DUBLIN HOSPITAL INITIATIVE GROUP

DRAFT THIRD REPORT

January, 1991
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1.1 Action Programme for the Health Services


The Action Plan included a Dublin Hospitals Initiative - to improve the integration and efficiency of the acute Dublin Hospital Services.

1.2 Dublin Hospital Initiative Group - Membership

The Minister asked David Kennedy to lead this Action Group. The other members of the Group were appointed for their experience in the provision of health services in Dublin.

The following were appointed members of the Action Group:

1. Professor David Kennedy (Chairman)  
   Deputy Governor, Bank of Ireland
2. Dr. Conor Burke  
   Consultant in Respiratory Medicine, James Connolly Memorial Hospital
3. Professor Davis Coakley  
   Consultant in Geriatric Medicine, St. James’s Hospital
4. Mr. Liam Dunbar  
   Chief Executive, St. James’s Hospital
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<td>5</td>
<td>Dr. Joseph Ennis</td>
<td>Consultant Radiologist, Mater Misericordia</td>
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<td>Hospital</td>
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<td>Dr. Brid Fallon</td>
<td>General Practitioner</td>
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<td>7</td>
<td>Professor Muiris FitzGerald</td>
<td>Consultant Physician, St. Vincent's Hospital</td>
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<td>8</td>
<td>Mr. Austin Groome</td>
<td>Chairman, Eastern Health Board</td>
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<td>Mr. David Hanly</td>
<td>Chairman, Comhairle na nOspideal</td>
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<td>10</td>
<td>Mr. Kieran Hickey</td>
<td>Chief Executive officer, Eastern Health Board</td>
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<td>11</td>
<td>Mr. Gerard Hurley</td>
<td>Consultant Radiologist, Meath Hospital</td>
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<td>Professor Michael MacCormac</td>
<td>Chairman, St. Vincent's Hospital</td>
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<td>13</td>
<td>Mr. Michael McLoone</td>
<td>Chief Executive, Beaumont Hospital</td>
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<td>Mr. Gearoid MacGabhann</td>
<td>Chief Executive, Mater Misericordiae Hospital</td>
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<td>15</td>
<td>Mr. Declan Magee</td>
<td>Consultant Surgeon, St. Colmcille's Hospital, Loughlinstown</td>
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<td>16</td>
<td>Ms. Eileen Mansfield</td>
<td>Matron, Adelaide Hospital</td>
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<td>17</td>
<td>Dr. John Mason</td>
<td>General Practitioner</td>
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<td>18</td>
<td>Dr. Brian O'Herlihy</td>
<td>Director of Community Care, Eastern Health Board</td>
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<td>19</td>
<td>Mr. Desmond Rogan</td>
<td>Secretary/Manager, Adelaide Hospital</td>
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<td>20</td>
<td>Mr. Niall Weldon</td>
<td>Chairman, Beaumont Hospital</td>
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<td>21</td>
<td>Dr. Leo Vella</td>
<td>Consultant in Accident and Emergency, Beaumont Hospital</td>
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The Secretariat to the Group was provided by the Department of Health.

Mr. Dermot McCarthy (Secretary)
Mr. Paul Griffin
Mr. Shay McGovern
Ms. Patsy Carr
Ms. Caroline Field

1.3 **Inaugural Meeting and Terms of Reference**

On the 26th February 1990 the Minister, in addressing the first meeting of the group, asked that it initiate measures to improve the co-ordination of hospital services and to improve the integration of hospital and other services.

The Minister asked that the initial report from this initiative would be presented to Government before the Summer Dail recess.
The hospitals covered by the exercise are:

Mater Misericordiae Hospital
James Connolly Memorial Hospital
Beaumont Hospital
St. James's Hospital
Meath Hospital
Adelaide Hospital
St. Vincent's Hospital

1.4 Reports Issued

The Group has completed three reports to date.

1.4.1 Interim Report (June 1990)

The recommendations fall under three main headings:

- proposals for more effective management of hospital workload (which do not require additional resources);

- proposals which have resource implications. The main recommendation is that there should be an improvement in geriatric services, both within and without the acute hospital;

- critique of existing organisational structure in Dublin.
Following the presentation of the Interim Report, the Group continued in existence to complete the following tasks:

- oversee the implementation of recommendations in relation to best practices;

- evaluate further the service developments proposed, including development of pilot projects on community/hospital interface and rehabilitation services;

- consideration of the options for structural change and management development; and

- identification of other measures to support effective operation of Dublin hospital services.

1.4.2 Proposed Organisational Structures

The Group finalised its second report on proposed organisational structures for the Dublin region and submitted it to the Minister at the beginning of October 1990.
1.4.3 Geriatric Services

A report on the development of services for the elderly, both in terms of the development of in-patient facilities, including the appointment of geriatricians, and the development of links with step-down facilities, was completed at the end of December 1990. The Group was aware that discussions on the future development of services for the elderly were taking place at that time and decided to submit that report to the Minister in advance of this report. However, the contents of that report are contained in full in Chapter 3 of this report.

1.4.4. Scope of this Report

The issues dealt with in this report are

- Out-Patient Services
- In-Patient Waiting Lists
- Geriatric Services
- Referral of patients from outside the Dublin area
- Implementation of the Group's Recommendations

These are outlined in detail in Chapters 1, 2, 3, 4 and 5 respectively. A summary of our recommendations is set out on pages vii to xix.
SUMMARY OF RECOMMENDATIONS

Out-Patients Services

The Group recommends that

1. each hospital should immediately undertake a systematic review of their out-patient services, focussing on patient need and the manner in which the service is provided.

2. the hospitals immediately establish, where they do not already exist, Out-Patient Services Groups, representative of medical, nursing and administrative staff to assist in the co-ordination and day-to-day operation of out-patient services.

3. standard referral forms listing demographic and clinical details be issued to all G.P.s and other sources of referral and that this method should be used to the greatest extent possible in requesting appointments.

4. appointments should generally be issued by out-patients staff.
5. The parameters of the booking schedule should be reviewed regularly, and amended if necessary in the light of experience, to ensure that operational targets for performance of out-patient clinics are attained.

6. Patients who arrive at out-patients without an appointment should, in general, not be seen since to do so is to undermine the effectiveness of the clinic system.

