also identified in the investigations into the death of Ms Savita Halappanavar at Galway University Hospital (October 2013).These findings must be at the forefront of all planning for services in 2014. Makes reference to the Moratorium on recruitment and promotion in place since 2009.

Table 26 Acute Hospital Division Operational Plan [2015]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[26] Acute Hospital Division Operational Plan [2015] Service Plan
The health service system (including health service reform)	**Recommendation/considerations:** *Priorities:* ▪ Work with Social Care Division to address to reduce the reliance on acute hospitals and decrease the number of delayed discharges ▪ Continue to roll out the Irish Healthcare Redesign Programme ▪ Commence the development of Integrated Care Programmes ▪ Continue to implement national clinical models of care with a particular focus on the frail elderly. The following are the key reform programmes being progressed: ▪ Establish and develop Hospital Groups, including Children Hospital Group. ▪ Establish and develop Community Healthcare Organisations. ▪ Develop clinically led; multidisciplinary, service user centred Integrated Models of Care Programmes. *Actions 2015:* ▪ Fully implement the seven Hospital Group constructs. ▪ Management Teams for each group in place with responsibility for performance, outcomes, operating within budget and employment limits, with quality and patient safety at the core of business. ▪ Hospital Groups develop and submit strategic plans by end of 2015 to set out how the Groups will provide high quality, safe, integrated patient care in a cost efficient manner. ▪ Hospital Groups develop and commence implementation of Healthy Ireland implementation plans. ▪ Finalise implementation of the Smaller Hospitals Framework to ensure that all hospitals irrespective of size work together in an integrated way to meet the needs of patients and staff with an increased focus on small hospitals managing routine or planned care locally and more complex care managed in the larger hub hospitals.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *Priorities:* ▪ Progress the appointment of Hospital Group Management Teams ▪ Development of Hospital Group Strategic Plans *Risks:*

	▪ The rising number of delayed discharges impacting on bed capacity with resultant cancellation of elective services *Actions 2015:* ▪ Increase the conversion of elective inpatient surgery to day case
Governance	**Recommendation/considerations:** *Actions 2015:* ▪ Hospitals commenced first assessment against the standards [National Standards for Safer Better Heathcare assessments]. The HSE will continue to work with the hospital groups to support their progress in implementing the national standards and improving their performance against standards. Hospitals develop implementation plan to address improvements identified. ▪ improve access to services in relation to waiting times for scheduled care, and emergency or unscheduled care in public hospitals, including outpatient and diagnostic services: 1) Continue implementation of the OPD Programme across all hospitals; 2) Commence monitoring and reporting waiting lists for diagnostic services in 2015; 3) The HSE is committed to publishing waiting lists at consultant and specialty level. A pilot exercise is underway in one of the major teaching hospitals whereby waiting list data is being shared between consultants. The findings from the pilot exercise will be evaluated and inform the requirements for national implementation in early 2015. ▪ Reduce waiting times for scheduled and unscheduled care with priority for those waiting the longest ▪ Reduce the number of Delayed Discharges: Develop a system wide approach, in conjunction with the National Clinical Strategy Programmes for discharge pathways with a particular emphasis on the frail elderly. The menu of options to be deployed to support the initiative is based on the experience gained previously including the €5m supplementary funding initiative in 2014. **For information:** One of the challenges facing the acute hospitals is that current capacity in community services is insufficient to meet growing demands associated with demographic pressures and which gives rise to inappropriate levels of admission to and delayed discharges from acute hospitals. This in turn negatively impacts on costs and key performance indicators in acute hospitals, in particular where elective work is concerned.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Programme for funding 2015: Develop a discharge pathway for those patients that require access to long-term care services in order to reduce the number of delayed discharges in hospitals.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Recruiting and retaining motivated and skilled staff is a key objective in 2015.

	The HSE is committed to maintaining and progressing compliance with the requirements of the European Working Time Directive (EWTD) for NCHDs. *Risks:* ▪ The significant requirement to reduce agency and overtime expenditure may affect service delivery ▪ The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce to deliver the desired model of care.
Funding	**Recommendation/considerations:** *Priorities:* ▪ Roll out the phased implementation of the Activity Based Funding model *Risks:* ▪ The budget and staffing assigned to Acute Hospital Division provides for an expected level of service demand. There is a risk that continued demographic pressures and increasing demand for services will be over and above the planned levels thus impacting on the ability to deliver services. ▪ Pay cost growth which has not been funded. Cash risk related to the requirement to reach agreement with the private health insurers in relation to a set of revised payment terms. ▪ Risks associated with the delivery of procurement and other savings. The Acute Hospital Division share of the total HSE funding amounts to €3,999,9m which represents a 6.2%increase in budget but requires us to reduce overall costs in 2015 by a 0.8% compared to projected 2014 final expenditure levels. The Acute Hospital Division will need to operate within the planned cost level for 2015 in order for the HSE to deliver a breakeven position and there is extremely limited scope to address any over run in one area by compensating under spends in another area. The HSE is committed to maintaining and progressing compliance with the requirements of the European Working Time Directive (EWTD) for NCHDs. **For information:** Within this the Acute Hospital Division has been given a more realistic budget with which comes greater responsibility to manage expenditure within the confines of an existing level of service thus ensuring that expenditure does not grow beyond the budget which has been provided. While we have been able to largely align 2015 funding to 2014 costs much of the additional resource to do this has been provided to the HSE on a once-off basis and will be provided to hospitals on a once-off basis. In order to improve our chances of securing

	recurring funding to replace this in 2016 and to build from there our hospitals will need to live within budget in 2015. The funding provided in 2015 will enable the HSE to deal with the 2014 level of unfunded costs. Service deficits from 2014 will be funded but this will not be at 100% in all cases. This will reflect the fact that an element of 2014 should not recur in 2015. This primarily relates to the level of agency cost growth during 2014 which it is not intended to fully fund in 2015. The 2014 Acute Hospital Division deficit brought forward to be funded once off in 2015 is €267.9m. The setting of more realistic budgets for 2015 has required a 'zero base' approach to be taken to ensure that any residual surplus funds are allocated to the ongoing support of services and therefore cannot be utilised to generate new spend in 2015 or thereafter. Significant savings have been enabled by the Haddington Road Agreement (Public Service Stability agreement 2013-2016) and its continuing flexibility measures will continue to extract cost and reduce the overall cost base in health service delivery in the context of the reform and reorganisation of the HSE as set out in Future Health and the Public Service Reform Plans of 2011 and 2013. It will continue to assist clinical and service managers to more effectively manage their workforce through the flexibility measures it provides. Service Area: NHSS (long stay residential care) Programme for Government €: 10m Expected Delivery: 300 places Service Area: Short stay beds in Dublin area Programme for Government €: 8m Expected Delivery: 115 beds Service Area: Home Care Packages Programme for Government €: 5 Expected Delivery: 600 additional people Service Area: Community Intervention Teams Programme for Government €: 2 Expected Delivery: 4 teams Total: €25million **Budget 2015**

	Hospital Group: University of Limerick Hospital Pay €000's: 205,166 NonPay €000's: 107,655 Income €000's: 58,670 Net €000's: 254,152
Other	No information identified.
Impact	No information identified.

Table 27 Emergency Department Task Force Report [2015]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Health Service Executive (HSE)[27] Emergency Department Task Force Report [2015] Report [NOTE: Extraction is focused on the key priorities identified by the 2014/2015 Task Force and the actions to address priorities]
The health service system (including health service reform)	**Recommendation/considerations:** ***Enabling consistent improvement across all hospitals*** **Objective:** To enable consistent improvement across all Hospitals and to support those Hospitals with persistent challenges in terms of hospital performance. **Short-term actions:** In the short term these Hospitals, working with the SDU and community partners, must prioritise the escalation responses that are known to assist with patient flow. Each of the actions recommended meets the SMART criteria, which can be applied by local management. ▪ Implementation of agreed target response times within ED as follows: - 3 hours for assessment/diagnosis within ED - 2 hours for admitting team to review and determine outcome - 1 hour for discharge from ED ▪ Implement agreed target that a senior clinical decision maker would see each patient within one hour of arrival in AMAU ▪ Daily Senior Decision Maker Review of predicted discharges, which can be a board-round review - (A senior decision maker in the context is a Consultant or a Registrar with delegated authority to discharge) ▪ 80% of patients to have a meaningful Predicted Date of Discharge, used to drive discharge planning, by end 2015 ▪ Introduce structured Demand and Capacity levelling across the 7 day working week - Each hospital to be able to indicate the number of discharges (average and 85th percentile) required each day of the week to meet typical admission patterns for a given day - Each general medical/surgical ward to have first bed occupied by an unscheduled-care patient admission by 09.30hrs, 7 days a week ▪ Number of discharges each day to be reviewed on a monthly basis through review of HIPE data.

	Following the immediate emergency response, each hospital must then focus on sustainable, medium to long term developments that will militate against future high trolley counts. Sites will require support from the Group CEO's and SDU to create a tailored, realistic plan that takes account of the range of particular factors that impact upon their individual performance. Due consideration must be taken of such factors as: ▪ Recent changes in leadership teams ▪ Prior interventions, including HIQA service reviews ▪ Projects currently in progress e.g. IHRP, LEAN projects ▪ Internal resources including ICT and performance reporting capacity. **Medium term actions:** There is a requirement to develop medium term strategies to address structural challenges in terms of capacity and manpower. Specifically there is a requirement for: ▪ Development of additional consultant and NCHD manpower in line with international norms and recommendations (AHD – 2016/2017) ▪ Requirement for medium term investment to develop the required residential care capacity to meet assessed needs. This will be a mix of public and private provision and therefore will also require an assessment of pricing and contractual arrangements with private providers to ensure their effectiveness in meeting assessed needs. This will be enabled once the report on the review of NHSS is published by the DOH. (Social Care – 2016/2017) ▪ Hospital Groups to drive reconfiguration of services and structuring of posts to attract and retain consultant and NCHDs (AHD, Hospital Groups – 2015/2016). ***Service Improvement and Re-design*** ▪ Irish Hospital Redesign Program ▪ Developing an Improvement Function and model ▪ Shared Learning ▪ Patient Engagement and Feedback. **For information:** In recent years, all hospitals are required to develop full year demand and capacity plans, to underpin their response to foreseeable peaks in demand. Such plans must address escalation requirements for dealing with all surge periods and include the production of specific plans for winter months, when there is typically an increased demand for in-patient beds arising from additional unscheduled hospital attendances. A key driver for this planning process has been the Special Delivery Unit (SDU). Since 2011, they have required hospitals and community to:

	1. Proactively plan for peak periods, including public holiday periods 2. Adjust planned scheduled care activity, to allow for higher unscheduled care demands in winter months 3. Maximise the efficiency of processes that: a. Deflect patients from admission e.g. rapid multi-disciplinary team assessment for frail elderly b. Provide rapid access to senior decision makers e.g. introduce acute medical assessment units c. Minimise admission delays when an in-patient bed is required e.g. use 'Visual Hospital' systems that facilitate faster identification of beds about to become available 4. Engage in active discharge planning, including setting predicted dates of discharge, more frequent ward rounds and discharge from hospital earlier in the working day (home by 11 a.m.), so that beds are available at the optimal time. 5. Have clear linkages and formalised an effective working relationships with community colleagues, particularly for patients requiring off-site rehabilitation or who require home support services, whether from HSE health care professionals or contracted agencies which provide skilled nursing care, e.g. intravenous treatments, or personal care services from home help agencies. Supported by SDU and as a result of the benefits of the Clinical Programmes, Hospitals achieved a significant and sustained reduction in the number of trolley waits during the period 2011-2013. Specifically, there was a 33% reduction in the Irish Nurses and Midwives Organisation (INMO) national trolley count in the period 2011 to 2013. The improvement over this period must be viewed against the backdrop of sustained reductions in budget and staffing level and an ageing population, specifically the following ▪ Sustained reduction in HSE budgets – €3.3b over the period 2008 – 2013 ▪ Loss of 12,000 staff during this period, loss of 5000 nursing staff since 2009 ▪ Ageing of the population (11.7% of population over 65, over 80's growing by 4% annually)
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *Key issues identified by the ED Task Force 2014 are summarised below:* ▪ Requirement to develop sustainable solutions to the issues of delayed discharges so that existing hospital capacity can be optimised. Specifically the wait times for Fair Deal must be 4 weeks if patient flow and egress issues are to be addressed. ▪ The number of delayed discharges must be reduced on a continuous basis such that it does not exceed 500. The current situation whereby it is routinely in excess of 730 means that in the majority of hospitals have in excess of 15% of the beds are blocked on an ongoing basis and in a number of sites the figure is as high as 25%. ▪ Requirement to drive process improvements so that hospital length of stay is reduced. There is variation in ALoS between Model 4 hospitals, in particular, even when adjustments are made for the proportion of beds

blocked as a result of delayed discharge. The SDU has identified that it would be possible to free up to 60 beds in a single Model 4 hospital if length of stay was reduced in line with the National Target.

Priorities in this regard include:

- Application of predicted date of discharge on a pan hospital basis- immediate target for this activity is 80%.
- Discharge from hospital – the first discharge from each ward start no later than 9.30 am on the day of discharge to align with times of maximum bed demand for newly admitted patients. A whole hospital system approach is required to achieve this including communication with families and development of appropriate waiting areas for discharged patients (e.g. discharge lounges) to ensure that there is appropriate clinical oversight of both discharged and newly admitted patients.
- 7 day discharges – The core principle is that the hospital understands its demand capacity requirements and that its discharges are appropriately aligned with its demand requirements including at weekends so that patient flow is managed effectively. Review of SDU data suggests that hospitals discharges are not sufficient to meet the capacity requirements resulting in queuing. Accordingly hospitals need to set a daily site specific target which is based on the average number of admissions by day of the week.
- Each hospital will be required to determine with assistance of the SDU, the average admission requirement for each of the week. This will indicate the discharges required by the hospital each day. Hospitals will be expected to report against this target.
- Optimisation of Model 2 hospitals to manage unscheduled demand effectively. The recent initiatives in UL and South/South West in terms of directing patients to Model 2 hospitals needs to be replicated, having regard to the fact that there is variation in the capacity and capability of small hospitals in different hospital Groups . Therefore there is a need for tailored solutions and requirement for some targeted investment to enable bi directional flow consistently across groups. This includes the appropriate level of clinical governance including expanding roles of nursing and other professional groups.

Capacity: Optimising Existing Hospital and Community Capacity

1. Reducing Delayed Discharges

Objective: Reduce delayed discharges to a maximum level of 500 by end 2015 in order to achieve and sustain reduction in delayed discharges to this level.

Short term actions:

- Agree what is meant by a delayed discharge so that it can be appropriately measured and targeted at hospital and community level (HSE AHD, Social Care – Immediate)
- Set and maintain NHSS wait time of 4 weeks through the provision of adequate funding in 2015 (HSE, Social Care – Q2 2015)
- Enforce regulatory guidelines for submission of financial and CSAR information to NHSS (HSE, Social Care in conjunction with AHD - Immediate)

	▪ Set and enforce timelines for processing of financial information by Nursing Home Section (HSE, Social Care - Immediate) ▪ Set and oversee individual Hospital targets to ensure that the total number of Delayed Discharges does not exceed 500 in 2015 and that no hospitals delayed discharges are in excess of 10% of its available beds. This should include individual Hospital weekly discharge targets for Social/Primary Care as identified by the SDU. (HSE Social Care/Primary Care in conjunction with AHD– Immediate) ▪ Set targets, by Hospital, for delivery of Home Support services to ensure minimum delay for patients in Hospitals accessing appropriate supports. It is recognised that home support is not a demand led scheme but is budget capped and must meet the requirements of those in hospital and in the community.(HSE, Social Care – Immediate) ▪ Define and implement a menu of appropriate clinical pathways using the information that is already available i.e. 27 Clinical Programmes each of which describe in detail an evidence based clinical pathway. (HSE AHD/CCP/Social Care – Q4 2015) ▪ Define Community/Acute Hospital Catchment Areas for older person's services specifically (HSE AHD/Social Care – Q2 2015) ▪ Develop and implement agreed metrics to ensure that agreed targets for delayed discharges are being met consistently at national and hospital level (HSE AHD/Social Care/Primary Care – Q2 2015). **Medium-term actions:** ▪ Develop Integrated care pathways across the acute hospitals/community interface in the context of the newly created Divisional structures (HSE AHD/CCP – Q4 2015). ▪ In conjunction with the DOH, continue to define the requirement for additional residential care capacity both in terms of long stay and short stay to support the continuum of care requirements and in particular in key locations where there is an identified shortfall in such capacity, both currently and over the coming years. ▪ Determine requirements in nursing and other staffing groups which will allow identified patient care needs to be met. (HSE Social Care 2016/2017). ▪ Work with the DOH and HIQA to find solutions to the current regulatory requirements so as to protect public bed capacity which is vital to support the acute hospital system. (HSE Social Care – 2015/2016). ▪ Work with the DOH to develop appropriate public long term capacity so that complex patient needs can be met consistently (HSE Social Care – 2016). ▪ Develop and establish a robust local clinical governance model with clear links to the discharging hospital and existing community services (HSE Social Care – 2015). ▪ The DOH to lead on appropriate workforce planning to ensure safe and agreed nursing staffing levels and nursing clinical governance systems are in place to accept discharged patients (DOH/ HSE 2016) Develop ring-fenced funding streams for certain patient groups (HSE/ DOH 2016), specifically:

- Older people
- Those with chronic illness
- Young people with chronic neurological conditions e.g. acquired brain injury, multiple sclerosis, motor neurone disease etc.
- Joint ownership of people that require a flexible network of care provided by Primary, Social, Acute Hospital and Mental Health Services.
- An appropriate ICT system to support all of the above.
- Develop a framework to plan proactively for the ageing population having regard to the projections for the next 6 years (HSE AHD/ Social Care/ Primary Care – Q4 2015).

2. Reduce length of stay

Objective: Reduce LOS in line with target set in 2015 HSE National Service Plan (Medical 5.8; Surgical 5.1, LOS All 5.0; lLOS adjusted 4.3)

Optimise Existing Hospital Capacity – Surgical Beds

Short-Term Actions:

- Increase DOSA rates to national overall target of 70% in 2015 with each hospital having a target set by the National Surgical Programme. Current performance is circa 65% however there is significant variation by site. Further development of robust pre-assessment models of care through investment in CNS's in pre-assessment is critical in this regard. (HSE AHD/Hospital Group CEO's, Immediate)
- Increase surgical rates and reduce overnight stays – initial target set for Laparoscopic Cholecystectomy (> 60%) (HSE AHD/ Hospital Group CEO's, Immediate)
- % of bed utilisation by acute surgical admissions that do not have a surgical primary procedure – reduction of 5 % in 2015 (HSE AHD/ Hospital Group CEO's, Immediate)
- Define targets for shift of inappropriate day-case workload to outpatient settings (HSE AHD/CCP Surgical, Immediate)
- Align shift of inappropriate day-case workload from Hospitals to Primary Care in the context of NSP priority for 2015 of increasing minor surgery in GP settings (HSE AHD/Primary Care, 2015/2016)
- Apply HIQA HTA criteria to prescribed cases to create additional day capacity within existing resources (HSE AHD/CCP Surgical, 2015/2016).

Optimise Existing Hospital Capacity – Medical Beds

Short-term Actions:

- Exam LOS variance for core patient groups at consultant level by clinical directors and hospital management supported by appropriate data (Hospital Groups/Hospitals - Immediate)

- Ensure daily reviews undertaken by senior decision makers (Hospital Groups/Hospitals - Immediate)
- Learn from experience of implementing reconfiguration in hospital groups in terms of optimising use of available bed stock in Model 3/4 Hospitals and effecting bi-directional flow. Effective planning in terms of predictive modelling, development of capability within Model 4 and development of agreed patient pathways is essential if reconfiguration is to be effective (Hospital Groups/Hospitals - Immediate)
- Embed the operation and use of existing AMAU's to ensure consistent compliance with target of 25 % of patients being seen and discharged on the same day (Hospital Groups/Hospitals - Immediate)
- Ensure consistent compliance in existing AMAU's with target of 56% of patients being discharged safely within 72 hours (Hospital Groups/Hospitals - Immediate).

Medium-term Actions:

- Extend use of outreach services (e.g. Heart Failure and COPD) to reduce inpatient stay (HSE AHD/Primary Care/CCPs, 2015/2016). With the Clinical Care Programmes implement and oversee agreed targets for these services in terms of reduced length of stay and re-admissions
- Determine consultant manpower and NCHD requirements for medicine and surgery to enable appropriate and timely assessment and decision making within ED (AHD / National HR – Q4 2015, Q1 2016)
- Extend existing community and public health nursing services and AHP staffing to enable effective discharge to community. (Social Care, Primary Care HSE).

CAPABILITY - Developing internal capability and Process Improvement

1. Appropriate admission avoidance

Objective: Develop and extend additional and alternative access routes to urgent care thereby obviating the need for Emergency Department attendance.

Short-term Actions:

- Embed Rapid access model in Mount Carmel Hospital to support the hospitals in South Dublin subject to appropriate engagement with representative bodies (HSE AHD/SC, Q2 2015)
- Embed the Rapid access model in Beaumont Hospital through strengthening of geriatrician links with emergency medicine and links with Day Hospital capacity (HSE AHD, Immediate)
- Extend the Community Case Management Initiative to 4 AMAU sites with 7 day access (HSE AHD, Q3 2015)
- Set targets for extended use of CIT model as identified in 2015 NSP to enhance nursing supports to nursing homes and to support ED diversion. (HSE Primary Care, Q2 2015)
- Ensure that expanded CIT model optimises the benefits from appropriate linkage with home help supports and realises the targeted bed days savings (HSE Primary Care, Q2 2015)
- Establish national campaign aimed at promoting the use of Local Injury Units/Rapid Access Services and G.P. OOH's services for appropriate conditions. Requirement to standardise name and purpose. There is a

cultural shift required to get patients in certain areas to utilise alternative services and this should be a focus of any such communication plan. (HSE AHD/Primary Care, Immediate)

- Review resource requirements for G.P OOH's services and CITs should the campaign result in an increased number of patients presenting at these services (HSE AHD/Primary Care – Q4 2015)
- Each CHO provide a live electronic contacts register of primary care and social care clinical and admin contacts (phone and email) to local hospitals for ease of communication. (HSE CHOs, Immediate)
- Make greater use of electronic communication, including references to the usage of "healthmail" which allows all hospitals to communicate clinical information securely to GPs(HSE Primary Care, Immediate)
- Commence discussions with relevant stakeholders including representative bodies to develop the expanded roles of nurses in areas of prescribing, IV fluids and antibiotic therapy within the long terms care facilities, including the potential for training and/or recruitment of Nurse Prescribers/ANPs in community to work collaboratively of GPs and OOH's services, good examples of similar nurse led walk-in treatment centres in UK. (HSE Primary Care, Immediate)
- Set specific response times for GP Out of Hours Services for particular patient cohorts and measure compliance with same. Such targets must take account of acuity of patient requirements with particular priority attaching to nursing home patients (HSE Primary Care, Immediate) Ambulance service to initiate alternative patient assessment initiative "Hear and Treat" subject to available resource (NAS, Immediate)

2. **Effective management of patients within ED**

Objective: Requirement to ensure timely and appropriate assessment, treatment and admission or discharge from ED in line with agreed targets (all patients seen and admitted or discharged within 6 hours- 95% compliance).

Short-term actions:

- Implement and oversee agreed target timelines for patients to be seen within ED and by admitting teams. For ED, 3.2.1 as per EMP (3 hours to be assessed by ED; 2 hours to be seen by admitting team; 1 hour to transfer to a bed). For admitting team/s – patient assessment should commence within 1 hour of referral. (Group CEO's/Hospitals, Immediate)
- Ensure appropriate level of senior clinical decision making in ED. There is a requirement to ensure that there is a senior decision making presence in ED during peak hours with consultant availability on 8am-8pm basis, subject to resource. (Hospitals/Group CEO's - Immediate)
- The HSE National Service Plan 2015 provides for 4 additional Consultants in Emergency Medicine and 4 AMAU physicians. This is a first step in addressing the requirement to enable extended day provision and appropriate cover at weekends particularly in Model 3 and 4 hospitals. (HSE AHD/Group CEO's – Immediate with appointment by Qtr. 3, 2015)
- Determination of nurse staffing and skill mix should be made using a robust evidence based methodology, applicable to the ED and AMAU context. The Task Force on Staffing and Skill Mix in

Nursing may support the development of a Framework for Nurse Staffing and Skill Mix in Emergency Nursing Care, as Phase II of its programme of work. (DOH/AHD,CCP – Q3 2015)

- Commence discussions with relevant stakeholders including representative bodies to optimise the existing skills amongst the wider ED & AMAU nursing resource, to enable competent nurses, working under protocol, to order, interpret and escalate diagnostic tests, such as bloods, for example. (DOH CNO, HSE, Relevant representative bodies - Immediate)
- Commence discussion with relevant stakeholders including representative bodies to maximise the development of ED & AMAU skills and competence to undertake advanced clinical assessment, interpretation and treatment in a standardised range of skills such as chest auscultation, palpation percussion, medicinal prescribing, ECG interpretation etc., through a combined ED & AMAU education programme, in tandem with the existing medicinal and x-ray prescribing programmes. (DOH CNO, HSE - Immediate)
- Each Hospital to ensure that on-call admitting Consultant is fulfilling their commitment to respond to ED activity. The recent surge in ED activity has highlighted the benefits of intensification of efforts on a pan-hospital basis to manage patient flow. In particular, the application of the following principles on a consistent basis has enabled better management of surge activity. (HSE AHD/Group CEO's – Immediate)

  Key requirements:
  - Daily specialist Consultant ward rounds in the acute specialties.
  - Daily handover of admitted patients to the relevant Consultant or specialty in that hospital.
  - Participation of the on call admitting team in escalation measures.
  - Availability of specialist Consultants to admit, discharge, or refer patients to FastTrack clinics.
- Support and enable enhanced roles for nursing and AHP grades to facilitate patient assessment and discharge. The Task Force will bring forward specific proposals to be advanced in 2015 in conjunction with relevant stakeholders. (HSE /CNO DOH in conjunction with Representative Bodies - Immediate)

Medium-term actions:

- Determine emergency department manpower requirements by reference to robust evidence based methodology including reference to international norms and recommendations. Analysis of requirements should have regard for the proposed reconfiguration of services within Groups and the potential to leverage existing resources more effectively across the Groups. (HSE AHD/Group CEO's - 2015)
- Seek to increase consultant numbers in line with international norms to enable effective assessment and decision making within ED.

3. Rapid access to inpatient care

	Objective: Implement targeted initiatives aimed at supporting rapid access to Consultant opinion that are underpinned by dedicated teams and supported by adequate diagnostic capability and robust clinical protocols. **Short-term actions:** ▪ AMAU model: ▪ Expansion of service to 7 day service in 4 sites in 2015 (SVUH, Mater and CUH, Tallaght with appropriate staffing supports as outlined in HSE NSP 2015. (HSE AHD, Q4 2015) (Ref. Section 1.2) ▪ Evaluate the impact on ED volumes and wait times, in the 4 sites, of the AMAU 7 day service and determine requirements for expansion to other sites during 2016. (HSE AHD/CCP, 2015)* ▪ Extend G.P Direct access to AMAU within agreed criteria for AMAU referrals. As part of this process, establish appropriate communication and referral pathways and governance with GPS to enable appropriate referral and feedback. (Hospital Groups/Hospitals – Immediate) ▪ Strengthen ED streaming to ensure optimisation of AMAU functioning and decongestion of ▪ ED Specifically, triage in ED should ▪ Seek to divert all clinically appropriate Medical patients to AMAUs ▪ Prioritise the selection of Elderly patients to ensure early assessment and appropriate management by AMAU physicians. (Hospitals/CCP, 2015) ▪ Development of ANP model of care for low acuity chronic illness, both in the ED and AMAU to assess, treat and discharge low acuity chronic illness, with the option for return clinics at the ED & AMAU for ongoing assessment and treatment similar to the current ED Minor Injuries model of care. (DOH CNO, HSE, 2014/2015) ▪ Access to diagnostics- Ensure full implementation of 8-8 working day, in line with the national protocol in all sites for diagnostic services, subject to review of resource requirements, and seek to optimise access for emergency services. (Group CEOs Hospitals, Q4 2015) ▪ Extend initiatives such as community case management for older persons with complex needs with other proposals such as CIT and develop agreed metrics to measure specific impact on admission and readmission rates. (HSE AHD/Social Care/CCP's, Immediate) ▪ Examine requirement for availability of community professionals, especially Community nursing, on a seven day basis. (HSE Primary Care/Social Care, Immediate) ▪ Targeted Use of Fast track units (e.g. Clinical Decision Units and Rapid Access): to reduce the volumes and wait times in EDs, provided they are delivered and overseen by senior decision makers and underpinned by robust clinical protocols. Requirement to develop and use metrics to measure the specific impact of fast track units in terms of activity, resource utilisation wait times and length of stay. (Group CEOs, Hospital Managers - Immediate)

	▪ Effective use of existing Acute Medical Assessment Units to support the reduction of ALOS and enable prompt assessment and management of specific patient cohorts. (Hospital Groups/ Hospitals – Immediate) ▪ Use of short stay (less than 5 days), high intensity capacity can result in the following benefits: Hospital Groups/ Hospitals – Immediate) ▪ Reduced ED 'trolley' waits / prompt admission ▪ 'Pull' to accommodation within appropriate ward ▪ Focused condition specific protocols, rather than individualistic approach ▪ Shorter average length of stay (approximately 2 day reduction) ▪ Prompt effective discharge – with no adverse increased readmission **Medium-Term Actions:** ▪ Evaluate the impact of the introduction of the 7 day AMAU Service on the four agreed sites for 2015 and seek to extend to other sites as appropriate (AHD – 2016) ▪ Extend AMAU model into paediatric services in Dublin by opening a Short – term Stay Observation Unit at Tallaght Hospital to drive contemporary practices in rapid access and turnaround of children being admitted across the three children's hospitals in Dublin (AHD – 2016) **4. Access to diagnostics** **Objective:** Develop rapid routine diagnostic reporting on an extended 12 hour, 7 day basis linking diagnostic reporting capacity to ED attendance patterns and patient need over the 24 hour period. **Short-term actions:** ▪ Access to diagnostics- Ensure full implementation of 8-8 working day for laboratory and radiology services in line with the national protocol in all sites for diagnostic services, and having regard to additional resource requirements. Within context of extended day, seek to optimise access for emergency services having regard to resources. It is recognised that there is a need to develop additional consultant manpower to meet additional reporting requirements.(Group CEO/Hospital Mgr. - Immediate) ▪ The prioritisation of inpatient access to diagnostics should be a core principle to effect reductions in length of stay. Requirement to implement agreed metrics to measure specific impact of extended day on wait times for diagnostics for emergency patients (Group CEOs, Hospital Managers, Quarter 4, 2015) ▪ Target 7 day radiography service initially on pilot basis using overtime. Evaluate impact on ED & AMAU performance and length of stay with emphasis on timelines for access for inpatient and emergency patients. Capital constraints need to be borne in mind. (HSE AHD - Qtr. 2 2015)

	▪ In the short term, options to deliver additional diagnostic capacity may be considered particularly for outpatient workloads in order to improve overall bed utilisation and patient flow. This should be progressed in consultation with relevant stakeholders in recognition of pre-existing protocols and agreements. (HSE AHD/Group CEO – Q2 2015) It is vital that safeguards are in place to ensure quality assurance, shared access to results, and avoidance of test duplication should the patient require hospital attendance. Any short-term initiatives should be carefully selected and evaluated in terms of overall impact on volumes and wait times in ED and control. **Medium-term actions:** ▪ Develop a plan for targeted increase in diagnostic capacity (MRI/CT) to ensure that GP and consultant access is appropriate (HSE AHD - 2016) ▪ Seek to secure the necessary additional consultant manpower to meet the additional reporting requirements associated with extended day and 7 day service. (HSE AHD, National HR – 2016/2017) **[Note: 5 extracted to staffing]** **6. Integrated discharge planning** **Objective:** Ensure whole hospital systems and processes and integrated planning with community services to enable effective discharge of patients. **Short-term actions:** ▪ Implement across all hospitals the date of discharge for all admitted patients (within 24 hours of admission) with target of 80% compliance by end 2015 (HSE AHD/Group CEO's - immediate) ▪ Ensure that appropriate systems are in place to enable effective discharge planning in collaboration with community partners. These should be formal with regular structured engagement to address any blockages or delays. (CHOs and Group CEOs -Immediate) ▪ Weekly reporting mechanisms to be developed to identify delayed and /pr discharges and to communicate same to community partners. (CHO and Group CEOs- Immediate) ▪ All patients due for discharge will have a senior decision maker review to allow for discharge before 11 a.m. (Group CEO's/Hospitals - Immediate) ▪ Implement target of 40% of patients to be discharged before 11 a.m. on a day to ensure required capacity is available for admission. A whole system approach is require to achieve this including communication with families and development of appropriate waiting areas for discharged patients (e.g. discharge lounges) to ensure that there is appropriate clinical oversight of both discharged and newly admitted patients. (Group CEO's/Hospitals – immediate)

- Agree daily targets for discharge in line with admission profile and ensure daily review of predicted discharges on seven day basis by senior decision makers is an integral part of the discharge process with oversight by the Clinical Director. (Group CEO's/ hospital managers - Immediate)
- Undertake weekly systematic review of all patients with extended length of stay (>14 days) to identify issues and actions required. (Group CEO's/Hospitals - immediate)
- Enable delegated discharge between clinical teams within agreed parameters. (Group CEO's/Representative Bodies/Professional bodies - Immediate)
- Delegated authority to senior nurses to support discharge based on agreed criteria and having regard to the consultant's ongoing responsibility for the patient. (Group CEO's/Professional bodies- Immediate)
- Report and publish daily and weekly discharges by hospital and Group to ensure consistent application of weekend and daily ward rounds by senior decision makers (SDU/Hospitals - Immediate)
- Active regular review of noncompliance with PDD (SDU/Hospitals - Immediate)
- Facilitate bi-directional flow and appropriate use of Model 2/3 Hospitals through expansion of NAS Intermediate Care service, subject to resource availability (NAS, 2015/2016)

7. Chronic Disease Management

Objective: Embed models for management of for chronic disease as part of core response to admission avoidance, early discharge and appropriate management of patient flow.

Short-term actions:

- Measure impact of existing funded chronic disease programmes to date in terms of reducing LOS Quantify reduction in length of stay for chronic diseases (e.g. COPD, Heart Failure) where speciality ambulatory care services have been developed under the clinical programmes. Maximise the national effect on length of stay reduction by filling geographical gaps in these services in the 2016 NSP (HSE CCP's - Immediate)
- Development of ANP model of care for low acuity chronic illness, both in the ED and AMAU to assess, treat and discharge low acuity chronic illness, with the option for return clinics at the AMAU for ongoing assessment and treatment similar to the current ED Minor Injuries model of care (CNO DOH and HSE,– Q4 2015)
- Implement and evaluate Service Plan 2015 requirements for Integrated Care pathways and Frail Elderly. Examine opportunity to extend the current geriatrician led model for frail elderly to community based ANPs with the aim of providing an effective model and pathway of care specific for older patients to expedite their care and treatment both inward and outward. (HSE, Acute Hospitals Division and CCP – Q4 2015)

Medium-term actions:

	▪ Increase coverage of Clinical Nurse Specialist (CNS) and AHPs for chronic disease support to General Practice in the 2016 Service Plan (commenced in 2015)(Primary Care – 2016) ▪ Commence implementation of the chronic disease self-management support strategy in 2016 NSP (Primary Care / CCP – 2016) **For information:** During 2014, ED performance in terms of trolley waits deteriorated and for the first time in three years, the downward trajectory was reversed in September 2014. According to INMO figures, the number of trolley waits was 6.5% worse than it was in 2013. This is a matter of serious concern to the HSE. Key contributory factors include: ▪ Growth in the wait time for NHSS from 4 weeks in January 2014 to 15 weeks at end of November 2014. ▪ Growth in the total number of delayed discharges of the order of 30% during 2014 contributed by the growth in the numbers awaiting NHSS and demand for sufficient levels of home care support. ▪ Significant changes in management structures in hospital and community services with resulting loss of corporate experience and context to drive and oversee consistent hospital performance. ▪ Challenges in attracting and retaining senior clinical decision makers at junior doctor and consultant levels notably in Model 3 hospitals. The impact of the consultant pay cuts and protracted pay discussions also impacted on Model 4 hospitals during 2014 as evidenced by the high vacancy factor at consultant level (> 200 Posts). As a result, there has been a growing reliance on agency provision and loss of experienced staff with resulting challenges in terms of admission rates and discharge of patients. During 2014, medical agency costs grew by more than 50% , with residual vacancies in a number of key areas notably acute medicine, emergency medicine and anaesthesia. ▪ Challenges in recruiting nursing staff as a result of moratorium provisions with increased reliance on agency staff. Loss of significant numbers of nursing posts due to the moratorium on recruitment and such reliance on agency has direct consequences for effective discharge planning at ward level and consistent implementation of predicted day of discharge, and effective planning of rosters at hospital ward level. ▪ Sustained growth in emergency admissions during 2014 of the order of 2% with 20% increase in the proportion of over 65s admitted on an emergency basis.
Governance	**Recommendation/considerations:** *Key issues identified by the ED Task Force 2014 are summarised below:* ▪ Leadership and governance issues – those hospitals that have delivered sustained improvements in Hospital performance typically have strong clinical and managerial leadership that support the consistent prioritisation of unscheduled care. This is also reflected in strong centralised operational processes and controls that enable an operational grip on the issues.

	▪ Oversight and Measurement- there is a requirement for effective management and control structures at hospital level that include effective demand capacity management, clear lines of accountability for bed management and discharge policy, robust whole system escalation measures and processes. **CONTROL: Leadership, Governance, Planning and Oversight** **1. Leadership and governance** **Objective:** To ensure effective leadership and oversight in Hospitals to implement and maintain sustained improvements and to manage periods of surge effectively. **Short term actions:** ▪ Establish clear lines of accountability within the hospital for the management of patient flow within each Hospital (Group CEO's/Each Hospital - Immediate) ▪ Establish leads for scheduled and unscheduled care in all Groups with clear reporting lines to COO for each Group (Group CEO, Q1 2015) ▪ Develop and maintain centralised bed management to ensure consistent oversight of scheduled and unscheduled workloads (Group CEO/Each Hospital, Immediate) ▪ Group and Hospital Clinical Directors to drive discharge planning and ward rounds (Group CEO/Each Hospital, Immediate) ▪ Empower and enable delegated discharge in accordance with National agreements and cross team discharge, having regard for the consultant's ongoing responsibility for their patient (Group CEO/Each Hospital/Clinical Directors, Immediate 2015) ▪ Embed and systematically review whole system escalation / de-escalation processes. patient (Group CEO/Each Hospital/Clinical Directors, Immediate 2015) **2. Operational Planning and Predictive Modelling** **Objective:** To ensure that there are systems and processes in place to enable appropriate planning and forecasting and to support operational effectiveness in relation to the management of unscheduled care. **Short term actions:** ▪ **Adjusting working practices to better match the general patterns** - **Rostering** ▪ Match services with need. E.g. team on call working in EDs, weekend and out of hours service options. Solutions will require examination of additional resource requirements (Group CEO/EMP, Immediate) ▪ Develop a greater range of services in community settings on a planned basis in the evenings and at weekends subject to resource availability e.g. wound care clinics, IV services, catheterization (HSE Primary Care, Qtr. 4, 2015) - **Skill Mix**

	▪ Optimise use of the human resource, transfer of duties to other grades/ professionals in accordance with existing agreements (Immediate, Hospitals supported by National Division) ▪ Working with key stakeholders including representative bodies to expand the roles of health professionals across the heath service to ensure optimal clinical outcomes. (Hospitals, SDU, Representative bodies - Immediate) - **Develop operational planning functions to anticipate and manage day to day supply and demand** ▪ Develop COO capability and resources at Hospital level within existing structures to oversee and manage Scheduled and Unscheduled Care (Group CEO's/Hospitals, Immediate) ▪ Operational grip – develop capability within COO function to enable reduction in numbers and wait times within 12 hour period of escalation and recovery within 48-72 hours. (Hospitals/SDU, Immediate) ▪ Develop flexible rosters to meet demand requirements and ensure consistent access to Senior ▪ Decision makers (Group CEO's/Hospitals/SDU/AMP, Immediate) ▪ Develop appropriate (weekly, monthly and annual) elective schedules in line with assessed need, seasonal requirements and having regard to overall capacity requirements (Hospitals/SDU, Immediate) ▪ Embed and systematically review whole system escalation/de-escalation procedures and processes (HSE AHD/Social Care/Primary Care – Immediate) ▪ Ensure compliance with national frameworks and improvement plans (Group CEO's/SDU, Immediate) ▪ Undertake whole system review of existing winter planning arrangements in terms of timeliness and adequacy (HSE AHD/Social Care/Primary Care/SDU, Immediate) **3. Measurement** **Objective:** To ensure that there are effective systems and processes in place to allow for routine measurement of performance at local Hospital/CHO and national level and to enable review and audit of performance **Short-term actions:** ▪ Reinforce system wide definitions that apply to all Hospitals and Emergency Departments - (SDU with Clinical Care Programmes, Immediate) ▪ Implement appropriate IT systems to support both ED (EDIS) the AMAU IT systems to measure agreed variables consistently across hospitals - (SDU with Clinical Care Programmes, Immediate) ▪ Report on agreed targets to be applied for 2015 as follows: - Weekly Targets for number of discharges required to maintain flow to be established. Acute Hospitals Division to set targets with individual Hospitals; HSE Social Care/Primary Care Divisions to determine capacity to deliver (consistently in order to meet target of 500 Delayed Discharges, Immediate)

- 95% compliance with 6 hour target for all patients to be seen and discharged or admitted from ED & AMAU (HSE NSP 2015)
- 100% compliance with 6 hour target for all patients to be seen and discharged or admitted from ED & AMAU

The Minister, in recognition of the immediate pressures on the Hospital system, has identified an interim target for 2015 as follows:

- No more than 70 patients on any day waiting in ED for admission greater than 9 hours

The Task Force has identified that the following targets should immediately be applicable:

- Zero tolerance of anyone waiting over 24 hours for admission – reportable event to National Hospital Director
- Over 75s – eliminate 9 hour breaches (100% compliance) – regarded as a reportable event to National Hospital Director (Group CEO's/Hospitals/SDU, Immediate)

Social Care

- NHSS waiting times to be maintained at 4 weeks (currently 11 weeks). If further funding is provided to support the scheme.
- When funding is approved to provide home supports, it is targeted that the service will be available in the person's home, within a 72 hour period.
- Specific metrics to be agreed on a hospital by hospital basis as a target for transitional care.
- Target times for processing NHSS applications will be agreed and monitored.
- Target Times for processing , approval and release of funding for Home Care Packages will be agreed (Social Care - immediate).

Primary Care – Immediate

- Target response time will be set for Out of Hours Services and will be monitored as part of the Performance Framework
- Metrics will be agreed between Acute Hospital Division and Primary Care to determine the impact of CITS in terms of admission avoidance and re-admission.

4. Oversight

Objective: To ensure effective oversight is in place at all levels to drive and maintain consistent hospital performance.

Short-term actions:

- Implement appropriate formal monitoring and oversight structures at National, Group/CHO and Hospital/Community levels that enable the following:

	- Daily review within and between Hospital/Community level with Hospital Group COO/CHO Care Lead(s). - Weekly oversight with relevant National Division and Group/CHO to review performance and effect appropriate interventions. - HSE Performance Accountability Framework between National Directors and Director General and also National Divisions and Group CEO/CHO to include formal regular review of hospital performance and Delayed Discharges. - Appropriate escalation framework to enable prompt intervention by the National Division's with the delivery system through the CHO and Hospital Group's. (HSE National Divisions/Group CEO's/CHO's/Hospitals, Immediate).
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *Key issues identified by the ED Task Force 2014 are summarised below:* ▪ Access to senior clinical decision making is critical in terms of addressing admission and discharge issues. A number of hospitals have a huge reliance on agency provision at consultant and NCHD level. The issue is most acute in Model 3 hospitals however in the past year; the issues of vacancies at consultant level in Model 4 hospitals are also evident. This vacancy factor must be viewed in the context that overall numbers of practising doctors are lower than the EU average. OECD analysis highlights that Ireland has 2.7 doctors per 1,000 populations while the average is 3.4. It is recognised that consistent delivery of senior decision making requires targeted investment in additional consultant, NCHD and other professional groups (nursing & AHP). With specific reference to Model 3 hospitals there is also a need to tackle the structural challenges that militate against recruitment and retention of doctors. ▪ As an immediate priority, there is a requirement to tackle the structural issues that are driving continued reliance on agency in these hospitals. This will require targeted action at Hospital Group level and should consider appropriate structuring of appointments at consultant level. In relation to NCHDs there is a requirement to engage with postgraduate medical training bodies to enable appropriate rotation. The role of Advanced Nurse Practitioner should be examined in terms of fulfilling senior decision making roles within appropriate setting and agreed criteria. ▪ Delegated discharge – The implementation of delegated discharge and agreement of appropriate criteria must be done in conjunction with the consultant representative bodies, having regard to the ongoing clinical responsibility of the consultant for their patients. The use of criteria-led, delegated discharge by senior nurses is an important component of enabling improved senior decision making. The CNM2 role is central to the implementation of delegated discharge.

	▪ Cross team discharging – cross- team discharging is already in operation in a small number of sites and has proven to be effective in enabling 7 day discharging. This needs to be extended across all hospitals within agreed criteria to ensure safe and appropriate discharge Standardised care pathways- there are a number of examples of where implementing standardised care pathways for frail elderly can enable hospital avoidance; reduce length of stay and prevent readmission. Of particular note in this context are the Rapid Access Models and the Community Case Management Models. A key requirement is to share the learning from these initiatives and seek to mainstream as part of the overall response to unscheduled care. **CAPABILITY** **8. Access to senior decision-making** **Short-term actions:** ▪ Ensure planned appointment of the 4 additional consultant posts to AMAU and 4 to ED, as provided for in the 2015 Service Plan, is targeted at addressing the requirement for consultant delivered services within ED and AMAU. (HSE AHD/Group CEO, Immediate) ▪ Advertise and recruit vacant consultant posts to reduce reliance on agency provision. As part of this process, seek to appropriately structure posts within Groups to support the staffing requirements of small and medium hospitals. Engagement with training colleges is required to support appropriate rotation of junior doctors. (HSE AHD/Group CEO, Immediate) ▪ For inpatients, ensure consistent use of predicted date of discharge to support reduction in length of stay and effective use of resources; agreed by Specialty, proactively managed against treatment plan, discharge confirmed day before. (Group CEO/Hospital Mgr., Immediate) ▪ Extend use of delegated discharge and cross team discharge to address current deficits in relation to senior clinical decision-making having regard to the consultants ongoing clinical responsibility for their patients. (HSE AHD/Hospital Groups/Hospital CEOs – Immediate) **Medium term actions:** ▪ Seek to increase the number of consultants and NCHDs in line with international norms and best practice. The targeting of these posts should be informed by robust analysis of consultant manpower requirements at hospital and group levels. (HSE AHD, National HR – 2016/2017) ▪ Develop additional capacity and capability within nursing to take on senior decision making roles in relation to delegated discharge. (HSE AHD, National HR – 2016/2017)
Funding	No information identified.
Other	No information identified.
Impact	No information identified.

Table 28 Acute Hospital Division Operational Plan [2016]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[28] Acute Hospital Division Operational Plan [2016] Service Plan [Note: Information taken from executive summary and Mid Lands specific section]
The health service system (including health service reform)	**Recommendation/considerations:** UHL Actions 2016: ▪ Continue the establishment of the hospital groups on an administrative basis in 2016, in advance of legislation. UHL Actions 2016: ▪ Implement the Irish Hospital Redesign Programme in Limerick University Hospital in 2016 which has been established to improve healthcare delivery in Irish hospitals, using a redesign approach in conjunction with the integrated programme for patient flow. ▪ Continue early implementation of the Model for Integrated Care Programme for Older Persons at University Hospital Limerick in association with local CHO, Clinical Strategy and Programmes and Social Care Division.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Overall key service objectives 2016: ▪ Sustain access to urgent and planned care by increasing efficiencies, streamlining processes and maximising capacity in hospitals ▪ support the development of implementation plans for integrated care pathways across all hospitals in collaboration with the Clinical and Integrated Care Programmes ▪ Care Improve performance in relation to unscheduled care by continuing to implement the Emergency Department (ED)Task Force report recommendations in conjunction with the Acute Hospitals Division and community healthcare services to ensure that all patients are admitted or discharged from ED within 9 hours but in particular those > 75 years of age. UHL Actions 2016: ▪ Reduce delays with opening of new ED, UHL: Prepare for the planned opening of the new Emergency Department in early 2017. ▪ Leben Building: Open the Leben building to provide new inpatient/outpatient unit with capital funded from charitable sources. It will include a 24 bed stroke unit, inpatient and outpatient Cystic Fibrosis units, a Specialist Breast Unit and a Dermatology Unit and restoration of the hospital's dining area. ▪ Continue to provide additional capacity as per Winter Capacity Initiative: • Additional 17 Medical Beds • Additional

	5 Isolation Rooms To address some of the capacity issues on the UHL site, 22 patient beds will be opened, in addition the group will commence a phased opening of acute Stroke/Neurology beds, and five beds/rooms for the treatment of patients with Cystic Fibrosis. Identified risks include (overall): ▪ Ability to contain activity to 2015 levels for emergency care and urgent and routine elective treatments ▪ Delayed discharges are not reduced to and maintained at.
Governance	**Recommendation/considerations:** Overall key service objectives 2016: ▪ Embed robust governance structures within the hospital groups in line with the HSE accountability framework ▪ Build effective managerial and clinical networks within hospital groups which will provide direct support to the smaller hospitals in the groups in particular. **For information:** The hospitals in Ireland are now organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the Health Act 2004 in line with National Service Plan (NSP) 2016 and allocated Group budgets… The Group Chief Executives report to the National Director for Acute Services and are accountable for their planning and performance under the HSE Accountability Framework. The UL Hospital Group is governed by an interim Board of Directors pending the development of new legislation to establish a new legal entity. An Executive Management Team led by the CEO is supported by four Clinical Directorates (Medicine, Peri-Operative, Child and Maternal Health and Diagnostics) who are accountable for the operation of the services across the sites.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Overall key service objectives 2016: ▪ Improve patient access and experience by the provision of integrated care in collaboration with social care, primary care, and mental health services ▪ Support the phased implementation of evidence based, integrated care pathways for older persons in conjunction with the Integrated Care Programme Older Persons (ICP OP) and National Clinical Care Programme older People (NCCOP) to improve quality, access and value for older persons requiring acute care. Integrated Care Programme for Older Persons - Work is already well established in Cork and Limerick, while programmes are being initiated in conjunction with Tallaght and Our Lady of Lourdes (OLOL) Hospitals. The priority in 2016 is developing this programme across 4 pioneer sites (CHO 7, Tallaght Hospital; CHO 8, OLOL;

	CHO 4, Cork University Hospital (CUH); CHO 3 University Hospital Limerick (UCHL) which will commence the implementation of the integrated care programme in 2016. **For information:** The purpose of the Integrated Care Programme for Older Persons is to augment primary and secondary care services for older people in the community enabling a shift from a model of acute, hospital-based episodic care to a model that reflects increased co-ordination and care planning based on the needs of the older person.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** The hospitals nationally will need to reduce total staff numbers in 2016 to achieve the financial targets contained within this plan… The Acute Hospital Division will continue to focus on further reductions in the cost and reliance on agency staff and overtime during 2016. There will also be a focus on workforce design based on service design and delivery, driven by clinical care pathways and efficient and effective staff deployment alongside the development of leadership and management competencies. …the Division continues to work collaboratively with Irish Medical Organisation, the Department of Health and other key stakeholders to work collectively towards the achievement of full compliance with the EWTD. Identified risks include (overall): ▪ The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce ▪ The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task including the scale of recruitment required and the information system constraints. **For information:** The whole time equivalent numbers employed by the acute sector fell significantly during the years of austerity and by Oct 2015 have returned to 2009 levels (Government Moratorium on public sector recruitment) but over that period there has been a reconfiguration of the skills mix. he data demonstrates a shift in the mix of staff reflecting an increase in medical staffing while there have been reductions in nursing and support services.
Funding	**Recommendation/considerations:** Acute Hospitals 2016 Available Budget: €4,053.5 million Acute Hospitals 2015 Projected Outturn: €4,134.8 million Acute Hospitals 2015 Closing Budget: €3,925.0 million ULHG Acute Services 2016 Budget: €255.243 million **For information:**

	This equates to €64m of the net 2015 allocation to keep up with the demographic pressure. Clearly model of care changes relating to the frail elderly area and chronic conditions are key to addressing this challenge. However in 2016 the pressure will continue to fall directly upon hospitals with limited additional financial provision… In summary, when account is taken of the 2015 cost of services, expected cost growths and initial cost saving measures, a preliminary funding shortfall of €150m remains to be addressed.
Other	No information identified.
Impact	No information identified.

Table 29 UL Hospitals Group Operational Plan [2016]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Health Service Executive (HSE)[29] UL Hospitals Group Operational Plan [2016] Operational Plan
The health service system (including health service reform)	**Recommendation/considerations:** The hospitals in Ireland are now organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the Health Act 2004 in line with National Service Plan (NSP) 2016 and allocated Group budgets. *Key service objectives for 2016 include:* ▪ Sustain access to urgent and planned care by increasing efficiencies, streamlining processes and maximising capacity ▪ Implement integrated care pathways for patients with Chronic Obstructive Pulmonary Disease (COPD), asthma, heart failure and diabetes in the context of the Integrated Programme for Prevention and Management of Chronic Disease ▪ Improve patient access and experience by the provision of integrated care in collaboration with social care, primary care and mental health services ▪ Commence implementation of the Maternity Strategy **For information:** University Hospital Limerick is the Model 4 hospital for the region providing major surgery, cancer treatment and care, emergency department services, as well as a range of other medical, diagnostic and therapy services. It is where all critical care services are located in addition to a 24/7/365 Emergency Department and it is a designated cancer centre. UHL is the second busiest Emergency Department in Ireland with over 57,000 patients annually. Emergency and complex surgeries are only undertaken at UHL. The hospital is the hub for Ennis hospital, Nenagh hospital and St. John's hospital which manage the majority of their local population through their medical assessment units and inpatient beds. Patients who require access to critical and complex care are seen at University Hospital Limerick and either stabilised and transferred to a local Model 2 hospital, namely Ennis or Nenagh or admitted to UHL if required. Croom Hospital is part of the UL Hospitals group. It is the dedicated orthopaedic hospital for adults and children in the Mid-West region. Croom hospital also accepts the transfer of Orthopaedic patients from UL hospital for post-acute. In addition to Orthopaedic services, Rheumatology and Pain Management services are also provided. The UL Hospital Group currently has two hospitals under the Activity Based Funding programme, University Hospital Limerick and Croom Orthopaedic Hospital. The remaining hospitals in the group will be in a position to fall under ABF in 2017.

	Service Arrangements and Compliance The HSE Acute Hospitals Division provides funding to 16 Voluntary Hospitals, known as Section 38 Agencies for the delivery of a range of healthcare services. St. John's Hospital is the only Section 38 agency provider in the UL Hospital Group.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** With regard to inpatient activity it is recognised that the imperative is to continue to shift to day case activity in terms of enabling optimum access at the most efficient cost. The planned work undertaken by the system will give priority to urgent and complex cases. In terms of activity the group will also seek to optimise existing capacity through reducing length of stay and shifting care to appropriate settings including primary care. ▪ Having regard to the available funding, it is expected that: ▪ Day case activity will be delivered at 100% of 2015 levels ▪ Inpatient activity target is to deliver 2015 levels ▪ Emergency inpatient activity will be delivered at 100% of 2015 levels ▪ OPD activity will be funded at 100% of 2015 levels ▪ The target for % of adults waiting < 15 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 90% compliance against this target. The projected compliance for 2016 is 95% ▪ The target for % of adults waiting < 8 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 66% compliance against this target. The projected compliance for 2016 is 70% ▪ The target for % of children waiting <15 months for elective procedure (inpatient and day case) was 100% in 2015 and it is expected that the outturn for 2015 will be 95% compliance against this target. The projected compliance for 2016 is 95% ▪ The target for % of children waiting < 20 weeks for elective procedure (inpatient and cay case) was 100% in 2015 and it is expected that the outturn for 2015 will be 55% compliance against this target. The projected compliance for 2016 is 60% ▪ The target for % of people waiting <15 months for first access to OPD services was 100% for 2015 and it is expected that the outturn for 2015 will be 90%. The projected compliance for 2016 is 100% ▪ The target for % of people waiting < 52 weeks for first access to OPD services was 100% for 2015 and it is expected that the outturn for 2015 will be 85%. The projected compliance for 2016 is 85% *Key service objectives for 2016 include:* ▪ Sustain access to urgent and planned care by increasing efficiencies, streamlining processes and maximising capacity ▪ Implement integrated care pathways for patients with Chronic Obstructive Pulmonary Disease (COPD), asthma, heart failure and diabetes in the context of the Integrated Programme for Prevention and Management of Chronic Disease ▪ Improve patient access and experience by the provision of integrated care in collaboration with social care, primary care and mental health services ▪ Commence implementation of the Maternity Strategy

	UL Hospitals Group Key priorities and Actions to Deliver on Goals in 2016 **CEO priorities** 7. Continues to place patient at centre and embody our brand of Caring, Courteous and Professional. Responsible: CEO & Executive Team. Quarter: Q1-Q4. 10. Progress ambitious capital development plans for ULHG ED, dialysis unit, CERC, Croom development, 96 bed single room block, Nenagh and Ennis Development and St. John's bed block feasibility study. Responsible: CEO. Quarter: Q2-Q4. 11. Progress new maternity hospital for group. Secure design funds and progress planning. Responsible: CEO & Executive Team. Quarter: Q1-Q4. 12. Continue to improve patient care, improve culture and staff value. Responsible: CEO & Executive Team. Quarter: Q1-Q4. **Priority Area:** Scheduled Care **Action 2016:** Improve performance in relation to scheduled care by ensuring active management of waiting lists for inpatient and day case procedures and reduce waiting times by strengthening operational and clinical governance structures including: Monitor and report chronological scheduling for routine inpatient and day case procedures including waiting lists for a range of diagnostics procedures; Commence monitoring of waiting lists for a range of diagnostics procedures; Adherence to NTPF guidelines in relation to scheduling of patients for surgery; Commence monitoring of scheduled waiting list cancellation rate; Reorganise hospital group services with an increased focus on small hospitals managing routine urgent or planned care locally and more complex care managed in the larger hub hospitals; Optimise capacity by reducing length of stay in line with the surgical programme targets and increasing day of surgery rates; Shift care to the most appropriate setting including increased day surgery rates and redirection of minor operations from hospitals to primary care; Improve day of surgery admission rates for all hospitals; Improve day case rate for laparoscopic cholecystectomy; Reduction in bed day utilisation by acute surgical admissions who do not have an operation in all hospitals; Collaborate with the Primary Care Division in relation to the transfer of appropriate minor surgery procedures to be undertaken in the primary care setting; Identify minor surgical procedures currently undertaken in theatre that could be undertaken in other hospital settings suc as procedure room or OPD; Ensure that all procedures are carried out in the most appropriate clinical setting and are coded accurately. **Target/Date:** All ongoing. **Priority Area:** Unscheduled Care **Action 2016:** Improve performance in relation to unscheduled care by continuing to implement the ED Task Force report recommendations in conjunction with the Acute Hospitals Division and community healthcare services to ensure that all patients are admitted or discharged from ED within 9 hours but in particular those > 74 years of age; Alleviate pressures on

	the hospital system over the winter period enabling achievement of the targeted reduction in trolley waits by opening a number of additional beds; Activate full escalation response in the event of red status on trolleygar or any patient breaching the 9 hour maximum trolley wait as per Mandatory National Directive 27/11/15; Implement the Irish Hospital Redesign Programme in Limerick University Hospitals in 2016 and continue to implement the programme in Tallaght Hospital, which has been established to improve healthcare delivery in Irish hospitals using a redesign approach in conjunction with the integrated programme for patient flow. **Target/Date:** Q1-Q4; Q1-Q2; Ongoing; Q1-Q4. **Priority Area:** Clinical and Integrated Care Programmes (Integrated Care for Patient Flow) **Action 2016:** Support the development of implementation plans for integrated care pathways across all hospitals in collaboration with the Clinical and Integrated Care Programmes; Support the establishment of the Integrated Care Programme for Patient Flow and prioritised work-streams; Merge the Irish Hospital redesign Programme to support the planned and phased implementation of a pilot project to design, test and deploy the application of scientific management practices in healthcare to tackle patient flow; The Clinical Strategy and Programmes will lead in the design and phased implementation of new service delivery models and methods supported by the Acute Hospital Division - Emergency service communication project – Enhancing Acute surgical Assessment services – enhancing musculoskeletal physiotherapy services – phased implementation and planned rollout NQAIS. **Target/Date:** Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4. **Priority Area:** Clinical and Integrated Care Programmes (Integrated Care for Older People) **Action 2016:** Support the phased implementation of evidence based, integrated care pathways for older persons in conjunction with ICPOP and the national Clinical Care Programme older People (NCCOP) to improve quality, access and value for older persons requiring acute care. This includes: NCCOP and ICPOP will engage with CHO and Hospital Group Leadership to prepare pioneer areas to work towards shifting models of care, building on local initiatives and combining the ICP operation framework, NCCOP and ICPOP will support the establishment of local Integrated Care Teams, NCCOP and ICPOP will establish project work streams to develop and evaluate model. **Target/Date:** Q1-Q4. **Priority Area:** Integrated Care Programmes for the Prevention and Management of Chronic Disease **Action 2016:** Support the phased implementation of integrated care pathways across all hospitals in collaboration with the Integrated Programme for Prevention and Management of Chronic Disease for patients with COPD, asthma, ischaemic heart disease and diabetes; Collaborate with ICPCD and the Office of the Chief Information Officer in the design of chronic disease registries for use in primary, secondary and continuing care. **Target/Date:** Q1-Q4; Q1-Q4. **Priority Area:** Integrated Care Programme for Children

	Action 2016: Support the establishment of the Integrated Care Programme for Children and associated work-streams; Complete the roll-out of PWES in UL. **Target/Date:** Q1-Q4; Q1-Q4. **Priority Area:** Ambulance Service **Action 2016:** Develop a performance indicator which will monitor time taken for clinical handover of patient in ED that will be based on the National Ambulance Handover Protocol for the Handover of Ambulance Patients in EDs and differentiates between completion of clinical handover and the time ambulance crew are available for next call, in conjunction with NAS. **Target/Date:** Q1-Q4. **Priority Area:** Capital Development **Action 2016:** Reduce delays with opening of new ED, UHL; New dialysis unit; Clinical Education and Research; Opening of the remaining units in the Leber Building; Progress the upgrading of Sterile Services ULHG; Expansion of existing Surgical Assessment Units; Opening of additional critical care beds; New pre-operative assessment and day of surgery admission unit; Croom Orthopaedic Hospital upgrading of theatres and OP facilities; progress the design of the new acute fracture unit; progress development of the new vascular suite and urology unit; progress implementation of robotic surgery program at UHL. **Directorates Responsible:** Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics; Medicine, Diagnostics, Facilities; Perioperative; Perioperative; Perioperative; Perioperative; Perioperative; Perioperative; Perioperative; Perioperative; Perioperative. **Target/Date:** Q4; Q3; Q4; Q1-Q2; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4. **Priority Area:** Winter Initiative **Action 2016:** Continue to provide additional capacity as per Winter Capacity Initiative: Additional 17 medical beds, additional 5 isolation rooms. To address some of the capacity issues on the UHL site, 22 patient beds will be opened in addition the group will commence a phased opening of acute Stroke/Neurology beds and five beds/rooms for the treatment of patients with Cystic Fibrosis; Support UL Hospital Executive in developing linkages with Primary and respite Care to support timely and appropriate patient flow across services; Continue development of Post-Operative Care Unit for high risk patient care post operatives to optimise patient safety and outcomes and reduce post-operative morbidity, thus enhancing patient and organisational outcomes; Reduce the MRI waiting times for non-life-threatening out-patients; Reduce the waiting time for GP and out-patient ultrasound referrals; review current capacity in Radiology and address deficits in MRI service; review current CT service provision across the hospital group, explore opening additional room at UHL and agree a plan to optimise the use of CT in both Ennis and Nenagh; Implement the winter resilience plan as required and ensure appropriate service provision when there is a surge in demand; Develop a modified appointment system for the obstetric ultrasound ant-natal clinics to improve the patient's pathway; Develop forward ordering KPI to improve the patients pathway when attending the Fracture and Orthopaedic Clinics.

	Directorates Responsible: Perioperative, Medicine, Child & Maternal Health, Facilities, Diagnostics; Perioperative, Medicine; Perioperative; Diagnostics; Diagnostics; Diagnostics; Diagnostics; Diagnostics; Diagnostics; Diagnostics. **Target/Date:** Q1; Q1; Q1; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4; Q1-Q4. **For information:** *Emergency Care* In 2015 there was a 3.2% increase in the number of patients presenting to the Emergency Department in University Hospital Limerick (57,297 up from 55,502 in 2014). The Local Injury Units (LIU) also saw an increase in patients, 4.2% in both Nenagh and Ennis, 1.5% in St. John's Hospital. The result of this pressure on emergency services was a 9.2% year on year increase in the number of emergency admissions. LIU's now account for just over 30% of all new emergency presentations for the group. *Scheduled Care* Additional capacity towards the end of 2015, reduced medical length of stay in Ennis, Nenagh and St. John's Hospital, and a 44% reduction in delayed discharges allowed the number of elective admissions to remain virtually unchanged for the group (+0.6%). Maintaining elective admissions was a critical factor in achieving all the inpatient and outpatient waiting list targets set in 2015. With a population of 379,327, the UL Hospital Group treated over 224,000 patients in all our outpatient centres.
Governance	**Recommendation/considerations:** The key components of the Performance Accountability Framework for the Health Services 2016 as they relate to the acute hospital services are as follows: ▪ Continued strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group Chief Executive Officers and the CHO Chief Officers ▪ Completion of Formal Performance Agreements between the Director General and the National ▪ Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers ▪ A developed and enhanced formal Escalation and Intervention Framework and process for underperforming services which includes a range of supports, interventions and sanctions for significant or persistent underperformance ▪ Continued cooperation with the National Performance Oversight Group with respect to accountability responsibilities with the focus on the balanced scorecard ▪ Accountability arrangements will be put in place in 2016 between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc.) in respect of delivery against their Operational Business Plans. Areas for development and improvement during 2016 include: ▪ The implementation of Improvement Leads and Improvement Teams.

	▪ Partnering of a high performing hospital or service with a poorer performing service as a 'buddy' arrangement to provide advice and support ▪ Inclusion of a clearly defined timeframe for improvement over the reporting year for services that fail to ▪ improve ▪ Differentiated approach to underperformance in respect of finance ▪ The application of sanctions for persistent underperformance. As part of the Performance Accountability Framework 2015 an enhanced Escalation and Intervention Framework and process was developed for implementation during 2016. The HSE's Escalation and Intervention Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators and a rules-based process for escalation at a number of different levels. *Key service objectives for 2016 include:* ▪ Embed robust governance structures within the group in line with the HSE Accountability Framework ▪ Develop and improve capacity for quality and patient safety within the group through the implementation of the patient safety and quality framework which will be established by the Acute Division, that will address patient advocacy, complaints, incident management and response, learning systems and service improvement. Leadership and Governance for Quality and Safety ▪ Ensure that authority and accountability for the quality and safety of services across all service areas is integrated into operational service management through appropriate leadership, governance, structures, and processes ▪ Develop capacity for development of quality and patient safety within Hospital Groups whereby each service has a defined patient safety and quality operating model to address service user advocacy, complaints, incident management and response, learning systems, service improvement, and change of culture ▪ Ensure compliance with all national standards and regulations as they relate to quality and safety of services along with a strong focus on continuous quality improvement of services ▪ Build capacity and capability for leadership and improvement in quality through formal education and training programmes and supporting staff to implement quality improvement initiatives in their services ▪ Strengthening the HSE's governance arrangements under the health service Accountability Framework by measuring, monitoring and reporting on the performance of the health service in relation to the quality and safety of care, with a specific focus on identifying and addressing areas of under-performance by recommending appropriate and proportionate action to ensure the improvement of services ▪ Putting in place an assurance system including measurement, healthcare audit and reviews that seek evidence that quality and safety is prioritised and committed to at all levels of the healthcare delivery system ▪ Establish positive and effective staff engagement as a keystone of quality improvement and person centred care by partnering with services to develop and test methodologies, build organisational leadership capacity and share learning.

	Actions 2016: ▪ Embed the hospital group structures within Acute Hospital Services (Target Date: Q1-Q4) ▪ Develop the Hospital Group Strategic plans and the Acute Division National Strategic Plan in conjunction with Systems Reform Group (Target Date: Q2). ▪ Consolidate arrangements between Hospital Groups and Academic Partners as per Reform Programmes (Target Date: Q1 – Q4) ▪ Comply with recommendations from local audits and potentially systemic recommendations (Target Date: Q1 - Q4) ▪ Complete Service Arrangements as appropriate in accordance with HSE Governance Framework for Funding Non-Statutory Provided Services (Target Date: Q1) ▪ Align Emergency Management structures for emergency planning and crisis response to new Hospital Groups. Appoint Hospital Group Leads for Emergency Management Working with the emergency management function of the HSE, ensure emergency structures across hospitals continues to develop (Target Date: Q1 – Q4). **For information:** The hospitals in Ireland are now organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the Health Act 2004 in line with National Service Plan (NSP) 2016 and allocated Group budgets. The UL Hospitals Group Operational Plan 2016 is aligned with this Acute Hospitals Division overarching Operational Plan. The Group Chief Executives report to the National Director for Acute Services and are accountable for their planning and performance under the Accountability Framework of the HSE. All targets and performance criteria adopted in the service plan and the divisional Operational Plan will be reported through this framework. UL Hospitals is governed by an interim Board and an Executive Management Team led by a CEO who reports to the Board. Our services are delivered across the six sites under the leadership of four clinical directorates namely, Medicine Directorate, Perioperative Directorate, Diagnostic Directorate, Maternal and Child Health Directorate. Each Directorate is led by a team of staff bringing Clinical. Managerial and Financial expertise together to provide quality driven safe services, focused on the experience and outcomes for the patient. The HSE's Accountability Framework was introduced in 2015 and has been further enhanced and developed for 2016. It sets out the process by which the National Divisions and Hospital Groups will be held to account for their performance in relation to Access to services, the Quality and Safety of those Services, doing this within the Financial resources available and by effectively harnessing the efforts of its overall Workforce.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Integrated Care Programme for Older Persons* The purpose of the Integrated Care Programme for Older Persons is to augment primary and secondary care services for older people in the community enabling a shift from a model of acute, hospital-based episodic care to a model that reflects increased co-ordination and care planning based on the needs of the older person. Given the ageing demographics there is

	an urgent need to build capacity in the provision of healthcare services that can meet this change in the model in both community and acute services. Work is already well established in Limerick. The priority in 2016 is developing this programme across 4 pioneer sites (one being CHO 3 University Hospital Limerick (UCHL) which will commence the implementation of the integrated care programme in 2016. Social care services will lead the process which is multi-agency and multi-divisional.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** ***2016 Developments*** The planning, approval, notification, management, monitoring and filling of service development posts will be in line with the existing process for approved and funded new service developments as specified in Acute Hospital Division Operational Plan. Other workforce additions, not specifically funded at the outset of the year, will be implemented only where offset by funding redirection within the allocated pay envelope in line with UL Hospitals Group strategic plans. 2016 will see a focus on the "The People Strategy" which has been developed in recognition of the vital role the workforce plays in delivering safer and better healthcare. *Public Service Stability Agreements 2013-18* The Lansdowne Road Agreement 2015 builds upon the agreement set out in the Haddington Road Agreement (HRA) until 2018. The UL Hospital Group will implement actions agreed by the division under the Public Service Agreements 2013–2018 through which change is achieved and is a central element of the strategy for recovery and a sustainable future for acute hospital services. The key enablers, such as additional working hours, that existed under the HRA up to now will remain for the duration of the extended agreement and will continue to assist clinical and service managers to manage their workforce through the flexibility measures contained. These enablers will support the reform, reconfiguration and integration of services and contribute to delivering a workforce that is more adaptable, flexible and responsive to needs of the services, while operating with lower pay expenditure costs and within allocated pay envelopes. In 2016, as per the Final Agreement for Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement the following tasks will transfer from Medical to Nursing staff in line with associated National Framework and Task Transfer Verification Process (December 17th 2015): ▪ Peripheral cannulation ▪ Phlebotomy ▪ Intra Venous drug administration — first dose; including in the appropriate setting ▪ Nurse led delegated discharge of patients. Workforce planning for UL Hospitals Group will focus on the strategic objectives of the group over the next 3 years which will take consideration of demographic requirements.

European Working Time Directive (EWTD)

Through the forum of the National EWTD Verification and Implementation Group, the Acute Hospital Division continues to work collaboratively with Irish Medical Organisation, the Department of Health and other key stakeholders to work collectively towards the achievement of full compliance with the EWTD. The Acute Hospital Division is also currently working jointly with National Human Resources in consultation with the Hospital Groups to develop a comprehensive framework plan to support the achievement of full compliance. UL Hospitals Group through the local EWTD steering committee will work to move the group toward the achievement of full compliance. UL Hospitals through the local EWTD steering committee will work to move the group towards the achievement of full compliance and the ongoing review of rosters/rotas.

Recruitment

The Acute Hospitals continue to work with national HR to recruit and retain highly skilled Medical and Nursing staff to approved positions to support services.

The division will support the work of the HR team established to address the operational and administrative barriers to successful Consultant recruitment and retention including:

- Developing a strategy for specialties within UL Hospitals Group to meet demand and demography whilst acknowledging neighbouring group services, recognising established national specialties and matching developing national strategies such as the provision of trauma services
- Developing a statement on shared service division within the relevant specialty
- Compiling information on the precise allocation of available facility resources including, for example, allocation staffed theatre time, protected beds, Outpatients (OPD), endoscopy sessions, Non consultant hospital doctor (NCHD) staffing, specialist nursing, allied health staffing and administrative resources. This will ensure that we attract and retain the best to work in the service.

Attendance and Absence Management

UL Hospital Group have made progress in 2015 in reducing our absenteeism. In 2016 we will continue to maintain and build upon the progress achieved during the past year in improving attendance levels through the consistent implementation of the Managing Attendance Policy and Procedures. The performance target for 2016, remains at less than or equal to 3.5% staff absence rate. In addition, the group will continue to support the implementation of an agreed performance management framework. In doing so, managers will receive support to manage absenteeism and performance appropriately.

Employee Engagement

Building on what the Group has already put in place further efforts will be made to ensure that the "employee voice" is heard and their views considered with appropriate feedback being given, alongside the further development of people management practices. In this context, the group will continue to actively engage with staff and will continuously seek to identify opportunities to involve more staff in planning and decision making. UL Hospitals have put in place an Information and

	Consultation with the union representing staff. This along with listening forums and communication roadshows have increased the communications with staff working in the group. **The Workforce Position** Government policy requires that the number of people employed in Acute Hospital Services is within the limit of the available funding. The management of funding for human resources in 2016 will continue to be based on the Pay Bill Management and Control Framework. Compliance with the framework and the requirement for Hospital Groups to operate within the funded pay envelope is a key priority for the Acute Hospital Division, alongside the management of risk and service implications. This approach sees a transition from moratorium to an accountability framework designed to support creation of annual and multi-annual workforce plans based on models of care that will deliver services within allocated pay resources. UL Hospitals will have greater discretion and flexibility in how they manage their workforce and payroll costs should they meet their budget targets. This needs to be achieved whilst ensuring services are delivered in line with the National Service Plan. The UL Hospital Group is currently working collaboratively with National HR and Finance to develop workforce plans that are closely aligned to funding projections and the group strategy**.** **Hospitals Employment Levels** The whole time equivalent numbers employed by UL Hospitals Group fell significantly during the years of austerity and by Oct 2015 have returned to 2009 levels (Government Moratorium on public sector recruitment) but over that period there has been a reconfiguration of the skills mix. The hospitals nationally and UL Hospitals will need to reduce total staff numbers in 2016 to achieve the financial targets contained within the Acute Hospital Division Operational Plan. The range of adjustment will vary depending upon the outturns for the group in 2015. **Reducing Agency and Overtime Costs** Whilst UL Hospital Group did a lot of work on reducing agency in 2015 we will continue to focus on further reductions in the cost and reliance on agency staff and overtime during 2016. This will involve services developing appropriate plans for agency conversion and reduction in overtime expenditure across all services and staff categories, to deliver appropriate and cost effective services. UL Hospitals Group will continue to monitor and review agency and overtime costs whilst working to support the directorates with implementing initiatives to reduce costs, such as redeployment, skill mix review, and changes in work practices. **Priority Area:** People Strategy 2015-2018 **Action:** Implement the People Strategy 2015-2018 within UL; Develop staff engagement programmes which aim to involve staff in service delivery planning; Support improved capacity within acute hospitals by right-sixing staffing levels through recruitment and retention of staff and facilitating an expansion of the role of care professionals within current resources; Support National HR team established to address the operational and administrative barriers to successful consultant recruitment and retention including: develop an agreed Hospital Group strategy for specialities, develop a statement on

	shared service division within the relevant speciality, compile information on the precise allocation of available facility resources for consultant services; Continue to work with National HR on Nursing Recruitment and Retention initiatives; Ensure that health education campaigns will include specific information and support to help staff improve their own health and wellbeing. **Target/Date:** Q1 – Q4 for all. **For information:** **University of Limerick** **WTE Dec 14:** 3,109 **WTE Oct 15:** 3,369 **Medical/Dental:** 432 **Nursing:** 1,410 **HSCP:** 332 **Management/Admin:** 556 **General Support Staff:** 239 **Patient and Client Care:** 399
Funding	**Recommendation/considerations:** The University of Limerick Hospital Group net 2016 allocation amounts to €255.243m. Significantly, 2016 is the year when the funding model is migrating from the historic block-budget approach to a model of 'Activity Based Funding' (ABF) for public hospital care covering inpatients and day-cases. *Existing Level of Service / Cost pressures* The cost of providing the 2015 level of service will grow in 2016 due to a variety of factors. Under Activity- Based Funding cost growth is considered under two headings - 'price' and 'volume'. 1. We know that we will have 'price' effects in the following areas. This means that our underlying price will rise, but we will not obtain any additional service for that expenditure:- ▪ National pay agreements ▪ Public pay policy requirements ▪ Quality and safety requirements ▪ New drugs and improved medical technologies ▪ Supplier price increases, and potentially some price savings if oil prices translate into our energy bills 2. In addition to the 2015 level of service we know that we will have 'volume' pressures in 2016 due to the nature of our demographic, over 85 population etc. Our challenge in this context is that the ABF targets have been locked with a price to fit within the funding envelope. Those targets are based on the rolling 12 months to the end of October 2015. We do not have funding to exceed that level of service.

	We must not grow our activity in 2016 as this will lead to increased non-pay expenditure on bloods, laboratory, medical consumables etc. It can also lead to increased expenditure on variable pay such as overtime. Further to these price and volume pressures, ULHG have a further €8.5m income challenge to be addressed in 2016. This relates to historic income-collection targets which have now been included in the expenditure budget. The HSE and ULHG will ensure that appropriate management effort and attention is applied to maximising the delivery of the any savings measures in the overall budgetary performance of the hospitals. Thereafter the HSE and the Department of Health have acknowledged the shared risks inherent in the extent of the savings. The Financial Control framework for 2016 will consist of four major components: 1. Headcount and other pay controls 2. Management of activity volume and clinical non-pay 3. System-wide approach to non-clinical non-pay 4. Maximising delivery of income targets. **1. Headcount and other pay controls** Following a number of years of economic recession, the hospital system did fill a range of risk-related posts in 2015 (260) which has been vacant due to the recruitment moratorium. The strategy to deliver the EWTD and efforts to reduce agency premium also involved increases in headcount. It is clear that the financial envelope which is available in 2016 does not allow for any further recovery of vacant posts. The HSE has already given hospital groups a pay framework for 2016 which will require them to improve the governance of headcount, further specific agency conversion where appropriate and manage expenditure on variable pay at 2015 levels - particularly through controlling activity volumes. **2. Management of activity volume and clinical non-pay expenditure** The three critical components of clinical non-pay expenditure are: 1. Activity volume 2. New drugs and increased volume of existing drugs due to treatment regimes 3. Improved medical technologies Increases in workload involve expenditure on consumables, medical and surgical devices, bloods, laboratory etc. The prices which have been offered to hospitals for 2016 under ABF are already discounted by 2% which means that hospitals cannot afford the levels of expenditure already being incurred and must make savings on these. Critically, there is no scope to increase clinical non-pay expenditure by growing volume. The monthly performance meetings with the hospital groups will focus heavily on the volumes being produced to ensure that these are within the targeted levels for the year which have been locked in place with prices to fit the funding envelope. To the greatest extent practical and consistent with the safe delivery of services hospitals will deliver services at 2015 levels. New drugs are an intrinsic element of hospital systems and good progress has been made in recent years in the area of high-cost cancer drugs supported by the National Cancer Control Program and their protocol-driven reimbursement system. So called 'orphan' drugs such as enzyme replacement therapy can increase expenditure steeply and are among some of the most expensive drugs in the system. Additional funding has been provided in the service plan for this aspect of hospital expenditure. Increased volume of drugs is a more difficult issue and

	can arise due to volume of patients and/or changes in treatment regimens which require more frequent administration of certain chemotherapy drugs. These types of cost will have to be managed carefully in the context of savings targets. Improved medical technologies such as the capacity to deliver thrombectomy in stoke care or transcatheter aortic valve implantation can suddenly bring considerable additional cost to the system and these items will have to be isolated and monitored during 2016 given the funding available. **3. System-wide Approach to Clinical Non-pay** Working with colleagues in ULHG, there will be reviews of all areas of non-clinical expenditure to achieve any potential savings. **4. Maximising Delivery of Income Targets** The changes in legislation in relation to bed designation have allowed the hospital system to increase its income generation. The €8.5m accelerated income target is a part of the increased target together with other factors such as an expected 4.55% growth in the private patient market. **Capital Infrastructure** Ennis Hospital, Co. Clare Project details: Redevelopment of Ennis General Hospital (phase 1) to include fit out of vacated areas in existing building to accommodate physiotherapy and pharmacy and development of a LIU. Project completion: Q4 2916/Q1 2017 (phased) Fully operational: Q1 2017 (phased) Additional Beds: 0 Replacement beds: 50 Capital Cost €m 2016: 0.45 Total: 1.19 2016 Implications WTE: 0 Rev Costs €M: 0.00 University Hospital Limerick Project details: Construction and fit out of renal dialysis unit over ED; Acute MAU and OPD reconfiguration. Ward 1B reverts to a 29 beds war and the acute MAU will be accommodated in the (old) Ward 61; Clinical education and research centre (co-funded with UL); Equipping of Leben building – breast unit, dermatology, stroke and cystic fibrosis OPD. Project completion: Q3 2016; Q4 2016; Q4 2016; Q4 2015.

	Fully operational: Q4 2016; Q1 2017; Q4 2016; Q1/Q2 2016. Additional Beds: 13; 5; 0; 0. Replacement beds: 11; 0; 0; 0 Capital Cost €m 2016:1.50; 0.50; 2.80; 1.00. Total: 7.20; 1.00; 11.20; 4.50. 2016 Implications WTE: 0; 0; 0; 0. Rev Costs €M: 0.00; 0.00; 0.00; 0.00. **Hospital Care** **ULHG – Activity Based Funding Targets by site** **Dooradoyle** **Inpatients** **Cases:** 26,122 **WU:** 23,900 **Daycases** **Cases:** 33,083 **WU:** 36,152 **Croom Orthopaedic Hospital** **Inpatients** **Cases:** 1,866 **WU:** 3,139 **Daycases** **Cases:** 3,296 **WU:** 5,316 **ABF Total** **Inpatients** **Cases:** 27,988 **WU:** 27,040 **Daycases** **Cases:** 36,379 **WU:** 41,468

	Ennis **Inpatients** **Cases:** 4,107 **WU:** 2,021 **Daycases** **Cases:** 6,399 **WU:** 7,393 **Nenagh** **Inpatients** **Cases:** 2,168 **WU:** 1,961 **Daycases** **Cases:** 6,349 **WU:** 9,471 **St. John's Limerick** **Inpatients** **Cases:** 3,456 **WU:** 4,280 **Daycases** **Cases:** 7,087 **WU:** 8,050 **Limerick Maternity** **Inpatients** **Cases:** 7,783 **WU:** 5,138 **Daycases** **Cases:** 256 **WU:** 186 **Non-ABF Total:** **Inpatients** **Cases:** 17,514

	WU: 13,400 **Daycases** **Cases:** 20,091 **WU:** 25,101 **UL Hospitals Total:** **Inpatients** **Cases:** 45,502 **WU:** 40,440 **Daycases** **Cases:** 56,470 **WU:** 66,569 **For information:** Substantial cost control and cost reduction by the UL Hospital Group will be required with a focus on controlling the total pay and non-pay costs as well as maximising income. *Risks to the delivery of Acute Hospitals plan within funding available* In identifying potential risks to the delivery of this operational plan, it is acknowledged that while every effort will be made to mitigate these risks, it will not be possible to eliminate them in full. Identified risks include: ▪ Capacity to cap the introduction of drugs and medical devices ▪ Capacity to control activity volumes to the targeted level under ABF ▪ Capacity to maintain and collect income ▪ Capacity to achieve pay and non-pay cost control at the level required while demographic impacts drive demand for services ▪ Ability to contain activity to 2015 levels for emergency care and urgent and routine elective treatments ▪ Continued or accelerated demographic pressures over and above those already planned for in 2016 ▪ The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce ▪ The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task including the scale of recruitment required and the information system ▪ constraints ▪ Pay cost growth which has not been funded ▪ Risks associated with the delivery of procurement savings ▪ Lack of contingency funding to deal with unexpected service or cost issues.