7. The appropriate method of organising out-patients is through the issue of specific appointment times rather than block-booking of patients.

8. Booking times and intervals should be reviewed regularly to ensure that they are appropriate. Average delays experienced by patients should be reviewed and measured regularly by the Out-Patients Services Group as a key indicator of the performance of the service. Such information should be brought to the attention of individual consultants on a regular basis.
9. A flexible approach should be adopted in the case of non-attenders and the Out-Patients Services Group should agree a policy with consultant staff for dealing with these patients. Should patients default on their appointment, they should be offered a further appointment. However, persistent non-attenders should be considered to have discharged themselves from the clinic and their care should be referred back to their G.P..

10. Each consultant should prepare a simple patient plan for junior staff to assist them in dealing with each patient.

11. Hospitals should consider introducing a system whereby all new patient appointment letters give information describing likely tests they will receive, facilities and services available, stating that delays may occur and identifying whom they should contact if they are concerned or dissatisfied with the nature of the services being offered.

12. The Out-Patients Services Group should arrange to have a regular analysis of patients' experiences and opinions.
13. as a general principle, staff should be specifically chosen for assignment to the out-patients department on the basis of their suitability and commitment, including, in particular, their ability to communicate effectively with patients.

14. a significant number of nursing personnel in out-patients should be released from certain "non-nursing" duties through the employment of non-nursing staff as receptionists/hostesses.

15. hospitals clarify who has responsibility for ensuring that all relevant records are available for patients booked to a clinic. However the lead responsibility is assigned, clear procedures should be developed and, ideally, team work on the part of all support staff regularly engaged in servicing discrete groups of out-patient clinics should be encouraged.

16. the programme of computerisation of both pathology and radiology departments and the introduction of information transmission and retrieval systems should be accelerated.
17. Consultants are notified regularly of the average waiting time for a routine appointment in their clinics. Furthermore, in order to minimise the disruption caused by non-attenders at clinics, each consultant’s list should be regularly validated where patients are waiting 6 months or more for a first appointment.

18. Details of waiting times for a first appointment in all out-patient departments should be circulated to G.P. s in the Dublin region on a regular basis.

19. Each hospital should, through the proposed Group and through their consultants, set about identifying ways of making the out-patient department more effective in dealing with patients and so further alleviate the pressure on the hospital’s in-patient and day case facilities. Certain procedures, with appropriate selection of patients, could be performed in out-patients with appropriate organisation, staffing and facilities and enable more demanding cases to be dealt with in both in-patient and day case facilities.

20. Hospitals review the booking system for appointments to ensure that patients travelling to the Dublin hospitals from outside the Eastern Health Board area are given suitable appointment times.
In-Patient Waiting Lists

The Group recommends that

1. comprehensive, standardised information be maintained and reviewed by each hospital concerning the numbers and types of patients awaiting admission.

2. validation to establish meaningful waiting list data be adopted as a firm policy in each hospital and that such policies ensure that appropriate management and clinical action is taken on foot of such reviews.

3. hospitals should immediately carry out a bulk postal review of patients who have been on a waiting list for more than an agreed period of time.

4. on completion of this comprehensive review and validation of current waiting lists, arrangements should be made by each hospital for the on-going review and validation of lists.

5. hospitals target waiting lists by ensuring that

   (A) explicit account is taken of waiting times in scheduling admissions, including theatre lists;
(B) specialty teams have reasonable activity targets to guide their attempts to minimise waiting by patients;

(C) the greatest possible use is made of alternative modes of care, especially day care.

6. where patients have been waiting for more than an agreed period of time and, in most cases, certainly for more than twelve months, this fact should be given particular weight in the assessment of relative need for admission.

7. hospitals should take steps to establish whether their activity levels, having regard to case mix, are broadly comparable with the productivity levels of similar services in other locations.

8. waiting times, even when validated, of themselves should not constitute a basis for requests for additional resources by hospitals.

9. a systematic review of the scope for increasing levels of day surgery for appropriate conditions should be carried out in the hospitals covered by our remit.
10. greater use of day surgery should be a significant element in hospital strategy to reach acceptable levels of waiting time for patients.

11. the development of appropriate systems and software to support good practice in the management of waiting lists should be given a high priority in the programme of I.T. development in hospitals.

12. G.P. should be regularly advised of average waiting times for admission.
Geriatric Services

The Group recommends that:

1. the provision of appropriate care for the elderly must be planned and managed as an integral and, indeed, central function of the acute hospital, on a par with planning and managing the A & E workload.

2. physicians in geriatric medicine should be appointed as a matter of extreme urgency in both the MANCH and Northside Hospitals (Mater, Beaumont/J.C.M.H.). These appointments should be full-time physicians in geriatric medicine, rather than physicians with an interest in geriatrics. In view of the scale of the service need, these appointments should be given priority over all other consultants appointments in the Dublin Hospitals.

3. the objective of policy should be for each major hospital to have:

   - a major commitment from at least two physicians in geriatric medicine;

   - an acute geriatric assessment unit;
4. each department of geriatric medicine should have access to sufficient rehabilitation beds to enable it to function efficiently.

5. the development of psycho-geriatric services should be accelerated and, in particular, that adequate in-patient facilities are made available for use by the psycho-geriatricians.

6. additional long-stay facilities - of the order of 150 places - should be provided, i.e., 50 places for each of the three major catchment areas in Dublin (Dublin North, Dublin South-East and Dublin South-West).

7. ear-marked funding should be provided to allow for the development of properly structured Departments of Geriatric Medicine with appropriate structural links to rehabilitation and long-stay facilities.
Arrangements for Referrals of patients from outside the Eastern Health Board area to Dublin Hospitals

The Group recommends that

1. referrals by specialty to Dublin hospitals from outside the region should be monitored regularly.

2. discussions should take place on a regular basis between hospitals and referring health boards on all aspects of the process of referral and discharge of patients.

3. the development of some specialist services which are highly dependent on referral to Dublin in hospitals outside Dublin should be considered as a matter of urgency.
Implementation Strategy

The Group recommends that

1. each hospital develop an effective quality assurance programme.

2. the main elements of a quality assurance programme should contain
   
   (a) a clear statement of objectives about processes and outcomes;
   
   (b) availability of measures of performance reflecting the targets;
   
   (c) structured, on-going arrangements for review of performance and feedback;
   
   (d) staff development and training to support specified targets.