Other	**Recommendation/considerations:** *Key service objectives for 2016 include:* ▪ Commence implementation of the Maternity Strategy ▪ Implementation of Activity Based Funding Model with the use of the Hospital Inpatient Enquiry system (HIPE) data to determine the volume of cases required to be undertaken by the group in 2016. Key objectives for 2016: *Safe Care* ▪ Acting to promote the reduction of risk to the public, staff and healthcare services by adopting a risk based approach to predicting, identifying and responding to service areas where significant performance, quality and safety concerns may exist ▪ Improve monitoring, investigation and learning processes from serious incidents across all service areas. Progress the implementation of recommendations from major reports and serious incidents across all service areas ▪ Continue support and commitment to the process of development, implementation and monitoring of National Clinical Effectiveness Committee (NCEC) National Clinical Guidelines and Audit in all ▪ appropriate services including Early Warning Systems, Clinical Handover, Healthcare Associated Infections (HCAIs) and Sepsis ▪ Putting in place an effective system to identify, manage, investigate and implement the learning from serious safety incidents, safety investigations and regulatory investigations and inspections ▪ Strengthening the HSE's regulatory capacity to fulfil its responsibilities in the area of medical ionising radiation ▪ Continue the implementation, control and prevention of HCAIs / antimicrobial resistance (AMR) in accordance with HCAI standards across all service areas including decontamination standards ▪ Reduction in medication errors ▪ Establish a National Independent Review Panel with an independent Chair and Review Team members as part of the HSE's enhanced arrangements for investigations. The Review Panel will focus on serious incidents that occur in disability services across the HSE and HSE funded services. *Effective Care* ▪ Continue to prioritise improvements in the quality and safety of care in maternity and perinatal services ▪ Prioritise the safeguarding of service users, and support improvements in services in residential intellectual disability services ▪ Provide leadership and support to enable the services develop capacity and capability to deliver on key national patient safety programmes in primary care, social care and acute settings to address internationally recognised causes of harm to people (including HCAI, medication safety, pressure ulcers, falls prevention and nutrition and hydration) ▪ Develop a national policy framework for Policies, Procedures, Protocols and Guidelines (PPGs) including education training and support and commence the development of a document control system national repository for PPPGs.

	Service User Experience ▪ Listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals ▪ Conduct a service user and patient experience survey in each hospital (in conjunction with Health Information and Quality Authority- HIQA) and commence patient experience surveys in primary care and community services ▪ Develop and implement a national person-centred care Programme which engages, enables and ▪ empowers people to be at the centre of service delivery ▪ Continue the development of a patient-centred and improvement culture in the HSE that will deliver on sustainable quality improvement with the implementation of a framework for improving quality which provides a structured approach to improving health and social care service delivery by enabling staff ▪ to focus on the key drivers for quality improvement ▪ Continue to develop access to advocacy for all patients and service users within, Hospital Groups and Ambulance Services; work to ensure that advocacy is available to older people in all settings; and provide advocacy services to patients, including work with Patient Focus ▪ Leading a national person-centred programme (including listening to and acting on the views, concerns and experiences of care of patients, service users, staff and other concerned individuals). **For information:** The services outlined in this operational plan are based on those agreed in the National Service Plan 2016 and the Acute Division Operational Plan. [Note: Further sections on the National Cancer Control Programme, are included but not extracted. Please see report for further detail].
Impact	No information identified.

Table 30 HSE Mid West Community Healthcare Limerick, Clare and North Tipperary [2016]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[30] HSE Mid West Community Healthcare Limerick, Clare and North Tipperary [2016] Report [Note: extracted data with focus to community services impact to hospitals]
The health service system (including health service reform)	**Recommendation/considerations:** A key priority for 2016 is to progress the further development of the structures and processes intended to ensure that the CHO area achieves what is intended for the people of the Mid West – high quality integrated services as close to home as possible. The HSE's HI Implementation Plan has identified three clear strategic priorities for action, because in one way or another, every part of the health service is engaged in improving health and wellbeing. These will be progressed in 2016 with a sector-wide focus on: System Reform Ensuring that we deliver the significant reforms which are underway to support a better health system. **For information:** CHO areas were designed in 2014 and commenced operation in 2015 replacing the then 17 areas.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** The Integrated Care Programme for Patient Flow will progress a number of priority projects to tackle some of the most pressing patient flow challenges in our health system. While working with and availing of the design and testing of models at national level we in the Mid West together with our colleagues in the UL Hospitals Group have targeted patient flow through facilitated discharges from acute care. In 2015 we targeted in excess of 7,000 facilitated discharges and will build on this work in 2016.
Governance	**Recommendation/considerations:** The nine CHO areas including the Mid West are in the process of being further developed under the leadership of the nine Chief Officers. 2016 will see the reorganisation of management and governance structures reporting to the Chief Officers and this will assist in the focus on improved services.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** The reform programme for Community Healthcare will drive the delivery of person-centred, integrated care across the Mid West with better outcomes for patients and service users. The model of care which we provide must be fit for purpose and the best that it can be.

	The Integrated Care Programme for Older People will address the needs of older people including those with complex requirements through the establishment of a pioneer area. This will implement and evaluate the provision of integrated care services. The provision of care across the spectrum of primary, community, pre-hospital and hospital services should be person-centred and coordinated. HSE Mid West and the UL Hospitals Group will continue to expand on our 2015 initiatives to provide better, easier access to high quality services which are close to where people live and are delivered in a joined up way, placing their needs at its core. It is a long term programme of improvement and change and will involve people at every level of the health services working together to create improved experiences and outcomes for the people in our care.
Staffing (including workforce planning, recruitment and retention)	No information identified.
Funding	No information identified.
Other	No information identified.
Impact	No information identified.

Table 31 Report from the site visit by the National Acute Medicine Programme (NAMP) to the University Hospital Limerick on March 1st [2016]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	National Acute Medicine Programme (NAMP) (HSE)[31] Report from the site visit by the National Acute Medicine Programme (NAMP) to the University Hospital Limerick on March 1st 2016 [2016] Report
The health service system (including health service reform)	**For information:** Valid points were made regarding the site being the centre of a hospital group that has no Model 3 hospital. This coupled with reconfiguration has resulted in patients attending acutely, who would previously not have presented with subsequent impact on discharge planning. For example the links between the hospital and community services in West Clare are not as good as they would have been from Ennis Hospital. HSCP Therapy Department Heads should be encouraged and supported to build relationships and networks, with community and within the hospital group to aid in these issues.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** UHL has implemented the NAMP over a three year period. Great commitment from the medical and nursing staff is clear. Nursing staff work well across ED/ AMU to identify appropriate patients. Consult services and rapid access OPD slots facilitate early discharge. Close links have been developed with St John's Hospital. The AMU physicians, who are all Geriatricians, provide a speciality service to St John's Hospital, and St John's physicians participate in the AMAU rota in UH. Ambulatory pathways for TIA and DVT have been developed. The DVT pathway is supported by dedicated nursing support. However, the NAMP has not been implemented to its full potential. Functioning is constrained by the location and size of the AMU. Ongoing pressures on capacity leading to the use of AMU for boarders have been a regressive step. The AMU needs to be protected as per the recent letter from the Director General. There is no Short Stay Ward under the governance of the AMAU physicians. At present it is estimated that 10-20% of acute medicine is through this pathway, this is far short of the goal of 40%. Diagnostics are available on an ad hoc basis only with few dedicated radiological and no cardiac diagnostics. There is no HSCP support whatsoever in place at present. Data collection is tedious and suboptimal. No data from the NAMP is shared with the local team. **For information:**

	UHL has adopted the National Acute Medicine Programme since 2013. The Acute Medical Assessment Unit has 12 assessment beds open for new assessments from 8 am to 5:30 pm every day. The AMU is located within the outpatient department and not in close proximity to ED. Patients are referred either directly by GPs or via ED following triage. The majority of patients come from the ED pathway. A Case Manager helps to identify appropriate patients. There is no dedicated short stay ward where beds are ring-fenced and the patients are under the governance of the AMU physicians. There is no dedicated office space. Flow in and out of the department is an ongoing challenge. The unit is constrained by its location, physical size, lack of isolation facilities and its opening hours. A new purpose build space intended for use as an AMU is used as overflow instead. Flow into the department is hindered by boarders. At present it is estimated that 10-20% of all acute medicine in through the AMU pathway. Egress is also difficult once patients are identified as needing admission. Consult services are provided in a timely fashion by cardiology, respiratory, GI, endocrine and neurology services. Rapid access lung and seizure clinics help to facilitate early discharge. A strong link has been developed between the UHL Acute Physicians and those in St John's Hospital. The physicians from St John's Hospital work 2 days per month in the AMU in UHL. The UHL provide Geriatric speciality service to St John's. This is a very innovative approach and appears to work well. ***Diagnostics*** Radiology- There is 3 dedicated CT brain slots per day, Monday to Friday. Access to in patient MRI and ultrasound is on a hoc basis but has improved. There are no dedicated cardiac diagnostics. However a new chest pain clinic is being developed which may reduce the need for exercise stress tests. Urgent endoscopy is facilitated through Ennis and Nenagh Hospitals. It was felt that access to diagnostics, such as ultrasound and CT was good. There is significant pressure on the MRI scanner with one scanner serving a population of 330,000. Whilst access to MRI was not felt currently to be a rate limiting step to patient flow, it was felt that a need for MRI was associated with clinical cases requiring admission. There are some developed pathways such as that for TIA, which has one a protected slot in the Vascular Lab each day. There did not appear to be a particular issue with access to cardiac diagnostics, however the team noted the fact that requests from AMU consultants have to be sanctioned by a Cardiology registrar and would question whether this step is necessary and could it be adding unnecessary delay. Access to therapy staff is poor with no allocated staff or presence of initiatives such as a Rapid Assessment Team. We would like to see far more engagement of therapy staff with the program and the delivery of care to

	acute medical patients in the unit. We were pleased to hear about the work being done by the complex discharge team, led by Mary Breen, and complimented by good linking by therapy managers. It would be good to see the learning from this shared across the group and nationally.
Governance	**For information:** There are 4 permanent acute physicians working in the AMU assessing new acute patients and performing review clinics. The acute physicians are on the general on call rota. For three consultants, the split between Acute Medicine and Specialty 80:20. All of these consultants are Geriatricians and they have dedicated specialty time through a commitment to St John's hospital. The lead role rotates every two years and one of the Acute Physicians sits on the Medical Directorate.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**For information:** There are 4 permanent acute physicians working in the AMU assessing new acute patients and performing review clinics. The acute physicians are on the general on call rota. For three consultants, the split between Acute Medicine and Specialty 80:20. All of these consultants are Geriatricians and they have dedicated specialty time through a commitment to St John's hospital. The lead role rotates every two years and one of the Acute Physicians sits on the Medical Directorate. An additional consultant participates in AMU for 4 days per 9 week rota. There are 2 registrars, 5 SHOs and two interns working in the AMU and also providing care for the patients admitted from participation in the general medical on call service. **Nursing Report- summary** An integrated nursing governance structure is in place with clarity around roles and responsibilities of newly appointed nursing leaders emerging. Nursing services across the ED, AMU and Medical Short Stay ward work closely together to ensure in so far as the current system allows, the appropriate streaming and subsequent care and quality of care of patients. The NAMP DON Lead was informed that a medical short stay unit of 15 beds is in operation since November 2015, with plans to extend to another 15 beds. However the governance of the medical short stay ward does not rest with the acute medicine physicians/ service. As a result the short stay unit accommodates patients from multiple specialities and severely limits the capacity of the nursing contribution to the care of acute medical patients. Rather, nursing focus is reoriented toward managing patient flow out of the unit to more appropriate locations (rather than 'pull') and toward surgical patient care. Clarity across all disciplines of the plans and current stage of acute floor service development, governance and operational plan would greatly enhance the enhancement of nursing skills, focus and professional development along with providing for rotation of staff across the 'acute floor' to 'spread' skills and competencies.

	There is a strong desire to extend nursing roles and to establish alternative pathways of ambulatory and nurse delivered care. A number of staff have, or are currently undertaking a foundation programme or the Postgraduate Diploma in medical nursing. The addition of ANP candidate(s) to the service would greatly enhance the nursing contribution to achieving NAMP objectives for intervention area 1 and 2 patients. A programme of measuring nursing outcomes or 'metrics' is in place and staff is aware of the outcomes. Safety pauses are also in place. Educational programmes to develop enhanced nursing skills to include arterial blood gas sampling and analysis, blood culture sampling, male catheterisation, and triage are required. The appointment of a dedicated medical nurse clinical facilitator to support core, specialist and advanced skills and competencies development and quality improvement would be of benefit recognising the specialist role of acute medicine nursing into the future. It is also recommended that a cohort of nurses undertake accredited programmes in nurse prescribing of medicinal products and ionising radiation. Barriers to nurse referral to other Health and Social Care Professionals exist which impact on patient experience time and should be examined and addressed. In light of 'boarding out' a system for Criteria Led / delegated discharge should be considered as an interdisciplinary project to improve patient experience and achieve potential reductions in LOS particularly at weekends in the longer stay medical wards (3 to 10 days LOS) and as an aid to effecting patient transfers to more appropriate settings.
Funding	No information identified.
Other	**For information:** *Data Collection* Generally data collection is manual and suboptimal. Data from the NAMP is not disseminated to the local team.
Impact	No information identified.

Table 32 Developing an Acute Floor Model for Ireland [2017]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Health Service Executive: The acute hospitals division[32] Developing an Acute Floor Model for Ireland [2017] Guidance [NOTE: Extraction is focused on the main features of what the acute floor should look like]
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** The Acute Floor concept is recognised as part of the solution as a platform for enabling front-line change. It relates to co- or proximally-located integrated acute services within a Model 3 or 4 hospital for patients presenting for unscheduled care. Key features of the Acute Floor include: ▪ A single point of access is through the Acute Floor Hub, for swift two-way communication with GPs and community partners, for rapid access to specialists, advising alternatives to admission or the best course of treatment, or directing to the most appropriate acute service. ▪ On presentation, patients are streamed by an appropriately trained clinical staff member to the appropriate clinical services, supporting flow and rapidly getting them to the expertise they need. Streaming is distinct from triage, being a swift and immediate signposting to the appropriate clinical service on the Acute Floor, with no duplication of the formal clinical prioritisation of the triage process. Triage will take place within the respective service, whether Emergency Medicine, Acute Medicine or Acute Surgery. ▪ The clinical service will triage when demand outstrips capacity, such that patients are seen based on clinical prioritisation and cared for by a multi-disciplinary, multi-specialty team, led by a senior clinical decision maker on the Acute Floor. ▪ Early access to senior clinical decision-makers is paramount, supporting patient safety, appropriate resource use, and patient flow. Senior clinical decision-makers in core specialties will be present on the Acute Floor to support decision-making on the floor during peak hours, with robust on call arrangements to ensure continuity of care and patient safety outside core hours. Access to senior clinical decision makers and the use of Early Warning Systems have been demonstrated to improve patient safety, reduce unnecessary admissions and reduce length of stay. ▪ Conversion of historical in-patient episodes the ambulatory care, together with early senior clinical decision makers would be expected to contribute to reduced length of stay. In a hospital with 85% midnight occupancy and with an average 5 day length of stay, a 0.5 day reduction in length of stay results in effective bed gains of 17 beds in a 200 bedded hospital, or 25 beds in a 400 bedded hospital. If occupancy is 100%, those gains are 20 and 30 beds, respectively.

	▪ Services will operate as a network, within a shared space of co-located, interconnected services, acting as part of a wider integrated health system, as opposed to discrete units or departments. ▪ Capacity is designed around patient needs and the patterns of demand rather than around traditional 9-5 working practices, and will shift to an increasingly predictive, data-driven model. Services designed around averages will consistently not be resourced to actual demand. Demand determines design – of services and teams. ▪ The design of the services and the space will promote ambulatory assessment and care as a primary option. Bed-based or traditional in-patient provision will no longer be the default. Dedicated pathway development will assist this shift in focus. Ambulatory care should be the first filter before admission is considered. Where admission is required, the flexibility will be needed for short-stay admission or timely access to specialist wards. ▪ Core diagnostics will be present on or near the Acute Floor to avoid becoming a rate limiting step. Where specialist radiologists are required, remote reporting is encouraged at the hospital group level. The development of GP direct access to specified diagnostics may enable more community-based care, and open up new models of care for those who do not need the full gamut of acute healthcare resources. ▪ The Acute Floor Hub and governance structures will support integration with primary care, social care and community services, such that patients are discharged without delay, built on proactive, systematic operating practices and governance. Patients will be cared for in the most appropriate setting, which may not be an acute hospital, and may be closer to home. Just widening the front door alone through the Acute Floor will not alleviate system pressures, and requires jointly building, embedding and improving new pathways across the healthcare economy. ▪ The widening of acute expertise to assess complex patients and frailty, and respond as a multi-disciplinary and multi-specialty team will promote independence and support timely onward care planning. ▪ Future training will develop broader skillsets for management of the acutely ill patient, and require new roles and career pathways, focussed on multidisciplinary team training and optimal team working, to respond to high volume demand and complexity, and to reduce delays and hand offs. ▪ Activity will be captured through an Acute Floor Information System, which will align to Activity Based Funding (ABF), recognising complexity and recognising the need for rapid access to senior clinical input, and avoiding unintended incentives to admit patients unnecessarily. **Given the variability in local infrastructure, service models and workforce across Ireland, developing the Acute Floor will involve some difficult decisions. The following design principles outline the intent behind the Acute Floor, and provide the consistency and a source of guidance to inform local, site-specific decisions:** **1. A person-centred focus** **2. Key access to services**

	3. Effective assessment and care **4. Integrated care** **5. Clinical justice** **6. Connected networks of care** **7. Integrated governance** It is intended that a national approach to implementation will compliment local development of Acute Floors across hospitals and a collaborative system of implementation will develop. There is a significant amount of enabling and other work (e.g. development of service standards, unified care pathways, etc.) that can be completed at a national level, eliminating the need for such work to be replicated across each Acute Floor. The approach to national implementation and oversight is likely to be informed by the pace of local implementation and the requirement of clinical leadership to operate in an Acute Floor environment. It is envisaged that any national level implementation structures work hand in glove with local implementers to assist and support local service development and continue to promote the value of the Acute Floor operational model. The following approach and timeline is suggested as one of several potential paths, which will need to be developed further, at both local and national level, as the Acute Floor moves into implementation. **Acute Floor recommendations (examples within each area extracted)** **Routes in** Designing the process for entry to the service to accommodate and enable predictable high volume appropriate routes of referral: including GP, OPD, Community services (see document for further information). **Assessment** ▪ Getting onto the front foot, to enable flow and reduce delays: ▪ At the single point of entry all patients rapidly streamed (within minutes) to the appropriate service by a suitably experience and independent clinician. ▪ When there is uncertainty about streaming or level of acuity, a fuller triage is to be carried out by a suitable snior clinician according to Manchester Triage System (level 2 defaults to Emergency Medicine Service unless prior agreement, with levels 3 & 4- stable patients and those with pre-defined clinical needs – suitable for the wider Acute Floor) (see document for further information). **Pathways** Pathways designed to respond to the variety within predictable high-colume demand, to take place in the most appropriate setting. ▪ Promoting and developing suitable alternatives to admission where present, including ambulatory care, CIT,

	Rapid Assessment and Treatemtn, Palliative care (see document for further information). ▪ With acute care hub, outreach, phone support and telemedicine to known patients, primary care or community, with rapid access to ambulatory setting (for exaple, OPD) (see document for further information). **Roles multi-disciplinary/multi-speciality team working** Recognition that a responsive and agile service needs the development of a broad skill base across disciplinary boundaries, with breadth as well as depth. ▪ Fundamental prerequisite of the presence of a lead clinician. ▪ Nursing and advanced nursing (including ANPs, CNSs) = protocol-enabled assessment, prescribing, discharge and clinical nurse manager (see document for further information. **Operating hours** Intent to align the services within the Acute Floor to the demand/presentation profile. This is likely to extend service provision across hours in the day and days in the week, recognising that period of transition will be needed, as well as balancing with sustainable staffing. ▪ Beyond a 24/7 emergency medicine service, move to extended AMUs working day that aligns with demand and over 7 days within 1-2 years. ▪ Move to full alignment with demand patterns and suitable staffing levels (which may or may not demand 24/7 working) over 3-5 years. On call cover will be needed for general surgery, acute medicine, frail and older peoples' services and anaesthesia during periods the Acute Floor is not fully operational. Options may be needed for cover to be spread across a network of sites (see document for further information). **Access to diagnostics** Recognised as a rate-limiting step in flow through Acute Floor, ease of access to core diagnostics and timeliness of reporting needs to be assured, without increasing competition for access for schedules care. In line with operating hours, diagnostics access needs to be configured to meet the demand profile. ▪ Core diagnostics located in/near the Acute Floor: CT, ultrasound, plain film x rays. ▪ MRI accessible on site (see document for further information). **Discharge planning and communication** A multi-disciplinary activity where the overall quality of care and ability to achieve flow is as much about how on-going care is managed across boundaries as it is about the care within the Acute Floor. ▪ Discharge planning present at each stage of patient journey, to start as soon as possible after admission. ▪ Timely two-way communication with community and primary care services, with same day electronic discharge communication, with ease of access to medical social care enables by an acute care hub (see document for further information).

	Estates and physical design Core generic features of a modern, flexible and shared space for the multi-speciality and multi-disciplinary care of the acutely unwell patient, making best use of local space and infrastructure. ▪ The ideals is to be co-located within the same space. Where not possible, clear process and clinical governance arrangements will need to be established, to ensure both flow and clear accountability for the patient ▪ Co-located or proximal to the emergency medicine service (see document for further information). **Information and coding** The introduction of a shared approach to data capture that supports (i) continuous and quality improvement (ii) the sharing of clinical information with providers outside the Acute Floor (iii) the ability to adjust services to respond to the nature of demand and (iv) to support a method of payment/resourcing which is equitable across the Acute Floor. ▪ Acute Floors will be expected to be compliant in capturing a nationally agreed minimum data set, through an Acute Floor Information System. Where sites have yet to install one, the AFIS being developed nationally is recommended. ▪ Data will need to measure access (time stamps or compliance with processed in care pathways), throughput/flor (both volumes and LoD), outcomes (mortality, readmission rates) and patient experiences/satisfaction (see document for further information). **Governance** ▪ A responsible consultant for each services needs to be identified and clear at all times the Acute Floor is operations, in the event of clinical escalation. The Clinical Lead is the ultimate point of clinical escalation. ▪ A designated Clinical Lead for the Acute Floor will be identified from one of the services contributing to the Acute Flow. This role may be designated locally and may rotate through the various specialities who contribute to the service. **For information:** In the last five years, there have been many initiatives aimed at improving the patient journey through the ED and during their hospital admission (about 25% of ED attendances result in a hospital admission). These initiatives include: ▪ Improved internal processes within emergency medicine services, (e.g. Streaming at triage, Advanced Nurse Practitioners, Clinical Decision Units) and other aspects of the National Emergency Medicine Programme.

	▪ The establishment of Acute Medical Assessment Units (AMAU) and Acute Medical Units (AMU's) and other aspects of the National Acute Medicine Programme. ▪ Acute Surgical Assessment Units (ASAU) and other aspects of the National Surgical Programme. ▪ The identification of increasing number of patients in whom frailty is a feature of their emergency presentation and early initiation of Comprehensive Geriatric Assessment (CGA) Interdisciplinary teams of Health and Social Care Professionals (HSCPs) are an increasing feature in many Emergency Medicine Services and AMAUs, "pulling" patients towards them for assessment, rather than awaiting the traditional "push" from inpatient wards at a later stage in their admission. Where appropriate this will involve engagement with the local geriatrician or other specialty consultant teams. ▪ An increasing emphasis on the importance of ambulatory care alternatives to admission across emergency medicine, acute medicine and surgery. ▪ Average length of stay has reduced over the same period by 8% equating to the generation of additional relative capacity of almost 900 acute beds. Ireland now has a low length of stay compared to other OECD countries (OECD 2015). However, there remains significant variation in how the health system has adapted to the challenges and implemented initiatives to address them. For instance, there is significant variation in structures, systems and processes that have been deployed to address urgent and emergency care in Ireland: ▪ 10 of the 26 hospitals that offer emergency medicine services on a 24/ 7 basis (not including the 3 dedicated Children's hospitals) do so without having a named Consultant in Emergency Medicine available and clinically accountable for the patients registering in the Emergency Medicine Service at all times of opening. ▪ There is significant variation in resourcing and performance in Emergency Medicine services, Acute Medical Assessment Units and Acute Medical Units across the country. ▪ There are infrastructural deficits in several areas across the country which have begun to be addressed but will remain an issue until capital developments are completed. ▪ It is important to ensure that patients who are seen in AMU/ AMAUs and utilise those scarce resources are high enough in acuity and that it is not used for patients who would be more appropriately managed in other environments such as out-patient clinics, or who could be managed in primary care if there were improved access to routine diagnostics. ▪ There is significant inconsistency in how data are recorded and utilised across the urgent and emergency care pathways in many Irish Hospitals. True service demand, including reliably captured data on demand and capacity, has been difficult to elucidate, and therefore effective planning becomes difficult to achieve (see section 8 – Outline specification for the Acute Floor, and 9.4 – IT enablers). ▪ There are significant difficulties in attracting, recruiting and retaining senior clinical staff in some specialties and some geographical areas. Extended hours working will necessitate robust workforce planning and recruitment policies.

	▪ The move to more specialised training for doctors has resulted in a reticence to maintain exposure to undifferentiated acute presentations due to difficulties maintaining acute care skills for some consultants in some specialties. ▪ There is an increasing number of patients for whom frailty is a feature of their emergency presentation. The need to place specific focus on this patient group is increasingly recognised. ▪ Equally it is recognized that mental illness, homelessness, alcohol and substance abuse are associated with significantly higher emergency medicine service attendance rates, and require a specific focus. ▪ Due to demographic and financial challenges, the numbers of emergency medicine service attendances by homeless persons has increased especially in several city hospitals necessitating specific pathways of care, for emergency medicine service and for in-patients with regards to timely egress. ▪ The potential of ambulatory care to support admission avoidance is not well developed or co-ordinated and even where there are options, they are often not well supported. Current funding streams do not accurately support this kind of initiative, making advances difficult to embed. ▪ If we are to address the problems of excessive trolley waits and long Patient Experience Times, then we need to address how patients flow in and through our health system.
Governance	**Recommendation/considerations:** Developing the Acute Floor is as much a challenge of engagement as it is a technical, capital or estates challenge, relating to working practices and clinical and operational leadership. It is therefore essential that the skills and planning needed for effective change and operations management and are mobilised and steered through a clear governance framework. Development and ongoing management will be led though each hospital's Unscheduled Care Group (being deliberate in extending to include CHO partners), linking with the Hospital Group level where appropriate. Overall operational responsibility will rest with the Unscheduled Care lead or Chief Operating Officer, and a Clinical Lead will hold ultimate responsibility for clinical governance. However, the latter role could rotate, to gain contribution from Acute Floor services. Given the outward looking and multi-disciplinary nature of the Acute Floor, governance will reflect this as a 'team sport', and foster inclusion of all relevant specialties and disciplines.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Broadening the front door through evolution of the Acute Floor will come as part of wider improvement work that encourages preventative and proactive care in non-acute settings. Community Health Organisations and Primary Care are critical partners, such that patients are treated and discharged without delay by the most appropriate senior clinician placing emphasis on the creation of co-ordinated multi-disciplinary, patient-centred care. The Acute Floor concept cannot be developed and deployed in isolation. It requires engagement and collaboration with partners on the in-patient wards and in the community who are critical in managing patients

	in the most appropriate setting, supported in gaining rapid access to specialist input and then contributing to a smooth and thorough handover to ensure a clear ongoing care plan. This requires the intentional design of care pathways across care settings in such a way as to guarantee timely access to quality of care and in some cases will necessitate an expansion of capacity within the system. Thus a well-designed, resourced and governed Acute Floor could be a key foundation stone in delivering upon goals articulated the Future of Healthcare Sláintecare Report. The Acute Floor, whilst located on an acute site, offers an interface between acute, primary care and community provision. Flow will not be achieved by widening the front door alone. It requires input from non-acute partners to: i) Reduce avoidable demand and acute episodes of care (by both developing new care pathways and providing rapid access to specialist advice). ii) Support discharge planning and arrangement of onward care at the earliest possible opportunity. iii) Improve the management of those with chronic, multiple or complex conditions through proactive care Broadening the front door, in and of itself, will not be sufficient to alleviate pressures on the acute system. There is a need to develop and build confidence in pathways which do not default to an admission, but enable care to be delivered in community or home settings. Whilst this document is principally focused on the developments needed within the acute setting, it will need to be supported by a broader body to strengthen community services. From the earliest stages of development, it is expected that non-acute providers will be involved in the design – to support patient pathways, clear communication flow and clarity of governance. Broader partners also have a key role to play in the governance. Primary care and GPs, CHOs and Integrated Community Teams (ICTs) are likely to be a core part of the local Acute Floor development group.
Staffing (including workforce planning, recruitment and retention)	No information identified.
Funding	No information identified.
Other	**For information:** In so doing, the Acute Floor model can be a key platform and enabler in delivering on key goals contained within the Future of Healthcare Sláintecare Report (May 2017) as follows: ▪ All care planned and provided so that the patient is paramount, ensuring appropriate care pathways and seamless transition backed up by full patient record and information ▪ Timely access to all health and social care according to medical need ▪ Care provided free at point of delivery, based entirely on clinical need ▪ Patients accessing care at most appropriate, cost effective service level with a strong emphasis on prevention and public health.

Impact	The National Patient Flow Improvement Programme (NPFIP) was rolled out in UHG and University Hospital Limerick in 2016 to test the 'scientific management' of patient flow. Patient Flow Improvement Programme Limerick and Galway This programme is delivered by GE in partnership with HSE, University Hospital Limerick, and Galway University Hospitals. As part of this programme, a five-year Capacity Strategy was conducted for both hospitals according to the strategic stages set out above. Although both hospitals were well over the recommended occupancy limits and both attendances and admissions were expected to rise with the aging population, several scenarios were identified to introduce capacity savings, for example increasing the hours of operation for the Acute Medical Unit, and aligning length of stay with best practice guidance. As an additional part of this programme, it was identified that operational flow management processes were unfit for purpose, including multiple overlapping communications and a reactive culture of bed placement rather than a proactive culture of operational capacity planning. For example, at GUH, bed management meetings alone could take over 2 hours per day, leaving little time to facilitate discharges and patient flow. These hospitals were able to demonstrate improvements by focusing on a few key areas, such as reframing the bed management meetings around capacity management, improving the flow of information to inform bed management, and targeting early morning discharges. As a result, pre-noon discharges have increased by 200-300% thereby creating inpatient capacity earlier in the day, and reducing pressure on ED.

Table 33 Acute Services Operational Plan [2017]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[33] Acute Services Operational Plan [2017] Service plan
The health service system (including health service reform)	**Recommendation/considerations:** *Priorities for 2017* ▪ Embed robust structures within Hospital Groups to provide direct support to the smaller hospitals in the groups in line with development of Hospital Group strategic plans. **For information:** The Hospital Groups continue to implement the Securing the Future of Smaller Hospitals: A Framework for Development. This will ensure that all hospitals irrespective of size work together in an integrated way to meet the needs of patients and staff, with an increased focus on small hospitals managing routine or planned care locally and more complex care managed in the larger hospitals.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *Priorities for 2017:* ▪ Open new Emergency Department at University Hospital Limerick. ▪ Implement the Patient Flow Project in pioneer sites (University Hospital Limerick and Galway University Hospital). ▪ Implement the winter initiative 2016/2017 aimed at alleviating pressures on the hospital system over the winter period with the opening of additional beds. ▪ The HSE will work with the DoH to develop proposals to address public hospital capacity issues within key specialties where there are significant outpatient and inpatient waiting times in light of the availability of €50m for this purpose in 2018. Risks to the delivery of Acute Hospitals plan within funding available: ▪ Service risks related to limited capacity in ICU.
Governance	**Recommendation/considerations:** *Priorities for 2017* ▪ Advance the appointment of national clinical leadership for early warning systems and clinical handover in collaboration with clinical strategy and programmes and quality improvement services. ▪ Embed robust structures within the hospital groups to facilitate effective managerial and clinical governance which will provide direct support to the smaller hospitals in the groups. ▪ Implement the ED Task Force report recommendations.

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Priorities for 2017:* ▪ Co-operate with the roll-out of the Integrated Care Programme for Older People as appropriate, in acute hospital demonstrator sites as ICPOP expand the number of pioneer areas from 7 sites currently under development to a total of 16 sites and continue to work with all pioneer sites to progress integration enablers.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** The development of funded workforce plans at both Hospital and Hospital Group level requires alignment to the on-going review of skill mix requirements alongside effective staff deployment to manage workforce changes that are necessary in support of service delivery. …the Division continues to work collaboratively with Irish Medical Organisation (IMO), the Department of Health (DOH) and other key stakeholders to work towards the achievement of full compliance with the EWTD.
Funding	**Recommendation/considerations:** Risks to the delivery of Acute Hospitals plan within funding available: ▪ Capacity to maintain and collect income. ▪ Capacity to achieve pay and non-pay cost control at the level required while demographic impacts drive demand for services. ▪ Capacity to invest in and maintain our infrastructure and address critical risks resulting from aging medical equipment and physical infrastructure. The financial allocation for 2017 allows us to reinstate the hospital group budgets at the 2016 closing level. **Acute Hospitals 2017 Budget:** €4,442.6 million* **Acute Hospitals 2016 Budget:** €4,248.6 million *Operational Plan budget reflects NSP 2018 €4,367 budget with NCCP added and transfer of library services to Health and Wellbeing and transfer of MS drugs to PCRS. **For information:** The financial allocation for 2017 allows us to reinstate the hospital group budgets at the 2016 closing level.
Other	No information identified.
Impact	No information identified.

Table 34 ULHG Operational Plan [2017]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	ULHG[34] ULHG Operational Plan [2017] Service plan
The health service system (including health service reform)	**Recommendation/considerations:** *Acute Hospital Division Priorities 2017* ▪ Embed robust structures within Hospital Groups to provide direct support to the smaller hospitals in the group in line with the development of the Hospital Group strategic plan. *UL Hospitals CEO Priorities 2017:* ▪ Progress Peri Operative Strategy to include increasing surgical procedures at Nenagh & Ennis Hospital. *Priorities for 2017:* ▪ Refurbishment of Old ICU to accommodate POA/DOSA/SAU in line with Surgical Clinical Programme, Corporate strategic goal no 2 and the Peri-Operative Strategic Plan and The CSI programme ▪ Open new Emergency Department at University Limerick Hospital ▪ Introduction of a Bed Bureau System to manager and triage all medical emergencies. **For information:** The hospitals in Ireland are now organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the Health Act 2004 in line with National Service Plan (NSP) 2017 and allocated Group budgets. The UL Hospitals Group Operational Plan 2017 is aligned with this Acute Hospitals Division overarching Operational Plan.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *UL Hospitals CEO Priorities 2017:* ▪ Open New Emergency Department that is aligned to new pathways that improves patient access across the services. ▪ Progress Capital Planning Applications for the 96 bed block at University Hospital Limerick. **Capital projects:** UHL ▪ Acute MAU and OPD reconfiguration. The AMAU will be accommodated in the (old) Ward 6A and adjacent areas ▪ Reconfiguration of former ICU to create a surgical and pre-operative assessment unit ▪ New Emergency Department

	Ennis Hospital: ▪ redevelopment of MidWestern Regional Hospital, Ennis (phase 1) to include fit out of vacated areas in existing building to accommodate physiotherapy and pharmacy and development of a local (minor) injuries unit Nenagh Hospital: ▪ ward block extension and refurbishment programme, incl. 16 single rooms and 4 double rooms.
Governance	**Recommendation/considerations:** *Priorities for 2017:* ▪ Embed robust structures within the hospital groups to facilitate effective managerial and clinical governance which will provide direct support to the smaller hospitals in the groups. ▪ Implement the ED Task Force report recommendations. ▪ Prepare for the implementation of the policy in Trauma Systems for Ireland.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *UL Hospitals CEO Priorities 2017:* ▪ Grow and flourish UL Hospitals Group that attracts and retains professionals with a focus on improving NCHD educational supports. Workforce Planning - The development of funded workforce plans at both Hospital and Hospital Group level requires alignment to the on-going review of skill mix requirements alongside effective staff deployment to manage workforce changes that are necessary in support of service delivery. … the Division continues to work collaboratively with Irish Medical Organisation (IMO), the Department of Health (DOH) and other key stakeholders to work towards the achievement of full compliance with the EWTD. **For information:** UL Hospitals Group WTE December 2016 **Medical/Dental:** 474 **Nursing:** 1,498 **Health & Social Care:** 366 **Management/Admin:** 602 **General Support Staff:** 264 **Patient & Client Care:** 450 **Total:** 3,596

	University Hospital Limerick: 2,383 **University Maternity Hospital:** 323 **Croom Hospital:** 151 **Ennis Hospital:** 220 **Nenagh Hospital:** 218 **St. John's Hospital:** 301 **Total:** 3,596
Funding	**Recommendation/considerations:** **UL Hospitals Group** **2017 Available Budget:** €277.730 million **2016 Budget:** €279.540 million The key components of ULHG approach to addressing its financial challenge, will involve pursing increased efficiency, value for money and budgetary control.
Other	No information identified.
Impact	No information identified.

Table 35 Ireland 2040 National Planning Framework: Submission by ULHG [2017]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	University of Limerick Hospitals Group (ULHG)[35] Ireland 2040 National Planning Framework: Submission by ULHG [2017] Framework submission
The health service system (including health service reform)	**Recommendation/considerations:** To achieve the best health outcomes and value for money we need to re-orientate the model of care towards primary and community care where the majority of people's health needs should be met locally. Acute services will also need to continue to evolve to deliver the high class healthcare that future generations will require and demand. We believe that the significant reform agenda delivered in healthcare services in the mid-west in the last decade and the unprecedented scale and pace of our ongoing change programme across all our sites means that we now have the core service elements in place to be able to effectively and efficiently respond to such population growth with careful planning & investment support in future years. We have also developed strong working relationships with all our partners in the HSE and the Irish Health Services in general and fully understand the benefits of collaborative working to drive real change and achieve success. The result of this careful planning means that the hospital group has been growing over the past number of years and we have added important facilities to our UHL campus including a state of the art Critical Care Unit, a 24 hour cardiology service, a Cystic Fibrosis Inpatient and Outpatient Unit, new Breast Unit, Acute Inpatient Stroke Unit, new Dialysis Unit and our new Emergency Department which is due to open shortly. Our new Clinical Education & Research Centre, a joint initiative with the University of Limerick now accommodates and supports the educational training and research needs of both the UL Hospitals Group clinical community and the UL Graduate Entry Medical School, the School of Nursing & Midwifery and the School of Clinical Therapies at UL. **For information:** The Report of the Acute Medicine Programme (2010) classified all acute Hospitals in Ireland under generic models that describe in precise detail what services can safely be provided at each site. University Hospital Limerick is the Model 4 hospital for the region, one of only three such Model 4 hospitals outside of the Dublin area and provides major surgery, cancer treatment and care, emergency department services, as well as a range of other medical, diagnostic and therapy services. It is where all critical care services are located in addition to a 24/7/365 Emergency Department and it is a designated cancer centre. The six hospitals were previously grouped together under the old Mid-Western Health Board structure, so therefore the notion of an alliance of clinical sites is nothing new to this region. However, significant

	reconfiguration of acute services has been successfully delivered in recent years and road networks have improved to such an extent that all of the clinical sites are now within relatively easy reach of one another, facilitating patient and staff flow so as to ensure that appropriate and safe care is provided to the right patients at the appropriate site. The reconfiguration of acute services in the mid-west has been quickly followed by the establishment of Hospital Groups and the development of a Strategic Plan for UL Hospitals and the mid-west to guide the growth and improvement of services. There has been a real focus on developing a functioning single hospital across multiple sites, providing a quality, safe and efficient service, developing ICT systems, promoting clinical education and research in association with the University of Limerick and prioritising capital investment as a critical enabler of these key goals. The recent government report "Securing the Future of Smaller Hospitals: A framework for Development", published in February 2013 is being fully embraced in the mid-west with a strong role envisaged for our smaller hospital providing more services into the future. As the Mid-West Community Health Organisation and the UL Hospitals Group uniquely share the same geographical area, joint programmes of activity are facilitated in the mid-west as we strive to achieve maximum efficiencies and effectiveness from a whole healthcare service delivery perspective.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** While the overall healthcare strategy will need to be based upon the development of primary care, ongoing phased investment in our acute services such as the planned prioritised bed capacity increase at University Hospital Limerick will also be needed to meet the population's needs. This need to increase bed capacity at University Hospital Limerick is now generally acknowledged and plans are being progressed to deliver an additional 96 inpatient beds in the short term subject to funding being made available as a result of the current mid-term capital review. We also have longer term plans for addressing ward quality by providing further new inpatient beds when the entire new block facing St Nessan's Road is ultimately completed. We have set aside the required expansion space on our model 4 hospital campus for potential development of replacement facilities at some point in the future and no doubt there will be many other such initiatives to be considered for all our hospital sites along the road to the Ireland of 2040. **For information:** Each of the six clinical sites making up ULHG has a proud history, has a track record of effectively meeting the needs of its particular population and has considerable local community support.
Governance	**For information:** Acute Services in the Mid-West are provided via the UL Hospitals Group. UL Hospitals is governed by an interim Board of Directors, an Executive Management team led by the Chief Executive and supported by 5 Directorates across the Group. UL Hospitals, with over 3,000 direct employees provides these acute services from various sites throughout the mid-west such as Ennis (Model 2), Nenagh (Model 2) & St John's Hospital (Model 2s) and

	also the University Maternity Hospital and Croom Orthopaedic Hospital along with the Group's largest acute hospital, University Hospital Limerick located in Dooradoyle on the periphery of Limerick City.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	No information identified.
Funding	**Recommendation/considerations:** Adequate infrastructure and healthcare equipment are critical to the delivery of safe modern health and social care services. In this context the capital budget for Health has not been restored to the allocation levels prior to 2008 notwithstanding the fact that there are also additionally a significant number of major government priority projects identified for Health. There is therefore an urgent need for increased capital funding in the Health Sector in the short to medium term and this will also need to be addressed as part of the overall 10 year plan. A capital investment strategy in healthcare infrastructure must form a key component of any investment plan in the Mid-West Limerick City Region if the region is to meet its potential and become a tier 2 city region. The most significant healthcare infrastructural investment required and planned for the mid-west arises from the government decision to relocate the University Maternity Hospital from its city centre location to the University Hospital Limerick campus at Dooradoyle. The current multi-site service has long been identified as a clinical hazard that needs to be resolved. Whilst this decision is referred to in the government's capital investment plan "Building on Recovery: Infrastructure and Capital Investment 2016 – 2021" as part of the programme for modernising healthcare provision, specific seed capital funding would need to be immediately allocated in the current Government Mid-Term review in order to progress the planning process and subsequently the enabling works required to prepare the campus for the ultimate delivery of the new maternity facility. If the State is serious about developing increased population centres outside of the greater Dublin region then strategic projects to develop key infrastructure in targeted regional centres will need to be given national priority. **For information:** ICT in the statutory hospital system has been underinvested in for a very long number of years. In line with the Healthy Ireland Strategy, there is a need for resources to further develop Health & Wellbeing initiatives for staff and the public which will have positive impact for staff morale, service delivery, mental health and hospital avoidance.
Other	No information identified.

Impact	Other reports referenced: ▪ The Report of the Acute Medicine Programme (2010) classified all acute Hospitals in Ireland under generic models that describe in precise detail what services can safely be provided at each site. ▪ The recent government report "Securing the Future of Smaller Hospitals: A framework for Development", published in February 2013 is being fully embraced in the mid-west. ▪ The future development of the UL Hospitals Group will need to be viewed in the context of the recommendations from the Future of Healthcare Committee who are due to publish their findings in April 2017 and will be setting out a 10 year plan for healthcare delivery in Ireland. The Committee are focusing on delivering a plan that addresses the severe pressures on the Irish health service, the unacceptable waiting times that arise for public patients, and the perception of poor outcomes relative to cost. ▪ With the launch of Ireland's first National Maternity Strategy by the Minister for Health on 27th January 2016 the required maternity services vision is now in place and the focus needs to be on delivering the strategy.

Table 36 Committee on the Future of Healthcare Sláintecare Report [2017]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Houses of the Oireachtas[36] Committee on the Future of Healthcare Sláintecare Report [2017] Report
The health service system (including health service reform)	**Recommendation/considerations:** Key recommendation: **Expand Health and Wellbeing** ▪ Increase Health and Wellbeing Budget – €233m over ten years. ▪ Resource and develop a universal child health and wellbeing service – €41m over first five years – Hire up to 900 more general nurses to work in the community with older people and people leaving the acute sector, to free up Public Health Nurses who have training in child health services to carry out child health work as part of the current Nurture-Infant Health and Wellbeing programme and the HSE's National Healthy Childhood Programme – Ensure that parents are supported to meet the emotional development needs of their children as well as their physical health needs through supporting the development of the parent-child relationship – Integrate an Infant Mental Health approach into the Primary Care Child Health and Wellbeing service – Child health and wellbeing services including parenting supports during pregnancy and in the early years of the child's life. **Critical Challenge 1: Improve Population Health** The Committee Recommends: ▪ Strengthen mechanisms for the full implementation of Healthy Ireland including leadership from the Taoiseach, government wide and health system implementation, taking population health and wellness into account in all workings of the government, possibly through Health Impact Assessment, and the prompt development and publication of an Outcomes Framework for Healthy Ireland. **Critical Challenge 2: Deliver Care at the Lowest Level of Complexity** The Committee Recommends: ▪ Use all available mechanisms and processes to ensure healthcare is delivered at the lowest level of complexity as is safe, efficient and good for the patients. This includes priority resourcing of primary and social care. ▪ Develop a culture and mechanism for collaboration, integrated care and shared local governance between CHO's and acute hospitals.

Critical Challenge 4: Disentangle Private and Public Care

The Committee Recommends:

- Current unacceptable waiting times for public hospital care in emergency departments, outpatient clinics (OPD) and planned day case and inpatient treatment must be reduced so that timely access is provided, based on need and not ability to pay.
- Provide public funding to replace the €649m (2016 figures) private patient income annually expected in public hospitals between year two and six of the plan.
- Consultants will ultimately only carry out public work in public hospitals. The provision of private care by consultants in public hospitals will be eliminated over a phased period. This will mean that all patients will be treated on the same, public basis in public hospitals, ensuring equity of access for all based on need rather than ability to pay. The Committee recognises and recommends that existing contracts may change through negotiation and the need for enhanced public only contracts for new entrants.
- An independent impact analysis should be carried out of the separation of private practice from the public hospital system, with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation.
- Careful workforce planning to meet current and future staffing needs, and measures to ensure that public hospitals (as well as all service provision units and centres) are/become an attractive place to work for experienced, high quality staff.
- Robust workforce planning which ensures that we maximise the utilisation of the skills of every worker currently available in the health service.
- Sufficient numbers of consultants and other health professionals to meet population need.
- The successful re-orientation of care delivery to primary and social care settings so that most care is provided (publicly) outside of hospital.
- One or a number of hospitals within each Hospital Group, as appropriate, should be designated as elective only.

For information:

Health Policy Context

At the heart of reform is the realisation of actual health system change. For a long period in Ireland services were delivered through health boards; voluntary, public and private hospitals; and a range of charitable and other organisations. This approach to health care delivery has resulted in fragmented and unsatisfactory care. In recognition of the need for a more integrated approach the 2004 Health Act organised health service delivery through a centralised body, the Health Service Executive (HSE). Since the HSE's establishment in 2005 it has been in a continuous state of re-organisation and restructuring with little apparent benefit to users of services

	and persistent disruption for staff. Recent steps towards integration include the creation of Hospital Groups and Community Healthcare Organisations. In recent years, the HSE has been developing five integrated care programmes in the areas of chronic diseases, older people, children, maternity and patient flow. Early results from the Integrated Care Programme for Older People show positive outcomes for older people as well as benefits to the health system. Other approaches to integrated care such as the Carlow/Kilkenny model demonstrate that collaboration between care professionals across primary, social care and hospital settings has positive benefits for patients, provides a better care pathway and facilitates more care outside of hospital. Such examples of good practice can help to prevent some of the traditional bottlenecks in the Irish health system. The 2016 Programme for Partnership Government identified seven priorities for health service delivery: ▪ A decisive shift of the health service to primary care with the delivery of enhanced primary care in every community ▪ Guaranteeing the future sustainability of rural practice and in disadvantaged urban areas ▪ Creating a Healthy Ireland ▪ Building capacity for our emergency and acute services ▪ Improving waiting times for hospital procedures ▪ Reforming the HSE into a more efficient, transparent health service for patients and staff ▪ Funding of the health service (which included a commitment to establish this Committee) ▪ Similar priorities were set by the Department of Health in 2016 which specified the need for: – Changing the mode of healthcare (enhancing health and wellbeing, not just providing services) – Providing care at the lowest level of complexity – Delivering the majority of care through primary care services Integrating care (usually led with active support from general practice and primary care) – Ensuring continuous, reliable models of care to manage chronic diseases (at the lowest level of complexity) – Ensuring patient safety and quality of care. This Department of Health report also identifies important strategic enablers for reform. These are organisational structures, workforce planning, better ICT systems, improved financial models, and stronger leadership and management capacity.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Key recommendation: **Expanding Public Hospital Activity** ▪ Expanding public activity in public hospitals – €649 million from Years 2 to 6 of the plan ▪ Increase numbers of public hospital consultants – €119 million between Years 4 and 10

	This will require: ▪ Increased public funding to replace current private income in public hospitals ▪ New governance structures to ensure quality care and accountability ▪ Changes to incentives and work contracts ▪ Alongside precise workforce planning to ensure the public system is an attractive place to work for staff who deliver high quality care ▪ The hospital sector will also need increased capacity in areas where it is currently under-resourced. **Critical Challenge 5: Ensure a System – Wide Response to Emergency Department Waiting Times** The Committee Recommends: ▪ Enable a system wide response to ED wait times so that integrated, patient-centred care is provided by enhanced primary and social care services including: ▪ Investment in hospital infrastructure and staffing in order to enhance capacity. The Committee recommends that the outcome of the Capacity Review currently underway should inform the detailed planning for the infrastructural investment provided for in the proposed Transitional Fund, as well as for the staffing required. ▪ Investment in these non-hospital services so that the management of the vast majority of chronic diseases takes place outside of hospital. ▪ The availability of direct access to diagnostics outside of hospitals for GPs. ▪ Improved processes and efficiencies within hospitals. ▪ Participation by service providers and engagement by the Implementation Unit (of this Reform Programme) with the Capacity Review to be completed in 2017 as part of the long-term solution to ED overcrowding and waiting list management.
Governance	**Recommendation/considerations:** **Recommendations Relating to Systemically Modelling Integrated Care** **Leadership and Governance** The Committee Recommends: ▪ That the Minister for Health is held responsible and accountable on a legislative basis for the delivery of healthcare, the health system and health reform. ▪ That under the new integrated care model of service delivery the Department of Health retains the Health Vote and that a more strategic Department continues its policy development and legislative role with an enhanced evaluation capacity. ▪ An independent board and Chair is appointed to the HSE at the earliest opportunity, by the Minister, following a selection process through the Public Appointments Service. Board membership reflects the skills required to provide oversight and governance to the largest public services in the State. ▪ The Chair of the Health Service Board is accountable to the Minister. ▪ The Health Service Director General is accountable to the Board.

	▪ The HSE directorate becomes a more strategic, patient-focused 'national centre' with a reduced number of national directors reporting to the Director General. ▪ Existing National Directors will be relocated into other roles strengthening the functions required for the new mode of integrated care, for example relating to building strengthened leadership capacity in the community for primary and social care. ▪ Greater alignment of service provision for integrated care across care domains is implemented at CHN level. This will include further mapping analysis and use of funding, information sharing and eHealth mechanisms. ▪ The geographic alignment of Hospital Groups and CHOs will help to support population-based health planning and delivery. Further analysis and consultation should be undertaken to identify how alignment can best be achieved with minimal disruption to key structures including at CHN level. ▪ Moving towards a form of regional health resource allocation with accompanying governance structures to formally connect Hospital Groups and Community Health Organisations for the provision of integrated care, using CHOs and CHNs as the core unit of health service coordination and provision. ▪ Establishment of regional bodies that will be accountable for implementing integrated care at sub-national level by strengthening the local care provision system, ensuring service coordination between the difference care domains, community network building and resource allocation for integrated or shared services. ▪ Integrated care such as the Carlow-Kilkenny Integration Model (CKIM) which established the Local Integrated Care Committee (LICC) structures in the Ireland East Hospital Group, be supported and developed. This model encompasses the WHO strategies of implementing integrated care by; – Empowering and engaging people – Strengthening governance and accountability – Reorienting the model of care – Coordinating services – Creating an enabling environment. ▪ Put in place a blueprint for clinical governance across the health system in a timely and optimal manner. ▪ This should be underpinned by legislation which specifies the structures, processes and responsibilities of boards, management and clinicians for the operationalisation of clinical governance within all organisations.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Key recommendation: **Primary Care Expansion** ▪ Expansion of community diagnostics and shifting treatment from the acute sector to the community ▪ Counselling in primary care: extend counselling provided by private providers through GP/primary care referral at a cost of the order of €6.6 million over three years.

	▪ Develop public psychology services in primary care at a cost of the order of €5m over two years to get this service up and running. This would fund 114 assistant psychologists, 20 child psychologists and allow for the development of a CBT online resource ▪ Universal GP care – €455 million over five years ▪ Universal primary care – €265.6 million over first five years of the plan. **Social Care Expansion** ▪ Universal palliative care – €49.8 million over the first five years of the plan ▪ Increasing homecare provision – €120 million in the first five years of the plan ▪ Additional services for people with disabilities – €290 million over ten years. **Mental Healthcare** ▪ Child and Adolescent Mental Health Teams – €45.7 million, delivered by Year 5 ▪ Adult Community Mental Health Teams – €44.5 million, delivered by Year 5 ▪ Old Age Psychiatry – €18.8 million, delivered by Year 5 ▪ Child and Adolescent Liaison – €4 million, delivered by Year 5 ▪ Intellectual Disability Mental Health Services: 120 additional staff – €8.5 million, delivered by Year 5. **Dentistry Expansion** ▪ Reinstate pre-economic crisis budget to Dental Treatment Services Scheme – €17 million in Year 1 – Develop a universal package of dental care. **Critical Challenge 3: Provide Diagnostic Services within the Community** The Committee Recommends: ▪ Ensure significant expansion of diagnostic services outside of hospitals to enable timely access for GPs to diagnostic tests. Primary care centres should be the hub of community diagnostic services so that all patients can access diagnostics in these centres.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Further costing and staffing requirements: Numbers of additional Consultants and Hospital staff needed to provide timely access to Public Hospital care. **Healthcare Workforce** The Committee Recommends: ▪ That the HSE and the Department of Health must develop their integrated workforce planning capacity so as to guarantee sufficient numbers of well-trained and well-motivated staff deployed in a targeted way to deliver care in the most appropriate care setting and that the Irish health system becomes a place where people feel

	valued and want to work. This will mean re-training of existing staff in many cases to ensure capabilities for integrated care. ▪ That recruitment should take place at regional level or at a more local level if practicable, and in conjunction with local clinical managers. ▪ That recruitment of hospital consultants and NCHDs should be to Hospital Groups rather than to individual hospitals, as part of meeting the medical staffing needs of smaller hospitals. ▪ Staff will be recruited on the basis of the most appropriate skill mix for the delivery of a new model of care and with the aim of ensuring flexible team work.
Funding	**Recommendation/considerations:** *Key recommendations:* **Reduce and Remove Charges:** ▪ Removal of inpatient charges for public hospital care – €25m in Year 1 ▪ Reduce prescription charge for medical card holders from €2.50 to €1.50 in Year 1 and to 50c in Year 3 – €66.7m in Year 1, a further 66.7m in Year 3 (€133.6m in total) ▪ Reduce the Drug Payments Scheme threshold from €144 per month to €120 and €100 at a cost of €75m in Year 3 and €184.9m in Year 6 (€259.9m in total) ▪ Halve the Drugs Payment Scheme threshold for single-headed households in Year 1 to €72 per month ▪ Removal of Emergency Department charge in Year 8. **Funding** ▪ Establish the National Health Fund. ▪ Funding flows into the NHF should include a mixture of general taxation and specific earmarked funds, to be decided by the Government of the day. ▪ Guaranteed expansion of health funding by between €380-465 million per year, for expanded entitlements and capacity to delivery universal healthcare. ▪ Implement transitional and legacy funding arrangements to a total of €3 billion over six years, to boost reinvestment into one-off system changing measures, training capacity and capital expenditure. ▪ Earmark/ring-fence funds to health care priorities, such as expanded primary and social care, palliative care, and mental health. ▪ Ring-fence savings that will arise from reduced tax-relief costs as people move from PHI to avail of improved public health provision and allocate these to expansion of entitlement and transitional funding. ▪ Disentangle public and private health care financing in acute hospitals and remove ability of private insurance to fund private care in public hospitals. **Component** **Cost (€M)**

	ehealth 875 Primary Centres and OOH 120 Community Diagnostics 60 Training Expansion – GPs 235 – Consultants 178 – Other Primary Care 252 System change 50 Renovation and Hospital Bed Capacity 1,230 €3,000 **Healthcare and Funding Mechanisms** The Committee Recommends: ▪ Phased pooling of funding to support integrated care and a simplification and harmonisation of current fragmented and disconnected resource flows to primary, acute and social care ▪ There is a need for a move towards a multiannual service planning and a multiannual budgeting process (3-5 years) to be phased in over the next 10 years ▪ Development and utilisation of a geographic resource allocation formula to ensure the equitable allocation of resources based on both population characteristics and activity levels.
Other	**Recommendation/considerations:** Key recommendation: **Legislation** ▪ There are several important areas for legislation associated with the programme of reform. These relate to key values and principles to embed into the Irish health system, new governance structures, funding mechanisms, and organisational realignment and enhancement. ▪ Legislate for a new HSE Board. ▪ Legislate for the National Health Fund and new funding mechanisms for the transitional funding, legacy funding and package expansion components, as required. ▪ Enact the Irish (Sláinte) Health Act which will provide the legislative basis for a universal entitlement to a broad package of health and social care for everyone living in Ireland with maximum waiting times and a Cárta Sláinte through: - Introducing Heads of Bill by 2017 for phased entitlement expansion to include all Irish residents by 2023, as described in Section 2 of the report - Introducing legislation by Spring 2018 for the following waiting time policies, to be implemented on a phased basis by 2023

	- No-one should wait more than 12 weeks for an inpatient procedure, 10 weeks for an outpatient appointment and 10 days for a diagnostic test - Individual waiting lists are published by facility, by specialty - Introduce a maximum wait time in EDs, working towards a four hour target - Hospitals that breach guarantees are held accountable through a range of measures including sanctions on senior staff, but not to the detriment of healthcare delivery. ▪ Legislate for accountability – that the Minister for Health is ultimately responsible for delivering health system change and for the delivery of care to the population. Staff at all levels within the health systems are also accountable for their delivery of relevant aspects of the health service to the population through specific, known performance measure and support for the development of needed skills to promote improvement. ▪ Legislate for national standards in clinical governance, national and local accountability structures right down to community and hospital levels, so that clinical governance covers all clinical staff including consultants. **Implementation** ▪ Progress on the report's implementation should begin immediately and be adequately resourced to ensure effective delivery. ▪ The Dáil should be briefed, with a debate on the progress of the report, by the Minister of Health every four months in the first year, to gain momentum, and every six months thereafter. This will help maintain progress, continue high-level political involvement and further consolidate sustained action and support. ▪ Set up a Programme Implementation Office under the auspices of An Taoiseach by July 2017, with the remit to oversee and enable the implementation of this report and develop a detailed implementation plan for the reform programme. ▪ The Implementation Office should work closely with the HSE and will have representation on the management teams at both national and regional level, and will report directly to the Minister for Health. ▪ As one of its first actions, the Implementation Office should devise a detailed implementation programme project plan for each year of the plan, identifying key milestones by December 2017 which can be monitored across sectors. ▪ A first draft of the detailed implementation project plan should be published by the end of 2017. It will be based on the deliverables detailed in this report and will operationalise the phased implementation of the reform. ▪ Supply the Implementation Office with appropriate financial resources (up to €10 million for its lifecycle) and relevant human resources with proven capacity in leadership, programme management, project management, content expertise and communication. ▪ Establish the Implementation Office, with all necessary infrastructure. ▪ Identify and recruit a senior level (equivalent to Secretary General), highly independent Lead Executive with specific experience in change management, by July 2017.

	▪ Recruit all staff by October 2017, with the majority being external recruits. **Critical Challenge 6: Legislative Underpinnings for Maximum Wait Times** The Committee Recommends: ▪ eHealth digital solutions be adopted and immediately resourced ▪ No-one should wait more than 12 weeks for an inpatient procedure, 10 weeks for an outpatient appointment and ten days for a diagnostic test ▪ Individual waiting lists are published by facility, by specialty ▪ Introduce a maximum wait time in EDs, working towards a four hour target ▪ Hospitals that breach guarantees are held accountable, through a range of effective measures including, ultimately, sanctions on senior staff, but not to the detriment of healthcare delivery. **Medicines and Medical Technologies** The Committee Recommends: ▪ Examination of strategies and models in use internationally to identify and implement best practice in medicines management, including evaluation, procurement and usage. ▪ International collaboration and active cooperation with other EU member states, to share information and utilise all opportunities for joint negotiation on medicines, in particular through our membership of the European single market. ▪ Appropriate oversight and audit of prescribing and dispensing patterns, including through the use of PCRS data where available. ▪ A population health approach to Health Technology Assessment to aid evidence-based decision making for funding medical technology use in the public system. This process is to be as transparent and timely as possible to ensure public awareness and understanding of decisions made. ▪ Continued strong support of the eHealth strategy – particularly ensuring the necessary funding for timely roll-out of the EHR system. ▪ The development of a national integrated hospital waiting list system. ▪ Streamlining the approval-to-spend-process between the Department of Health and the Office of the Chief information Officer at the HSE. ▪ The HSE should develop guidelines addressing parental access to the electronic health records of their children. **Information and Research** The Committee Recommends: ▪ The Community Health Networks (CHNs) are utilised as the optimal population level for data collection and integration to allow for meaningful, robust analysis and planning.

	▪ Developing the research capacity of clinicians, healthcare professionals and managers is important in this context as integrated care needs underpinning with robust evidence and evaluation. Working with academic partners is useful in this regard and optimising available funding for applied and participatory research and training is encouraged. ▪ Sustained resourcing of the change process . ▪ The continued funding and development of integrated management systems for financial control and workforce planning. ▪ A focused initiative to learn from and expand the Integrated Care Programmes. ▪ Professional and personal skills training for new forms of dialogue across disciplines with new partners (for example, patients, other public bodies), and increased opportunities for learning on the job.
Impact	No information identified.

Table 37 Framework for Ambulatory Care On the Acute Floor [2018]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	National Acute Medicine Programme (HSE) and Royal College of Physicians Ireland[37] Framework for Ambulatory Care On the Acute Floor [2018] Framework
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Frail older patients should be a priority for Ambulatory Care as hospital admission in this patient cohort creates its own specific challenges in terms of increased length of stay, increased functional decline and increased risk of admission to long term care instead of back to their home. Although the clinical conditions data is vital to inform service design it is important that Ambulatory Care does not become too pathway specific which risks excluding other relevant patients who would benefit from Ambulatory Care. The NAMP advises that the process approach where all potential patients should be considered for Ambulatory Care is highly effective and workable once there is clear inclusion and exclusion criteria and there are appropriate resources available, particularly access to diagnostics over the extended time period normally reserved for emergencies only, to ensure patients are likely to have a same day discharge, or receive ambulatory care over a short time period, e.g. 72 hours, without a hospital admission. This requires extended working hours and movement to 7 day opening across AMU/AMAU's on the Acute Floor and increased access to clinical diagnostics & HSCP services. Other challenges including the allocation and protection of diagnostic slots and having designated high priority OPD clinic slots to allow egress from Ambulatory Care services. This needs to be in place if Ambulatory Care is to work. This requires discussion, collaboration and consensus with colleagues in other departments e.g. radiology and cardiology to ensure they have a good understanding of what can be achieved by introducing Ambulatory Care, given that it will require a change in working practices and planning from them also. The NAMP is currently compiling recommendations on minimum requirements in workforce planning and access to clinical diagnostics to align with implementation of the Ambulatory Care framework. **For information:**

	The Ambulatory Care Framework outlines the factors critical to the successful implementation of sustainable, effective Ambulatory Care. The data presented is relevant to Acute Medicine however the framework is transferable across all urgent and emergency care specialties. Having the list of clinical conditions seen in the over 75 year age group can help focus services to the relevant ambulatory sensitive conditions to assist with the development of Ambulatory Care aligned to the 'Frailty at the Front Door' model which is utilised and successfully implemented in the Geriatric Emergency Medicine Service (GEMs) in St Luke's Hospital Kilkenny, and which NAMP recommends should be replicated across all Acute Floor services as a priority. The boarding of patients effectively shuts down Acute Medical (& Acute Surgical) Units and obstructs the ability to deliver existing services or plan any future potential increase in activity. In units where there has been active measures to prevent boarding, productivity has increased dramatically and assisted in reducing patient admissions and LOS of medical patients streamed through AMU compared with those through ED.
Governance	**Recommendation/considerations:** Consider who has responsibility for Ambulatory Care patients who may present outside the hours of the service, there must be solid communication streams in place to reduce risk of harm.
Community healthcare (including GPs, and nursing homes)	**For information:** The Oireachtas Committee on the Future of Healthcare: Sláintecare Report (2017)3 outlines that health care provision must shift from the current hospital centric system to an integrated model of care led by community and primary care.
Staffing (including workforce planning, recruitment and retention)	No information identified.
Funding	**For information:** It is also important to acknowledge that an incentive exists, to admit patients to Irish hospitals, because of the income derived from inpatient admission of patients who hold private medical insurance. This income will be lost if Ambulatory Care service becomes fully functional for relevant patients. Currently 12.7% of income for acute hospitals derives from Private health insurance. SláinteCare plans to remove private health insurance from acute hospitals and replace the expected €649m income from public funding over a phased basis. Under this plan the provision of private services in public hospitals will be eliminated.
Other	No information identified.
Impact	No information identified.

Table 38 Acute Hospital Services Divisional Plan [2018]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[38] Acute Hospital Services Divisional Plan [2018] Service Plan [Note: Key focus on Section 3: acute hospitals division]
The health service system (including health service reform)	**Recommendation/considerations:** The Hospital Groups are continuing the development of clinical networks of specialist services. These will consolidate secondary and tertiary care in appropriate locations, in line with "The Framework for Smaller Hospitals", improving clinical outcomes and streamlining elective and emergency pathways across hospitals. Corporate plan goals: ▪ Commence monitoring of time from decision to admit to admission to Intensive Care Unit ▪ Improve pathways for care of older people living with frailty in acute hospitals in association with the Integrated Care Programme for Older Persons (ICPOP). ▪ Continue to ensure that no patient remains over 24 hours in ED. ▪ Continue to implement measures to address seasonal increase and reduce delayed discharges in association with community healthcare. ▪ Support the continued roll-out of the Integrated Care Programme for Patient Flow. ▪ Generate improved capacity by improving internal efficiencies and more appropriate bed usage by reducing length of stay, early discharge and improving access to diagnostics ▪ Continue to improve day of surgery rates and increase ambulatory services as clinically appropriate. ▪ Improve efficiencies relating to inpatient and day case activity by streamlining processes and maximising capacity in acute hospitals.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Additional bed capacity will be provided in 2018 to address some of the demand for inpatient beds. Using performance improvement tools (e.g. NQAIS systems), the acute hospitals will continue to monitor performance, identifying areas that will maximise ambulatory care services, improving day of surgery rates, and minimising length of stay. A key focus in 2018 will be on improving access to emergency care and continuing the on-going work to reduce trolley waits and improve ED performance. Acute services will be pursuing, during 2018, implementation of the acute floor clinical design model as an important integration and co-ordination mechanism for unscheduled care presentations. The acute floor implementation process will incorporate implementation of the acute floor information system and will target a number of phase 1 implementation sites.

	Priorities for 2018: ▪ Increase critical care capacity. ▪ Improve the provision of unscheduled care and scheduled care maximising the resources available. ▪ Increase acute hospital capacity by opening additional beds. Corporate plan goals: ▪ Open additional beds and new units to increase capacity and improve access over the winter period: University Hospital Limerick: 17 Short Stay beds. Capital Infrastructure plans: ▪ **UHL:** Reconfiguration of recently vacated ED to create a medical short stay unit – project completion Q4 2018 and operational Q1 2019 (17 additional beds as noted above). **For information:** Management of bed capacity is challenged by the large number of delayed discharges in acute hospitals and particularly for patients who have particular requirements for rehabilitation, complex, disability or residential care needs including younger adults in need of long term care. Pressure on bed capacity is also impacted on by the lack of single occupancy rooms for infection control measures. Bed utilisation rates are greater than 90%, particularly in larger hospitals therefore discharge by 11am is promoted to improve admission waiting times for patients from Emergency Departments (EDs).
Governance	**For information:** Improving access times to inpatient, day case elective procedures and outpatient consultations is a constant challenge which the service is continuing to address by implementing waiting list action plans and by working with the National Treatment Purchase Fund (NTPF) to drive the roll-out of the National Inpatient, Day Case and Planned Procedure Waiting List Management Protocol. The acute hospitals will optimise capacity to undertake additional NTPF elective surgery cases.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Corporate plan goals: ▪ Further develop GP referral guidelines and standardised pathways, supported by efficient electronic referral systems.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Corporate plan goals: ▪ Extend and roll out nationally the Phase 1 Framework for Staffing and Skill Mix for Nursing in General and Specialist Medical and Surgical Care in acute hospitals within the allocated resources. ▪ Implement a pilot for the Phase 2 Framework for Staffing and Skill Mix for Nursing in emergency care settings. ▪ Enhance the training and development of Advanced Nurse Practitioners in association with DOH and NMPDU

	▪ Continue to improve compliance with the European Working Time Directorate with particular focus on the 24 and 48 hour targets. **For information:** **Staff Category December 2017: Acute Services (University of Limerick)** **Medical/Dental:** 504 **Nursing:** 1,559 **HSCP:** 388 **Management and Admin:** 646 **General Support:** 331 **Patient & Client Care:** 547 **Total:** 3,974
Funding	**Recommendation/considerations:** Corporate plan goals: ▪ Monitor and control hospital budgets and expenditure in line with allocations. ▪ Identify and progress realistic and achievable opportunities to improve economy efficiency and effectiveness. ▪ Secure reductions in cost and or improvements in efficiency of services currently provided. **For information:** In cases where total demand for services exceeds what can be supplied, taking account of realistic efficiencies that can be achieved and the available funding level and planning assumptions provided by the Department of Health (DoH), the HSE is required to manage within the available resources Acute Hospitals Introduction while seeking to prioritise services to those in greatest need. Within acute services, this primarily applies to elective services. To address this funding gap, the HSE, in partnership with the DoH and our staff, suppliers and providers will, during 2018, seek to implement realistic and achievable measures to improve efficiency and effectiveness, a subset of which will reduce this funding gap to the greatest extent feasible. In the case of some services, given that the HSE is the statutory public provider and the realities around the relatively fixed nature of certain costs, there is a requirement to respond to need even if this exceeds what can be supported by any level of realistic efficiencies coupled with the available funding. Within acute services, this primarily applies to emergency and maternity services and will lead to an estimated overall funding gap in 2018 of €244.6m / 4.4%. In arriving at the overall funding gap of €244.6m / 4.4%, assumptions have already been made in relation to cost avoidance The income budget for Groups remains substantially unchanged from 2017 with the exception that the Accelerated Income Target of €44m has been removed. It is acknowledged that there will be specific issues relating to income

	billing and collection in 2018 and that there is a potential shortfall in this area of €60m nationally based upon the 2017 pattern of charging. While we can estimate the shortfall, the requirement for the Hospital Groups for 2018 is to ensure that all charges required under the Health Acts are raised and collected to the greatest extent possible. **Group: UL Hospitals** Goss Allocation Under ABF (€'000's): 376,302 Income (€'000's): 69,574 Net Allocation under ABF (€'000's): 306,728
Other	No information identified.
Impact	From UHLG[39] Operational Plan 2018 In addition, a new short-stay medical unit which has capacity for 17 admitted patients in the area of the old ED opened on the 18th September 2017.

Table 39 ULHG Operational Plan [2018]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	UHLG[39] ULHG Operational Plan [2018] Service Plan
The health service system (including health service reform)	**Recommendation/considerations:** *Priorities for 2018:* ▪ Review of Model 2 Hospitals to increase Ambulatory Care, Day Surgery and further service provision as part of overall UL Hospitals operational plans. ▪ Commence Planning for future Health Service Realignment as defined in Sláintecare Report. Integrated Care Programme for Older Persons - This programme is building on local initiatives to incrementally develop pathways for older people across primary and secondary care, especially those with more complex care needs.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *Priorities for 2018:* ▪ Progress Capital Development Planning for acute bed capacity. - 96 Bed Block - Elective Surgery Bed Capacity at Croom & St John's Hospitals. - Critical Care Bed Capacity Development. Integrated Care Programme for Patient Flow - This programme is developing a standardised approach to managing patient flow in a number of areas including urgent and emergency care, scheduled care, outpatients and community healthcare. The programme will develop a plan to support the reorganisation of urgent and emergency care in line with best outcomes and the best experience for patients. Develop Specialist Hospital Care Networks In parallel with the requirement to shift less complex acute care from hospital to community settings, there is a need to ensure that the secondary and tertiary care sectors are able to deliver the complex, specialised 18 and emergency care that will be required by patients. The provision of integrated care is a key element of this model of care. A bid to build an additional 96 bed block on the UHL site has been submitted to the Department of Health and approval has been granted for funding of the design stage of the build. Corporate Plan Goal 2: ▪ commence monitoring of time from decision to admit to admission to Intensive Care Unit. ▪ Improve pathways for care of older people living with frailty in acute hospitals in association with the Integrated Care.

	Programme for Older Persons ▪ Continue to ensure that no patient remains over 24 hours in ED. ▪ Generate improved capacity by improving internal efficiencies and more appropriate bed usage by reducing length of stay, early discharge and improving access to diagnostics. ▪ Continue to improve day of surgery rates and increase ambulatory services as clinically appropriate. ▪ Improve efficiencies relating to inpatient and day case activity by streamlining processes and maximising capacity in acute hospitals. Capital Infrastructure plans: ▪ **UHL:** Reconfiguration of recently vacated ED to create an medical short stay unit – project completion Q4 2018 and operational Q1 2019 (17 additional beds as noted above). **For information:** On the 29th May 2017, one of Ireland's largest and most advanced Emergency Department opened in University Hospital Limerick. The opening of this new ED, over three time the size of the old department, marked a major milestone for UL Hospitals Group and has been transformational in terms of our ability to deliver emergency care to patients in a dignified space, respecting their privacy. The new ED, includes cutting edge diagnostics such as a unique track-mounted 128-slice CT scanner and dedicated triage and isolation rooms. The department is laid out in pods with individual treatment rooms. There are separate areas for major injuries, minor injuries, resuscitation and diagnostics - and a dedicated space for paediatric patients with separate triage, waiting and treatment areas. In addition, a new short-stay medical unit which has capacity for 17 admitted patients in the area of the old ED opened on the 18th September 2017.
Governance	**Recommendation/considerations:** *ULHG priorities for 2018* ▪ Development of teams for after action review ▪ Further support engagement with CHO with joint management of adverse events and complaints ▪ Quality improvement committee to continue lunch time session ▪ Complaint officer training and review training scheduled ▪ Develop Governance structures for QIPs ▪ Capacity and Capability review in line with local governance process & national review ▪ Development of multidisciplinary systems analysis framework ▪ Development of local department reports on QPS activity ▪ Development of risk registers to align escalation and de-escalation protocols.

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Design new community-based models to provide improved care and outcomes for service users, close to their home and at the lowest level of complexity that is deemed safe, and redesign care from traditional secondary care models to community-based models. Corporate Plan Goal: ▪ Continue to implement measures to address seasonal increase and reduce delayed discharges in association with community healthcare. ▪ Further develop GP referral guidelines and standardised pathways, supported by efficient electronic referral systems. Support the continued roll-out of the Integrated Care Programme for Patient Flow.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Corporate Plan Goal: ▪ Extend and roll out nationally the Phase 1 Framework for Staffing and Skill Mix for Nursing in General and Specialist Medical and Surgical Care in acute hospitals within the allocated resources as appropriate. ▪ Implement a pilot for the Phase 2 Framework for Staffing and Skill Mix for Nursing in emergency care settings as appropriate. ▪ Enhance the training and development of Advanced Nurse Practitioners in association with DOH and NMPDU. ▪ Continue to improve compliance with the European Working Time Directive with particular focus on the 24 and 48 hour targets. Particular attention will be directed to the further development of measures to support the sourcing, recruitment, and retention of nursing and midwifery staff in light of identified shortages. **For information:** **University Limerick Hospitals by Staff Category (December 2017)** **University Limerick Hospitals Group** Medical/Dental: 504 Nursing: 1,559 Health and Social Care Professionals: 338 Management/Admin: 646 General Support: 331 Patient & Client Care: 547 Total: 3,974 **Croom Hospital**

	Medical/Dental: 20 Nursing: 68 Health and Social Care Professionals:2 Management/Admin: 19 General Support: 16 Patient & Client Care: 40 Total: 164 **Ennis Hospital** Medical/Dental: 14 Nursing: 103 Health and Social Care Professionals: 22 Management/Admin: 42 General Support: 16 Patient & Client Care: 30 Total: 226 **Nenagh Hospital** Medical/Dental: 15 Nursing: 105 Health and Social Care Professionals: 14 Management/Admin: 37 General Support: 15 Patient & Client Care: 50 Total: 236 **St. John's Hospital** Medical/Dental: 25 Nursing: 125 Health and Social Care Professionals: 22 Management/Admin: 67 General Support: 36 Patient & Client Care: 27 Total: 303 **University Hospital Limerick**

	Medical/Dental: 401 Nursing: 945 Health and Social Care Professionals: 325 Management/Admin: 436 General Support: 225 Patient & Client Care: 363 Total: 2,695 **University Maternity Hospital** Medical/Dental: 29 Nursing: 212 Health and Social Care Professionals: 3 Management/Admin: 37 General Support: 24 Patient & Client Care: 37 Total: 342 **Other** Nursing: 1 Management/Admin: 7 Total: 8
Funding	**Recommendation/considerations:** Corporate Plan Goal: ▪ Monitor and control hospital budgets and expenditure in line with allocations. ▪ Identify and progress realistic and achievable opportunities to improve economy efficiency and effectiveness. ▪ Secure reductions in cost and or improvements in efficiency of services currently provided. The 2018 Allocation of €308.561m compares to a final 2017 allocation of €291.264m. Plans are required to: ▪ Operate strictly within allocated pay frameworks, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed. ▪ Comply strictly with public sector pay policy and public sector appointments. ▪ Identify further opportunities for pay savings to allow for reinvestment purposes in the health sector workforce and to address any unfunded pay cost pressures. ▪ Ensure Hospital Group CEOs have delegated authority to manage their pay and staffing requirements.

	For information: Some risks to our ability to deliver the level and type of service include: ▪ In the case of some services, given that the HSE is the statutory public provider and the realities around the relatively fixed nature of certain costs, there is a requirement to respond to clinical need even if this exceeds what can be supported by any level of realistic efficiencies coupled with the available funding. ▪ Delivering a volume of activity, driven by need, which is beyond funded levels. ▪ Sustaining a level of service in areas where the nature of the response is such that activity cannot be stopped or spend avoided, such as emergency services in our hospitals. ▪ Progressing at scale and pace for the required transformation agenda within the funding levels available. ▪ Meeting the regulatory requirements in the hospital services, within the limits of the revenue and capital available and without impacting on planned service levels. ▪ Effectively managing our workforce including recruitment and retention of a highly skilled and qualified workforce, required rationalisation of the use of agency personnel and staying within our pay budget. ▪ Investing in and maintaining our infrastructure, addressing critical risks resulting from ageing medical equipment and physical infrastructure, and adhering to health and safety regulations. The UL Hospitals Group budget for 2018 is €308.561m. Gross Budget Allocation - €378.655m Income Budget Allocation – (€70.094m) Net Budget Allocation - €308.561m.
Other	No information identified.
Impact	No information identified.

Table 40 Health Service Capacity Review 2018 [2018]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	PA Consulting Group[40] Health Service Capacity Review 2018 [2018] Review [Note: Data extracted from executive report. The report provides three separate reform scenarios, however, the details of these scenarios are not included in this data extraction.]
The health service system (including health service reform)	**Recommendation/considerations:** There will be a requirement for greatly increased levels of investment in primary and community based care and added impetus to health and wellbeing initiatives To bend this demand curve, capacity investments over and above the baseline scenario in primary and community based care will be required to ensure a real and sustained shift in the model of care. Health and wellbeing initiatives will need continued support and investment if they are to achieve their desired impact in the coming decades. There is broad consensus that it is neither feasible nor appropriate to plan investments around the current pattern of delivery. Significant reform is needed. International evidence indicates that this should involve greater levels of investment in primary and community based care to create a responsive health system which meets needs and (reasonable) expectations to deliver health gain, and as a consequence mitigates the extent of additional acute hospital capacity needed. Three aspects of a reformed health system have been considered: health and well-being initiatives, recalibration towards community-based care, especially for older people and productivity improvements. All involve a shifting of care away from hospitals which is supported by enhanced models of care within hospitals. Taken together, these represent a best case for the level of capital investment in hospital capacity needed. <u>Key findings:</u> The analysis has established two extremes that define the range of potential capacity needs and the level of reforms involved. Further work would be needed to assess the optimum reform strategy that takes account of workforce, the whole life cost of services, eligibility arrangements and their impact on implementing reforms, the feasibility of delivering infrastructure and impact on operational services in the timeframe. It would also need to take account of the wider implications arising from major reconfigurations of services across hospitals. **For information:** It is clear that nobody believes we should build capacity around the system as it is currently configured. It is not feasible from a financial and sustainability perspective, and even more importantly it would go against the widely

	held consensus on the need to develop a more appropriate model of care. The development of capacity in line with the baseline scenario is simply not an option. The second scenario presented in the report is based on a desired future state for the health service. It seeks to demonstrate the potential impact on capacity across the health service of three interlinked reform areas, namely: ▪ health and wellbeing initiatives ▪ an improved model of care that repositions the health service towards a community-based care model with a specific focus on older persons ▪ productivity measures with a specific focus on acute hospital services. New Hospital Group structures can optimise the configuration of services across the hospital network, procedures can be undertaken in lower acuity settings, and throughput and patient flow can be improved across the system. The demand for healthcare is expected to grow significantly across the primary, acute and social care settings in the next 15 years as a result of demographic and non-demographic change. This includes: ▪ Up to 46% rise in demand for primary care ▪ 39% rise in the need for long term residential care ▪ 70% increase in demand for homecare ▪ 24% increase in non-elective inpatient episodes in public hospitals.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** To reach international standards of bed occupancy would see the need for an immediate injection of the equivalent of an additional 1,260 beds in the system. In practice, an increment in capacity is likely to be achieved with a mix of hospital beds, residential care, homecare packages and enhanced primary care services, as well as management measures to improve patient flow and open currently closed beds. <u>Key findings:</u> The baseline forecast is for a sharp rise in the capacity needed across all sectors by 2031 to meet forecast demand, including: ▪ A 37% rise in the primary care workforce ▪ Up to 12,000 residential care beds in social care ▪ 70% increase in homecare ▪ 7,150 extra hospital beds in public hospitals including around 5,800 inpatient, 1,000 day case, 160 AMU and 190 adult critical care beds. (This assumes improved occupancy)

	Full implementation of all three reforms would alter the capacity needed across all sectors by 2031 to: ▪ 2,590 extra hospital beds including around 2,100 inpatient, 300 day case, and 190 adult critical care beds ▪ A 48% increase in the primary care workforce ▪ 13,000 residential care beds ▪ 120% increase in homecare (home help hours and homecare packages). <u>Recommendations:</u> Short term hospital bed capacity improvements - Plans should be made for the urgent provision of additional capacity in acute hospitals to alleviate currently high levels of bed occupancy, and difficulties with appropriate access to acute hospitals and patient flow. Capital investment - Capital investment has a key role to play both in enhancing service provision and as a driver of reform. Investment should support a clear and sustained programme of reform and productivity improvement. Capital investment plans for the period to 2031 should incorporate provision for enhanced capacity of at least an additional: ▪ 2,590 hospital beds (Inpatient, adult critical care and day case beds) ▪ 13,000 residential care beds ▪ Primary care facilities to reflect the need for a 48% uplift in the primary care workforce. Planning for delivering additional capacity should take place immediately and should be based on population need. In the case of acute hospitals, a key principle will be the need to achieve greater separation between scheduled and unscheduled care. Hospital Groups should be tasked with determining capacity needs of their region as part of Strategic Planning. In addition, a significant programme of investment in ICT and eHealth will be required. **<u>Acute Care (Public Hospitals)</u>** **POD:** AMU beds **Current Capacity 2016:** 430 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 590 (+37%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 430 (+0%) **POD:** Day case beds **Current Capacity 2016:** 2,140 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 3,140 (+47%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 2,440 (+14%) **POD:** In-patient beds (95%)

	Current Capacity 2016: 10,500 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 14,600 (+39%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** - **POD:** In-patient beds (85%) **Current Capacity 2016:** 10,500 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 16,300 (+56%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 12,600 (+20%) **POD:** Adult Critical Care Beds (100%) **Current Capacity 2016:** 240 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 340 (+43%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** - **POD:** Adult Critical Care Beds (80%) **Current Capacity 2016:** 2400 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 430 (+79%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 430 (+79%) **POD:** Bed totals **Current Capacity 2016:** 13,310 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 18,670 (95% planned occupancy) 20,460 (planned occupancy) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 15,900 **For information:** Occupancy levels across the acute hospital system in Ireland are far in excess of international norms. These levels of occupancy compromise patient safety, contribute to the spread of healthcare associated infections, and impede the efficient and effective use of resources and reduce the availability of surge capacity.
Governance	**Recommendation/considerations:** <u>Recommendations:</u> Further consideration should be given to: ▪ The feasibility of implementing the scenarios, particularly in meeting workforce needs and overcoming workforce constraints both in and out of hospital ▪ The corresponding impact of other services that were outside the scope of this Review – including mental health and disabilities

	▪ Wider implications of some changes, such as the reconfiguration of hospitals and public access to safe and high quality services ▪ The development of clear evaluation frameworks to continuously monitor and assess the impact of reform initiatives as they are rolled out ▪ How additional capacity should be planned and delivered at a regional level based on population need ▪ Development of robust and comprehensive data systems.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** **<u>Social Care (Older Persons)</u>** **POD:** Residential Care – long term beds **Current Capacity 2016:** 26,200 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 36,300 (+39%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 36,700 (+39%) **POD:** Residential Care – short term beds **Current Capacity 2016:** 3,800 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 5,600 (+46%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 6,300 (+62%) **POD:** Home Care Packages **Current Capacity 2016:** 15,600 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 26,600 (+70%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 34,600 (+122%) **POD:** Intensive homecare **Current Capacity 2016:** 200 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 330 (+70%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 660 (+230%) **POD:** Home help hours (millions) **Current Capacity 2016:** 10.6 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 17.8 (+69%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 23.1 (+118%)

Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** **<u>Primary Care</u>** **POD:** GP WTEs **Current Capacity 2016:** 3,570 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 4,970 (+39%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 4,600 (+29%) **POD:** Practice Nurse WTEs **Current Capacity 2016:** 1,400 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 1,900 (+40%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 2,600 (+89%) **POD:** Public Health Nurse WTEs **Current Capacity 2016:** 1,500 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 2,200 (+46%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 2,600 (+67%) **POD:** Physio WTEs **Current Capacity 2016:** 540 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 740 (+38%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 840 (58%) **POD:** S & LT WTE **Current Capacity 2016:** 470 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 440 (-6%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 420 (-11%) **POD:** OT WTE **Current Capacity 2016:** 500 **Forecast of Capacity in 2031 (without reforms and showing % change from 2016):** 660 (+32%) **Forecast of Capacity in 2031 (with reforms and showing % change from 2016):** 760 (+50%)
Funding	**Recommendation/considerations:** <u>Recommendations:</u> Investment in out-of hospital care - Multi-annual expenditure plans should be established to support the development of enhanced capacity in primary and social care and health and well-being initiatives.