3. follow-up action in the short term should include
   
   (a) circulation of this Report to all hospitals concerned;
(b) the organisation of a seminar on out-patients departments and waiting lists;

(c) each hospital be asked to furnish a progress report within six months.

4. the Department of Health should establish a small advisory group to assist in the implementation exercise and to review progress made by hospitals on specific recommendations.

5. each hospital undertake to have their services – either in whole or in part – put forward for compliance with international standards for quality service.

6. the pilot project on acute hospital and community services be expanded.

7. existing activity be reviewed and focussed on the particular problems in relation to rehabilitation of patients who do not require acute hospital care.
Out-Patient Services

1.1 Introduction

1.1.1 Out-patients departments are among the busiest areas of the acute general hospital. In any year, far more people are seen at out-patients than are admitted to hospital. The out-patients department is therefore, in many ways, the public face of the hospital. We know that, for many patients, out-patients departments are unattractive places and provide services in a way which is unacceptable to many consumers. Waiting times for appointments, delays in being seen and the content of the clinical consultation all give rise to considerable levels of complaint. Our primary objective in reviewing the operation of out-patients departments is to establish ways in which the quality of the service to the public can be improved, while maximising the clinical value of the out-patients service.

1.1.2 A major objective of hospital policy is to meet the needs of patients in the most cost-effective manner possible. This includes appropriate efforts to distribute workload away from traditional in-patient care to other delivery modes within the hospital, such as out-patient and day care, and through the operation of special units like day wards, five-day wards and programmed investigation units.
The philosophy underlying the development of out-patient services is based on the need to reduce hospital admissions for medical and surgical patients and to provide patients with the highest possible level of treatment and care within the resources available.

1.1.3 An out-patient is defined as a patient attending hospital on referral for specialist-based consultation, investigation or therapeutic procedures on one or more occasions, and who is not admitted as an in-patient. For clarity, this also excludes patients attending A & E Departments. The main components of the service provided in the out-patients department, which is physically and functionally linked with the main hospital, are provided by the clinical, diagnostic and medical records departments of the hospital.

1.2 Throughput

1.2.1 In 1989, the total number of attendances at out-patients departments in the hospitals covered by the Group’s work was 442,241. This is almost three times the number of patients treated on an in-patient basis, including day cases, in these hospitals.
1.3 Establishment of Sub-Group

1.3.1 Arising from its terms of reference, because of the very real and obvious public dissatisfaction with the present organisation of out-patient services, the Group decided to examine the operation of out-patient services. It was considered that the most appropriate means of addressing this issue was to establish a sub-group with the following terms of reference:-

- to review current arrangements for the referral, scheduling and treatment of patients at out-patients departments and to develop protocols to ensure that the most efficient and effective use is made of this resource in the context of providing care which is appropriate to individual needs in the most convenient way.

- to examine the numbers, categories, priority status and average waiting time of patients on the out-patients waiting list.

- to examine the methodology for placing persons on the out-patients waiting list and the frequency and method of review of those on such lists.
- to develop protocols for regular monitoring and validation of the out-patients waiting list.

- to develop strategies designed to clear waiting list backlogs efficiently.

- to identify the contribution of computerisation in achieving the above objectives.

1.3.2 The Sub-Group met on eight occasions and during the course of its work visited the East Birmingham Hospital, Birmingham and St. Bartholomew’s Hospital, London to discuss with hospital representatives their approach to the organisation and management of out-patient services. The Group was greatly assisted in its work by the representatives whom we met from both the hospitals covered by our remit and those we visited in both Birmingham and London. Their enthusiastic response to our requests for information and at our meetings was immensely helpful.

1.4 Approach to work

1.4.1 The initial exercise undertaken by the Sub-Group was to carry out a detailed survey of waiting times for new appointments with each consultant in each of the hospitals covered by the Group’s remit. While the average waiting time for a new out-patients appointment in December 1990
was eight weeks, there were significant variations by consultant/specialty and by hospital. The survey had identified long waiting times in many specialties, but particularly in E.N.T., Ophthalmology, Dermatology and Orthopaedics.

- E.N.T.
Waiting time for a new appointment varied from 11 weeks to 38 weeks.

- Ophthalmology
Waiting time for a new appointment varied from 3 days to 13 weeks.

- Dermatology
Waiting time for a new appointment varied from 1 week to 16 weeks.

- Orthopaedics
Waiting time for a new appointment varied from 1 week to 39 weeks.

1.4.2 The Sub-Committee also had information on the ratio of new/return patients to Out-Patients in 1989 which highlighted the high proportion of return patients to O.P.D. (almost 80% of all attendances). Details of these attendance rates are given in Table 1.
1.4.3 Hospitals were also asked to provide information on the types of problem experienced in operating out-patients departments. These were subsequently discussed with representatives of both the nursing and administrative staff from each hospital. Following the meeting with hospital representatives, a problem-oriented questionnaire was issued to these staff. This approach had been found to be successful in previous exercises carried out by the Group. The questionnaire featured a problem list related to the progress of patients through out-patients. Respondents were requested to rank the various potential problem areas using a semi-quantitative scoring system. Respondents were also asked to list their Top Five Priority solutions to these problems. There was a 100% response rate by the hospital representatives which permitted a clear picture to be formed of the major problems and their priority solutions. The Group is very appreciative of the widespread co-operation it received and wishes to acknowledge the high level of commitment and interest of hospital representatives in scrutinising the deficiencies in the existing system.

1.4.4 While the solution to some of the problems identified may have resource implications, it is clear that many can be overcome by changes in practice within the hospitals.
1.5 Definition of role

1.5.1 Although a central theme of policy in relation to hospital care is to increase the proportion of patients treated on an ambulatory basis rather than as in-patients, most of the hospitals covered by the exercise are not oriented to cope with the requirements for effective ambulatory care.

1.5.2 Until recently, structured management and medical input into the organisation of the out-patient services has been minimal. There is a perception amongst the staff involved in the various departments that out-patient services are regarded as having a low priority within the hospitals and that this has manifested itself in the allocation of staff and resources. Staff in out-patient departments perceive that they rarely have an input into the decision-making process in relation to their service or in the determination of priorities. A remarkably similar picture emerged during our discussions with staff in out-patient departments in the U.K.