Other	**For information:** Note: The outcomes of the Review have been presented in two scenarios: 1. a "baseline status quo" scenario which assumes the system continues to operate as is, with no change in configuration, utilisation or productivity, and 2. a "reform" scenario which examines the potential of a range of reforms that would align with current national policies and reflect a desired future state for our health services in 15 years.
Impact	No information identified.

Table 41 Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care settings in Adult Hospitals in Ireland [2018]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource**	Department of Health (DoH)[41] Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care settings in Adult Hospitals in Ireland 2018: Final report and recommendations by the Taskforce on Staffing and Skill Mix for Nursing [2018] Framework
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	No information identified.
Governance	**Recommendation/considerations:** Central to this in practice is the recommendation for the autonomy of the Group Director/Director of Nursing to determine safe staffing and skill mix levels across the hospital/hospital group, as part a member of the management team. In order to fulfil this function safely, effectively and efficiently the Group Director/Director of Nursing, as a member of the management team needs to determine, control and influence the size and utilisation of the nursing budget.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Therefore, it is recommended to factor bed occupancy and bed utilisation rates at ward, hospital and hospital group level, and to use this information in decisions on setting safe ward nurse staffing and skill mix requirements. In analysing the data, patterns of predictable higher acuity may become apparent, for example days with increased numbers of complex surgeries. Therefore, it is recommended that this information is used to interpret possible patterns of predictable demand over the spectrum of the week/month/year, and to allocate the nurse staffing resource according to these patterns.

Funding	**Recommendation/considerations:** Based on this high level review, it was proposed that the required level of investment to underpin the framework implementation could for the most part be resourced through the current totality of the nursing investment along with the additional efficiencies that would be realised through for example better patient outcomes. **For information:** Therefore, based on the evidence to date, the proposed approach to fund the ongoing implementation plan, is one of invest to save. This would require an initial 'seed investment fund' operated on the basis of a centrally managed fund by the HSE, subject to on-going Government commitment to fund the implementation of the Framework, based on year on year formal evaluation of the utilisation, impact and outcomes from the invest to save model. It is recommended that the HSE develop an implementation plan.
Other	No information identified.
Impact	No information identified.

Table 42 Report of the National Acute Medicine Programme site visit to UHL [2022]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	NAMP (HSE)[42] Report of the National Acute Medicine Programme site visit to UHL [2022] Report
The health service system (including health service reform)	**Recommendation/considerations:** **5.2** Maximise effectiveness of systems such as Navigational Hub, bed bureau and Healthlink by using them to signpost patients to the most appropriate pathway of care in advance of presenting to the hospital.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** **1.1** Zero tolerance of boarding. On the day of the visit, 100% of AMU assessment capacity was occupied by boarders. AMU assessment spaces need to be protected to enable the timely assessment of acutely ill medical patients in a safe and dignified manner. **3.1** Provide access to isolation facilities for AMU patients. **3.2** Secure a location for medical short stay patients in the short to medium term to care for acute medical patients with an anticipated length of stay of up to 72 hours. **3.3** Provide for additional assessment spaces in future capital developments to cater for ambulatory care patients and any additional senior decision making staff such as ANPs and HSCPs that can review/discharge patients. **5.4** Plan and provide for an adequate number of assessment and MSSU beds; based on number of admissions annually. **For information:** University Hospital Limerick has 530 inpatient beds. The Acute Medical Unit (AMU) in University Hospital Limerick (UHL) was established in 2013 and predominantly provides a rapid assessment facility for some medical patients who are acutely unwell and who present to the emergency department (ED). During the Covid-19 pandemic, the pathway for accepting GP referrals through the UHL bed bureau was curtailed but has recently resumed. The Acute Medical Unit at University Hospital Limerick has been in place since 2013. It is open to admissions between 8am and 12 midnight seven days per week. Medical cover is provided by the Consultant Physicians assigned to the unit between 8am and 5pm (Monday to Friday). Outside of those core hours, cover is provided by the physician's on-call. Since the last visit by the NAMP in March 2016:

	▪ The AMU has moved to a nearby area with 13 assessment beds, 6 trolleys, 1 work up space and 6 chairs which is adjacent to the ED. Unfortunately, there are no isolation spaces in the new unit. ▪ There has been a sustained increase in admissions to the AMU in recent years. ▪ Streaming and triage processes at the front door of UHL were modified as part of the Covid-19 pandemic preparedness planning process.
Governance	**Recommendation/considerations:** **1.2** The AMU should have a named clinical lead, which rotates every two years. **1.3** An AMU Governance Group, comprising all relevant disciplines and stakeholders should be established. **1.4** An operational plan should be co-designed and implemented between stakeholders in the AMU and the Acute Floor to ensure that there is no ambiguity as to who responsible for patient care at any time on their patient journey. **1.5** Carry out a detailed analysis to understand and address the local factors contributing to the extended PET time (14.7 hours) of patients in AMU. **4.1** Review the Manchester Triage Scores (MTS) and Early Warning Scores (EWS) of patients attending the AMU to ascertain the appropriateness of referrals and acuity in a model 4 setting. **4.1** Carry out an immediate review of reasons behind extended length of stay for patients admitted and discharged directly from AMU. **5.3** Co-design and agree operational policy with Acute Floor stakeholders on the streaming of patients to AMU. **5.6** Use all data sources on and ongoing basis to progress the alignment of service demand with resources available. **5.7** Such data should be collated, circulated and discussed regularly by all acute medicine stakeholders at UHL. **6.1** Undertake assessment of RAMU service to determine if activity meets criteria for AMU activity. **6.3** Gather and collate data on review clinics, virtual clinics and Healthlink referrals (where applicable). **For information:** At present, the AMU does not have a designated clinical lead, as recommended in the model of care. The model of care strongly advocates that each unit should have a designated clinical lead, which rotates every two to three years. This role enhances the governance of the unit and facilitates advocacy for the service, patients and staff. Since the last visit by the NAMP in March 2016: ▪ Processes around recording and collation of AMU activity have improved significantly since the last visit. ▪ A medical oversight committee was convened in 2021, which produced a comprehensive Strategic Plan for the Development of the Acute Medical Unit at University Hospital Limerick (June 2021).

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** **4.2** Strengthen GP communication and AMU referral processes through LiCC and bed bureau to help align demand with services available. **5.1** Strengthen engagement with GPs/primary care through fora such as LICCs.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** **2.1** Filling current gaps in medical Consultant and NCHD funded posts should be prioritised as a matter of urgency. **2.2** Review staffing levels required, in context of core hours for the admission of patients. The phased implementation of options such as extension of consultant cover to 8pm, whilst closing unit to admissions at 8pm also warrants consideration. **2.3** Progress plans for recruitment of additional staff, as set out in the Strategic Plan for the Development of the AMU at University Hospital Limerick (June 2021). **2.4** Progress plans for the phased recruitment of Advanced Nurse Practitioners in Acute Medicine. **2.5** Assign a HSCP lead to the AMU, as recommended in the Model of Care for model 4 units. This in turn will drive the delivery of multi-disciplinary care and allocation of HSCP resources in an equitable manner. **4.3** Seek opportunities for employment and utilisation of Advanced Nurse practitioners and HSCPs who can enhance the multidisciplinary element of acute medical care and increase scope for admission avoidance. **4.4** Undertake a review of the number of chronic disease patients attending the AMU with a view to re-directing to chronic disease pathways e.g. community hubs. **4.5** Undertake review of patients attending UHL from outside of Limerick/those that could be treated in St John's, Ennis and Nenagh model 2 hospitals. The NAMP suggests that UHL gives due consideration to options such as: ▪ the extension of consultant cover until 8pm ▪ closing the unit to admissions at that point. The staff at UHL AMU highlighted the need to recognise acute medicine as a medical specialty in order to train, recruit and retain NCHDs. This need was acknowledged by the Acute Medicine Programme, which is currently working through its Clinical Advisory Group to contribute to a new training programme in Acute Medicine. Currently, there is no HSCP lead for the AMU, as recommended in the Model of Care for model 4 AMUs. We recommend this as a priority, to provide management of the service, to drive service development and to promote the AMU HSCP team at hospital management level. **For information:**

	The medical team at UHL highlighted the challenges they face in providing the necessary staff to run the AMU. The unit is currently funded for 6 physicians, in reality there are only 2.5 – 3 WTE consultants available to staff the unit. The on-call physicians provide cover after 5pm. Agreements are in place locally regarding the handover of inpatients over 75 years and sub specialty inpatients. Funding is in place for 3 registrars and 4 SHOs. The actual level of NCHD cover falls short by approximately 1.4 WTE on an ongoing basis. The unit has approval for 22.46 WTE nurses, which includes 2 x CNM2s, 5 x CNM1s and 15.46 staff nurses. The nursing team is supported by 5.38wte HCAs. The AMU does not have any Advanced Nurse Practitioners. We note the significant bid made for ANPs in Acute Medicine in the recent strategic plan. At the time of our visit to UHL, the AMU had an allocation of 1 x Physiotherapist, 1 x Occupational Therapist and 0.5 WTE Social Worker. Given the volume of admissions through the unit and the age and frailty of many patients, this is a very low allocation of HSCP staff.
Funding	**Recommendation/considerations:** **6.2** Allocate sufficient resource to ensure all admissions are coded on HIPE within the required timeframe.
Other	No information identified.
Impact	No information identified.

Table 43 Report of the unannounced inspection of the Emergency Department at UHL against the National Standards for Safer Better Healthcare [2022]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource**	HIQA[43] Report of the unannounced inspection of the Emergency Department at UHL against the National Standards for Safer Better Healthcare [2022] Inspection report
The health service system (including health service reform)	**Recommendation/considerations:** <u>Compliance plan</u> ▪ *Standard 5.5* Highlighted in the report is the absence of a model 3 hospital within the group in comparison to other hospital groups. To explore the provision of a Model 3 hospital with the National system, to support the model 4 site and manage a higher acuity patient while increasing capacity. ▪ *Standard 1.6* - Model 2 Hospitals to take transfers from ED following review from ED consultant or SPR. If a medical review is requested by the Model 2 consultant it should take place in the Model 2 MAU. - Ensure Ennis/Nenagh/SJH's take a minimum 5 patients per day including weekends. Croom Orthopaedic to take 2 patients per day.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** The medium to long-term measures introduced or planned by the hospital group to manage the issue of capacity and patient flow included, a proposal to: ▪ develop a Model 2S (specialist) five day service to increase capacity for patients waiting for sub-acute care whose planned treatment was consistently cancelled due to the need to create capacity for unscheduled care admissions. In early March 2022, the chief executive officer of the hospital group had written to Department of Health requesting that the development of this service be considered in the rollout of the Sláintecare plans. At the time of HIQA's inspection, there was no further available information that the development of this specialist service would advance as proposed. ▪ build an additional 96-bed block to further increase the bed stock at University Hospital Limerick and ensure consistency in bed numbers with other Model 4 hospitals. At the time of inspection, the 96-bed block had full planning permission and the tender process was completed, the hospital group had requested funding for the build from the Department of Health. <u>Compliance plan</u>

	▪ *Standard 5.5* - To maximise the use of all beds on the St. John's hospital site and reopen the 8 beds in Nenagh Hospital. To be completed by Q2 2022 DON & Estates. - To establish following completion of the Deloitte review if the review to assess the current workforce and the delivery of care to those presenting to the adult emergency department from presentation to admission and discharge needs to be completed. - To build an additional 96 (44 replacement beds for the renovation of nightingale wards) bed block to further increase the bed stock and ensure consistency in bed numbers in line with other Model 4 hospitals. The 96-bed block for UHL has full planning permission, fire certification and is fully designed. The tender process has now been completed and a recommendation has been made to the HSE for their approval to appoint a contractor. Construction of this four storey, single room inpatient facility will take approximately 18 months to complete. A shortfall of over 200 beds on the UHL site has been identified. ▪ *Standard 3.1* - To renew the focus by the Patient Flow Teams and the Directorates on Red to Green to assist patient flow and reduce length of stay. - To complete a review of the conversion to admission rate across the Group with the development of a corresponding implementation plan on completion. - As part of the weekly Unscheduled Care Meeting to explore a cap for the DTOC's with CHO3 to create capacity. - Collaborate with the CHO3 and the deputy chief Nurse DOH to progress the virtual ward concept. - To complete the cohorting of patients to the relevant specialist ward and reduce the risks to patients. - ▪ *Standard 1.6* - To re-establish the AMU & SAU pathway's to ensure that they are operating in line with the model of care to support patient flow. - To review the Avlos for all medical consultants and address any deviations. **For information:** The hospital has an inpatient† bed complement of 530 beds (98 of these inpatient beds were added in late 2020 and early 2021) and 149 day case‡ beds. Emergency department: four triage rooms (three for adults and one for paediatrics) and 49 single treatment cubicles set out in four zone. Non COVID-19 patients were assigned to Zone A. Patients from Zone A were further streamed to the Acute Medical Unit or Acute Surgical Assessment Unit. Patients with suspected or confirmed COVID-19 were assigned to Zones B and C. The resuscitation area was part of the COVID-19 pathway. On the day of inspection, the number of patients in the resuscitation area was double its intended capacity. Patients were boarding in the

	resuscitation area while awaiting an inpatient bed, which had the potential to impact on the department's capacity and ability to deal with acutely ill patients and or major trauma and emergencies. This was a concern for inspectors. The emergency department also has a Clinical Decision Unit with 12 cubicles. This is a designated area where patients were monitored and treated for a period of time, usually for six to 24 hours, according to disease-specific protocols under the care of a consultant physician specialised in emergency medicine. In effect, the Acute Medical Unit was acting — like many other areas of the hospital — as an overflow ward for non COVID-19 patients from the emergency department, and was not functioning as designed, as an alternate flow pathway for patients in order to take pressure from the emergency department. This indicated to HIQA that the normal means of facilitating patient flow were simply not working at the hospital at the time of inspection. Quality improvement plans related to these serious reportable events were reviewed by inspectors and showed that hospital managers had or were in the process of implementing recommendations to: ▪ improve bed inpatient capacity and critical care services in the hospital. The hospital had increased bed capacity by 98 beds and had increased its critical care capacity by 11 beds.
Governance	**Recommendation/considerations:** <u>Compliance plan</u> ▪ *Standard 5.5* 1. To review the current UHL site management arrangements. 2. To review the current escalation plans to ensure that measures enacted are effective and contribute to reducing the numbers in the Emergency Department. This review will also consider the effectiveness of the bank holidays weekends and seasonal changes preparedness. 3. To review the internal escalation processes within the Emergency Department to ensure that delays are minimised for the patients availing of the service. - Triage risk mitigation and escalation process has been developed and agreed. 4. To ensure that the Deloitte Review into the analysis and review of patient flow across the Group, including CHO3 is completed with the development of the appropriate implementation plan. ▪ *Standard 6.1* 1. Nurse management to complete a review of Nurse staff levels within the Emergency Department to ensure a high quality safe and reliable healthcare service is provided. 2. To secure approval for the UHL site to be one of the first hospitals for the implementation of the Phase 2 safer nurse staffing framework for ED patients. 3. To seek approval from National Cost and Numbers subgroup to apply the safer staffing framework Phase 1 for

	medical and surgical wards to the admitted patients in the ED. 4. To ensure that all nursing staff have undertaken their mandatory and essential training appropriate to their scope of practice. **For information:** On the day of inspection, inspectors were not assured that the management arrangements in place to support and promote the delivery of high-quality, safe and reliable service were effective in managing the demand, overcrowding and patient flow in the hospital's emergency department. This included the adequacy of management arrangements for escalation of specific issues identified on the day of inspection – such as, sudden or unexpected change in staffing levels; the long waiting times for patients from reception to triage; or delays in patient flow that resulted in the boarding of 60 admitted patients in the department who were awaiting an inpatient bed in the hospital…. Documentation reviewed by inspectors detailed the measures that management at the hospital group had introduced or were planning to introduce to improve staffing levels and patient flow in the emergency department, and increase capacity for emergency, cancer and critical care services at the hospital.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** <u>Compliance plan</u> ▪ *Standard 1.6* - Implementation of Pathfinder Programme with completion of the recruitment process for the necessary resources. Maximise frailty at the front door team to ensure patients are appropriately referred in order to achieve "discharge to assess" rather than admission. - To explore with the National Team the development and extension of the OPTIMEND service to 8 - 8 Mon –Fri. Unscheduled Assessment Bays Inpatient Ward (OOHs) - opening of 2 unscheduled care bays in inpatient ward to operate out of hours to 'pull' patients post triage from ED to Haem/Onc Service. - To develop an over 75 year assessment area in ED (extend OPTIMEND/FIIT Team service as an admission avoidance measure). - To maximise and monitor the numbers seen by the specialist community supports such as ICPOP at the Integrated Unscheduled Care meetings. - To work with our CHO3 colleagues to deliver a Mobile Diagnostics service (aimed at Private Nursing Homes) through a managed delivered service as a hospital avoidance measure. ▪ *Standard 3.1* - To embed the initiatives around frailty at the door & Igpop and maximise use of the service. - To progress the initiatives identified in the Unscheduled Care Joint Plan between the ULHG and CHO3 to improve patient flow once approved and funding secured. - To review the access to rehab and step down facilities to ensure that delays for patients are minimised.

	- To develop and foster closer working relationships with our CHO3 colleagues through the Unscheduled Care committee. - To work with CHO colleagues to address the reduction in GP referrals and increased self-presentation rate to UHL. **For information:** In 2020, the hospital had introduced some person-centred initiatives as part of an improvement plan to improve the patient experience times for older persons attending the emergency department. These person-centred initiatives included participation in the OPTIMEND study, frailty at the front door and the Integrated Care Programme for Older Persons (ICPOP) hubs. With the OPTIMEND initiative, a dedicated team of health and social care professionals in the hospital's emergency department were focused on ensuring the timely assessment and intervention of people aged 65 years and over to enhance the quality of care, improve the patient experience and optimise overall patient flow. The Integrated Care Programme for Older Persons (ICPOP) was a national initiative that aimed to integrate primary and secondary care services for older people, especially those with more complex needs. The programme comprised 10 steps that enabled integrated care for older people to be implemented, evaluated and sustained. As part of this programme and to offer an alternative pathway for patients aged 75 years and over, the University Limerick Hospitals Group was progressing the development of ICPOP hubs. Each acute hospital in the hospital group was resourced to appoint at least one consultant for integrated care. ICPOP hubs were operational in Limerick, Ennis and Clare and were accepting referrals from the emergency department at University Hospital Limerick. The frailty at the front door initiative was introduced as part of the ICPOP to identify frail older people presenting to the hospital's emergency department that need timely and appropriate intervention. This initiative involved the person's complete episode of care in the emergency department being managed by designated medical and nursing staff from triage to discharge and or admission with the person followed up in the ICPOP hub in the community. Implementing these initiatives means that the older person attending the emergency department can receive timely and appropriate care, as per their assessed needs, which is the essence of person-centred care. While it was not possible for inspectors to evaluate the effectiveness and impact of these initiatives within the confines of a short unannounced inspection, the fact that work was ongoing to embed alternate pathways for patients is acknowledged as positive by HIQA.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** The medium to long-term measures introduced or planned by the hospital group to manage the issue of capacity and patient flow included, a proposal to: ▪ increase the number of non-consultant hospital doctors at the hospital to assist senior decision makers during core and outside core working hours. Hospital managers need to ensure that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care in the emergency department and that there are contingencies in place to ensure that the service can meet increase in demand such as that caused by the increased numbers of patient presentations. It is

	also essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. Compliance plan ▪ *Standard 5.5* To explore with the National Team the provision of additional of non-consultant hospital doctors to assist senior decision makers during core and out of hours. A bid has been submitted as part of the estimates process in 2021 for 96 additional NCHD posts to support the increased work demands and the newly appointed consultant posts. ▪ *Standard 6.1* The Senior Nursing Management team have redeployed nursing staff with experience to the Emergency Department. **For information:** On the day of inspection… there were significant deficits in nurse staffing levels which impacted on the functioning of the department. The University Limerick Hospitals Group was successful in recruiting 286.12 WTE staff nurses to University Hospital Limerick in 2021. However, despite this increase in staffing, HIQA found that on the day of inspection the nurse staffing levels in the emergency department were insufficient to meet the needs of people attending the department. …HIQA sought confirmation from the hospital group that the nursing staff levels and deployment patterns were appropriate to maintain the safety of healthcare in the emergency department. HIQA also sought assurance that adequate contingency arrangements were in place to maintain appropriate nursing staff levels in the department, in the event of surges in presentation rates and or short-notice absenteeism. The response received from the hospital group provided some assurance that the hospital had a contingency plan to address the staffing deficit and ensure the timely triage, medical review and assessment of patients attending the emergency department. Quality improvement plans related to these serious reportable events were reviewed by inspectors and showed that hospital managers had or were in the process of implementing recommendations to: ▪ ... ▪ improve access to specialist infection prevention and control expertise in the emergency department. ▪ support staff education and training in the early warning system, recognition and escalation of clinical deterioration and medication safety in the emergency department. ▪ improve clinical audit activity within the emergency department. ▪ review staffing levels, which included medical, nursing and health and social care professionals, in the emergency department.

Funding	**Recommendation/considerations:** The medium to long-term measures introduced or planned by the hospital group to manage the issue of capacity and patient flow included, a proposal to: ▪ improve base funding for service improvement. <u>Compliance plan</u> ▪ *Standard 5.5* To explore with the National Acute Hospitals Team, the funding of staff for the provision of an assessment area in the Emergency Department for older people as a hospital avoidance measure. ▪ *Standard 6.1* To secure support and additional funding for the provision of additional consultants and NCHD resources to support the delivery of a high quality and reliable service.
Other	**For information:** HIQA has been in ongoing communication with the hospital group regarding the overcrowding in the emergency department at University Hospital Limerick since July 2020. In May 2021, the hospital group provided HIQA with a detailed analysis of the factors that they considered contributed to ongoing overcrowding in the hospital's emergency department, and the measures enacted or in planning to alleviate the situation. Correspondence received from the hospital group outlined the short, medium and long-term measures to increase inpatient bed capacity and improve patient flow in the hospital. In January and February 2022, the number of people presenting to the hospital's emergency department was unprecedented, leading to instances of significant trolley numbers in the emergency department, including patients already admitted awaiting an inpatient bed on a ward. At that time, HIQA sought further assurances from the hospital group on measures enacted to address overcrowding in the hospital's emergency department and the associated risks to patients. Short-term measures, in keeping with the standard HSE national emergency department escalation protocol, enacted by the University Limerick Hospitals Group to address the overcrowding situation in the emergency department at University Hospital Limerick included: ▪ cancelling or curtailing scheduled care. ▪ transferring patients to Model 2 hospitals where possible. ▪ utilisation of all surge beds and additional trolleys in inpatient wards. ▪ maximising and utilisation of community and rehabilitation beds. ▪ using beds in specialist hospitals to transfer patients needing rehabilitation when no community rehabilitation beds were available. ▪ engaging and communicating with the public advising them to only use emergency department for emergency cases and to choose alternative options, such as general practitioner and injury units for non-urgent cases.

	At the time of inspection, chronic overcrowding related to the emergency department was the one open high-rated risk recorded on the hospital's corporate risk register. The hospital had articulated on its risk register a number of actions and controls to manage and minimise the risk. These included: ▪ transferring a targeted number of patients to the Model 2 hospitals in the University Limerick Hospitals Group every day. ▪ monitoring breaches of patient experience time. ▪ activating the hospital's escalation plan. ▪ holding huddles two times a day with directorate management teams, management from Model 2 hospitals, the bed management manager, the unscheduled care manager and patient flow assistant director of nursing to address operational issues and patient flow challenges. ▪ implementing the hospital's escalation plan when 10 or more patients were on trolleys. ▪ using trolleys on inpatient wards once the decision to admit is made.
Impact	Hospital management had developed a plan comprising short, medium and long-term measures to address the issue of overcrowding in the hospital's emergency department. However, evidence collected during HIQA's inspection of the hospital's emergency department showed that the short-term measures enacted by management had limited impact on the day-to-day workings of the emergency department. From HIQA Inspection Report February 2023:[44] Following HIQA's inspection in March 2022, the HSE convened a support team comprising representatives from the HSE's National Acute Operations, Special Delivery Unit, National Community Operations including Primary Care Operations, Older Persons Operations and Performance and Integration Unit to support hospital management to identify and achieve sustainable operational effectiveness and efficiencies across UHL….The support team were onsite at UHL for a four week period between May and June 2022 and also throughout July 2022 to support hospital management and clinical staff to improve operational and clinical efficiencies across the hospital. ULHG and UHL also received significant support and financial resourcing (approximately €6m per annum) to improve operational and clinical effectiveness and efficiencies at UHL and across ULHG, and to further strengthen and enhance integration with the Midwest Community Healthcare Organisation (MWCH). Since HIQA's last inspection of the emergency department in March 2022, hospital management at UHL have received substantial external supports and resources to strengthen and improve operational effectiveness and efficiencies in the emergency department, at wider UHL level, and to further strengthen and enhance integration with MWCH. Specifically, ULHG and MWCH were supported to:

	▪ enhance and increase operational effectiveness and efficiencies in the unscheduled care pathway with the appointment of a head of operational services at UHL. This person had recently been appointed at the time of this inspection. ▪ maximise the use of community based service models such as home support, aids and appliances and community diagnostics to achieve greater integration and sustainable services between the acute and community sectors. Work was progressing on this measure at MWCH level at the time of this inspection. ▪ implement the HSE's Enhanced Community Care programme across the Midwest region. Work was progressing on this measure at the time of this inspection. ▪ implement the eight Primary Care Networks with chronic disease management teams across the Midwest region to deliver care and services in a non-acute hospital setting and thus avoid hospital admission. Work was progressing on this measure at MWCH level at the time of this inspection. ▪ enhance the ICPOP model of care for older people as a hospital admission avoidance measure. At the time of this inspection, three ICPOP ambulatory care hubs provided specialist geriatric care in Limerick, Ennis and Thurles. ▪ increase consultant medical staffing in UHL's emergency department — approval was granted for an additional two whole-time equivalent (WTE) consultants in emergency medicine, which supported a change to deployment patterns for consultants in the department across seven days. ▪ increase NCHD medical staffing in UHL's emergency department — approval was granted for an additional 20 WTE NCHDs. ▪ establish a dedicated Geriatric Elderly Medicine Unit (GEMU) for attendees aged 75 years and over who presented to UHL's emergency department. The establishment of this unit was an important hospital admission avoidance measure given the ageing profile of the Midwest region and increasing number of attendees to UHL over the age of 75 years. ▪ expand the OPTIMEND multidisciplinary team in UHL's emergency department by 25 WTE to enable the multidisciplinary assessment of and intervention to patients aged 75 years and over who attend UHL's emergency department. OPTIMEND was up and running at the time of this inspection ▪ increase resources at UHL for the Rapid Response Frailty team to support the OPTIMEND team. Work was progressing on this measure at the time of this inspection. ▪ re-establish the AMU and ASAU at UHL to function as they should be in line with the HSE's National Acute Medicine Programme's model of care to support continuous, effective patient flow across ULHG. UHL's AMU and ASAU were not functioning as intended at the time of this inspection ▪ increase GP access to diagnostics in primary care through the provision of a mobile diagnostic service, which was established in the community at the time of this inspection. ▪ increase patient flow coordinator and CNM positions at UHL to specifically focus on patient discharges at weekends. Work was progressing on this measure at the time of this inspection.

	▪ implement the 'Red to Green' bed days system across all clinical areas in UHL to facilitate the identification of patients waiting for diagnostics, review or transfer. The system was implemented in all clinical areas visited during this inspection. ▪ build capacity in the Model 2 hospitals in ULHG by extra resourcing of medical, nursing and administrative staff to enable the AMU in these services operate 8am-8pm over a seven day timeframe, and to allow greater volumes of direct referrals to the units by GPs, thereby avoiding the need to attend UHL's emergency department. The scaling up of the AMUs in Model 2 hospitals across ULHG was underway at the time of this inspection. An additional 50 staff were recruited to the Models 2 hospitals to resource their AMUs. It is projected that this will provide an additional 7,200 slots per year for patients directly referred to the units from GPs. ▪ introduce the Pathfinder programme, providing alternative care at home to people over 65 years of age. ▪ During this inspection, there was evidence that the majority of initiatives arising from the increased support and resourcing of UHL were in the process of being implemented to a greater or lesser extent. However, many of the initiatives introduced had only recently become operational (since January 2023).

Table 44 Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland. Final Report and Recommendations by the Taskforce on Staffing and Skill Mix for Nursing [2022]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource**	DoH[45] Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland: Final Report and Recommendations by the Taskforce on Staffing and Skill Mix for Nursing [2022] Framework
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** It is recommended that, as outlined in the Workplace Relations Commission (WRC) agreement of 2016, where the issue exists, patients whose emergency care is complete and remain in the ED while awaiting admission to a ward are staffed separately from patients receiving emergency care. The staffing model for this cohort of patients should be based on the WRC Agreement and the Framework for Safe Nurse Staffing and Skill-Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland (Department of Health 2018).
Governance	**Recommendation/considerations:** It is recommended that each hospital where the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings is implemented, will put in place a Local Implementation Group (LIG) that comprises collaborative representation from nursing, finance, human resources, IT, quality and safety and representation from the office of the National Lead for Safe Nurse Staffing and Skill Mix in the HSE. It is recommended that the LIG be chaired by the Director of Nursing and will consult with the Executive Management Team at hospital level and Chief Director of Nursing at Hospital Group level. It is recommended that, where Safe Nurse Staffing Coordinators are established, they include emergency care settings to support existing governance and oversight systems in line with safe nurse staffing policy. It is recommended that the Director of Nursing, as Chair of the LIG, based on the recommended evidence-based approach, endorses the safe nurse staffing and skill mix requirements to the Hospital's Executive Management Team. These recommendations should be verified by the LIG in coordination with the National Lead for Safe Nurse Staffing and Skill Mix. ▪ The National Safe Staffing Implementation Group was established to guide, support and monitor the HSE

	implementation of the Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland (2018). The group has designed structures and processes for implementation of the Safe Nurse Staffing and Skill Mix Framework in the HSE. It is recommended based on learnings from implementation of Phase 1, that the HSE continues to evolve this governance structure ensuring alignment with the Report of the Expert Review Body on Nursing and Midwifery (2022). ▪ A National Lead for Safe Nurse Staffing and Skill Mix was established in 2020 to oversee and deliver implementation of the Framework. This senior leadership position plays a key role in coordinating national implementation of the Framework. The National Lead should work closely with Directors of Nursing and Chief Directors of Nursing and Midwifery at hospital group level in implementing the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings. ▪ The National Lead for Safe Nurse Staffing and Skill Mix will coordinate the necessary steps with the Director of Nursing or designate (e.g., Safe Nurse Staffing Coordinator) in the implementation of the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings. ▪ LIG will be established in each hospital for implementation of the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings. ▪ The National Lead for Safe Nurse Staffing and Skill Mix should work closely with Directors of Nursing and Chief Directors of Nursing and Midwifery at hospital group level to determine the indicators that will be reported to measure the impact of implementing the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings. Monitoring the longitudinal impact of the Framework on patient, staff and organisational outcomes is necessary. The LIG is ideally placed to provide this oversight function in the initial phases of implementation.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** It is recommended that a systematic, triangulated evidence-based approach to determine safe nurse staffing and skill mix based on patient need be implemented nationally in emergency care settings. It is recommended that application of the evidence-based model to determine the required nurse staffing complement be supported by data that is routinely collected in emergency care settings. This data includes the number of patient presentations by triage category as well as patient outcome indicators. It is recommended that the number of RNs allocated to triage in ED should be determined by the number of patient presentations. EDs with annual presentations greater than 40,000 should have a minimum of two RNs allocated to triage per shift, 24/7. EDs with annual presentations less than 40,000 patients should have a minimum of one RN allocated to triage per shift, 24/7. The assessment of staffing for triage must always take the professional judgement of the senior nursing management team into consideration.

	The recommended minimum frequency to re-assess nurse staffing requirements in EDs is at six monthly intervals per annum using routinely collected patient data to identify seasonal variation. More frequent measurements may be required if, for example, there is a change / redesign of the service. It is recommended, that the RN: HCA skill mix ratio for EDs is 85:15 once a safe nurse staffing level exists. It is recommended that the assessment of staffing requirements must always take the professional judgement of the senior nursing management team into consideration. Professional judgment should also take into account the physical environment of the department and associated services. It is recommended that organisations support leadership and professional development of all grades of CNMs in unscheduled emergency care settings (CNM 1, CNM 2 and CNM 3). It is recommended that staff should have access to the expertise of a Clinical Skills Facilitator in unscheduled emergency care settings as it is recognised that these roles are essential for the maintenance of competencies of nurses caring for emergency care patients and will significantly enhance the department's ability to oversee induction, training and ongoing professional development requirements of staff. It is recommended that RNs in unscheduled emergency care settings should be supported to achieve the capabilities and competencies as outlined in the enhanced nurse contract. It is recommended that staff commencing in emergency care settings, including graduates, should be provided with a structured induction programme and the opportunity to undertake a relevant Level 8 foundation programme in order to develop the future emergency nursing workforce. It is recommended that RNs in unscheduled emergency care settings should have access to relevant continuing professional development, higher/postgraduate diploma and master's level education to facilitate the development of the workforce and succession planning for future clinical, leadership, management, specialist and advanced practice roles. As recommended in the Review of the Role and Function of the Healthcare Assistant (HSE, 2018), all HCAs working in emergency care settings will have QQI Level 5 as a minimum qualification or be provided with a supportive pathway to acquire this qualification. 13 It is recommended that all emergency care settings have a minimum of one HCA 24/7, and that this must be considered when applying the recommended skill mix.

	It is recommended that recruitment processes be streamlined to deliver timely recruitment to avoid gaps in staff replacement in emergency care settings. It is recommended that 100% of the CNM 2 role is in a supervisory capacity when they are in place as a shift leader in an ED. This acknowledges the need to ensure that senior leadership is in place 24/7.
Funding	No information identified.
Other	**Recommendation/considerations:** It is recommended that on-going research in the emergency care settings is continued. This will facilitate the future support of a longitudinal evidence-based approach to policy on safe nurse staffing and skill-mix in response to changes in population health. It is recommended that emergency care setting and organisation wide mechanisms are put in place to measure and monitor, at a minimum, routinely collected outcomes related to nurse staffing in EDs including, but not limited to, patients leaving without being seen, time to triage, time to be seen, ED care time and patient and staff experiences. Consideration should be given to incorporating these outcomes in IT systems at ED level, should these systems become available. It is recommended that LIGs collate relevant patient, staff and organisational outcome data to provide longitudinal evidence to support Directors of Nursing and Chief Directors of Nursing to support the governance and monitor the impact of the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings.
Impact	The testing of the pilot Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings provided some key insights on the benefits of the introduction of a Framework that have included: 1. Patient benefits: decreased ED care time, reduced time to triage, reduction in number of patients who left ED prior to completion of their treatment and a reduction in levels of care left undone. 2. Staff benefits: increased perceptions of care quality, reduction in missed meal breaks, improved nurse to patient ratios, decreased levels of burnout and increased levels of job satisfaction 3. Organisational benefits: efficiency savings through reduced agency usage.

Table 45 ULHG Patient Flow Report [2022]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource**	Deloitte[46] ULHG Patient Flow Report [2022] Report
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** As described in the findings there is a requirement for an additional 302 inpatient beds and 63 day beds. There are a number of options for how this additional capacity could be configured including additional bed capacity on the UHL site, a standalone model 3 hospital, an elective only facility or a combination of the above. We would recommend a detailed options appraisal to arrive at the option that would deliver maximal benefits. There are a set of recommendations outlined in this document that could deliver benefits in terms of admission avoidance and improved egress. The total quantum of bed savings that could be realised from these benefits is estimated to be 30 beds. This means that there remains a large gap between capacity and demand even if significant efficiencies can be gained. ***Patient Flow at Pre-Admission*** A review of the AMU / ASAU referral process and ED pathways should be conducted to align with national guidance. The current model of referrals to the AMU and ASAU should be reviewed and realigned with national guidance to re-introduce access for GPs to the assessment maintain referrals from the ED following assessment by the ED team. Staffing in the ED, AMU and ASAU will be required to implement this recommendation. A range of ED avoidance measure have been identified in the recommendations section of this document including consultant assisted triage in the ED, documentation of ED avoidance pathways for NCHDs, improving OPD access and providing AMU access for GPs. All of these measures could help with increasing demand. ***Patient Flow at Post-Admission*** A number of measures have been identified to improve timely discharge including speciality cohorting on wards, Increased nursing involvement in ward rounds & care planning, implementation of criteria led discharging for common conditions, streamlining ward rounds and increasing HSCP staffing on wards. Implementation of some of these measures could be considered immediately, others such as speciality cohorting will require reduced inpatient occupancy rates through additional bed capacity to be successful. Renewed measures to reduce DTOCs such as focus on discharge planning from admission and streamlined access to rehab beds could help to reduce bed days lost due to DTOCs.

	Bed capacity needs to be increased to meet demand. To address the immediate demand of circa 87 beds would be required to bring the occupancy rate to 80%. By 2036 202 additional beds are required and an additional 100 replacement beds, a total of 302 inpatient beds. There are a number of options for how these beds could be configured including additional beds, a detailed options appraisal is required to arrive at the most appropriate solution. **For information:** ULHG has put a significant focus on addressing these waiting lists and a total of five initiatives are now in place within the UL Hospital Group and are designed to target both the longest waiters and urgent time critical patients. The initiatives are a mix of virtual and face to face consultations, procedures and diagnostics and are supported by numerous specialities across the Hospital Group. These include: ▪ Advanced Clinical Prioritisation (ACP) initiative has delivered 8,047 virtual consultations and is expected to achieve 13,600 by year end. ▪ The National Treatment Purchase Fund (NTPF) initiative is on target to achieve over 4,500 consultations across ten specialities by year end. ▪ The Scheduled Care Transformation Programme (SCTP) was introduced this year and is a once off funding initiative providing out of hours consultations for additional activity within the Hospital Group. It is supported by twelve specialties and since starting in April of this year, has delivered 4,048 consultations and procedures. ▪ Safety Net Agreement (SNA) initiative has delivered 6,802 consultations and procedures to date and is due to cease on the 20th of the month. ▪ Access to Care was introduced in July of this year and will provide additional support to patients, including inpatient and day cases.
Governance	**Recommendation/considerations:** The implementation plan should therefore be accompanied by a structured and robust project and change management plan that is adequately resourced and funded, as the staff across the hospital are already working in high pressure and full-time roles so new change resources will be required to support it. We would recommend that a formal programme structure be established to manage the implementation plan with dedicated project management and project support resources including a dedicated PM with acute hospital operations experience and clinical leadership involvement. We would also recommend a more detailed review of staffing, leadership & culture to be undertaken and for any recommendations arising from this review to be incorporated into the overall implementation plan. It would also be beneficial to seek patient feedback and to better understand the patient experience and to identify the key challenges from the perspective of the patient. ***Leadership & Governance*** It is recommended that the role of the Head of Operational Service for the UHL site which has been recently recruited be embedded into the governance structure to take on additional operational responsibility from the

	Directorates and allow for them to play more of a strategic role. It is also recommended that the CDs are supported to have additional capacity through a strengthened and formalised ACD role and provision of admin support for them in their role. The reporting and escalation requirements from the Directorates need to be clarified and clearly communicated to reduce duplication of escalation and drive autonomy at Directorate level. The culture of ULHG is mixed with evident staff fatigue following a difficult number of years. It is recommended that a targeted programme of staff engagement (such as that being initiated by the HR Director) strive to address staff issues or concerns where this is possible and also to celebrate successes and share future development plans with staff. The development of a transformation office including Change and PMO would further support the Strategy function with the implementation of key strategic initiatives. Finally, the QPS department has developed a detailed future org structure which requires funding for key posts. Given the strong role this department plays in driving quality and patient safety it is recommended that funding be provided for these posts.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Integrated Community and Hospital Services* The impact of enhanced community services on inpatient admissions has not been quantified as the proposed impact of the measures is not yet clear nor is the timeline for these benefits to be seen. To date implementation of initiatives such as the ICPOP hubs has not been correlated with a reduction in ED attendances. There are challenges nationally in accessing primary care and solutions to address this at a national level would be beneficial. In addition, ramping up and increasing throughput in existing funded community services would be useful. It would also be beneficial to evaluate the impact of increased community services on demand for acute services.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** ***Patient Flow at Pre-Admission*** …ED staffing needs to be increased to manage the increased demand, particularly Consultants and NCHDs. ***Patient Flow at Post-Admission*** … Similar to the ED, additional staffing is required on the wards particularly HSCP staffing and bed management resources.
Funding	No information identified.

Other	**Recommendation/considerations:** ***Improve technology to improve efficiency & quality of care*** While this is largely outside of the control of ULHG and Midwest Community Healthcare locally, it is recommended that the eHealth systems across the hospital and CHO are upgraded to a fit-for-purpose single electronic healthcare record to improve visibility, efficiency and quality of care as has been demonstrated in numerous studies internationally. The lack of a single patient record is having significant impacts on patient flow. Interim measures as also recommended such as implementation of order comms and upgrading the ICT infrastructure.
Impact	***Estimated impact:*** Adjustments based on recommendations: ▪ Review AMU pathway: opportunity to reduce the emergency admissions by 10% (2,625), these admissions are likely to be associated with a shorter ALOS (1 day) equating to a potential bed saving of 8 beds. ▪ Admission avoidance measures: 30% of emergency admissions have an ALOS of 1 day. Implementation of admission avoidance measures could have an impact on these admissions. Assuming a further 50% of these 1 day admissions could be prevented there would be an additional saving of 8 beds. ▪ Timely discharges: Implementation of the measures described in this document to improve timeliness of discharges could be expected to reduce the ALOS by 3 hours. If this was achieved it would save 10 beds. ▪ DTOCs: Earlier and improved discharge planning and use of standardised processes for accessing step down and rehab beds could reduce the ALOS of medically discharged DTOCs. If there was a reduction by 2 days from 15 days to 13 days this would save 4 beds per year.

Table 46 Overview Report: Monitoring programme against the national standards in emergency departments in 2022 [2022]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource**	HIQA[47] Overview Report: Monitoring programme against the national standards in emergency departments in 2022 [2022] Overview
The health service system (including health service reform)	**Recommendation/considerations:** The need to continue to urgently build additional capacity within the whole healthcare system, both acute and community, through implementation of the recommendations from the Department of Health's 'Health Service Capacity Review', which was published in 2018. In particular, there is a need to assess capacity requirements at a regional basis as recommended in the capacity review and the prioritisation of investment to be informed by the outputs from such assessment. This will also require associated investment in additional supports to aid infrastructural capacity, inclusive of diagnostic services.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** HIQA recognises that not all issues that emergency departments face can be addressed at a local level. Irish emergency departments are often a window into wider capacity and patient flow issues across the local health service which need to be supported by effective and reactive governance at hospital group, community health area and HSE level. Issues identified in this report require strategic planning to build capacity within our health service and to include alternative pathways in the community to ease pressures on an already strained health service.
Governance	**Recommendation/considerations:** More responsive leadership, governance and management is needed at local, regional and national level, which acts to address performance issues when identified. Such an approach needs to recognise that – notwithstanding contextual challenges – some hospitals cope better than others with the demands placed upon them and that this is often driven by better local operational management. Such an approach should also not only be confined to just acute services. A collective approach to ownership of this problem across both acute and community services in a region, with seamless planning and a shared approach to escalation in the event of overcrowding is needed. In short, emergency department overcrowding needs to be recognised as a whole health system problem, and the normalisation of comparatively poor performance should not be tolerated. **For information:** HIQA found that while the majority of emergency departments had management arrangements in place to address patient flow through the emergency department, the hospital and onwards to the community, these measures were not always effective in ensuring the delivery of quality and safe services.

	With the exception of two of the hospitals in the sample of seven that HIQA inspected, significant opportunities for improvement were identified across hospitals relating to patient dignity, privacy and autonomy, workforce and protecting patients from harm associated with the design of service delivery. All hospitals where noncompliance's with standards were identified were issued with compliance plans and three hospitals were issued with high-risk letters in relation to findings.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** The further progression of Sláintecare will help the health service to move away from the current overly hospital centred model of care to an integrated model of care that can support geographically isolated regions of Ireland. The continued development and support of alternative care pathways based on the needs of communities must be advanced. This needs to be supported by improved access to primary care services and greater investment and enhanced access to diagnostic services.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** A need to advance a more effective approach to strategic workforce planning at local, regional and national level that enables effective anticipation and management of manpower shortages. This acknowledges that recent developments to benchmark and enhance nursing and medical consultant staffing levels in our emergency departments represents an important initial step along this road to improvement. More effective identification, monitoring and management of patient safety risks associated with overcrowding in emergency departments, with timely escalation and response to risk within hospitals should they occur. Particular areas for focus should aim to address short-term staffing deficits relative to demand, timely responsiveness to surges in presentation, and close attention to treatment times inclusive of triage times and times to medical assessment. **For information:** Overall, HIQA found that the mismatch of demand and capacity alongside insufficient staffing levels were major contributing factors across five emergency departments, which will continue to pose a risk to patient safety unless adequately addressed.
Funding	No information identified.
Other	Note: References Health Service Capacity Review 2018 and the HSE Winter Plan 2022-2023 published in October 2022.
Impact	No information identified.

Table 47 Full Report: Review of Medical Assessment Units [2023]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[48] Full Report: Review of Medical Assessment Units [2023] Report
The health service system (including health service reform)	**Recommendation/considerations:** There are improvements that can be made in terms of standardising the processes, referral pathways, access to diagnostics and staffing in the MAUs to further alleviate the pressure of the Emergency Departments and provide improvements in patient experience These include standardising and widening the referral pathways by agreement through the Local Integrated Care Committees (extending the hours of operation to ensure that there is time to see, treat and discharge 2 patients per treatment space per day, implementing review clinics and ensuring there is a consultant review prior to admitting patients with the aim of reducing admissions where clinically appropriate and ensuring there is adequate access to diagnostics to enable the units to see, treat and discharge patients safely. <u>Insights and recommendations: Standardisation and stabilization of existing services</u> 1. Maximise the activity within existing units: It is recommended that all efforts are made to increase the activity within the units to maximise the existing resources and support ED avoidance and admission avoidance where possible In conjunction with the Acute Medicine Programme, units should identify their daily capacity in line with their physical capacity and staffing levels. A plan to increase activity should then be developed by the units Measures could include: ▪ Communications with GPs and out of hours doctors particularly for weekend referrals ▪ Exploring deferred care pathways with EDs where suitable patients could be seen the next day ▪ Exploring additional access routes for patients such as Healthlink GP referrals if not in place, self-presentations with GP referrals in addition to the GP phone calls ▪ Reviewing opening hours to ensure the hours that are staffed can be maximised, this may mean extending the opening hours to a 12 hour day to allow for increased throughput prior to the units closing Units that are open 8 hours per day tend to have a lower occupancy rate over these hours compared with units open 12 hours per day This may be the result of lack of patient booking. 2. Increase access to diagnostics: There is a known challenge with radiographer resourcing however some of this may be as a result of temporary contracts that cannot be filled It is recommended to review the radiography posts to determine the impact of the vacant posts and determine how the funded posts and be filled and used effectively In addition, similar to the Injury Units the use of private capacity can be explored

	in the short term…It should be noted that partnerships or arrangements with private imaging centres are only a quick fix, short term solution as private imaging will also not allow for scans to be uploaded or accessed on NIMIS for radiologists to refer to Strong consideration needs to be given to direct resourcing of radiographers at sites With regards to laboratory services there is an opportunity to use Point of Care Testing (where there is no access to lab onsite or restricted access such as in Nenagh and St John's where there is no access onsite with all samples being sent to the lab in UHL and in St Columcille's where there restrictions in terms of the hours onsite labs are available This could improve TATs and therefore ALOS for patients in the MAUs if used extensively in Model 2 hospitals It may also support the ability to increase activity within the units with improved access to lab diagnostics. 3. Standardise Access Pathways for patients and strongly support Local Integrated Care Committees (LICC) integration: The access pathways for patients into MAUs are variable across the units and should be standardised. Given the low occupancy rates in some of the units, it is recommended that all clinically appropriate access pathways should be in place for patients to access the service. The pathways that are acceptable under the clinical programme are listed below but should be agreed with the Local Integrated Care Committees (which should include GP representatives: ▪ GP phone call to the unit (or centralised booking system/navigation hub for ULHG) and patients booked to a slot ▪ Healthlink referral from a GP and patient booked into a slot and phoned • Self presentations with GP letter ▪ Ambulance conveyance for patients that meet the criteria usually with a phone call to the unit in advance For sites where this is available it would be beneficial to standardise the hours it is in operation and the criteria for acceptance and process for acceptance ▪ Patients referred by the Model 3 or 4 hospital following triage including deferred care with patients booked in for the next day ▪ Patients referred by other services within the Model 2 hospital e g Injury Unit, OPD. The majority of these pathways apply in the busiest sites (St Columcille's and Ennis) and in the sites with the lowest activity such as Roscommon have the least access points to the MAU only accepting patients via GP phone call and now by ambulance with very small numbers It is strongly recommended that the associated LICCs be utilised in standardising these access pathways, and MAU GP representation on these committees be prioritised. 4. Same day discharge rate: There is a high degree of variability in the rate of same day discharge from the units with Ennis, St Columcille's and St John's having the highest rate 80 These units have strong medical governance with consultants seeing patients prior to admission They also have review clinics to follow up patients who have been discharged These clinics allow for patients to be discharged safely from the MAU and followed up as appropriate based on the clinical need MAUs with review clinics tend to have a higher

	proportion of same day discharges 80 for both Ennis and St Columcille's) Most sites have noted that they conduct review clinics however a standard approach to this would be beneficial Increasing the same day discharge rate for all sites to that of Ennis, St John's or St Columcille's would save approximately 3 000 bed nights (assuming a 2 day ALOS and excluding Bantry) or 10 inpatient beds in the Model 2 hospitals This may increase capacity for additional attendances at the individual MAUs and free capacity in the Model 3 or 4 sites. <u>Insights and recommendations: Future developments</u> 8. MAU provision across all Model 2 Hospitals: *recommendations for MAUs in Monaghan, Dundalk and St Michael's in Dun Laoghaire* **For information:** The Medical Assessment Units, similar to the IUs, are varied in terms of their operations, governance, staffing and leadership They have all developed from the reconfiguration of hospitals under the Smaller Hospitals Framework The National Acute Medicine Programme (provides guidance for the operations and governance of Medical Assessment Units (NAMP was established in 2010 to address the unsatisfactory management of acutely ill medical patients in Ireland It aimed to improve quality of care and safety, streamline access to healthcare, and reduce cost through efficiency gains. The demand for MAUs is driven through GPs and available slots in the MAUs making them quite different in demand terms to injury units where patients can walk in without a referral This means that the activity in the units is not necessarily a reflection of demand but of the capacity within the services and indeed within GPs The activity within the units has remained largely static over the period 2019 2022 with the exception of Ennis and St John's were there have been significant increases There is relatively low occupancy in most of the units also and the reasons for this appear to be multi factored including restricted access to diagnostics, capacity issues in GPs to provide referrals, medical governance of the units, staffing issues, restricted opening hours and restricted access routes into certain units This means there is considerable potential to develop the service in the MAUs to divert additional suitable patients away from EDs, avoid admissions and improve patient experience There is currently over 27 k admissions to MAUs annually and there is the potential to increase this by approx 34 k additional admissions if all sites captured a proportion of the catchment population as much as the busiest unit. There is variation across the units from the recommendations outlined in the Report of the National Acute Medicine Programme 2010 outlined overleaf However for the most part the units are aligned with recommendations around the clinical governance, staffing and operations All sites have clinical governance from a medical consultant for example The MAUs were established originally through the reconfiguration of hospitals under the Smaller Hospitals Framework rather than being planned in line with populations

	The main policy documentation related to the Medical Assessment Units is the Report of the National Acute Medicine Programme 2010 and some of the areas highlighted in this report are detailed below: Hours of operation: The NAMP Report 2010 outlines MAUs may be operational from 8 AM 8 PM, 7 days/week and there are some inconsistencies to this across the units with 3 of the 7 units open shorter hours per day and only 5 days per week This has the potential to impact the ability of units to admit more than one patient per bed per day as there is limited time to see, treat and discharge them within this shorter period Access to Diagnostics: The NAMP Report 2010 mandates that MAU and medical in patients have must access to same day diagnostic tests, particularly diagnostic imaging, however, a number of sites have restrictions to access to diagnostics which in turn has implications for the effective and efficient delivery of care including the overall occupancy of the units and the use of the resources.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	No information identified.
Governance	**Recommendation/considerations:** <u>Insights and recommendations: Standardisation and stabilization of existing services</u> 6. Enhance hospital group governance for the MAUs: Some of the MAUs are well integrated into the overall Hospital Group governance structures and part of the plan to manage unscheduled care However this is variable across the sites It would be beneficial to have leadership from the Hospital Group with responsibility for the development and performance management of the MAUs This would support the development of the units in terms of the funding and staffing as well as the development of areas that could help to improve the utilisation such as improved access to diagnostics POCT It would be useful to identify a dedicated point of contact in the Hospital Group with responsibility for ensuring the MAUs are developed and maximised. **For information:** *The main policy documentation related to the Medical Assessment Units is the Report of the National Acute Medicine Programme 2010 and some of the areas highlighted in this report are detailed below.*
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** <u>Insights and recommendations: Future developments</u> 9. Alignment with the Navigation Hub project: The National Acute Medicine Programme has recommended the establishment of an acute integrated virtual pre admission navigation hub within each integrated service area (in order to support the efficient streaming of patients to the most appropriate available care setting These hubs will be run by case managers (who will be accessible to GPs and consultants and will have contact with on call physicians for MAUs, EDs, public health liaison nurses and CNMs in order to facilitate communication between GPs and on call physicians when needed, and to facilitate appropriate patient referral These CMs will be

	accessible to GPs and consultant via phone, fax, email or letter with planned integration of Healthlink into the system also CMs will be fully appraised of the current available options for patient streaming within an ISA and will thereby be able to direct patients where most appropriate, including rapid access OPD appointments, day care facilities, referral to the MAU or ED, or streaming directly to specialty services Furthermore the CMs will work to coordinate the use of bed resources within their given ISA Seed funding under Slaintecare has been provided to Galway University Hospital for a navigation hub It is recommended that the development of existing and proposed MAUs be closely aligned with the Navigation Hub project, ensuring that steps are taken to facilitate hub access to MAUs and ensure ease of communication between them Supporting development of the hubs and their integration with MAUs will help optimise patient flow, increase efficiency of GP referral pathways and support the standardisation of MAU access referral pathways as outlined in recommendation 2 and support MAUs in drawing unnecessary activity away from EDs by working to minimise inappropriate referrals.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Insights and recommendations: Standardisation and stabilization of existing services 5. Enhance medical leadership with a Lead MAU consultant with dedicated on site presence in each site 5 There is good medical governance in all of the units from consultants, however there are different models of delivery of governance and service in place Some units such as Ennis, Bantry and Nenagh have a dedicated consultant with responsibility for the MAU, while other sites, including St Columcille's and Mallow, have the consultant on call for the inpatient beds covers the MAU It is clear that having a dedicated consultant in the unit and committed to the development of the units is extremely beneficial in terms of both the efficiency of the unit and the development of the unit Ennis, for example, has a dedicated consultant with responsibility for the unit and with an onsite presence 5 days per week Ennis is also the busiest MAU in the country with the highest rate of same day discharges Some of the benefits that can be seen in sites with a dedicated consultant to lead them are high activity, high rates of same day discharge with consultants reviewing patients prior to admission, expanded access routes into the unit and the ability to see and treat high volumes of patients even in the absence of full access to diagnostics throughout all hours of operation Further evidence for the impact of a dedicated consultant can be seen from Nenagh who have just appointed a dedicated consultant 2023 and activity in this MAU has started to increase. 7. Develop and implement guidelines around minimum staffing levels: It would be beneficial for there to be guidelines around the minimum staffing levels required to run an MAU 12 hours a day and 7 days per week as well as guidelines in terms of staff to patient ratios for the busier units This would help to guide the requirements for additional staff as activity increases Individual units have implemented ratios locally to guide how many slots are available however a standardised national view would be very beneficial Given the low activity occupancy in some units there is an opportunity to increase throughput and maximise the resources that are already within the unit The MAU in Roscommon for example sees only 701 patients per year which is the equivalent of just over 3 patients per day on a 5 day per week The below is a set of draft

guidelines for discussion with national clinical lead for acute medicine These set out the minimum staffing for a 12 hour, 7 day per week service and the increases that will be required to scale in terms of numbers of patients per day The minimum staffing levels have been taken as per recommendations to have a minimum of a senior clinical decision maker (ANP or NCHD) on site for the opening hours as well as minimum leadership roles such as Consultant and CNM 2. Ennis requirement for an additional 3 WTE ANP or NCHD and 2 3 WTE Staff Nurses.

Insights and recommendations: Future developments

10. Expand Role of the ANP: The role of the ANP in medical assessment units is developing and there are a number of sites with ANPs including Ennis, Bantry and Roscommon It has been estimated that over 30 of patients in the Medical Assessment Units can be managed by ANPs Given the challenges with junior doctor staffing and the continuity provided by ANPs to services it would be of benefit to explore the development of this role in other units that require additional senior clinical decision makers St Columcille's, for example has the highest patient to senior clinical decision maker ratios with almost 4 5 k admissions and only 3 WTE NCHDs to cover the 12 7 service When considering the additional staffing required (per recommendation 7 the recruitment of ANPs to these new posts should be considered Acute Medicine Programme recommends that there be 3 ANPs for every MAU running a 7 days/week service.

11. Ensure all Model 2 sites are training sites for junior doctors, and MAUs in Model 2 Hospitals are included in BST Training Programmes: Ensure that all of the Model 2 hospitals are training hospitals in conjunction with the associated Model 3 or 4 hospital There is an opportunity to influence the process which is underway with Institute of Medicine and RCPI due to produce a report in July on a new training approach The Basic Specialist Training Programme (is scheduled to start in July 2023 and it is essential that MAUs and Model 2 hospitals are included in BST/HST training schemes to improve patient care and to stabilize the workforce Trainees in the BST programme complete rotations over the course of two or three years depending on their specialty During the programme trainees are continually observed and challenged to develop their skills in diagnostics, problem solving, communication and teamwork while gaining knowledge and experience through a varied case load The training is delivered through a combination of self-paced online material, live virtual tutorials, and in person workshops The programme content includes modules for effective communication, research, person centred care, leadership management, and patient safety and QI.

12. Leverage / integrate with the work of the NDTP on development of the general internal medicine role: Staffing of the MAUs with dedicated consultants and with high quality NCHDs with a broad general internal medicine expertise can be challenging, impacting on the ability to deliver a high quality service There is work ongoing by the NDTP on developing the general internal medicine consultant pathway This work could be leveraged or integrated into the development of a longer term staffing plan for the MAUs to create stable

	staffing for the MAUs with strong clinical leadership through dedicated MAU consultants who are general internal medicine consultants and also to potentially provide training opportunities for junior doctors on this pathway. **For information:** *The main policy documentation related to the Medical Assessment Units is the Report of the National Acute Medicine Programme 2010 and some of the areas highlighted in this report are detailed below:* Governance - The NAMP Report 2010 mandates that every MAU should have a designated lead consultant physician, who will be jointly appointed to the model 2 and associated model 3 or 4 hospital, and while most units are in line with this, some units do not have a dedicated lead consultant on site but rather have the consultant on call for the inpatient beds covers the MAU. Staffing - While the NAMP Report 2010 does not provide recommendations around minimum staffing levels, it refers to data from 24 UK AMUs/AMAUs/MAUs that provides high level guidelines for staffing for occupied beds The minimum staffing level benchmarks for this report have been arrived at by taking into consideration staffing levels at busier units and discussing and validating them with national clinical leads ANPs - The development of clinical nurse specialist and advanced nurse practitioner posts specialising in acute medicine, incorporating skill sets and competency development, is recommended under the NAMP Report 2010 Medical assessment units currently do not have a wide base of ANPs.
Funding	No information identified.
Other	**Recommendation/considerations:** <u>Insights and recommendations: Future developments</u> 13. Enhance data set: The HIPE data set is a comprehensive data set that can be used for detailed analysis The main deficit in the data set is the recording of review clinics which are carried out in the MAU These contribute to the overall activity of the units and are not represented in the data set as they are not admitted patients. **For information:** It should be noted that there are Injury Unit services provided within the Model 3 and 4 hospitals where patients arrive via the ED and are streamed to these after triage These units are also not included within the scope of this review. The busiest MAU in Ennis sees 7 600 patients per year who would have otherwise attending the ED, this equates to almost 20 more patients per day through the ED and even with a 1 day ALOS it would equate to almost 20 additional inpatient beds required in the model 3 or 4 hospital.
Impact	No information identified.

Table 48 Report of an inspection against the National Standards for Safer Better Healthcare (UHL) [2023]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HIQA[44] Report of an inspection against the National Standards for Safer Better Healthcare (UHL) [2023] Inspection report
The health service system (including health service reform)	**Recommendation/considerations:** Compliance plan ▪ *Standard 5.5 (relating to the ED)* - Promotion of pre-hospital alternative pathways to signpost adults to the MAU's on the model 2 sites via bed bureau. (ongoing) - Expanded the patient flow team to maximise the efficiencies across the patient flow process to ensure timely discharges and the maximum number of model 2 transfers. (ongoing) - Increased AMU Slots in Model 2s at weekends as an Ed avoidance measure: Ennis, Nenagh & St Johns MAUs all working at weekends with a total of 32 slot available each day over the weekend (18 Ennis, 8 at St Johns and 6 at Nenagh). To increase to 12 on the Nenagh site in July. (July 2023) - ULHG are actively engaging with CHO3 to maximise capacity in Rehab, Long term Care/Home Care Support across the region. (ongoing) ▪ *Standard 3.1 (relating to the ED)* **Interim measures** - To continue to maximise the number of inter hospital transfers from the ED to create capacity. *[Note: Standards for wider hospital and inpatient clinical areas not included here].*
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Compliance plan ▪ *Standard 5.5 (relating to the ED)* - To continue to improve the discharge process: 35 % increase in discharges before 1600 (Feb to April 22 vs 23) enabled by: -Implementation of Patient flow co-ordinators now fully established to 9 members working across the site to identify and resolve blockages to discharges -New medical rota ensuring that there is a level spread of the medical take across the consultant body with an increase number of consultants participating in the on call rota (ongoing).

	▪ *Standard 1.6 (relating to the ED)* **Long-term Measure** - It has been identified that there is currently a shortfall of over 200 beds on the UHL site. Building works have commenced on the UHL site to construct an additional 96 bed block (44 replacement beds for the renovation of nightingale wards) single room inpatient facilities and will take approximately 18 months to complete. This will further increase the bed stock and ensure consistency in bed numbers in line with other Model 4 hospitals. Date for Completion Q1 2025. - A further 96 bed block is at the early stages of planning and will provide additional single room inpatient facilities Date for Completion 2027. - A steering group to be established to oversee the completion/ commissioning of the two 96 bed blocks and the phased renovation of the Nightingale wards. Date for Completion July 2023. ▪ *Standard 3.1 (relating to the ED)* - To review the ED floor plan in line with the fire plan for the ED to maximise the use of the available space and promote physical distancing between trolleys. Process and SOP around management of these patients to be developed. Date for Completion September 2023. *[Note: Standards for wider hospital and inpatient clinical areas not included here].* **For information:** **Model of Hospital:** 4 **Number of beds:** 530 inpatient beds; 149 day case beds Hospital management and the HSE recognise and acknowledge that a key causal factor of overcrowding of UHL's emergency department is UHL's inpatient bed capacity, which is insufficient to meet the growing demand in the Midwest region. At the time of this inspection, a 96-bed building project was underway to increase extra inpatient capacity at UHL by the end of 2024. However, under current plans, 50% of the extra inpatient capacity gained from this build will be replacement beds that will be used to bring UHL into compliance with best practice standards in infection prevention and control. Therefore, any anticipated gains in increased inpatient capacity at UHL may be limited when that new build comes online in 2024. UHL's emergency department comprised four triage rooms (three for adults and one for paediatrics) and 49 single treatment cubicles set out in four zones, which included a clinical decision unit. The department also comprised a dedicated paediatric area with audio-visual separation from the adult emergency department area as recommended in the HSE's National Emergency Medicine Programme.

Governance	**Recommendation/considerations:** Compliance plan ▪ *Standard 5.5 (relating to the ED)* - To review the governance of the AMU & existing pathways. To develop additional pathways in conjunction with diagnostics. - Patients will be referred directly from primary care via the bed bureau with some onward referrals from other sources including the emergency department (ED), outpatient department and other care settings, co-ordinated by the bed bureau. - The decision regarding discharge/admission within 6 hours of patient arrival will be monitored carefully each day. - To increase the range of dedicated same day diagnostic imaging, laboratory and other services to be in place to support assessment. - The AMU will only admit patients for a short period for acute treatment and/or observation to its AMU beds where the estimated length of stay is less than 48 hours. - Patients who require admission for longer than 48 hours will move from the AMU to ward 1B. - To relocate the AMU so that it is collocated/ proximal to the ED. Date for completion October 2023 - A full review of the ASAU Model of care will be undertaken to identify all the areas that require attention. Date for completion October 2023. **New Acute Care and Emergency Directorate**: ▪ Creation of a single entity with responsibility for oversight & management with a focus on supporting staff in improving patient experience and meeting key performance indicators. A sharper focus on performance and the impact of QIPs to help drive improvements across the floor as a whole. Date for completion September 2023. ▪ Establishment of the Quality, Risk and Patient Safety measures within the new directorate structure (Incident/SIMT, Risk, QI initiatives) Date for completion September 2023. ▪ Safety huddle will continue to be a priority in the emergency department to ensure that there is a multidisciplinary approach to patient care and that there is the appropriate escalation of concerns (ongoing). **Patient flow and pathways:** ▪ Every effort is made to encourage the use of existing patient flow pathways. This is managed through daily hospital management team meetings which includes all of the sites, across the Group and the CHO3 to maximise flow across the system. Operations team meetings at held at 9am and 4pm, chaired by the Head of Service for the site. The development of additional pathways will be looked at by the new Acute Care and Emergency Directorate. Date for completion October 2023.

	▪ Daily review of patients in ED with diagnostic requirements through Red2Green with early communication to pathology, radiology & cardiology to ensure prioritisation. (ongoing) ▪ Enhanced command and control arrangements: -daily solution focused multi-agency hospital management team meetings led by Head of Operational Services and with EMT Oversight to ensure that all stakeholders are sighted on challenges and the group position. -Formal 'battle rhythm' established with bed meetings three times a day to focus on site position, triangulate intelligence and mitigate surges. -Improved use of data including use of HPVP to enhance planning and identify areas of focus including PET times. (ongoing) ▪ To continue to improve the number of DTOC's (median of 6 days for 2023 vs 9 days for2022 at 33%) Improvement enabled by: -MDT approach to DTOCs and focus on 10-day length of stay which in turn reduces the 14 day AVLOS. -Daily CCG and MDT rounds with key focus areas are planned discharges, outstanding diagnostics or consults, ward level trolley PETs, delayed transfers of Care, deteriorating patients, high risk patients and staffing levels. (ongoing) ▪ The internal escalation processes within the Emergency Department have been reviewed to ensure that delays are minimised for the patients availing of the services. Further improvements will be looked at to enhance operational efficiency in the Emergency Department and build on the gains in recent months. We will review our data to drive and sustain operational efficiencies. (ongoing) ▪ Escalation plan has been reviewed and signed off by the Executive Management Team. This is closely monitored and executive and directive management teams are made aware of the UHL site position, level of escalation, 3 times a day. (ongoing) ▪ *Standard 6.1 (relating to the ED)* **Interim measures** - The internal escalation procedures within the ED have been revised and are monitored by the multidisciplinary team at the hospital management team meeting and at the safety Huddles within the department on a daily basis. - To monitor the efficiencies accrued from the additional resources through reviewing the ED KPI's at the unscheduled care meetings and at the monthly performance meeting for the newly formed Acute Care and Emergency Directorate: Date for Completion September 2023. ▪ *Standard 3.1 (relating to the ED)* **Interim Measures** - With the increased NCHD & consultant staffing compliment in the Emergency Department, there is a commitment to work on reducing the % of attendees to the emergency department are in the department for more than six & 9 hours after registration by 5% within 6 months and 10% by year end. Date for Completion December 2023.

	- Continuous flow of trolleys to ward trolley spaces to reduce the overcrowding and enable the ED to work more efficiently. This is supported through the Daily solution focused multiagency hospital management team meetings led by Head of Service for the site (ongoing) - The bed meetings, which are held three times a day to focus on status of the site, long PETS _ specific focus on long waits across the acute floor (ongoing) - Establishment of the new directorate with responsibility for acute and emergency care only which will provide greater operational grip. Date for Completion September 2023. - To progress the current discussions on an Emergency Medicine Programme for over 75's which focuses on frailty, identifying admission needs and prioritises this patient cohort for a bed when admission is required– Older Persons Pathway. Date for Completion November 2023. - To review the ED floor plan in line with the fire plan for the ED to maximise the use of available space to further promote adequate physical distancing between trolleys. Process and SOP around management of these patients in the locations identified to be developed. Date for Completion September 2023. - Continuous flow of trolleys to ward trolley spaces to reduce the overcrowding in the ED. (ongoing) - Robust governance and oversight of the ED numbers and escalation plan to ensure that there is full utilisation of the available bed capacity across the group through the daily multi-agency hospital management team meeting and the bed management meetings. (ongoing) - This is supported through the Daily solution focused multi-agency hospital management team meetings led by Head of Service for the site. (ongoing) - To implement the Emergency Medicine Early Warning System (EMEWS) by September 2023. It is planned to have completed the training of all staff in ED by the end of August 2023. This will be in line with the completion of the Safer staffing recruitment for the ED and the changeover of doctors in July. Date for Completion September 2023. - Establishment of the new directorate with responsibility for acute and emergency care only which will provide greater support and oversight for the ED Date for Completion September 2023. - Governance of both risk and incident management is in place within the ED and in the Medicine Directorate. A Risk advisor is in place to support the Medicine Directorate and ED. Recommendations from incidents, complaints and reviews are being actively worked on once received to ensure that they are being implemented (ongoing). *[Note: Standards for wider hospital and inpatient clinical areas not included here].*
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** <u>Compliance plan</u> ▪ *Standard 5.5 (relating to the ED)* - The GEM unit resources for the Rapid Response Frailty team have been recruited and complement the existing OPTIMEND Service (AHP) to ensure that older persons follow the appropriate pathway and are

	safely discharged home when appropriate from the ED. These services operate out of the dedicated GEM (Geriatric Elderly Medicine) area. The aim of the unit is for the patient group to be supported directly to the unit from Triage for ED and HSE team input in a dedicated over 75's unit. (ongoing) - In the Emergency Department current patient pathways include but are not limited to: GEM/Optimend, IcPOP (Older Persons Assessment Liaisons) and working with the Community Intervention teams in CHO3, Pathfinder, AMAU, ASAU pathway, ophthalmology, Stemi, DVT, First time seizure. (ongoing) ▪ *Standard 1.6 (relating to the ED)* **Interim measures** - Further development of the Pathfinders service which commenced 24 Oct 2022 - To expand the referral pathways i.e. Mental Health services, MAUs, supporting discharges direct after ED assessment. - To reduce age criteria from 65 to 60. - To commence taking calls from Co. Clare. (Solutions to low call volume discussed with NAS & agreed) (ongoing) - To review the current pathways in operation between the Acutes and CHO3 to ensure optimal use and hospital avoidance (i.e. CIT, IGPOP) Date for Completion October 2023. ▪ *Standard 3.1 (relating to the ED)* **Interim Measures** - Improved pathways for frail elderly through greater use/ referral to the Geriatric Emergency Medicine Unit (GEM Unit): 45% increase in pts seen per week on previous quarter with 65% discharge rate (as at April 2023 @ 30.4 pts per week) - To fully implement the GEM unit service once building works have been completed, AHP staffing complement have been recruited and operational issues resolved. The additional Allied Health staff, will ensure timely assessment and early discharge. Date for Completion September 2023. - To progress the following: - AHP service 8 –8 service Mon –Fri & Sessional hours on Sat & Sun. (incl. Public Holidays) -Set targets for throughput in unit 15 –20 pts/day and maintain d/c rates of 65% - Implement outcome measures. (quality & satisfaction) -Amend criteria to meet needs of additional patient cohorts in line with international evidence. (ongoing) - In Quarter one of this year we have implemented the Safety huddle in the ED. The aim of the Safety huddle is to promote behaviours that support a culture of safety including collective leadership, communication and multidisciplinary team working. The Safety huddle is held at the same time each day. Members of the MDT are encouraged to identify, share and action patient safety concerns and escalate accordingly. (ongoing)

	- Existing internal escalation processes within ED have been further reviewed, have been agreed and are being implemented (ongoing) *[Note: Standards for wider hospital and inpatient clinical areas not included here]* **For information:** A new dedicated assessment area — Geriatric Emergency Medicine Unit (GEMU), was established since HIQA's last inspection and became operational in October 2022. This unit had a defined eligibility criteria and had a dedicated team of health and social care professionals and NCHDs, who assessed and treated people aged 75 years and over that presented to UHL's emergency department. The initiative was aimed at avoiding hospital admission for this cohort of patients in a setting within the emergency department that was more appropriate to their specific needs, with appropriate follow on referral to and delivery of care by community services such as the HSE's Integrated Care Programme for Older Persons (ICPOP) and OPTIMEND.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** <u>Compliance plan</u> ▪ *Standard 6.1 (relating to the ED)* **Interim Measures** - The Nursing Department in UHL has a designated Assistant Director of Nursing for workforce planning (ongoing) Proactive recruitment of Nurses and Healthcare Assistants both nationally and internationally will continue in 2023. Graduate recruitment campaigns are ongoing. A team from the Nursing and Midwifery Workforce Planning and Development Department completed a Face-to-Face Staff Nurse Interview Campaign in India in January 2023. 76 Staff Nurses were successfully panelled. A number of other interview days have since been completed to meet the job order. 63% of Staff Nurses recruited from this campaign are being recruited specifically for specialist areas including Paediatrics, Renal, Critical Care, ED, Theatre and Cardiology. This Staff Nurse recruitment will enable the implementation of Safer Staffing in ED, UHL to complete the implementation of the Safe Staffing Framework in the Emergency Department Date for Completion September 2023. - A review of NCHD resources was completed and a submission for a further 10 SHO's and 10 Registrars was made nationally which was approved. 2 additional Consultants & 1 Reg. were also approved and are in post. - By July 2023 for the changeover of doctors, the current recruitment position indicates that there will be 21 additional NCHDs in post in the Emergency Department. Date for Completion August 2023. - The additional NCHD's have allowed for an increase of 3 to 4 NCHD's on night duty and a greater spread of cover during the day including cover of the GEM unit (ongoing) - The additional consultant has allowed for a consultant at triage to be present from 8am to 8pm. Mon- Friday (ongoing)

	- There is a greater availability of consultants on the shop floor to enable earlier review of patients. (ongoing) **HCA Recruitment** - Recruitment and Nursing/Midwifery Manpower have plan in place for HCA Campaign to run in Q2 2023 (HCA campaign is ran every quarter). ULHG will link with LCFE and Central College Limerick to attract students completing Level 6 Qualification. Date for Completion October 2023. ▪ *Standard 1.6 (relating to the ED)* **Interim measures** - Patients who are identified as End of Life Care are prioritised for a bed on the ward, if one is not available, the patient is accommodated in a single cubicle in the Clinical Decision Unit within the ED. (ongoing) - Patients who present to the ED who are part of the Haematology/Onc service are prioritised for isolation if required and are transferred to the 2 assessment cubicles in Haematology/Onc Ward (6B) for work up if Resus is not required. (ongoing) - To review the ED floor plan in line with the fire plan for the ED, so as to maximise the available space and promote physical distancing between trolleys. Process and SOP around management of these patients to be developed. Date for Completion September 2023. - Escalation plan to be further reviewed to reflect the current practice of flowing patients on trolleys to ward trolley spaces from ED in order to mitigate overcrowding in ED, rather than in stages as per the escalation plan. Date for Completion July 2023. - The continued monitoring of performance data at USC meetings. (AVLOS, DTOC's, • PET times etc.) (ongoing) - To further explore and develop a streamlined pathway for the >75's who attend ED which is currently in discussion. Date for Completion October 2023. - Enhanced Operational Grip - Daily solution focused multi-agency hospital management team meetings led by Head of Service for the site and with EMT Oversight to ensure that all stakeholders are sighted on challenges and group position. (ongoing); -A formal 'battle rhythm' approach is adopted to bed meetings, which are held three times a day to focus on site position, triangulate intelligence and address any surges (ongoing). - To continue to improve the discharge process: 35 % increase in discharges before 1600 (Feb to April 22 vs Feb to April 23) enabled by: -Implementation of Patient flow co-ordinators now fully established to 9 members working across the site to identify and resolve blockages to discharges. (ongoing) -New medical rota is in place with an increase number of consultants participating in the on call rota. This ensures that there is a level spread of the medical take across the wider consultant body. - To continue to improve the number of DTOC's (median of 6 days for 2023 vs 9 days for2022 at 33%) Improvement enabled by: - MDT approach to DTOCs and focus on 10-day length of stay which in turn reduces the 14 day AVLOS. (ongoing); -Daily CCG and MDT rounds with the focus on the following key

areas: planned discharges, outstanding diagnostics or consults, level of ward trolley & the PETs for same, delayed transfers of Care, deteriorating patients, high risk patients and staffing levels. (ongoing)
- Long Stay Tuesday Forum established where patients with long lengths of stays are actively reviewed and any actions to progress to discharge identified and progressed. The team comprises the Head of Service, Allied Health professionals, CHO3 representatives, nursing, Unscheduled Care Lead and Bed Management. (ongoing)
- Integrated DTOC meeting established, which meet weekly to ensure delayed transfers of care are minimised. (ongoing)

▪ *Standard 3.1 (relating to the ED)*

Interim measures
- A clinical skills facilitator within the ED is rolling out the training on EMEWS and has commenced with 30% of the staff having completed same. It is planned to have completed the training of all staff in Ed by the end of August 2023. This will be in line with the completion of the Safer staffing recruitment for the ED. Date for Completion September 2023.
- The placement of an ED Consultant at triage Monday-Friday 8am-8pm (ongoing).

The SAFER staffing levels for the ED were reviewed and approval has been received nationally to progress implementation. A number of these additional nursing resources have commenced.

[Note: Standards for wider hospital and inpatient clinical areas not included here]

For information:

In total, the emergency department now has an approved funding for 11 WTE consultants in emergency medicine, with all 11 WTE positions filled at the time of this inspection — nine on a permanent and two on a temporary basis….The uplift in the number of consultants in emergency medicine, ensured a senior clinical decision maker at consultant level (often two consultants) was on-site in the hospital's emergency Page 24 of 83 department each day 8.00am to 8.00pm, with availability on a 24/7 basis. One consultant in emergency medicine was on-site in UHL's emergency department from 8.00am to 1.00pm on Saturday and Sunday. Consultants in emergency medicine were supported by 46 WTE NCHDs at registrar (25 WTE), senior house officer (SHO) (20 WTE) and intern (1 WTE) grades. This included an uplift of 20 WTE NCHDs since March 2022. In summary, since HIQA's last inspection, UHL's emergency department gained an additional two WTE consultants in emergency medicine and 20 NCHDs at registrar and SHO grades.

Completed

There is considerable work underway to fill the vacant posts within the Health and Social care professionals. Significant number of posts have been approved and there are currently 16 recruitment campaigns arranged.

	(23 recruitment campaigns for allied health professionals have been advertised in Jan/February of this year. There should be a Page 75 of 83 significant uplift in numbers of Health and Social care professionals over the summer months with the new therapists graduating who have indicated a commitment to the group. It is anticipated that many of the AHP vacancies will be filled by way of International Recruitment with a Relocation Package to support same. Date for Completion September 2023. Under the HR Circular 006/2023, the HSE is offering Health & Social Care Professional 2023 graduates from all professions who are successful at interview a permanent contract. With this new change to the type of contract issued, early indications are that it is increasing the number of candidates applying for posts within the HSE. Plans are in place to put a proposal to Pharmacy management with regard to running a rolling recruitment campaign. Date for Completion December 2023.
Funding	**Recommendation/considerations:** <u>Compliance plan</u> ▪ *Standard 3.1 (relating to the ED)* - To secure approval for additional core nursing and HCA staff (16 nurse &5 HCA's) & AHP's to care for the patients who are identified as requiring admission who are located within the emergency department following review of the ED floor plan. Date for Completion December 2023. - Additional equipment has been sought to support the ongoing care needs of patients in the ED e.g. Omnicell Drug dispensing system, ECG machines, pressure relieving mattresses for trolleys. Date for Completion October 2023. *[Note: Standards for wider hospital and inpatient clinical areas not included here].*
Other	**Recommendation/considerations:** ▪ *Standard 5.5 (relating to the ED)* - To complete a review of ED infrastructure on the glass corridor to improve/support patient care and dignity and maximise the viable footprint to meet physical distancing requirements. Date for Completion (September 2023). ▪ *Standard 1.6 (relating to the ED)* **Interim Measures** - Comfort packs are provided to patients which include eye mask/sleep mask, foam ear plugs. Toiletry packs are also available. (ongoing) - An emergency clothing stock has recently been introduced to the Emergency Department which provide clothing to patients, who find themselves in the department without essentials from home (ongoing). - Additional rounding is taking place by HCA's ensuring patient have pillows/blankets (ongoing). - The PALS Managers complete rounds within the department to support patients in the Department. They offer the comfort packs, pillows, clinical care updates if required. They offer to contact family/N.O.K. if a

	patient requires same. They offer support and give the contact details for the PALS service if required. They offer to address any immediate concerns the patient has and make every effort to resolve them quickly (ongoing). - The PALS team are currently in the process of recruiting PALS Volunteers for the Emergency Department to further support the patients. Date for Completion September 2023. - To promote the dignity, privacy and autonomy of patients, a cubicle is protected for use by the clinical teams when carrying out intimate clinical care within the zones in the ED (ongoing). - Portable screens are also available for use (ongoing). *[Note: Standards for wider hospital and inpatient clinical areas not included here]*
Impact	*From the declaration of a 'major incident':* In early January 2023, a record increase in the number of attendees to UHL's emergency department resulted in the executive management declaring a major incident at the hospital. At that time, a number of measures was introduced to manage the incident, including increasing availability and accessibility to community services over seven days (7/7) for a three week period. In addition, a change in approach was introduced whereby a small number of non-urgent 112/999 patients were directly conveyed to the Acute Medical Assessment Unit in Ennis Hospital as part of a formally agreed new protocol with the National Ambulance Service (NAS). The latter measure remains in place at the time of writing this inspection report. From HIQA[49] Report of an inspection against the National Standards for Safer Better Healthcare (UHL, November 2023: Since the previous inspection in February 2023, the hospital had established an Urgent and Emergency Care (UEC) Directorate responsible for the operational and strategic governance of the emergency department and acute medical unit in UHL and the injury units and medical assessment units in St John's Hospital, Nenagh Hospital and Ennis Hospital… Evidence of progress on some areas of initial key focus was seen during member passed by to get the required assistance. Another patient commented that 'they keep moving me up and down the corridor to make room' and 'it is so difficult to sleep on the corridor'. Inspectors observed staff promoting and protecting patients' privacy and dignity, in so far as possible within the context of a very overcrowded environment. For example, to ensure privacy and dignity, patients were brought to an assessment cubicle when being clinically assessed. Patients who spoke with inspectors were knowledgeable on how to make a complaint. However, one patient commented that 'it might not make any difference' referring to the fact that there were so many 'sicker patients in the department,' complaints regarding 'long wait" or 'lack of an inpatient bed" could not be resolved promptly by staff. Overall, there was consistency between what inspectors observed in the emergency department and what patients told inspectors about their experiences of receiving care in the department. Capacity and Capability Dimension Inspection findings in relation to the capacity and

	capability dimension are presented under two national standards (5.5 and 6.1) from the two themes of leadership, governance and management and workforce. Page 8 of 34 the inspection and in data provided, and are included throughout this report. Significant gains will need to be achieved by the hospital beyond those identified through this inspection to meet all set targets. Progress on priorities was monitored monthly by the UEC. The University Hospital Limerick Hospital Group and Mid-West Community Healthcare Organisation Integrated Unscheduled Care Committee was set up in October 2022. This multidisciplinary committee was assigned the responsibility to prepare and implement an integrated response to ensure patients accessing unscheduled care at the hospital. To ensure timely access to care in the most appropriate setting, while optimising patient flow through acute and community services, and improving compliance with national key performance indicators. ▪ *Standard 6.1 (relating to the ED)* - The Governance of the AMU was changed in June 2023 from the Medicine Directorate to the Urgent & Emergency Care Directorate. **Completed** - Patients are referred directly to AMU from primary care via the bed bureau with some onward referrals from other sources including the emergency department (ED), outpatient department and other care settings, co-ordinated by the ULHG bed bureau. **Completed** - A streamlined pathway for the >75's who attend ED is currently in place to the GEMS unit. The GEM unit resources, the Rapid Response Frailty team, pathfinder's team complement the existing Service to ensure that older persons follow the Page 30 of 34 appropriate pathway and are safely discharged home when appropriate from the ED. These services operate out of the dedicated GEM (Geriatric Elderly Medicine) area. The aim of the unit is for the patient group to be supported directly to the unit from Triage for ED and HSE team input in a dedicated over 75's unit. **Completed** - CCD & consultants meet with GP's in the region on a quarterly basis at the GP forum where overcrowding and alternative pathways to ED are discussed. **Completed** - Education meetings are being held twice yearly for the GP's. Webinar for the GP's held twice yearly by the Communications team. **Completed** ▪ *Standard 1.6* - Patients are risk assessed within the ED to determine suitability to be allocated to corridor 2 & the zones. At handover a review is undertaken by the team as to the most appropriate patient location. This is recorded on the handover sheet. **Completed** - A Protected Cubicle is in place for use by the clinical teams when carrying out intimate clinical care within the zones in the ED to promote the dignity, privacy and autonomy of patients, a cubicle is protected. Completed

	- Patients at end of life in ED UHL are always prioritised for a single room while awaiting a bed on the wards. This is either an ED cubicle but is predominantly a room in the CDU. There is a dedicated bereavement suite within the Emergency Department for families and loved ones. **Completed** - Patients who present to the ED who are part of the Haematology/Oncology service are prioritised for isolation if required and are transferred to the 2 assessment Page 32 of 34 cubicles in Haematology/Onc Ward (6B) for work up as per pathway - if Resus is not required. **Completed** - The 2 PALS Managers allocated to the ED complete rounds within the department to support patients in the Department. They offer the comfort packs, pillows, clinical care updates if required. They offer to contact family/N.O.K. if a patient requires same. They offer support and give the contact details for the PALS service if required. They offer to address any immediate concerns the patient has and make every effort to resolve them quickly **Completed** - The PALS team manage an emergency clothing and toiletries stock within the ED which provides clothing to patients, who find themselves in the department without essentials from home. **Completed**

Table 49 Urgent and Emergency Care Operational Plan 2023 [2023]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[50] Urgent and Emergency Care Operational Plan 2023 [2023] Plan [Note – Main actions from report included only. Further specific actions can be found in the report.]
The health service system (including health service reform)	**Recommendation/considerations:** *Hospital avoidance actions:* ▪ Injury Unit (IU) expansion* IU hours will be expanded and standardised in line with the IU Review. ▪ Medical Assessment Unit (MAU) expansion* Maximise the level of patients attending MAUs with expansion of criteria appropriate patient pathways for National Ambulance Service (NAS) referrals. *In Hospital Operations:* ▪ Extended Diagnostics Arrangements will be put in place for extended hours for public, private and mobile diagnostics to avoid delays in flow. (surge measures). *Discharge operations:* ▪ Transfer non acute patients to appropriate alternative care All clinically appropriate patients in Model 3 and Model 4s to transfer to alternative care settings including Model 2s, Rehabilitation Beds and Transitional Care Beds (TCBs).
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Emergency Department (ED) Operations: ▪ Predicted Date of Discharge All patients will have a Predicted Date of Discharge (PDDs) with sites and CHO specific targeted weekly discharges.
Governance	**Recommendation/considerations:** *In Hospital Operations:* ▪ Patient Flow Patient flow processes to be enhanced with additional staff resources prioritised to fulfil critical roles. ▪ Length of Stay (LoS) All sites will adhere to an integrated weekly review of all patients with a LoS greater than >14 days. *Discharge operations:* ▪ Integrated Operations Hubs All regional areas (sites and CHOs) will have integrated operational hubs and action teams on site. Meetings are to be timely, focused and target driven.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Hospital avoidance actions:* ▪ Nursing Home Conveyances Expand mobile X-Ray service to Southeast and Galway/Mayo Roscommon.