1.5.3 Although some hospitals have now established Out-Patient Services Groups, representative of medical, administrative and nursing staff, most have no such structure. These Groups, where they exist, are involved in co-ordinating this service and in developing standards and protocols for the operation of the department in order to develop an effective and patient-centred service.
1.5.4 In general, there is an absence of a clear definition of the role of the out-patients department and, consequently, of operational standards and procedures by which to systematically evaluate performance. This reflects the generally traditional and unfocussed approach to out-patient services within clinical practice. We are also struck by the generally limited application of information technology in this area.

1.5.5 The principal purpose of the information systems which have been developed for out-patients is the registration of patients. Little use is made of the data collected for performance evaluation or review. As a result, difficulties are experienced by patients at the various stages of their association with the hospital out-patients department. These difficulties are mirrored in the problems experienced within the hospital by all categories of staff in providing what is a very pressured service to the public. The consequences are, all too often, frustration on the part of staff and dissatisfaction and complaints from patients. Staff feel they are not providing an adequate service and patients feel that they are not receiving a quality service.
1.5.6 We outline below the principal sources of difficulty at the various stages of the interface between out-patients departments and the public. These are based on the strongly-expressed opinions of the out-patients staff with whom we consulted and on our own observations. Our recommendations in the final section are designed to address both the underlying and specific factors giving rise to these difficulties.

1.6 Difficulties in modes of Referral to Out-Patient Clinics

1.6.1 Each clinician has one or more out-patient clinics per week. Appointments for these clinics are sought by a number of methods, including

(a) by the patient on the instruction of the patient's G.P. or other doctor;

(b) by the patient's G.P. or other doctor;

(c) by or on behalf of a consultant in another hospital;

(d) by or on behalf of another consultant within the same hospital;
(e) by nursing staff on the ward on the patient's
discharge on the instruction of a consultant or
member of his team

(i) for a return appointment to this consultant;

(ii) for an appointment with another consultant.

(f) by a patient on the instruction of a doctor
following attendance at the A & E Department;

(g) by a member of the medical staff in the A & E
Department on behalf of a patient;

(h) by a public health nurse (review appointments which
may have been missed - geriatrics);

(i) by the patient following review by the consultant
at the clinic;

(j) by self-referral of a previously registered
patient.

The multiplicity of sources of referral and of requests
for appointments give rise to many problems.
1.6.2 Urgent cases from the Accident and Emergency Department, special G.P. representations and ward referrals are generally seen at short notice at clinics, often leading to overbooking. In addition, a significant proportion of patients may attend without appointment.

1.6.3 Appointments may be requested by telephone or in writing and confirmed by either of these methods. Contact by telephone is particularly time-consuming and does not allow for any proper analysis by staff of the patient's status in terms of priority. The variety of methods of seeking and issuing appointments compounds the difficulties arising from the diversity of sources of referral. Apart from the resulting confusion, these features make it particularly difficult for patients' details to be validated and urgent cases to be identified and dealt with appropriately.

1.7 Problems with Waiting Times for Appointments

1.7.1 As already stated, the Group undertook a survey of waiting times for new out-patient appointments. Long delays are generally experienced by new patients in obtaining an appointment for certain specialties, e.g. Orthopaedics, E.N.T., Ophthalmology, where new patients can be waiting up to eight months for an appointment, depending on the nature of the problem. Hospital representatives stated that they felt these longer waiting times for appointment were totally unacceptable.
1.7.2 There were wide variations in waiting times for appointments between individual consultants, sometimes in the same specialty and hospital. The Group did not have an opportunity to research the reasons for such differences. The Group is strongly of the view that further research into this area should be undertaken.

1.7.3 There may be many reasons for delays in obtaining an appointment; for instance, an inadequate number of consultants or clinics in a particular specialty/hospital. However, procedures and operational practices may contribute significantly to such delays.

1.8 Problems with Appointments Systems

1.8.1 Most of the hospitals have recently introduced a scheduled appointments system, either computerised or manual. The interval between patients varies between clinics. Patients, if properly informed about the appointments system, generally arrive on time for appointments. In the response to our questionnaire, hospital staff indicated that patients generally observe appointment times, when these are given. However, there seem to be wide variations in practice within hospitals/clinics.
Considerable difficulties continue to exist because of the traditional method of block booking for certain clinics and patients' perception that they will be seen on a first come/first served basis.

1.8.2 Difficulties can also arise with patients dependent on public or health board transport which may not arrive to suit out-patient appointment times. It is not clear to what extent appointment systems do, in practice, take into account the likely arrival time in Dublin of patients dependent on health board transport from the other regions.

1.8.3 In general, each consultant determines the ratio of new to return patients per clinic, the time interval between patients and the time at which new patients attend his/her clinic. In practice, it would appear that the present organisation of the service militates against the effective operation of individual consultants' clinics. The absence of structured review of the performance of out-patients and regular feedback means that the booking arrangements rarely reflect the requirement for efficient management of the out-patients workload. Furthermore, many clinics operate without any reference to stated policy on booking parameters.
1.9 Problems of Delays experienced by Patients in Out-Patients

(a) Registration

1.9.1 Once patients arrive in the out-patients department, they are registered by the clerical staff in advance of being seen by the relevant consultant or one of his team. Two systems operate in the Dublin hospitals: the first involves a central registration area for all new patients, with return patients going directly to the relevant clinic. The second system involves all patients registering at the clinic which they are attending.

1.9.2 The major problems identified in regard to registration were:

(a) patients attending without appointments leading to overloading of clinics;

(b) difficulties in locating charts/test results for patients attending;

(c) patients arriving early for their appointments, despite being given an appointment time. This arises mainly because of their perception that they will be dealt with on a first come/first serve basis. This causes congestion in the Department.
(d) delays experienced while all relevant details are recorded for new patients, whose particulars have not been notified to the hospital when an appointment was requested.

1.9.3 Hospital representatives pointed out that over 20% of patients due to attend at a particular clinic do not arrive. Generally, these patients do not notify the hospital. This creates major difficulty for planning the number of patients to be booked at the clinic and at subsequent clinics. (Non-attenders may attend the consultant’s next clinic without an appointment). It also tends to lead to over-booking which, on occasion, can result in long delays for patients at registration and subsequently.

(b) Post-Registration

1.9.4 Despite the availability of booking systems for out-patients, both staff and patients appear to anticipate an inevitable delay before patients are seen by a consultant. While some of the problems causing delays are associated with patient behaviour - arriving early, attending without appointments - it is clear that hospital practice contributes significantly to the delays. Based
on our discussions with hospital representatives, much of the current pressure arises because of: competing commitments of medical staff in-house or in casualty; late arrival by doctors; cancellation of clinics at short notice; and an inadequate number of doctors assigned to clinics to cater for the number of patients presenting.

1.9.5 Furthermore, the high proportion of return to new patients significantly contributes to this problem. Almost 80% of all patients attending out-patients are return patients. If, as seems likely, a significant proportion of return appointments could be avoided through discharge of patients to primary care services, the numbers attending out-patients could be reduced and the value of each out-patient consultation increased. Equally, there is clear potential for introducing more effective systems to minimise delays for patients when they do attend out-patients.

1.10 Physical Condition of Out-Patients Departments

1.10.1 With regard to physical amenities, it is clear that some progress has been made in recent years. New capital developments, such as the new out-patients department at St. James’s, incorporate high standards of design and layout. Patient facilities, such as snack bars, have been installed in most out-patient departments, although
over-crowding continues to be a problem in all of the hospitals covered by the Group's work. We consider that one of the patient's fundamental rights is the right to privacy. Hospital representatives have informed the Group that this right cannot be guaranteed in some of the hospitals because of space/design problems.

1.10.2 Another legitimate expectation on the part of patients is to be provided with adequate information on their condition and treatment, which are likely to be a source of major concern to the individual. It was strongly emphasised to the Group that, because of the level of staffing available in out-patients and the present organisational arrangements, patients' difficulties can be unnecessarily aggravated as a result of poor communication. Clinics, as currently organised, often do not allow staff the flexibility to provide patients with such information. Another major source of complaint by patients relates to delays in receiving treatment. Again, staff do not generally have the time to explain the reasons for such delays to patients.
1.10.3 Hospital representatives also emphasised that delays in dealing with patients in out-patients can arise as the result of the non-availability of charts and test/x-ray results. This problem is particularly acute where the appropriate facilities are not on-site. Ease of access to these services and an efficient communication system are crucial to the effective operation of the out-patients service. The Group's recommendations in our Interim Report relating to the computerisation of information transmission and retrieval systems would directly address this problem and would greatly facilitate more effective patient management.

1.11 Problems with Discharge from Out-Patients

(a) Discharge policies

1.11.1 Apart from physical problems, discharge of patients can be delayed through the operation of frequent recall of patients. Hospital representatives estimated that a significant proportion (some estimated in the region of 20%) of patients could be discharged from out-patients, a large proportion of these to their G.P., if they were seen by more senior medical staff or if junior staff had clear guidelines on the discharge of patients. It is clear that, in the majority of cases, return patients are seen by quite junior hospital doctors who appear to be
reluctant or unable to discharge patients. The recall of such patients to further clinics, in addition to inconvenience for the patients concerned, leads to a lengthening in the average waiting time for new appointments.

1.11.2 A study carried out in Manchester in the mid-1980s found that, in general surgery, less than half the new patients and only a third of all patients were seen by a consultant. In the medical clinics, just over one-quarter of patients were seen by doctors who had less than six months' experience in their specialty after registration.

(b) Transport

1.11.3 The major difficulty experienced by patients when their out-patients consultation is finalised relates to transportation. Because of the limited nature of routine transport services, especially for patients attending from outside Dublin, some patients can be left, often for hours, in the Out-Patients Department after being seen. Although the number of such patients is small, this is a major problem for the individuals concerned.
1.12 **Limited Role of Out-Patients**

1.12.1 It was represented to the Group that many more procedures could be performed in out-patients if the organisational deficiencies detailed above were rectified. International literature details many examples of rapid turnover, low-tech procedures carried out in out-patients departments in hospitals. Such developments could significantly reduce the need for return out-patient attendances, and even for admission of patients.

1.13 **Conclusions and Recommendations**

1.13.1 In our Interim Report, we presented a range of measures which we considered would enable the workload of the acute general hospital in Dublin to be managed with greater effectiveness and efficiency. In dealing with the area of out-patient services, the Group has endeavoured to highlight the perceived deficiencies in the present organisation of this service and to develop protocols/procedures to improve the operational management of the Out-Patients Department.

1.13.2 The recommendations presented in this report represent not only the considered views of Group members, but also the expert opinion of those involved in the delivery of out-patient services, both in Dublin and in the hospitals visited by the Group in the U.K.
1.14. **Role of Out-Patient Services**

1.14.1 It is evident from our discussions with hospital representatives, both in the hospitals covered by our remit and in those hospitals which we visited in the U.K., that there is generally a low level of commitment to the out-patients service within the acute hospital. Despite stated policy that hospitals should develop modes of service delivery other than conventional in-patient care and, despite the very large numbers attending out-patients departments, insufficient consideration has been given to defining the role and objectives of this service.

1.14.2 The Group are of the view that each hospital should immediately undertake a systematic review of their out-patients services, focussing on patient need and the manner in which the service is provided. The objectives of this review should be to identify specific measures, including action on the points detailed in the following paragraphs, which would have the effect of making the most effective use of the resources available in out-patients, minimising delays for patients in receiving appointments and being seen in out-patients and facilitating the earliest appropriate discharge from the care of the hospital.
1.14.3 We recommend the immediate establishment, where they do not already exist, of Out-Patients Services Groups, representative of medical, nursing and administrative staff, to assist in the co-ordination and day-to-day operation of out-patient services. Such groups would be initially charged with carrying out the review proposed above and with developing and maintaining

(a) operational procedures for all out-patient clinics which would be circulated to and followed by all staff involved in the day-to-day running of the Department;

(b) target standards for the operation of out-patients against which performance of clinics can be measured on a regular basis to ensure optimum patient care. A set of operational standards which might be applied is attached at Appendix A;

(c) performance indicators reflecting the targets set for out-patient clinics.

Among the specific issues to be considered by these groups would be:
the particular strategies necessary to target long waiting times for appointments;

- the need for more clinics in certain disciplines;

- the possibilities for developing alternative ways of dealing with certain types of referral, e.g., refraction cases in ophthalmology.