	▪ Nursing Home Conveyances Flex Enhanced Community Care (ECC) model to provide an interface with both public and private nursing homes to improve hospital avoidance and to support post-hospital discharge. ▪ Communications Deliver national and local communications campaigns to provide information on alternative pathways, keeping well, vaccinations and respiratory illnesses. ▪ Community Intervention Teams (CIT) Additional maximum hours to be put in place to support ED avoidance, admission avoidance and discharge for patients (surge measure). ▪ Extended General Practitioner (GP) Hours Extend GP Direct Access to community diagnostics for GP out-of-hours (OOH) Co-Ops (surge measure). *Emergency Department (ED) Operations:* ▪ Ambulance turnaround improvement* Hospital Ambulance Liaison Person (HALP) service to be permanently deployed in all Model 3 and 4 hospitals. ▪ NAS Private Capacity Additional capacity will be in place through voluntary and private ambulance services to improve egress and general flow (surge measure). *Discharge operations:* ▪ Transitional Care Funding (TCF) All patients awaiting Nursing Home Support Scheme (NHSS) funding to be transferred to private Residential Care Facilities (RCFs) using TCF (surge measures) ▪ Long Term Care (LTC) All patients awaiting LTC placement to be transferred to private RCFs using TCF or public RCFs (surge measures).
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *Emergency Department (ED) Operations:* ▪ Patient Flow Additional and extended hours for senior decision makers, staff integral to patient flow and in EDs. All patients at 8am on a trolley will be rounded to expedite patient flow. *In Hospital Operations:* ▪ Patient Flow Patient flow processes to be enhanced with additional staff resources prioritised to fulfil critical roles. ▪ Staff Patient Flow Targets Key staff involved in the patient pathway are to be clear on their expected targets per day (Discharges before 1100hrs, PDDs). ▪ 6/7 Day Operations In parallel to the 7 day programme, extended hours for senior decision makers, patient flow and Health and Social Care Professionals (HSCPs) across all services to be optimised (surge measures).
Funding	No information identified.
Other	No information identified
Impact	No information identified.

Table 50 ULHG Strategic Plan 2023-2027 [2023]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	ULHG[51] ULHG Strategic Plan 2023-2027 [2023] Strategic plan [Note: Focused on Strategic priorities which provide specific plans]
The health service system (including health service reform)	**Recommendation/considerations:** **3.10:** Start work to develop an electronic health record, an associated data lake (a centralised repository which stores all your structured and unstructured data at any scale), and population health management capabilities. These will generate insights and opportunities for improvement across the region. **4.2:** Oversee a phased approach to shared information access across services. Do this using a single platform, electronic health record (EHR) and supporting data lake across the Midwest. A data lake is a centralised repository for storage of all structured and unstructured data at any scale. The ultimate aim is to reach HIMMS Level 3. **4.8:** Focus on improving equitable access to the healthcare system for individuals across the Midwest, for instance through extension of services outside of standard working hours. **4.11:** Support the expanded use of a bi-directional patient flow based on patients' needs and rights to access alternative care pathways.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	No information identified.
Governance	**Recommendation/considerations:** **4.4:** Review organisational structures and governance arrangements to develop a blueprint of the future operating model of the organisation as it transitions to HSE Midwest. As an enabler, operational excellence will support the following initiatives: Create pathways of care that drive success, to define and agree standards for the creation of pathways of care in collaboration with key partners and patients and monitor compliance across the Group, to assess how well pathways of care are performing and develop a plan that reduces undue costs and inefficiencies, to develop a guide outlining the principles and required steps for collating, processing, and using insights from patients on pathways of care. Strategic Transformation Office - As part of implementing the 2023–2027 Strategic Plan, we will establish a Strategic Transformation Office (STO) to provide a coordinated and centralised approach.

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** **1.3:** We will collaborate with patients to co-design and put in place health and social care services within the UL Healthcare Network. **1.5:** We will design and put in place a health promotion programme in collaboration with Public Health Mid-West. This will focus on delivering person-centred care and redesigned care pathways tailored to the needs of the region. **3.11:** Promote a culture of evidence-based care delivery across acute and community settings in collaboration with various partners such as: Public Health Mid-West, the National Ambulance Service, General Practitioners (GPs). **3.15:** Develop a Creative Life and Health Promotion Centre (Patient and Staff Experience Centre) to make sure that patients receive the support and advice to engage with care and live healthier lives. **4.1:** Continue to design and develop the Hospital Street using the Johns Hopkins Hospital model as a guide. A Hospital Street model has healthcare facilities that are better connected and strategically located to provide improved access for patients and reduce reliance on acute services. **4.3:** Leverage the work undertaken by the regional pod to set up clear leadership, organisational structures and governance arrangements. Collaborate more with health and social care and community partners as we progress towards setting up HSE Midwest as a Health Region. **4.5:** Collaborate with key health and social care partners to streamline resources and processes to make sure that services seamlessly follow the patient across acute and community settings. **4.6:** Support the delivery of the funded enhanced care delivery model, co-designed with community care. This will incorporate end-to-end care pathways to make sure that care is provided in the most appropriate setting.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** We will assess education and training needs regularly to make sure we embed an environment of continuous learning in the organisation… we will continue to use the HSE's Performance Achievement process. This process aims to develop staff and create a forum to discuss learning and development needs. It fosters an increased level of support across the organisation and boosts staff confidence. Greater emphasis will also be placed on the development of leadership capabilities across the Group… We will explore the opportunity to provide shared posts with UL to enable staff to pursue research opportunities and, ultimately, to foster clinical excellence. We are also committed to investing further in our infrastructure and staff facilities to make sure we have appropriate settings for our staff. **2.1:** Streamline the induction process for new staff. Use a suite of resources and an orientation package to ease the relocation process; Familiarise new staff with the Midwest; Help new staff access local services. **2.2:** Design and put in place a recruitment operating model that outlines the future recruitment needs and processes. It will also enhance the recruitment experience for candidates.

	2.3: Develop a strategic workforce plan that assesses our current and future resourcing and capability gaps and identifies the steps required to bridge them. **2.4:** Develop an education and training model for UL Hospitals Group in parallel with the AHSS. This will create a reputation of excellence and give staff tools and skills to succeed in their careers. **2.8:** Develop a staff retention plan. Part of this will include analysing exit interviews into themes and follow up with quality improvement plans. **2.10:** Make staff part of the decision-making process by setting up multi-disciplinary teams across the organisation. **2.12:** Develop a high-performance culture that prioritises continuous improvement. **3.6:** Train staff to increase their understanding of research and evidence implementation. This will be part of an overall shift towards a values-based culture that focuses on quality improvement, using staff experience as a main indicator for success. **4.7:** Focus on developing the future workforce and associated funding requirements through collaboration with staff when designing shared staffing models across the acute hospital and community. **4.9:** In line with Sláintecare, focus on population health. This will enable services and staff to work flexibly together across the system to promote health and wellbeing management throughout the patient journey. **4.10:** Collaborate with services across the health and social care landscape to: further health equity, increase access to care in the Midwest.
Funding	**Recommendation/considerations:** As an enabler, financial resilience will support the following initiatives: Evaluate our finances £ evaluate our income realisation, as part of this initiative, we need to consider legislative changes for statutory charges for hospital services as well as the impact of the new Public Only Consultant Contract 2023.
Other	No information identified.
Impact	No information identified.

Table 51 Report of an inspection against the National Standards for Safer Better Healthcare (UHL, November 2023) [2024]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HIQA[49] Report of an inspection against the National Standards for Safer Better Healthcare (UHL, November 2023) [2024] Inspection report
The health service system (including health service reform)	**Recommendation/considerations:** Compliance plan *Standard 5.5* ▪ AMU KPI - 75% of patients to be discharged or admitted within 6 hours To improve compliance with the KPI by 50% by the end of Q3 and to 75% when the 96 bed block opens in Q1 2025. ▪ Criteria for referral to the AMU is currently under review to ensure that the most appropriate patients are being referred to the unit to comply with max. length of stay of 48 hours. (To be completed end of Q2 2024). *Standard 3.1* **Interim Measures** ▪ To continue to maximise the transfer of patients to the model 2 sites with daily review of performance (ongoing) ▪ Daily review of patients in ED with diagnostic requirements through Red2Green with early communication to pathology, radiology & cardiology to ensure prioritisation. (Ongoing) **For information:** The hospital was also undertaking significant work both internally and with colleagues in the community setting to establish measures to seek to improve patient flow and provide alternate pathways for patients for example, with the addition of progressive pathways through GEMU and App Car initiatives. On the day of inspection, these supported pathways aimed to provide the right care to patients, in the most appropriate setting.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** The hospital had medium and long-term plans to increase inpatient bed capacity and building works had commenced on the UHL site to build a new 96 bed block. The new block will consist of single ensuite inpatient rooms. The current proposed date for completion is Quarter 1, 2025. Under current plans, 44 of these beds will be replacement beds that will be used to bring UHL into compliance with best practice standards in infection prevention and control. Therefore, based on current plans, the full 96 bed complement will not be added to the bed stock at the hospital on the conclusion of this build. This should be risk assessed by management to ensure this has been appropriately considered in the context of persistent high levels of overcrowding in the ED. A further 96- bed block was at the early stages of planning and would provide an additional 96 single en-suite inpatient rooms, with a proposed completion date of 2027.

	Standard 1.6 **Longer term measures** ▪ UHL has a well-advanced major capital development plan underway for the construction of a new 96 Bed block. The development will significantly increase the bed capacity of the hospital, increase patient flow and will support patient flow from the ED. (To be completed Q1 2025) ▪ To progress a further 96 inpatient bed block. (To be completed Q1 2027) Q1 2024. *Standard 3.1* **Interim Measures** ▪ To continue to move patients from the ED to inpatient ward corridors when inpatient capacity has been exhausted, surge capacity opened in line with the escalation plan to address overcrowding in the ED (ongoing). ▪ To utilise the designated floor spaces as per the fire plan to maximise patient safety and dignity (ongoing). ▪ To increase the numbers of patients going through the Geriatric Emergency Medicine Unit (GEM Unit) unit on a daily basis. Target to be agreed. (To be completed in Q2 2024) **For information:** **Model of Hospital:** 4 **Number of beds:** 536 inpatient beds; 140 day care beds The emergency department provided care for undifferentiated patients with acute and urgent illness and injuries. The emergency department has a planned capacity for 49 service users divided into three zones A, B and C, a paediatric area, a clinical decision unit and a resuscitation area. There were three adult and one paediatric triage rooms. Associated pathways from the emergency department included the geriatric emergency medicine unit (GEMU), the acute medical unit (AMU) and the acute surgical assessment unit (ASAU). The AMU operated 24/7 with clear referral criteria. The unit had a planned capacity of 25, with direct referral from triage and primary care, coordinated by the bed bureau service in University Hospital Limerick. The unit now also functioned as a short stay unit (less than 48 hours) for patient treatments or observations. On the day of inspection, the AMU was functioning as a pathway for patients from the emergency department's triage area and patients referred from GPs…. The pathways for the AMU were under review at the time of inspection. The acute surgical assessment unit (ASAU) operated 24/7 and had a planned capacity of 24.The ASAU was functioning as an alternate flow pathway for patients from ED following triage and for GP referrals, but this function was limited due to inpatients accommodated in the ASAU. These findings are similar to the findings on the two previous inspections.

	The hospital was performing relatively well in relation to patients' ALOS and DTOCs in comparison to many other model 4 hospitals, which demonstrated good patient flow processes through the hospital and on to the community. The AMU and ASAU, although providing a pathway from the ED, had their full functionality with respect to how they were designed to work impeded by patients accommodated in these units awaiting inpatient beds. Consequently, as a means of promoting patient flow they were less effective than they were designed to be. A new dedicated assessment area — Geriatric Emergency Medicine Unit (GEMU), was established since HIQA's last inspection and became operational in October 2022. This unit had a defined eligibility criteria and had a dedicated team of health and social care professionals and NCHDs, who assessed and treated people aged 75 years and over that presented to UHL's emergency department. The initiative was aimed at avoiding hospital admission for this cohort of patients in a setting within the emergency department that was more appropriate to their specific needs, with appropriate follow on referral to and delivery of care by community services such as the HSE's Integrated Care Programme for Older Persons (ICPOP) and OPTIMEND.
Governance	**Recommendation/considerations:** *Standard 5.5* ▪ ED PET for patients over 75 Years admitted or discharged within 24 hours National target is 99%. Target set by the ED team to achieve full compliance with this KPI. (To be completed end of Q3 2024). ▪ The rate of conversion for ED patients noted in the HIQA report incorporates AMU, ASAU, and CDU data. ED conversation rate data, specific to ED will be reviewed by the Directorate Management Team (UEC) to ensure compliance with the national rate. (To be completed Q2 2024) ▪ The ED internal escalation processes within the Emergency Department will be reviewed to ensure that delays are minimised for the patients availing of the services. Further improvements will be looked at to enhance operational efficiency in the Emergency Department and build on the gains in recent months. We will review our data to drive and sustain operational efficiencies. A review of the ED internal escalation plan will be completed. (To be completed Q2 2024) ▪ UHL will continue to work actively on identifying and addressing opportunities both inside and outside the Hospital to optimise its bed capacity and improve the effectiveness and efficiency of care and experience for patients attending the ED. Specific measures are being implemented to improve patient flow and reduce ED congestion as outlined in the Hospital's response to the Leadership, Governance and Management standard judgement. *Standard 1.6* **Interim measures** ▪ A speech privacy memo will be issued to all staff within the Emergency department and incorporated into the ongoing communication training being rolled out in the department. (To be completed Q1 2024)

	Standard 3.1 **Interim Measures** ▪ To improve the discharge rate of patients at the weekend across all sites, performance will be monitored on a weekly basis. (To be completed in Q4 2024) ▪ When capacity demands patients are risk assessed within the ED to determine suitability to be allocated to corridor 2 & the zones. At handover a review is undertaken by the team as to the most appropriate patient location. This is recorded on the handover sheet. (Completed) ▪ The Urgent and Emergency Care Directorate will review the provision of a call bell system on corridor 2. (To be completed in Q2 2024) ▪ MDT Safety huddle will continue to be a priority in the emergency department to ensure that there is a multidisciplinary approach to patient care and that there is the appropriate escalation of concerns. (Ongoing) ▪ Every effort is made to encourage the use of existing patient flow pathways. This is managed through daily hospital management team meetings which includes all of the sites, across the Group, community/ region to maximise flow across the system. Operations team meetings at held at 9am and 4pm, chaired by the Head of Service for the site. (Ongoing) ▪ To implement EMEWS in the Emergency Department. (Completed January 2024) ▪ To ensure that staff within the Emergency Department have completed their BLS training. (To be completed end of Q2 2024) ▪ To upskill further staff on the Manchester Triage System. (To be completed in Q2 2024) **For information:** Overall, it was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care in the emergency department. Operationally, the department was functioning better than on previous inspections, but still has a way to go to match the best performing emergency department's inspected by HIQA. The newly Page 12 of 34 formed UEC Directorate provided a single entity for the strategic and operational function of the emergency and urgent care services across the six hospital sites of the ULHG. In summary, the hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the emergency department. Some improvements were seen on the day of inspection in comparison to the previous two inspections and data provided demonstrated increased Page 15 of 34 activity in many services to support patient flow and higher compliance with national metrics related to unscheduled care. A greater degree of operational grip with a focus on improving PETs was evident on this inspection, relative to findings from HIQA's prior inspections in 2022 and 2023.

	On the day of inspection, there was evidence of strong executive, clinical and nursing leadership in the emergency department. Since the previous inspection, the Emergency and Urgent Care Directorate had been established with a remit across the emergency and urgent care areas of the six hospital sites within ULHG. It was led by a Clinical Director, Director of Nursing and General Manager which enhanced governance and operational effectiveness for unscheduled care.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Standard 3.1* **Interim Measures** ▪ LHG collaborate with the community services to maximise capacity in Rehab, Long term Care/ Home Care Support across the region through a number of forum, the USC meeting and the DTOC meeting (Ongoing) **For information:** The hospital's use of GEMU/OPTIMEND, ICPOP, pathfinder, model 2 hospitals, community links such as CIT and the recently established APP Car were supporting hospital avoidance and discharge.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *Standard 1.6* **Interim measures** ▪ Nursing Staff are allocated to the various areas and Zones at the beginning of each shift with full cover for breaks. Only patients who are mobile are allocated to corridor 2. Audit of compliance with same to be completed. HCA are allocated to each zone to be on hand at all times for the patients in each zone to communicate & assist with hygiene needs, pillows/blankets, provides comfort & toiletry packs (which include eye mask/sleep mask, foam ear plugs) in the ED. Safer staffing levels have been implemented. (To be completed in Q2 2024) ▪ Nursing staff were supported by 22.38 healthcare assistants with a remaining 6.8 positions to be filled. To complete the recruitment of the remaining 6.8 WTE. (To be completed in Q2 2024) **Longer term measures** ▪ To progress the implementation of ULHG workforce plan, to ensure that the necessary multidisciplinary team resources are in place the new build. (To be completed Q4 2024) *Standard 3.1* **Interim Measures** ▪ Nursing Staff are allocated to the various areas and Zones at the beginning of each shift with full cover for breaks. Only patients who are mobile are allocated to corridor 2. Audit of compliance with same to be completed. HCA are allocated to each zone to be on hand at all times for the patients in each zone to communicate & assist with hygiene needs, pillows/blankets, provides comfort & toiletry packs (which include eye

	mask/sleep mask, foam ear plugs) in the ED. Safer staffing levels have been implemented. (To be completed in Q2 2024) **For information:** A consultant in emergency medicine was allocated to triage from 8am to 8pm Monday to Friday to support patient assessment and to direct patients to the most appropriate area for assessment and management. This included referral to the acute medical unit (AMU), the acute surgical assessment unit (ASAU), the geriatric emergency medicine unit (GEMU) or an MAU in a model 2 hospital. A senior clinical decision-maker at consultant level was on-site in the hospital's emergency department Monday to Friday 8am to 8pm, at weekends from 8am to 1pm. A consultant was on call each night and at weekends. As per the ED Internal Escalation Framework, if 20 or more 'category 2' patients (patients requiring very urgent emergency are) were waiting greater than 30 minutes for an ED doctors review (excluding resuscitation), the emergency medicine registrar would contact the emergency medicine consultant on call to attend the ED to review the situation and to implement further actions as defined in per the ED Internal Escalation Framework. The consultants in emergency medicine at University Hospital Limerick were supported by 45 approved non-consultant hospital doctors at specialist registrar (NCHD) (five), registrar (14), senior house officer (25) and intern (one) grade. All except one registrar post was filled at the time of inspection. This was an improvement on the previous 2023 inspection, when 20% of NCHD posts were vacant. The hospital was an approved training site for non-consultant doctors on the basic training scheme and higher specialist training scheme in emergency medicine. Inspectors were informed that the increase in nursing staffing levels in the ED had raised issues in terms of the nursing skill mix within the department. To mitigate the risk, clinical facilitators in the ED were providing education, training and upskilling for new nursing staff. Hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare. There had been a considerable improvement in the staffing complement in ED for all disciplines since the previous 2023 inspection. The increase in nursing staff in the ED had raised issues with nursing skill mix, which the hospital were addressing through additional onsite education and support. Plans to upskill staff in the Manchester triage system and basic life support should be progresses by the hospital following this inspection.
Funding	**For information:** The hospital and group had received support and financial resourcing to improve operational and clinical effectiveness and efficiencies at UHL and across ULHG, and to further strengthen and enhance integration with the Mid-West Community Healthcare Organisation (MWCH). During this inspection, there was evidence that initiatives arising from the increased support and resourcing of UHL were in the process of being implemented.

Other	**Recommendation/considerations** *Standard 1.6* **Interim measures** ▪ There are 13 toilets in the ED department for patient use. The Urgent and Emergency Care Directorate will review and update the signage for easier location of the toilets & 2 shower facilities. (To be completed Q2 2024) ▪ Patients are risk assessed within the ED to determine suitability to be allocated to corridor 2 & the zones. At handover a review is undertaken by the team as to the most appropriate patient location. This is recorded on the handover sheet. (Completed) *Standard 3.1* **Interim Measures** ▪ ED PET for patients over 75 Years admitted or discharged within 24 hours National target is 99%. Target set by the ED team to achieve full compliance with this KPI. (To be completed end of Q3 2024)
Impact	No information identified.

Table 52 Briefing note for the Department of Health - Overview ULHG [2024]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	ULHG[52] Briefing note for the Department of Health - Overview ULHG [2024] Briefing note providing evidence on action
The health service system (including health service reform)	**Recommendation/considerations:** Update on additional measures of support: ▪ A further 20 permanent step-down transition and rehab beds will be procured in Clare. ▪ The opening hours of the region's three Medical Assessment Units at Nenagh, Ennis and St John's are to be extended to 24/7 on a phased basis. <u>Nenagh CNU</u> The HSE is seeking to support UL Hospitals Group by temporarily running the new Community Nursing Unit (CNU) in Nenagh as a step down sub-acute facility. Nenagh CNU has capacity for 50 residents. An additional 65 WTEs are required to facilitate the opening of this facility as a CNU. The additional 65 WTEs are now approved and a recruitment plan is under development. Initial indications indicate a timeline of approximately one year to recruit these staff. On this basis, the REO decided to repurpose the facility in the interim pending HIQA registration and the recruitment of staff. This temporary measure is intended to provide immediate services to elderly people in north Tipperary who have been identified for sub-acute and rehabilitation needs. This unit will be used for a period of about one year as a step down sub-acute facility which will be run by a private provider with expertise in such services. A procurement process has commenced to identify a suitable provider in line with HSE procurement rules. The facility will be a collaborative partnership between the HSE and the successful provider. It is intended that this arrangement will be reviewed within one year and that Nenagh CNU will open 12 – 18 months after the contract commences with the private provider. This interim use will greatly support the region pending the completion of the first of two new 96 bed blocks for UHL scheduled to be completed in early 2025. **For information:** The expanded Medical Assessment Unit services across UL Hospitals Group are making a significant and positive impact on delivering timely care to thousands of patients referred by their GPs to hospital for urgent medical attention. All three Mid West MAUs are currently open from 8am-8pm. We are working with all stakeholders on planning for the continued expansion of our MAU services including a further extension of opening hours (please see further detail below). MAUs provide diagnosis and treatment for patients referred with a wide variety of medical conditions, including chest infections, COPD (chronic obstructive pulmonary disease), pneumonia, urinary

	tract infections, fainting episodes, clots in the leg, and anaemia. Patients are reviewed by a senior clinician and may require x-rays, blood tests, scans or further diagnostic imaging. Our Injury Units in St John's Hospital, Ennis Hospital and Nenagh Hospital are open every day for injuries in adults and children aged 5 and upwards.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Additional bed capacity is a key priority for UL Hospitals Group. Details of current and planned projects which will help address capacity shortages and improve patient flow in the coming years include: 1. 96-bed block - Work commenced on the first 96-bed ward block at UHL in September 2022. It is currently envisaged that the construction phase will be complete by Q1 2025. Once handed over by the contractors, the new build will need to be equipped and commissioned and staff trained following the completion of a recruitment campaign. We anticipate that this much-needed additional bed capacity for the region will become operational in mid-2025. We are pleased to confirm that this bed block will provide 71 new beds and 25 replacement beds to the UHL bed stock next year. Recruitment for this bed block will commence in the near future to ensure immediate readiness in 2025. 2. Second 96-bed block - Excavation works are due to begin in the coming weeks on the second 96 bed block and a design team will be appointed in the near future to complete the planning application. The construction phase of this bed block will be completed in two stages, and will be carried out directly adjacent to the 96-bed block currently under construction at UHL. Subject to planning and procurement, it is envisaged this project will be delivered by 2027. This bed block will provide 96 new beds comprising of 48 medical beds and 48 surgical beds. 3. Rapid build ward - The HSE has submitted a planning application for a 16-bed rapid-build ward at University Hospital Limerick, a development that is part of the overall package measures recently outlined by the Minister of Health to manage high demand for emergency care at the hospital. The development will provide for 16 single inpatient bedrooms, staff facilities, and car parking, as well as space for future medical use. It is envisaged that this capacity will be available in advance of next winter's surge. 4. Surgical Hub - We are pleased to have recently lodged a planning application with Limerick City and County Council for the proposed surgical hub at Scoil Carmel in Limerick. Surgical hubs are a key priority for the HSE and UL Hospitals Group in improving access for surgical patients and reducing waiting lists. These plans are aligned with the Programme for Government and key HSE policies including Slàintecare and the National Waiting List Action Plan. Our planning application provides for two new operating theatres and two procedure rooms in a state-of-the-art development on the Scoil Carmel site. It is proposed that the new surgical hub will operate as a satellite of University Hospital Limerick with key staff moving between the sites. A further information request has recently been issued by the planning authority in respect of the planning application for the site. There have also been a number of observations received by the planning authority in respect of

	the proposal. Additional information will be submitted in due course to the planning authority following consideration of the matters raised. Update on additional measures of support: ▪ A change in the bed profile for the first 96 bed block increasing the number of additional beds from 48 to 71. We have approval to immediately commence recruitment for opening these beds in mid-2025. ▪ 16 additional beds in a rapid build ward are to be commissioned at UHL with this capacity to be available in advance of next winter's surge. We have received the go ahead to immediately commence recruitment for this ward. **For information:** There are 872 inpatient beds across UL Hospitals Group. **Hospital Site:** University Hospital Limerick **Bed Capacity: 535** (of which 51 are Paediatric beds and 28 critical care) **Hospital Site:** St. John's Hospital **Bed Capacity:** 89 **Hospital Site:** Ennis Hospital **Bed Capacity:** 50 **Hospital Site:** Nenagh Hospital **Bed Capacity:** 52 **Hospital Site:** Croom Orthopaedic Hospital **Bed Capacity:** 44 **Hospital Site:** University Maternity Hospital Limerick **Bed Capacity:** 83 inpatient beds, 19 cots in the Neonatal Unit ED admission-avoidance for over-75s: The Geriatric Emergency Medicine (GEM) unit at UHL recently expanded to 9 treatment bays and to 24-hour operations during weekdays. This unit assesses elderly patients in ED with a view to avoiding unnecessary admission to hospital. This unit is open 7 days a week.

Governance	**For information:** Year to date, our average discharges are 59 per day, which is in line with weekday performance across other model 4 hospitals, however, we are significantly below all other model 4 hospitals in respect of our weekend discharge performance.
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** Update on additional measures of support: ▪ The procurement process is underway for the temporary operation of the 50-Bed Community Nursing Unit in Nenagh as a step down sub-acute and rehabilitation facility for one year until the first 96 bed block at UHL is opened. ▪ GP and Advanced Nurse Practitioner-on-the-door services for the ED in an effort to alleviate overcrowding and allow the ED staff to treat urgent and emergency patients in a more timely manner which has already commenced. <u>Enhanced Community Care Strategy</u> UL Hospitals Group and HSE Mid West Community Healthcare have formalised a governance structure to deliver on the investment in community care, hospital avoidance, chronic disease and older persons. Under the joint governance structure of this project, a number of sub-committees have been formed. These are jointly chaired by staff from UL Hospitals Group and HSE Community Healthcare Mid West. The sub-committees include: ▪ Older Persons Integrated Care Workstream ▪ Chronic Disease Integrated Care Workstream ▪ Integrated Care CHNs Programme ▪ Health Pathways Programme ▪ Integrated Decision Making Forum Project. In addition, an Integrated Care Enablers Programme has been formed to support each of these workstreams and programmes ensuring support from IT/Telehealth/Data, Communications, Diagnostics, and HR. **For information:** Pathfinder: A collaborative ED-avoidance programme run by the Group's allied health staff and the National Ambulance Service (NAS). Pathfinder aims to deliver safe alternative care at home for over-65s in the Mid West region. Alternative Pre-Hospital Pathway: A new collaboration between UL Hospitals Group and the National Ambulance Service sees definitive care provided in the community by emergency medicine doctors and paramedics to patients who call 999/112. This reduces the number of ambulances bringing patients directly to the ED.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** Update on additional measures of support: ▪ Safer Staffing will be extended to all wards in UHL with immediate sanction to commence recruitment.

	▪ A Social Inclusion integrated Hospital to Community Team that will tackle the demographic and social challenges which lead to over utilisation of hospital pathways. ▪ A CAMHS Paediatric Liaison Team to provide in reach into the paediatric wards to support children with mental health needs. ▪ Sanction to immediately recruit an additional 31 WTEs for Chronic Disease Management and ICPOP Teams. **For information:** At the end of January 2024, there were a total of 5,769 WTE staff employed at UL Hospitals Group. Safer Staffing: Safer Staffing levels for ED nursing staff have been reviewed and national approval was received to recruit 21.5 WTE additional staff nurses. Recruitment for these posts is now complete with 21.5 staff nurses in post since September 2023. Safer Staffing has also been implemented on medical and surgical wards at UHL. In the past year, an additional two consultants in emergency medicine have been recruited for the Emergency Department in addition to an extra 20 NCHDs. (registrars and SHOs)
Funding	**For information:** UL Hospitals Group welcomes the significant additional in-year investment announced by the Minister for Health Stephen Donnelly TD during his recent visit to University Hospital Limerick, representing an additional €160m in capital funding and €79m recurring revenue funding.
Other	No information identified.
Impact	No information identified.

Table 53 Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-'31 [2024]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	DoH[53] Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-'31 [2024] Plan
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** Government already committing to a further 441 additional new acute inpatient beds and 574 replacement acute inpatient beds that are in various stages of development (including the National Children's Hospital, the National Maternity Hospital and commitments for bed capacity for a number of Regions). On top of the bed capacity that has already been committed to/underway, this capacity expansion plan sets out a further 2,997 additional new beds and 355 replacement acute inpatient beds to be added across the hospital network for Ireland over the period 2024–2031. Excluding beds already opened, this will result in a total planned capacity increase of 3,438 additional new acute inpatient beds and 929 replacement acute inpatient beds over the period 2024 to 2031. **For information:** Since 2020 an additional 1,218 additional new acute inpatient beds have been opened to date (March 2024).
Governance	**Recommendation/considerations:** The pace of delivery of this overall plan and the basis on which it may need to adapt is dependent on several critical factors, including: ▪ Site readiness that is dependent on decanting activity off-site, progressing enabling works to free up space to build additional capacity, engagement with providers to relocate existing and access new utility service capacity. ▪ Engagement with planning authorities and the statutory planning process. ▪ Public Procurement requirements and Infrastructure Guidance for appraisal and delivery.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** The pace of delivery of this overall plan and the basis on which it may need to adapt is dependent on several critical factors, including:

	▪ Available construction sector capacity and modern construction technologies that can respond to each of the projects at site and regional level. ▪ Operational delivery will also be dependent on recruitment of necessary workforce to bring this new capacity into service. **For information:** As well as an increase in bed capacity, Irish hospitals have received an unprecedented uplift in funding and workforce since 2020.
Funding	**Recommendation/considerations:** The pace of delivery of this overall plan and the basis on which it may need to adapt is dependent on several critical factors, including: ▪ The provision of capital funding allocated through the National Development Plan currently provided to 2026. ▪ The provision of current funding as part of the annual Estimates process agreed by Government to support pay and non-pay costs. **For information:** As well as an increase in bed capacity, Irish hospitals have received an unprecedented uplift in funding and workforce since 2020. The indicative cost range for the proposed additional acute inpatient bed capacity is estimated between €0.75 million to €1.1 million based on recent construction projects and performance and the need to protect the state's interest in any future market engagement.
Other	No information identified.
Impact	No information identified.

Table 54 HSE Urgent and Emergency Care Plan (2024-2026) [2024]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[54] HSE Urgent and Emergency Care Plan (2024-2026) [2024] Plan
The health service system (including health service reform)	**Recommendation/considerations:** *Hospital avoidance actions:* ▪ Standardising the opening hours of all Acute Hospital delivered Injury Units (IU) to provide a 7-day service, 8am to 8pm including Bank Holidays. ▪ Open additional IUs. ▪ Optimise the usage of Paediatric Rapid Access Clinics. *ED Operations:* ▪ High levels of streaming on arrival at the emergency department e.g. to Medical Assessment Units, GEMs Units, Injury Units, ICPOP assessment and other appropriate services. ▪ Standardised Paediatric care pathways are in place in EDs to ensure an integrated approach to the particular care requirements of presenting children and young people including the transfer of care to specialist or secondary care services (e.g. HDUs, CHI, Disability Services including Intellectual Disabilities, CAMHs, emergency placements etc.). *In Hospital Care delivery:* ▪ All sites will have plans in place to transition to hospital wide cohorting of patients to specialty or dedicated wards, commencing with the cohorting of Older Adults (≥ 75 years) to specialist geriatric wards by year end. ▪ All clinically appropriate patients in Model 3 and Model 4s to transfer to alternative care settings including Model 2s, Rehabilitation Beds and Transitional Care Beds (TCBs). ▪ Sites that deliver services to children and young people to maximise the implementation of short stay paediatric pathways to facilitate appropriate early treatment and patient discharge. ▪ Arrangements will be put in place for extended hours for public, private and mobile diagnostics to avoid delays in flow (surge measures).
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *ED Operations:* ▪ All EDs to have plans in place to screen all patients ≥ 75 years for Delirium and Frailty at triage (or within 15 minutes of registration) and provide early access to specialist emergency and gerontology care.

	In Hospital Care delivery: ▪ Open a 10 bedded Acute Virtual Ward in University Hospital Limerick (UHL) and in St Vincent's University Hospital (SVUH) in Q2, scaling to 25 virtual beds for each site by year end to deliver 50 virtual beds in total. ▪ Sites to make optimal use of the additional Acute beds delivered under the Capital Plan in 2024.
Governance	**Recommendation/considerations:** *Hospital avoidance actions:* ▪ Deliver national and local communications campaigns to provide information on alternative pathways, keeping well, vaccinations and respiratory illnesses. ▪ Campaigns to promote self-care at home, alternative pathways and vaccination programme (surge measures). *ED Operations:* ▪ Establish UEC (Older Adults) Clinical and Operational Regional Governance Groups to plan for and deliver the Older Adults Pathway as part of an Age Friendly Health System by end of 2024. *In Hospital Care delivery:* ▪ Hospitals will implement protocols for inpatients with Length of Stay over 14 days transitioning to over 7 days. ▪ Each hospital/community to have a centralised operational hub or equivalent that provides visibility of all available bed capacity in hospitals, community and private facilities to support demand and capacity management, utilising as standard the "every bed used every day" approach. *Discharge operations:* ▪ Operational processes will be in place to support the discharge of patients prior to midday and on a 7/7 basis to support a consistent level of discharge each day. An integrated system of governance and accountability will support the delivery of this plan by providing ongoing monitoring and oversight of UEC activities and performance. The integrated UEC governance and oversight arrangements with DoH and at national and regional HSE level are set out in figure 1 below. The oversight and implementation of the UEC Plan will continue to be facilitated by a monthly cycle of Taskforce meetings and associated Ministerial meetings. These groups are comprised of senior representatives of the DoH and HSE. At service level Regional Executive Officers will be responsible for operational performance including the delivery of the UEC plans and will be key members of the UEC Oversight Group. Local integrated governance structures and arrangements have been established to facilitate the delivery of planned UEC service improvements. Each Health Region will ensure monitoring and reporting arrangements are in place to assess implementation of local plans, efficacy of same and performance against UEC KPI targets taking account of agreed local performance

	trajectories. In addition to the UEC actions and priorities that require local delivery, there are actions that will be progressed at a national level to ensure consistency of approach in the implementation of new programmes such as the roll out of Acute Virtual Wards or because they fall under the remit of National teams including, Technology and Transformation or Communications. These projects and programmes will be reported and monitored as part of the overall UEC programme. UEC Emergency Measures If there are exceptionally high levels of escalation which cannot be mitigated alone by implementation of the immediate operational actions and surge capacity measures, an emergency can be declared by 1) Mandated implementation of emergency measures by the National HSE UEC Oversight Group or 2) Mandated implementation of emergency measures locally by the REO. UEC Emergency Measures will include: 1. The CEO will determine the requirement for and will initiate a National Crisis Management Team (NCMT) approach to ensure patient quality and safety is maintained and that specific actions are mandated to manage UEC demand. 2. Senior leaders, senior decision makers and staff with key roles pertaining to UEC across Health Regions to defer or cancel annual leave to ensure leadership is on site to manage UEC demand. 3. Internal communications to be released across Health Regions to alert all staff of emergency measures. 4. Cancel elective surgery activity for a defined period of time, excluding time critical/ time sensitive surgery, and reprioritise staff members and inpatient capacity to emergency demand. 5. Enhanced focus on epidemiological data to determine the scale of demand and corresponding actions required. 6. Urgent communication with GPs and local nursing homes to be enhanced to increase awareness of emergency measures and the associated response required. National Governance: The HSE UEC Oversight Group is the forum where the surge measures will be launched and where the impact of these measures will be monitored continuously. The Chair of the HSE UEC Oversight Group is responsible for the execution of surge measures. The HSE UEC Oversight Group will meet twice weekly once emergency measures have been triggered. Twice weekly meetings will also be held with Regional Executive Officers, and their operational and clinical service leads chaired by the HSE UEC Oversight Group chair. The purpose of these meetings is to ensure that all implementation and tactical operational issues are escalated and resolved. Local Governance: Integrated meetings will continue to take place twice weekly at a minimum to monitor UEC activity and the impact of surge measures. There will also be short operational pulse meetings with Regional Executive Officers, and relevant operational and clinical service leads on a daily basis to address tactical operational issues that need to be escalated and to inform national situational awareness.

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Hospital avoidance actions:* ▪ Operationalise an Emergency Dept. in the Home (EDITH) Service in UHL. ▪ Work with GP Out of Hours Services to maintain/increase GP OOH contacts and reduce the level of GP OOH referrals to EDs. ▪ Put plans in place to expand the use of video enabled care for select services e.g. Older Adults, chronic disease and specialist services to avoid unnecessary hospital attendances. ▪ Flex the ECC model to support over 2,800 admissions to nursing homes (NH) through inpatient geriatric assessment, Community Specialist Team (CST) led advance care planning and access to CHN services. ▪ Community Specialist Teams (CSTs) for Chronic Disease Management will deliver 19,000 patient contacts each month. ▪ CSTs for Integrated Care Programme for Older Persons (ICPOP) will deliver 11,750 patient contacts each month. ▪ Maximise usage of existing NAS alternative care pathways (Pathfinder, Hear and Treat, Community Paramedics). ▪ Extended GP hours over OOH periods and weekends will be delivered (surge measures). ▪ CHOs to roster additional and extended hours for staff to support patients at risk of hospital admission (incl. ICPOP Nursing Home in-reach teams) (surge measures). *ED Operations:* ▪ Additional capacity will be in place through voluntary and private ambulance services to improve egress and general flow (surge measure). *In Hospital Care delivery:* ▪ All regions working in conjunction with Public Health Service Improvement teams, to utilise their baseline UEC demand projections by service and site to develop site specific UEC improvement trajectory plans. ▪ Optimise full use of available private capacity of 140 beds as per the established Private Hospital Framework (current framework is in place until December 2024). ▪ All sites and CHOs to roster additional and extended hours for senior decision makers, staff integral to patient flow and HSCPs across acute and community services (surge measures). *Discharge operations:* ▪ All patients to have a comprehensive plan for discharge, developed in conjunction with community services. A predicted date of discharge is to be assigned at the time of admission. ▪ In anticipation of their final care plan being fulfilled, all available options are to be put to suitable patients who are experiencing a DTOC if they have already been approved for NHSS long term care. Patient choice to be

	prioritised, however in line with the discharge policy, patients will be safely transferred on the third offer provided to them. ▪ Discharge and transfer of care processes will be in place to ensure that families, carers or community/ long term care services receive a full and timely handover of care. ▪ Sites to make optimal use of the additional community beds delivered under the Capital Plan in 2024. ▪ Timely approval and delivery of home support hours to enable increased access to care and supports in the community and egress from acute hospitals, through the delivery of 22 million home support hours to approximately 54,100 people. ▪ The continued use of Transitional Care Funding to facilitate the discharging of all eligible patients to private nursing home beds.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *ED Operations:* ▪ Prioritise care and compassion for older adults identified as at risk in our EDs by rostering a designated person to keep them informed and assist them as needed during each shift. ▪ Senior Decision Makers on-site in ED, 7/7 including Bank/Public Holidays. ▪ Consultant daily rounding of admitted patients each morning in EDs and surge beds to expedite decisions and treatment. ▪ Progress the implementation of the initial Safe Staffing Phase 2 for EDs. *In Hospital Care delivery:* ▪ All patients will have senior clinical review every morning to expedite decisions and treatment. ▪ Senior clinical and operational decision makers rosters to be developed on a 7/7 basis and implemented to meet the predictable increased weekend and public holiday demand. ▪ Roster amendments and additional services should be developed on a 6/7 basis in the interim, ultimately working to a 7/7 basis and implemented to meet the predictable increased weekend and public holiday demand. *Discharge operations:* ▪ Additional maximum hours to be put in place to support ED avoidance, admission avoidance and discharge for patients (surge measures).
Funding	**For information:** Funding for surge measures, this calendar year, has been provided for in the Health Budget 2024 (€13.26m).