1.14.4 Individual hospitals should determine the specific role, executive or advisory, of such groups. A designated person should, however, be responsible for and be seen to be responsible for the operation of this service. One model which operates in the U.K. involves the appointment of an out-patient services manager who is responsible for this service on a day-to-day basis.

1.14.5 All matters relating to the organisation and management of this Department should be reviewed by this Group within the remit given to it by the hospital authorities. This should include the introduction of procedures for regular review and monitoring of the operation of the Department to ensure that services are being provided in an optimum manner.
1.15 Appointments Systems in Out-Patients

1.15.1 As outlined earlier, patients are referred to out-patients from a number of sources. The present arrangements often result in out-patients staff being unaware of "appointments" having been made and in overloading of clinics. This results in long delays for patients, both at the point of reception/registration and in the clinics.

1.15.2 The objectives of a booking system for appointments should be to:

(a) allow staff to plan clinics and make the optimum use of the time available to each consultant;

(b) reduce time spent clarifying details with G.P.s and patients on the phone and leave this facility available for urgent referrals;

(c) reduce the long delays in registration of patients on their first visit to out-patients.
1.15.3 There are two principal elements to a booking system: the method by which appointments are sought and the method by which such appointments are issued. One approach which operates very successfully in the N.H.S. and which the Group saw in the hospitals which we visited in the U.K. involves requests for appointments from G.P.s or from other consultants being sent by letter. A standard pre-printed letter, listing demographic and clinical details, is issued for use by referring doctors.

1.15.4 We recommend that such standard referral forms should be issued to all G.P.s and other sources of referral and that this method should be used to the greatest extent possible in requesting appointments. We recognise that this will represent a major change in the way appointments are sought by patients and their family doctors. However, we are convinced that the benefits to patients and referring doctors will make the process of change worthwhile. The arrangement which we recommend, while resulting in a slight delay in the issue of appointments, would result in a major increase in the effectiveness of out-patients. Urgent cases could continue to be referred by phone or by marking the referral form appropriately. Consultants or their staff could then authorise the making of an urgent appointment within the booking schedule.
1.15.5 With regard to the process of issuing appointments, the objective is to provide an effective booking schedule agreed by the relevant consultant. The schedule, which should be automated, would reflect the number of patients to be booked for an individual clinic, the intervals between appointments, the ratio of new to return patients and the provision (if any) to be made for very urgent cases without appointment. For the booking schedule to operate with the greatest effect, we consider that all appointments should be issued by out-patients staff. However, where booking systems and the supporting information technology facilitate it, some appointments could be made by other hospital staff within a common booking schedule.

1.15.6 The parameters of the booking schedule should be reviewed regularly, and amended if necessary in the light of experience, to ensure that operational targets for performance of out-patient clinics are attained.

1.15.7 Patients who arrive at out-patients without an appointment should, in general, not be seen since to do so is to undermine the effectiveness of the clinic system. In cases where the issue of a future appointment would not be sufficient, the patient could be referred to the accident and emergency department or seen in the out-patients clinic at a time reserved for urgent cases on the booking schedule.
1.15.8 We are convinced that the issue of specific appointment times, rather than block-booking of patients, is the appropriate method of organising out-patients. While accepting that patients may not always be seen on time or may not arrive at the appropriate time, the issue of specific times for attendance is the minimum to be expected of a patient-centred service which is, in a very real sense, the "shop-window" of the hospital. Booking times and intervals should be reviewed regularly to ensure that they are appropriate. Average delays experienced by patients should be reviewed and measured regularly by the Out-Patients Services Group as a key indicator of the performance of the service. Such information should be brought to the attention of individual consultants on a regular basis.

1.16. Failure of Patients to attend for Scheduled Appointments

1.16.1 Approximately 20% of patients currently fail to attend for appointments, the majority of whom do not notify the Out-Patients Department prior to the time of their appointment. Such a high percentage of non-attenders probably reflects the delay in out-patient appointments in some specialties as well as aspects of the present organisation of out-patient services.
Dear Mr. Kennedy,

It is clear that the Group you are presently Chairing has been established because of perceived difficulties within the Health Service and the composition of this Group suggests that the concern relates principally to the hospital end of the service.

At present, perceived problems relating to the hospital service include:

1. Patients being admitted unnecessarily to hospital beds,
2. Admissions from Accident & Emergency Departments taking up a disproportionate number of beds,
3. Limited bed resources not being used on a priority basis,
4. General Practitioners being unable to admit emergencies directly to hospital and instead having to refer to Accident & Emergency Departments,
5. Acute beds being blocked by chronic or long-stay patients,
6. Inappropriate discharge of patients from hospital,
7. The New GMS Contract leading to excessive demands for hospital services.

I believe our Group should address itself to establishing whether these perceptions are true or false. I believe that this can only be done by the collection and analysis of objective data. Where it is established that there is a problem in any of these areas, then it will be necessary on the same basis to measure the extent of that problem. As each of the major hospitals in Dublin have their own particular patient mix and characteristics, it will probably be necessary to look at data from each of the hospitals.

Some work has been done in relation to the appropriateness of hospital admissions. Several years ago, Dr. Hynes and Dr. Johnson, separately, looked at in-patients in a hospital to determine whether the decision to admit had been appropriate. Although in each instance, the work was somewhat subjective, it did show a significantly high percentage of hospital admissions to be appropriate. More recently, there is to hand the Accident & Emergency Survey which again shows that approximately 90% of all hospital admissions originating from Accident & Emergency Departments were appropriate at the time of the survey. It is important to bear in mind that the closer one comes to 100% appropriate hospital admissions, the more certain one can be that patients who should be admitted are being refused admission. Consequently, the optimum percentage of appropriate hospital admissions is open to some question, but probably lies somewhere in the early 90's.
Consequently, on the basis of these studies that have been done in Dublin hospitals, it would appear that the hospitals are relatively efficient from the point of view of appropriate admissions and that the scope for improvement in this area is very limited.

The foregoing would suggest that the present difficulty at hospital level can only be resolved by:

a) the provision of more acute hospital beds. However, if this was desirable, which is questionable, it is probably unrealistic in the current climate.

b) more effective use of acute hospital beds.

It might be profitable to examine the whole area of use of acute hospital beds. It might be useful to carry out studies to determine whether unnecessary use of acute hospital beds is caused by:

i. patients waiting for tests,
ii. patients awaiting second opinions,
iii. patients who have completed their investigations and treatment but cannot be discharged due to other difficulties (such as nowhere to go).

Again I think it would be important to seek objective data and if problems were identified in these areas, then it would be necessary to measure the extent of the problem. Again it would need to be done on a hospital by hospital basis. In this regard, the survey by Dr. Hynes, which I referred to earlier, which was undertaken in a Dublin Hospital, while identifying that a high proportion of patients who were admitted to hospital had been appropriately admitted, also identified that with approximately 20% of in-patients, there were avoidable delays before discharge. While about half the patients who fell into this category could be classed as longer-stay patients, the other half were in the category of short-stay patients. The work Dr. Hynes did in this regard was carried out approximately 4 years ago and consequently things may have changed since. However, this is an area that could usefully be explored in each of the hospitals and indeed in so far as a similar exercise has been carried out before, it could be completed quite speedily as the "instruments" for undertaking such a study are already available and tested.

Our Group might usefully examine the feasibility of having hostel-type accommodation available in the major hospitals for patients who do not need a high degree of nursing care – something along the lines of the Mayo Clinic in the United States. Further, the feasibility of establishing units of lower complexity for convalescent patients might usefully be examined.

The whole area of long-stay patients blocking acute beds needs to be examined. This would constitute defining what is meant by a long-stay or chronic patient, measuring the extent to which such patients block acute beds and making some assessment of the type of facilities required to move such patients on to a more appropriate care setting. I am aware of a study presently being undertaken by Dr. Catherine Hayes, Registrar in Community Medicine, which examines admissions to one Dublin Hospital for patients over 65 years of age.
3.

It might be useful to meet with both Dr. Hynes & Dr. Hayes to discuss the work they have done in this area and their findings.

The numbers of patients who are attending at out-patient departments or accident & emergency departments, but who are not admitted to hospital, may at times be somewhat of an inconvenience, but they are not the root of the problem and consequently initially excessive time should not be spent examining the situation in this area. What might be usefully considered however, is having separate procedures for hospital admissions of patients referred for same by general practitioners. That is, having some assessment and admissions system separate from accident & emergency departments.

It might be useful to examine in detail the situation in some United Kingdom District General Hospitals to see what the case mix is for such hospitals in relation to hospital admissions coming from accident & emergency departments, emergency admissions referred directly from general practitioners, and elective admissions. Similarly, it might be worthwhile examining the relationship and procedures re coordination etc. that some of the hospitals in the U.K. have with health services in the community. Finally, an examination of the Mayo Clinic type operation, which is highly dependent upon hostel-type accommodation, might usefully be considered.

Yours sincerely,

Brian P. O’Herlihy,
Director of Community Care &
Medical Officer of Health.
Dear Dr. O’Herlihy

Thank you for your very thoughtful letter on the work of our Group and your helpful suggestions as to how we should focus our attention.

Kieran Hickey has sent me a copy of the study carried out by Dr. Hynes which I found extremely interesting and relevant to our work. On the face of it, if one assumes that our conclusions can be extrapolated to other hospitals, it would appear that the scope for improving bed utilisation, while not negligible, is relatively limited. This does, of course, beg the question as to whether there are people outside the community unable to gain access to the hospital system who would be more appropriate users of the service.

It would appear from Dr. Hynes' work that there is some scope for improving utilisation by looking at the provision of extended care or respite accommodation, both for chronically young and elderly people and this could be achieved initially by focusing on the area of discharge planning through the hospital. In this respect, of course, one has to consider the possibility that if additional facilities are provided they would be taken up primarily by people who otherwise would have been cared for at home.

The other area suggested from Dr. Hynes' work would be the elimination of delays caused by the lack of full diagnostic and therapeutic services at weekends and the extent to which these could be minimised by greater use of five-day wards.
I am aware of the work which is now being undertaken within Sub-Group B to get more objective data under these headings (and a number of others) at your initiative. I would hope that the outcome of this would be to enable us to draw firm conclusions in respect of the areas to be prioritised.

I would suggest that your other proposals for areas of examination can and should be taken up in the short term by one or other of the sub-groups currently working and I have circulated a copy of your note to each of the three Chairmen. I think most of your suggestions appropriately fit into the terms of reference of your own working group and should probably be progressed in that forum.

Again, thank you for taking the trouble to write to me in such detail.

Yours sincerely

[Signature]

David Kennedy
1.16.2 We believe that if delays and the level of unnecessary recall of patients are reduced, the problem of non-attenders will also reduce. However, some level of non-attendance is likely and this should be monitored and reflected in the booking schedule. A flexible approach should be adopted in such cases and the Out-Patients Services Group should agree a policy with consultant staff for dealing with these patients. Should patients default on their appointment, they should be offered a further appointment. However, persistent non-attenders should be considered to have discharged themselves from the clinic and their care should be referred back to their G.P.

1.17. Commitment to Out-Patients

1.17.1 The implications for patient care of cancelled clinics and the late start of clinics have already been documented. Problems which are likely to restrict clinic activity, such as staff leave, should be notified to out-patients staff as early as possible to enable bookings to be restricted. On the days on which consultants hold clinics, these clinics should be regarded as the first priority of consultants and their teams. Competing commitments in A & E, theatre and in-house should be kept to the minimum.
1.17.2 We are of the view that many consultants do not have an explicit specific set of objectives for the care of their patients attending the out-patients department. In particular, the re-attendance of the large majority of patients who are return patients may indicate that more structured arrangements for planning out-patient clinics could reduce the volume of attenders and consequent delays for patients, while increasing the benefit of attendance for individual patients.

1.17.3 More senior input into out-patients is necessary to deal with the problems caused by inappropriate re-attenders. The Group recommends that each consultant should prepare a simple patient plan for junior staff to assist them in dealing with each patient. Consultants should consider allocating a short period of time in advance of each clinic to reviewing the case notes of all re-attenders/return patients. As well as easing the waiting time problem, this would also lead to improved confidence and reporting amongst junior hospital doctors. Similarly, prior review of the referral forms for new patients, which we have recommended above, would enable better use to be made of the time available for consultation within the out-patients clinic.
1.18. Information to Patients

1.18.1 Although all hospitals now state that they operate scheduled appointments systems of some type, patients still perceive that they will be treated on a first come/first serve basis. Hospital management must inform the public and referring G.P.s about the correct operation of the system. It must be made clear to patients who arrive early that they will not be seen by consultant staff until the appointed time and that, as a result, some delay will occur.