Other	**For information:** **National Service Plan 2024** Total Budget Allocation: €23.8bn Total Additional Enduring WTE: 2,951 Additional Community Beds; short stay: 27 Additional Community Beds; long stay: 147 Additional Acute In-Patient Beds: 163 Additional Critical Care Beds: 22 Note: Total budget and WTE allocation includes €2.8bn and 683 WTE for disability services and excludes Capital Budget (€1.2 bn)
Impact	No information identified.

Table 55 UHL Support Team Report 2024 [2024]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[55] UHL Support Team Report 2024 [2024] Report
The health service system (including health service reform)	**Recommendation/considerations:** <u>De-escalation plan:</u> All diagnostic resources to be dedicated to UEC and Inpatients for the duration of the reset. HSCPs to prioritise patients in accordance with clinical need not location, again to ensure no unnecessary delays in the patient journey. All teams to be staffed appropriately with redeployment of staff as and when required. A targeted number of daily transfers to Model 2 sites to be identified and an SOP to support appropriate transfers to be developed and implemented. Transport to be available to meet demand. Bed Management to have more visible presence in ED and at ward level and be seen as part of the Patient Flow Team working hand-in-hand with Senior Nursing Management and Hospital Management. Each Model 2 site will be critical to the reset: ▪ Croom to undertake Trauma only for the two week period with a minimum number of daily transfers to be accepted. No Outpatient or Pre-Assessment activity to be undertaken with all available capacity, including Day Beds, to be utilised to decant from UHL. All diagnostic capacity to be optimised to support UHL. ▪ Nenagh, Ennis and St. John's to cancel all scheduled activity for the two week period with all available capacity, including Day Beds, to be utilised to decant from UHL. AMU and IU to remain operational and a minimum number of transfers to be accepted daily over the two week period. All diagnostic capacity to be optimised to support UHL. <u>10 Key Workstreams for Action</u> 4. Each 'speciality' to be reviewed by the respective Clinical Director and Directorate Nurse Manager to identify issues of concern that impact on the specialty's ability to proactively see and treat patients and positively impact on patient flow across the Mid West. Directorates must work collaboratively to address identified concerns and ensure optimisation of resources and equity of access. (Following the reset significant engagement is required with all clinical and non-clinical stakeholders and their teams to develop short, medium and long term plans for all of the services in the region).

	6. All services across the Mid West need to be better integrated to ensure appropriate prioritisation of patients in line with available resource. There are pockets of excellence in both the acute and community settings and yet overcrowding is largely seen as an ED / Medical issue. All staff need to work collaboratively to prioritise, identify, implement and sustain solutions which enhance and support patient flow. 10. A review of ICT (Data & Analytics) is required to ensure timely access to and sharing of data amongst key stakeholders. It is clear that there are a number of systems in place but it is equally clear that not all 'talk to one another' and the fact that systems are largely standalone supports a siloed approach in the hospital. Bed Management undertake much manual data work which detracts from visible presence and engagement with the ED and appears to result in 'batch' allocation of inpatient beds. In addition there is concern regarding 'paper lists' used for patient handover. **For information:** Senior Clinical staff in the ED noted positively their ability to refer suitable patients to the MAUs in the three Model 2 sites as an effective enabler to admission avoidance.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** <u>10 Key Workstreams for Action</u> 5. A full review of diagnostic demand and capacity is required across the Mid West (acute, community & private). There is no evidence to suggest that available capacity across the Mid West is exhausted to support admission avoidance and safe and timely discharge. 9. The Support Team strongly recommend a review of the use of space in UHL and indeed right across the group to ensure optimisation of the clinical footprint. **For information:** It appeared to the Support Team that there was a level of acceptance in relation to the 'intractable' nature of the overcrowding problem in UHL and a corresponding belief that the overcrowding would only be resolved by capacity enhancement. The combination of increasing demand, increasing complexity and increasing admissions has resulted in additional pressures on inpatient beds. Undoubtedly with the growing and ageing population, additional bed capacity is required into the future. It was further observed by the Support Team that a significant mismatch occurred at weekends with far greater admissions than discharges on Saturdays and Sundays, resulting in a very difficult starting position on a Monday

	morning. This ongoing cycle has resulted in an overcapacity build-up which the site is unable to eliminate given the constant high levels of demand and acuity.
Governance	**Recommendation/considerations:** De-escalation proposal: An experienced, Senior Operations Manager is required to lead and execute the reset and gradual resumption of services thereafter. The Support Team strongly recommends that this be a Senior Manager from outside of the Mid West Region and that this person be onsite for the duration of the reset. Directors of Nursing (DON) and Assistant Directors of Nursing (ADON) to take charge of and be responsible for an individual inpatient area for the duration of the reset. The current senior nurse management resource allows for the DONs and ADONs to work directly with front line staff to optimise discharge and address any impediments to patient flow. The DONs and the ADONs need to lead on the implementation of a 'Plan for Every Patient' in the inpatient area that they are responsible for on a daily basis. The Senior Operations Manager is the senior decision maker for patient flow. The Senior Operations Manager is the singular decision maker who delegates clear actions and timelines and convenes an hourly face to face status huddle with the team. 10 Key Workstreams for Action 1. A Hospital CEO, Hospital Director of Nursing and Hospital Clinical Director are required to be on the ground in the hospital to lead and support the various teams in what is a large and very complex organisation, i.e. an onsite Triumvirate Team. 2. A full review of the Medical and Surgical resource is required to ensure that capacity and capability is enabled and optimised right across the Mid West and that appropriate governance and structures are in place to oversee and support same. 8. The Hospital's 'UEC Escalation Plan' requires revision to ensure that the sequenced actions identified effectively support patient flow, i.e. assessment units need to be able to function, scheduled care needs to continue, use of private capacity needs to be incorporated, staffing resource to focus on patient flow needs to be included etc. **For information:** Notwithstanding the above, it is unclear from an operational perspective as to who is in charge on the UHL site on any given day. (Noted that a member of the management team was on leave for the period of the review) It is also unclear as to the specific actions identified from the various fora to address patient flow concerns on the day. Furthermore, it is not clear as to what 'Handover Plan' is shared at the day and night interfaces.

	The Support Team acknowledge the introduction of the Emergency Medicine Early Warning System (EMEWS) in January 2024 and the positive impact this has had on patient safety concerns in the department. The Support Team noted the presence of effective hospital admission avoidance pathways in UHL's Clinical Decision Unit (CDU), but noted with concern that this unit was more typically used to accommodate admitted patients, including Oncology, 'End of Life' patients and those requiring isolation. There was much evidence to support the view that 'decision to admit' is largely made by specialty NCHDs and, in turn, that overcrowding and a 'nervousness' amongst the NCHD group results in a higher conversion rate. Standard Manchester Triage is in use in UHL for adult patients. The Triage Nurse works with the Consultant in Emergency Medicine (EM) to identify potential streaming options for patients. These include referral to the Acute Surgical Assessment Unit (ASAU), Acute Medical Assessment Unit (AMAU) and Geriatric Emergency Medicine Unit (GEMU). Given the volume of admitted patients in the Emergency Department (overcrowding) and in the various Assessment Units the opportunity for these units to function is non-existent. There is a separate Paediatric Emergency Department with its own waiting area and triage function. The Support Team noted continued use of the hitherto triage standard for patients under 16 years of age (Manchester Triage) despite the introduction of the Irish Children's Triage System (ICTS) nationally in recent years. Access to ED Diagnostic Imaging was confirmed as an enabler to patient flow. Staff advised that this represents significant improvement on recent years. The Support Team are of the view that a not inconsiderable number of patients, who could and should access Diagnostics as an outpatient, are admitted (and subsequently experience prolonged lengths of stay waiting for diagnostics).
Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** <u>De-escalation proposal:</u> Senior staff from Community Mid West to be on site in UHL and the Model 2s for the duration of the re-set to ensure discharge plans are in place for those requiring community supports on discharge, support acute staff in engaging with families and work hand-in-hand with colleagues to ensure that the necessary services and supports are in place to facilitate safe and timely discharge over 7 days. All community units to ensure maximum capacity with a targeted number of daily discharges in community units, timely transfer of patients from UHL and Model 2 sites and maximum usage of CIT. Support from the private system to be optimised.

	For information: The Support Team notes the range of initiatives / ED avoidance measures in place including Pathfinder, GP at the Front Door, APP Car, ICPOP and signposting to Injury Units and the effect that these have on the ED conversion rate vis- a- vis other Model 4 sites.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** De-escalation proposal: All inpatient areas to be staffed appropriately with redeployment of staff as and when required. Consultants and their teams to review their patients every day and be responsive in respect of consults to ensure no delays in the patient journey. All staff must be aware of Demand and Capacity on any given day. 10 Key Workstreams for Action 3. A full review of the nursing workforce is required to ensure that patient care and patient flow are optimised. Recruitment and retention of front line nursing staff needs to be a priority. Consideration should be given to temporarily pausing the filling of promotional posts to ensure no further denuding of staff nurse and CNM posts. 7. In line with the current restrictions in place on recruitment in the HSE each site / location needs to look at existing resources and ensure optimal usage of same. Much concern was expressed to the Support Team regarding front line vacancies at clerical / admin level as well as at HSCP and Nursing levels and in many instances was cited as a disabler to optimal patient flow. **For information:** The Support Team recognise the significant uplift in medical staffing numbers in the ED since 2023 and the positive impact of same in terms of ED operations. Transfer / Discharge Teams comprising a Porter, a Healthcare Assistant and a Facilities Staff Member to be introduced in UHL to ensure quick turnaround times for acute inpatient beds 24/7. Active engagement and involvement by ANPs and CNSs across all specialties was not visible in the ED. It was further noted that there are significant vacancies at CNMII level which is a particular concern.
Funding	No information identified.

Other	**Recommendation/considerations:** The Support Team proposes a 'full reset' of the UHL site over a two week period in Summer 2024 with a gradual resumption of services thereafter, to support scheduled care, unscheduled care and cancer services into the future. **For information:** It is acknowledged that demand for urgent and emergency care in UHL has increased year on-year. Increases in activity have also been seen in the Model 2 Injury Units and Medical Assessment Units. Increasing demand for urgent and emergency care continues against the backdrop of significant investment in community services in recent years. The aim of the 'reset' is to address this historical backlog of inpatients (who at present are on trolleys in ED and at ward level, on trolleys and beds in surge areas and on trolleys and beds in assessment units – hence none of these areas can function as they should, nor can they serve as a release valve for the ED), restore balance and enable daily active management of flow (scheduled care, unscheduled care & cancer services). The reset will allow the ED and Assessment Units and Day Wards to function appropriately. This will result in a reduced daily conversion rate in ED, reduced daily demand for inpatient beds for unscheduled care and 'real' capacity for scheduled care. Furthermore, addressing the trolleys in the wards and clinical areas would relieve the pressure on frontline staff and create capacity for them to focus on improved patient flow processes together with the overall patient experience. It is the view of the Support Team that the 'reset ' can support a shift in the level of acceptance in relation to the 'intractable' nature of the overcrowding problem and demonstrate to front line staff a willingness to adopt extraordinary measures in an effort to de-escalate the site. The full reset will entail a sole focus on inpatients and unscheduled care for a two week period by all staff across the Mid West region to de-escalate the UHL site (noting some time critical exceptions). Having de-escalated the site, scheduled services would then resume on a gradual basis in line with a new rule-set, revised reporting structures and new team ethos whereby all services and specialties support each other and work together.
Impact	No information identified.

Table 56 Independent Investigation University Hospital Limerick (Frank Clarke report) [2024]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	Frank Clarke[56] Independent Investigation University Hospital Limerick (Frank Clarke report) [2024] Report NOTE: This report and its recommendations are to be considered as a part of the Terms of Reference for the overall Mid West Review. Therefore a limited extraction was undertaken focusing on the recommendations of the report].
The health service system (including health service reform)	**Recommendation/considerations:** *Recommendation 9:* It is clear from the figures presented to this Investigation that the Emergency Department in UHL has a higher number of presentations and a higher percentage of presentations resulting in admissions than other Model 4 hospitals nationally. The HSE should commission a detailed study on this in order to better understand the reasons and possibly put systems in place in the community to reduce the level of presentations, admissions and the consequent pressure on beds in the Dooradoyle site. *Recommendation 14:* The development of an appropriate index or indices to reflect medical inflation on an objective basis should be considered in order for the health service to plan and to improve accountability and properly inform public debate. *Recommendation 17:* This Investigation was commissioned following the tragic death of Aoife Johnston in UHL on the 19th December 2022. The HSE should, if and when the Johnston family consider it appropriate, liaise with the family with a view to memorialising Aoife.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	**Recommendation/considerations:** *Recommendation 2:* Consideration should be given by the HSE to identifying whether there are ways in which patients who attend at the Emergency Department and who are potentially in need of urgent treatment, but who do not arrive by ambulance, can be assessed in triage more quickly, instead of having to wait in a queue system. *Recommendation 3:* A review should take place to seek to identify whether there are ways in which more resources could be allocated to the triage system in the ED in UHL in circumstances where demand, in the shape of presenting patients (and especially those referred with conditions requiring urgent intervention), requires same.

	Recommendation 4: A review should take place to seek to identify whether there are ways in which more resources could be allocated to the EMEWS system in the ED in UHL in circumstances where the hospital has told this Investigation in June 2024 that this system is staffed from the current staffing compliment but that this is already proving challenging when there are high volumes of admitted patients across the department. *Recommendation 6:* A review should take place to identify such other serious conditions, apart from sepsis, that require prompt treatment to ensure that measures are in place to minimise the risk of doctors and nurses in the ED being, in practice, unaware of the particular risk attaching to specific patients when the ED is particularly busy. *Recommendation 7:* A patient, once seen and prescribed medication by a doctor, should not be waiting over an hour, as happened here, for those medications to be administered. Equally the ad hoc system of a doctor asking a nurse in a busy ED to administer a prescription to a patient with no prompt follow-up is unsatisfactory. It is recommended that a full review of the system in the ED in UHL for the administration of all prescribed medications (not simply medications prescribed for symptomatic relief) should take place in order to obviate the risks of delay once medication is prescribed. *Recommendation 8:* A review should take place to ascertain whether there are additional measures which could be adopted to ensure that the Resus area is, to the greatest extent possible, used only for patients whose clinical requirements necessitate their being in such an area in order to ensure proper patient management. *Recommendation 16:* The evidence provided to this Investigation points to the UHL hospital site in Dooradoyle coming close to capacity in terms of built infrastructure. The evidence also points to a growing, ageing population in the region with increasingly complex health needs. Research should urgently be carried out to identify whether the limitations on the Dooradoyle site are such that it cannot be expanded beyond a number of beds which is below the number likely to be required on even an optimistic scenario concerning admissions, patients stay and discharge. It would appear that such an analysis, should it lead to the view that those limitations do create a long term problem, might well inform decisions as to whether alternative measures need to be adopted to deal with ED demand in the Midwest region. If a conclusion is reached that Dooradoyle cannot, in the medium term, be expanded to a sufficient extent to accommodate admissions arising from ED, then alternative solutions must necessarily be found.
Governance	No information identified.

Community healthcare (including GPs, and nursing homes)	**Recommendation/considerations:** *Recommendation 1:* Steps should be taken by the HSE to determine whether there are circumstances in which it could be recommended that a GP, on identifying a risk of sepsis in a patient, takes the initial treatment steps required at that time while also referring the patient to an ED for further assessment and, if necessary, additional treatment. *Recommendation 10:* It is recommended that the communications systems in UHL and the wider hospital group are reviewed with a view to ensuring that, when important decisions are made at Senior Management level, including on the operation of protocols or otherwise, these are effectively and clearly communicated to managers and staff on the ground.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** *Recommendation 11:* The roles and responsibilities of the EM Consultants-on-call should be reviewed and clarity should be brought to the question of if, and if so when, it might be appropriate for the Consultant on-Call to attend, not for the purposes of providing an additional pair of hands when the ED is under pressure, and not where such a consultant is required to come in where their particular expertise is required for an individual patient, but where circumstances might warrant a Senior Clinician who is not dealing with individual patients being in a position to exercise an overall view on the situation in the Emergency Department. *Recommendation 12:* A review should take place of the coordination of the roles of doctors in the ED, in particular when the ED is busy and all doctors, have many patients to attend to. Consideration should be given to the need, in such circumstances to have a senior doctor present at an appropriate time to form an overall clinical view of the Department and co-ordinate doctors as necessary during such busy periods. *Recommendation 13:* Objective measures (much like Safer Staffing) should be applied in determining the allocation of staff and resources across the health service in order to increase efficiency and transparency. *Recommendation 15:* Consideration should be given by the HSE, the Department of Health, and the Department of Finance to questions surrounding the approval of staff numbers being dealt with at the same time as approval for capital expenditure which is needed to construct or adapt premises to provide extra capacity within the health service. Capital expenditure and the long term commitment to current expenditure which arise from the approval of additional staff seem to be inextricably linked in a functioning health service. There is little point in building additional capacity if it cannot be utilised in a sufficiently timely fashion because of the absence of staff.
Funding	No information identified.

Other	**Recommendation/considerations:** *Recommendation 5:* It would seem information is available on the electronic system used in the Emergency Department which notes if a patient is identified as query sepsis either by a GP or the triage nurse. The system does not seem to be flag this in any particular way so that it appears to be necessary to pull up the individual screen in respect of any particular patient in order to identify the position. This should be addressed by the hospital to ensure that once a patient, presenting with symptoms that point to a serious condition like sepsis which requires prompt treatment, enters the hospital system, this is highlighted and immediately evident on the electronic system and all paper records, without a clinician or nurse having to open the individual detailed screen.
Impact	No information identified.

Table 57 HSE National Doctors Training and Planning Emergency Medicine Workforce 2024-2038 report [2024]

	Information extracted
Author(s) [Reference] **Title [Year]** **Type of resource [LINK]**	HSE[57] HSE National Doctors Training and Planning Emergency Medicine Workforce 2024-2038 report [2024] Report
The health service system (including health service reform)	No information identified.
Hospital capacity (including inpatient bed capacity, ED capacity and surge capacity)	No information identified.
Governance	No information identified.
Community healthcare (including GPs, and nursing homes)	No information identified.
Staffing (including workforce planning, recruitment and retention)	**Recommendation/considerations:** It was estimated that, by 2038, there will be a demand for 311 WTE consultants in public EDs. This value represents only demand for adult/mixed services, with demand for specialised paediatric emergency care considered separately, as outlined later in the report…When accounting for paediatric emergency care and also the private sector, the total demand for Consultants in EM in 2038 was determined to be 335 WTE. Achieving the recommended consultant staffing levels will allow the Emergency Medicine Programme to optimise the process of care within EDs by designating specific areas and duties to multiple consultants on duty at a given time. As it is clear HSE policy to move towards a consultant-delivered health system, the expansion of the Non-Training Scheme Doctors (NTSD) cohort is a concerning issue which ideally will be addressed by conversion of some of these posts to training posts and expansion of the consultant numbers. The rapid expansion in NTSDs is generally reflective of recruitment in individual clinical sites to meet immediate demand or service gaps. The ongoing strategic restructuring of the EMP at national and regional level should address such immediate staffing shortfalls and the Unscheduled and Emergency Care (UEC) pathway outlined in the Model of Care (MoC) should reduce the reliance on NTSDs in EM in the future. It is imperative that NTSD posts are converted to training posts, as this will ensure the supply of trainees to the training pipeline which is the desired source of new entrants into the consultant workforce. Additionally, this is

	consistent with the objectives set out by Sláintecare regarding moving towards a consultant-delivered health system. [20] This is also in compliance with the WHO Code on ethical recruitment in healthcare and underpins the development of a sustainable consultant workforce. [21] **Scenario 1. Demand Due to Demographic Aging:** Considerations of demographic aging alone results in a demand for Consultants in EM in HSE funded services of approx. 402 WTE. Of particular note is that this value represents services in EM being provided in the same manner as they currently are today. No provision is made for proposed future networking of the service. Accounting for the private sector, the national demand increases to approximately 425 WTE. Supplying this demand target would require the consultant workforce more than doubling in size in the next 15 years. Scenario 2. Demand Due to Demographic Aging and Networking of the Emergency Care: As outlined above, the current development of the MoC for EM aims to significantly improve the care pathway for patients through a number of pillars. Pillar 1 involves reorganisation of the programme in line with the National Trauma Strategy with MTCs, TUs, LEHs, and IUs. Pillar 2 seeks to improve the infrastructure through MDTs and health information systems. The MDTs involve enhanced integration of Advanced Nursing Practitioners, physiotherapists, and other Health & Social Care Professionals within the ED environment. With this planned networking, the consultant workforce required to service the projected demand for 2038 is 311 WTE. This increases to 320 WTE when including 9 WTE demand for Consultants in PEM. Accounting for the private sector, the total value is increased to approx. 338 WTE. This value is taken as the WTE demand for Consultants in EM in 2038 for this report. **Current (2024) and projected (2038) Consultants in EM per HR (WTE) across public and private sectors** **Health Region:** HSE Dublin & Northeast **Consultant workforce 2024 (WTE):** 36.8 **Consultants per 100k population 2024 (WTE):** 2.99 **Recommended consultant workforce 2038 (WTE):** 95 **Consultants per 100k population 2038 (WTE):** 6.85 **Health Region:** HSE Dublin & Midlands **Consultant workforce 2024 (WTE):** 32.0 **Consultants per 100k population 2024 (WTE):** 2.79 **Recommended consultant workforce 2038 (WTE):** 45 **Consultants per 100k population 2038 (WTE):** 3.39

	Health Region: HSE Dublin & Southeast **Consultant workforce 2024 (WTE):** 27.9 **Consultants per 100k population 2024 (WTE):** 2.77 **Recommended consultant workforce 2038 (WTE):** 35 **Consultants per 100k population 2038 (WTE):** 3.14 **Health Region:** HSE Southwest **Consultant workforce 2024 (WTE):** 22.9 **Consultants per 100k population 2024 (WTE):** 2.99 **Recommended consultant workforce 2038 (WTE):** 64 **Consultants per 100k population 2038 (WTE):** 7.62 **Health Region:** HSE Midwest **Consultant workforce 2024 (WTE):** 12.0 **Consultants per 100k population 2024 (WTE):** 2.82 **Recommended consultant workforce 2038 (WTE):** 23 **Consultants per 100k population 2038 (WTE):** 4.94 **Health Region:** HSE West-Northwest **Consultant workforce 2024 (WTE):** 27.2 **Consultants per 100k population 2024 (WTE):** 3.50 **Recommended consultant workforce 2038 (WTE):** 49 **Consultants per 100k population 2038 (WTE):** 5.79 **Health Region:** CHI **Consultant workforce 2024 (WTE):** 21.3 **Consultants per 100k population 2024 (WTE):** 1.99 **Recommended consultant workforce 2038 (WTE):** 40* **Consultants per 100k population 2038 (WTE):** 4.5 **Health Region:** National Ambulance Service **Consultant workforce 2024 (WTE):** 2.0 **Consultants per 100k population 2024 (WTE):** 0.04 **Health Region:** Private **Consultant workforce 2024 (WTE):** 9.0

	Consultants per 100k population 2024 (WTE): 0.17 **Recommended consultant workforce 2038 (WTE):** 18 **Consultants per 100k population 2038 (WTE):** 0.3 **Total (including PEM)** **Consultant workforce 2024 (WTE):** 191.1 **Consultants per 100k population 2024 (WTE):** 3.57 **Recommended consultant workforce 2038 (WTE):** 369 **Consultants per 100k population 2038 (WTE):** 6.17 **Total (excluding PEM)** **Consultant workforce 2024 (WTE):** 169.8 **Consultants per 100k population 2024 (WTE):** 3.4 **Recommended consultant workforce 2038 (WTE):** 329 **Consultants per 100k population 2038 (WTE):** 5.5 ▪ It will be necessary to recruit 50-55 additional Consultants in EM from outside of the Irish training programme in the next 5-6 years to meet immediate expansion demand in the workforce while the training output capacity gradually increases. Beyond this, the demand for Consultants in EM will be met sustainably by the domestic training pipeline. ▪ The specific configuration of the Consultants in EM workforce in the future will be outlined by the MoC. As this is under assessment, the specifics are liable to change following the publication of this report. The expansion of the EM training programme will be required regardless of this. Following the publication of the EM MoC and corresponding networking of services, as well as other associated service developments across other elements of the health system such as CHI and the Trauma Networks, this workforce plan will be reviewed and revised to ensure that the training and workforce roadmap to 2038 are aligned with service requirements. **For information:** **Consultant Population ratios** **Midwest** **Model 4:** 11.64 **Model 3:** - **Model 2:** 0.36 **Specialist Paediatric:** - **Other (includes academic institutions and the NAS):** -

	Total: 12.0 **Consultants/100k:** 2.82 **HSE Dublin & Northeast** **Consultants/100k:** 2.99 **NTSDs/100k:** 9.76 **Trainees/100k:** 2.93 **HSE Dublin & Midlands** **Consultants/100k:** 2.79 **NTSDs/100k:** 7.05 **Trainees/100k:** 2.44 **HSE Dublin & Southeast** **Consultants/100k:** 2.77 **NTSDs/100k:** 10.32 **Trainees/100k:** 1.79 **HSE South – Southwest** **Consultants/100k:** 2.99 **NTSDs/100k:** 9.14 **Trainees/100k:** 1.17 **HSE Mid West** **Consultants/100k:** 2.82 **NTSDs/100k:** 8.92 **Trainees/100k:** 2.58 **HSE West and Northwest** **Consultants/100k:** 3.50 **NTSDs/100k:** 13.00 **Trainees/100k:** 2.19 **CHI*** **Consultants/100k:** 1.99 **NTSDs/100k:** 2.42

	Trainees/100k: 1.77 **Total** **Consultants/100k:** 3.57 **NTSDs/100k:** 10.08 **Trainees/100k:** 2.58 *CHI ratio calculated for national paediatric (U-16) population. EM has the highest proportion of NTSDs to consultants across all specialties within the HSE, and this number grew by 13% over the course 2022-2023. **Patient Attendances at publicly funded EDs for 2023 (actual) and 2038 (projected) per Health Region** **HSE Dublin & Northeast** **2023 Attendances (actual)*:** 343,425 **2038 Attendances (projected):** 427,472 **WTE Demand 2038:** 106.85 **HSE Dublin & Midlands** **2023 Attendances (actual)*:** 268,397 **2038 Attendances (projected):** 345,198 **WTE Demand 2038:** 86.3 **HSE Dublin & Southeast** **2023 Attendances (actual)*:** 148,332 **2038 Attendances (projected):** 175,129 **WTE Demand 2038:** 43.78 **HSE Southwest** **2023 Attendances (actual)*:** 259,109 **2038 Attendances (projected):** 297,708 **WTE Demand 2038:** 74.42 **HSE Midwest**

	2023 Attendances (actual)*: 79,999 **2038 Attendances (projected):** 90,540 **WTE Demand 2038:** 22.64 **<u>HSE West & Northwest</u>** **2023 Attendances (actual)*:** 241,476 **2038 Attendances (projected):** 271,645 **WTE Demand 2038:** 67.91 **Total:** **2023 Attendances (actual)*:** 1,340,738 **2038 Attendances (projected):** 1,607,692 **WTE Demand 2038:** 401.9 ***Patient attendances for PEDs have been removed for 2023 figures.**
Funding	No information identified.
Other	**Recommendation/considerations:** The primary recommendation of this report is the expansion of all levels of the training programme for EM. The consultant workforce in EM is required to almost double in size over the next 15 years. This will only be achieved with significantly increased output from the training programme in Ireland. Even with increased training output, it will be necessary to hire consultants from outside of the domestic training programmes to meet immediate unmet demand and service expansion targets while the training programme expands in capacity. Intake at Core Specialist Training in Emergency Medicine (CSTEM) will need to increase from current levels of 30 per annum to 40 over the next 5 years. Advanced Specialist Training in Emergency Medicine (ASTEM) will need to increase annual intake from current levels of 16-18 to 30 over the next ten years. Additionally, retention rates of trainees between these training stages will need to improve substantially, as many trainees currently leave EM training after CSTEM to pursue other training in specialties within the Irish health system. Fundamental to increasing training capacity will be the conversion of Non-Training Scheme Doctors (NTSDs) to training posts. EM has a substantial dependence on non-training doctors compared to other medical specialties in the Irish health system. NDTP is continuously working with training bodies and clinical sites to identify NTSD posts which can be converted to training posts.
Impact	No information identified.

References

1. Mid Western Health Board. Mid-Western Health Board (MWHB) Service Plan, 2001 [Internet]. Ireland: Mid-Western Health Board (MWHB); 2001 [updated 2001; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/338160.
2. Department of Health and Children. Quality and fairness: a health system for you: health strategy [Internet]. Ireland: Department of Health and Children; 2001 [updated 2001; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/46392.
3. Department of Health and Children. Primary care : a new direction : quality and fairness - a health system for you: health strategy / Department of Health and Children [Internet]. Ireland: Deparment of Health and Children; 2001 [updated 2001; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/46389.
4. Mid-Western Health Board. Operational plan 2002: Mid-Western regional hospitals [Internet]. Ireland: Mid-Western Health Board; 2002 [updated 2002; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/43311.
5. Comhairle na nOspidéal. Report of the Committee on Accident and Emergency Services / Comhairle Na nOspideal [Internet]. Ireland: Comhairle na nOspidéal; 2002 [updated 2002; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/44735.
6. Department of Health and Children. Acute hospital bed capacity: a national review / Department of Health and Children [Internet]. Ireland: Department of Health and Children; 2002 [updated 2002; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/46287.
7. Watson Wyatt Worldwide, Prospectus Strategy Consultants. Audit of structures and functions of the health system on behalf of the Department of Health and Children [prospectus report] [Internet]. Ireland: Department of Health and Children (DOHC); 2003 [updated 2003; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/64538.
8. Healthcare Consultancy Ltd. Report on nurse staffing levels in emergency departments [Internet]. Ireland: Healthcare Consultancy Ltd.; 2003 [updated 2003; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/45023.
9. Capita / HSEA. Capita's report to the employers and unions: national review of bed management function: final report [Internet]. Ireland: Capita / HSEA; 2003 [updated 2003; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/44451.
10. Department of Health and Children. Commission on financial management and control systems in the health service / [chairperson: Niamh Brennan] [Internet]. Ireland: Department of Health and Children; 2003 [updated 2003; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/46721.
11. Department of Health and Children, Hanly D. Report of the National Task Force on Medical Staffing [Hanly report] [Internet]. Ireland: Department of Health and Children; 2003 [updated 2003; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/46569.

12. Comhairle na nOspidéal. Acute medical units / Comhairle na nOspideal [Internet]. Ireland: Comhairle na nOspidéal; 2004 [updated 2004; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/44659.
13. Health Service Executive Emergency Department Task Force. Emergency Department Task Force report [Internet]. Ireland: Health Service Executive (HSE); 2007 [updated 2007; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/45363.
14. PA Consulting Group, Balance of Care Group. Acute hospital bed review: a review of acute hospital bed use in hospitals in the Republic of Ireland with an Emergency Department (summary, conclusions and recommendations) [Internet]. Ireland: PA Knowledge Ltd.; 2007 [updated 2007; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/99753.
15. Horwath Consulting Ireland, Teamwork Management Services. Review of acute hospital services in HSE Mid-West. An action plan for acute and community services [Internet]. Ireland: Horwath Consulting Ireland, Teamwork Management Services; 2008 [updated 2008-04; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/65219.
16. Health Information and Quality Authority (HIQA). Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at the Mid-Western Regional Hospital Ennis [Internet]. Dublin: Health Information and Quality Authority (HIQA); 2009 [cited 2024 November 08]. Available from: https://www.hiqa.ie/sites/default/files/2017-01/investigation_report_mid-western_regional_ennis.pdf.
17. Comptroller and Auditor General. Health Service Executive emergency departments [Internet]. Ireland: Comptroller and Auditor General; 2009 [updated 2010-03-29T13:00:36Z; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/95148.
18. Royal College of Physicians of Ireland, Irish Association of Directors of Nursing, Midwifery Therapy Professions Committee, Quality Clinical Care Directorate HSE. Report of the national acute medicine programme [Internet]. Ireland: Health Service Executive (HSE); 2010 [updated 2010; cited 2024 December 11]. Available from: http://hdl.handle.net/10147/622886.
19. Health Service Executive (HSE). Health Service Executive regional service plan 2011 area west [Internet]. Ireland: Health Service Executive (HSE) West Office of the HSE West Regional Director of Operations; 2011 [updated 2011-02; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/125205.
20. Health Service Executive (HSE). Health Service Executive HSE West service plan 2012 [Internet]. Ireland: Health Service Executive (HSE); 2011 [updated 2011; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/304792.
21. Clinical Strategy, Programmes Directorate, Health Service Executive, Health Service Executive Quality, Patient Safety Direc, Irish Committee for Emergency Medicine, et al. The National Emergency Medicine Programme [Internet]. Ireland: Health Service Executive (HSE); 2012 [updated 2012-06;

cited 2024 December 05]. Available from: http://hdl.handle.net/10147/578807.
22. Department of Health (DoH). Future health a strategic framework for reform of the health service 2012 – 2015 [Internet]. Ireland: Department of Health (DoH); 2012 [updated 2012-11; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/253172.
23. Health Service Executive (HSE). Mid-Western Regional Hospitals Group service plan 2013 [Internet]. Ireland: Health Service Executive (HSE); 2013 [updated 2013-02; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/270940.
24. Department of Health (DoH), Health Service Executive (HSE). Securing the Future of Smaller Hospitals: A Framework for Development [Internet]. Ireland: Department of Health (DoH); 2013 [updated 2013-02; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/623977.
25. University of Limerick Hospitals Group (ULHG). UL Hospitals Group Operational Plan 2014 [Internet]. Ireland: University of Limerick Hospitals Group (ULHG); 2014 [cited 2024 November 29]. Available from.
26. Health Service Executive (HSE). Acute Hospital Division Operational Plan 2015 [Internet]. Ireland: Health Service Executive (HSE); 2014 [updated 2014-12; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/552508.
27. Department of Health (DoH), Health Service Executive (HSE). Emergency Department Task Force: 2015 [Internet]. Ireland: Department of Health (DoH); 2015 [updated 2015-04; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/575347.
28. Health Service Executive (HSE). Acute Hospitals Division operational plan 2016 [Internet]. Ireland: Health Service Executive (HSE); 2016 [updated 2016-02; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/605673.
29. University of Limerick Hospitals Group (ULHG). University of Limerick Hospitals Group operational plan 2016 [Internet]. Ireland: Health Service Excutive (HSE); 2016 [updated 2016-03-03; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/603473.
30. Health Service Executive (HSE). HSE Mid West community healthcare 2016 Limerick, Clare and North Tipperary [Internet]. Ireland: Health Service Executive (HSE); 2016 [updated 2016; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/605036.
31. National Acute Medicine Programme (HSE). Report from the site visit by the National Acute Medicine Programme (NAMP) to the University Hospital Limerick on March 1st 2016 [Not available online]. Ireland: 2016. Available from:
32. Acute Hospitals Division - Health Service Executive (HSE). Developing an Acute Floor Model for Ireland [Internet]. Ireland: Health Service Executive (HSE); 2017 [cited 2024 December 11]. Available from.
33. Acute Services Division Health Service Executive (HSE). Acute Services Operational Plan 2017 [Internet]. Ireland: Health Service Executive (HSE);

2017 [updated 2017; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/621074.
34. University of Limerick Hospitals Group (ULHG). UL Hospitals Group Operational Plan 2017 [Internet]. Ireland: Health Service Executive (HSE); 2017 [updated 2017-02; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/621123.
35. University of Limerick Hospitals Group (ULHG). UL Hospitals Group submission to the Ireland 2040 National Planning Framework [Internet]. Ireland: University of Limerick Hospitals Group (ULHG); 2017 [cited 2024 December 03]. Available from: https://cdn.npf.ie/wp-content/uploads/0582-UL-Hospitals-Group.compressed.pdf.
36. Houses of the Oireachtas. Committee on the Future of Healthcare Sláintecare Report [Internet]. Ireland: Houses of the Oireachtas; 2017 [cited 2024 November 27]. Available from: https://assets.gov.ie/22609/e68786c13e1b4d7daca89b495c506bb8.pdf.
37. Health Service Executive (HSE), Royal College of Physicians of Ireland. Framework for Ambulatory Care On the Acute Floor [Internet]. Ireland: Health Service Executive (HSE); 2018 [cited 2024 December 11]. Available from: https://www.hse.ie/eng/about/who/cspd/ncps/acute-medicine/resources/ambulatory-care-framework-excluding-data.pdf.
38. Health Service Executive (HSE). Acute Hospital Services Divisional Plan [Internet]. Ireland: Health Service Executive (HSE); 2018 [updated 2018; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/622999.
39. University of Limerick Hospitals Group (ULHG). UL Hospitals Group Operational Plan 2018 [Internet]. Ireland: University of Limerick Hospitals Group (ULHG); 2018 [cited 2024 November 28]. Available from: https://www.lenus.ie/handle/10147/623021.
40. PA Consulting Group. Health Service Capacity Review 2018: Review of health demand and capacity requirements in Ireland to 2031 (Main report) [Internet]. Ireland: PA Consulting Group; 2018 [cited 2024 November 26]. Available from: https://assets.gov.ie/10132/7c2a2299ca924852b3002e9700253bd9.pdf.
41. Office of the Chief Nurse Department of Health (DoH). Framework for Safe Nurse Staffing and Skill mix in General and Specialist Medical and Surgical Care settings in Adult Hospitals in Ireland 2018: final report and recommendations by the Taskforce on Staffing and Skill Mix for Nursing [Internet]. Ireland: Department of Health (DoH); 2018 [updated 2018-04-16; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/623138.
42. National Acute Medicine Programme (HSE). Report of the National Acute Medicine Programme site visit to University Hospital Limerick. Ireland: 2022. Available from:
43. Health Information and Quality Authority (HIQA). Report of the unannounced inspection of the Emergency Department at University Hospital Limerick against the National Standards for Safer Better Healthcare (March 2022).[Available on request] [Internet]. Ireland: Health Information and

Quality Authority (HIQA); 2022 [cited 2024 November 22]. Available from: https://www.hiqa.ie/areas-we-work/find-a-centre/university-hospital-limerick.

44. Health Information and Quality Authority (HIQA). Report of an inspection against the National Standards for Safer Better Healthcare (University Hospital Limerick, February inspection) [Internet]. Ireland: Health Information and Quality Authority (HIQA); 2023 [cited 2024 November 28]. Available from: https://www.hiqa.ie/system/files?file=inspectionreports/university-hospital-limerick-21-22-february-2023_0.pdf.
45. Department of Health (DoH). Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland: Final Report and Recommendations by the Taskforce on Staffing and Skill Mix for Nursing [Internet]. Ireland: Department of Health (DoH); 2022 [cited 2024 November 27]. Available from: https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf.
46. Deloitte. UL Hospital Group Patient Flow Report [Internet]. Ireland: Deloitte; 2022 [cited 2024 November 18]. Available from.
47. Health Information and Quality Authority (HIQA). Overview Report: Monitoring programme against the national standards in emergency departments in 2022 [Internet]. Dublin: Health Information and Quality Authority (HIQA); 2022 [cited 2024 November 20]. Available from: https://www.hiqa.ie/sites/default/files/2022-12/Healthcare-overview-report-2022.pdf.
48. Health Service Executive (HSE). HSE Operations: Integrated Planning Full Report: Review of Medical Assessment Units [Not available online]. Ireland: 2023. Available from:
49. Health Information and Quality Authority (HIQA). Report of an inspection against the National Standards for Safer Better Healthcare (University Hospital Limerick) [Internet]. Ireland: Health Information and Quality Authority (HIQA); 2024 [cited 2024 November 01]. Available from: https://www.hiqa.ie/system/files?file=inspectionreports/University%20Hospital%20Limerick%2C%2021%20November%202023.pdf.
50. Health Service Executive (HSE). HSE Urgent and Emergency Care Operational Plan 2023 [Internet]. Ireland: Health Service Executive (HSE); 2024 [cited 2024 November 27]. Available from: https://www.hse.ie/eng/services/publications/hse-urgent-and-emergency-care-operational-plan-2023.pdf.
51. University of Limerick Hospitals Group (ULHG). UL Hospitals Group Strategic Plan 2023-2027 [Internet]. Ireland: University of Limerick Hospitals Group (ULHG); 2023 [cited 2024 November 27]. Available from: https://healthservice.hse.ie/filelibrary/ul-hospitals-group-strategic-plan-2023-2027.pdf.
52. University of Limerick Hospitals Group (ULHG). Briefing note for the Department of Health - Overview UL Hospitals Group [Internet]. Ireland: University of Limerick Hospitals Group (ULHG); 2024 [cited 2024 December 05]. Available from: https://www.ihca.ie/_fileupload/briefing-note-for-department-of-health-160424.pdf.

53. Department of Health (DoH). Acute Hospital Inpatient Bed Capacity Expansion Plan 2024–2031 [Internet]. Ireland: Department of Health (DoH); 2024 [updated 2024-05-29; cited 2024 December 05]. Available from: http://hdl.handle.net/10147/641721.
54. Health Service Executive (HSE). HSE Urgent and Emergency Care Operational Plan 2024: Q2 2024 –Q1 2025 [Internet]. Ireland: Health Service Executive (HSE); 2024 [cited 2024 November 28]. Available from: https://about.hse.ie/api/v2/download-file/file_based_publications/Urgent_and_Emergency_Care_Operational_Plan_2024.pdf/.
55. Health Service Executive (HSE). University Hospital Limerick: Support Team Report 2024 [Internet]. Ireland: Health Service Executive (HSE); 2024 [cited 2024 November 28]. Available from: https://about.hse.ie/api/v2/download-file/file_based_publications/UHL_Support_Team_Report_2024.pdf/.
56. Clarke F. Independent Investigation, University Hospital Limerick [Internet]. Ireland: Health Service Executive (HSE); 2024 [cited 2024 December 05]. Available from: https://about.hse.ie/api/v2/download-file/file_based_publications/Independent_Investigation_University_Hospital_Limerick_.pdf/.
57. National Doctors Training and Planning (NDPT). Emergency Medicine Workforce in Ireland 2024-2038: An expert stakeholder informed review. [Internet]. Ireland: Health Service Executive (HSE); 2024 [cited 2024 December 03]. Available from: https://www.hse.ie/eng/staff/leadership-education-development/met/plan/specialty-specific-reviews/emergency-medicine-workforce-in-ireland-2024-2038.pdf.

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