1.18.2 Hospitals should consider introducing a system whereby all new patient appointment letters give information describing likely tests they will receive, facilities and services available, stating that delays may occur and identifying whom they should contact if they are concerned or dissatisfied with the nature of the services being provided.

1.18.3 As with any consumer service, the best guide to performance is that based on the opinions and experiences of the users of the service. For that reason, we recommend that the Out-Patients Services Group arrange to have regular analysis of patients' experiences and opinions. This would entail routine measurement of low performance compared to the target standards, especially
as regards delays for patients. Similarly, samples of patients should be asked regularly for their views on the performance of the service, covering such issues as delays, comfort and information provided. This should be drawn on in the review and amendment of operational procedures.

1.19. **Staffing**

1.19.1 As well as the need for more senior medical input into out-patients, consideration must also be given to the type and level of other staff employed in out-patients departments.

As a general principle, we recommend that staff should be specifically chosen for assignment to the out-patients department on the basis of their suitability and commitment, including, in particular, their ability to communicate effectively with patients.

1.19.2 Nursing staff currently assigned to out-patients presently spend a large amount of time engaged in administrative duties, regulating the flow of patients to clinics, following up patient records/tests/x-ray results and explaining delays to patients. It is questionable whether much of this activity represents a satisfactory outlet for
expert nursing skills. The authorities at St. Bartholomew's Hospital, London estimated that about 70% of the activity of nurses in out-patients did not require nursing skills or training. We consider that a significant number of nursing personnel in out-patients should be released from these duties through the employment of non-nursing staff as receptionists/hostesses. Such staff, who might have some health care background, would be selected and trained for the particular demands of a busy out-patients department operating to targets set down by the hospital. A greater emphasis should be placed on communicating with the public about delays and on developing the quality of personal service to patients in the Department to which they are entitled. In tandem with such an altered staffing mix, we envisage a more active involvement by clinical nurse specialists in future developments in out-patients departments as outlined in para. 1.22.5 below.

1.20. **Availability of tests/x-ray results**

1.20.1 Procedures must be instituted to ensure that, when a patient attends out-patients, all relevant records are available. At present, delays due to the absence of test results and charts can be attributed in part to the fact that out-patient staff may not be aware of the patient's attendance when arranged by the consultant or ward staff.
This would not arise under our proposals for booking of appointments. Some of the present problems arise due to the fact that clear responsibility is not assigned for ensuring that all relevant material is available for patients booked to a clinic. Such responsibility should be clarified at hospital level, whether this is seen to be the duty of out-patients department staff, consultants' secretaries or medical records staff. However the lead responsibility is assigned, clear procedures should be developed and, ideally, team work on the part of all support staff regularly engaged in servicing discrete groups of out-patient clinics should be encouraged. This should assist in the smooth operation of clinics and facilitate the prompt resolution of any difficulties which may arise. We recommend that the programme of computerisation of both pathology and radiology departments and the introduction of information transmission and retrieval systems referred to in 1.10.3 above should be accelerated.

1.21. Management of Waiting Lists

1.21.1 As already stated, only four of the hospitals covered by this exercise notify consultants of the average waiting time for an appointment in their clinics. Arrangements do, however, exist in all of the hospitals for prioritising appointments for urgent cases. These include
consultant or staff review of all referrals;

consultant or staff review of all referrals marked urgent;

out-patient staff responding to G.P. requests.

1.21.2 It is evident from the data presented earlier that, despite these arrangements, patients frequently experience long delays before receiving a first appointment, particularly in some specialties. Patient dissatisfaction with the present arrangements is, consequently, widespread. While some of these delays may reflect a lack of resources of manpower or out-patient department accommodation, some are also likely to reflect current practice in the organisation of out-patients services. Resource constraints can be addressed effectively only when good practice models are seen to apply.

1.21.3 One of the key elements of good practice is for consultants to be notified regularly of the average waiting time for a routine appointment in their clinics. Furthermore, in order to minimise the disruption caused by non-attenders at clinics, each consultant’s list should be regularly validated where patients are waiting 6 months or more for a first appointment. It is likely that some proportion of these will no longer require treatment, having been dealt with elsewhere or otherwise being no
longer interested in attending. Such cases, besides artificially increasing the average waiting time, directly affect the speed with which other patients who require care can be seen. Validation would require the routine issue of letters to patients waiting 6 months or more and the application of an agreed procedure to deal with those who fail to reply or who state that they are no longer interested in attending.

1.21.4 Significant variations in the average waiting time between consultants and hospitals exist for certain specialties. The Group is of the opinion that the details of the waiting times for a first appointment in all out-patient departments should be circulated to G.P.s in the Dublin region on a regular basis.

1.22. Development of the Out-Patient Service

1.22.1 The Group has already recommended that each hospital set out clear principles of care and operational procedures for their Out-Patients Department. The Group also recommended the establishment of a structure – an Out-Patients Services Group – to oversee the implementation and management of these procedures.
1.22.2 Each hospital should, through the proposed Group and through their consultants, set about identifying ways of making the out-patients department more effective in dealing with patients and so further alleviate the pressure on the hospital's in-patient and day case facilities. The Group is aware of certain hospitals where diagnostic, investigative and routine surgical procedures are carried out in the out-patients department, particularly in the areas such as oncology and diabetes clinics, which might otherwise require admission to a bed.

1.22.3 Hospital-based reviews should consider the manner in which out-patient services can complement and support primary care services. Out-Patient Departments should not undermine the scope of General Practitioners in managing patient care and G.P. access to diagnostic services should be as streamlined as possible.

1.22.4 A significant number of procedures, currently carried out on an in-patient basis or in day-case units, could be performed in out-patients with appropriate organisation, staffing and facilities. Such procedures, with appropriate selection of patients, would enable more demanding cases to be dealt with in both in-patient and day case facilities, thus reducing delays for the patients concerned.
1.22.5 In the course of its review of out-patient services, hospitals, through their Out-Patients Services Group, should consider surveying each of the clinicians to ascertain what further services could be offered to patients in this Department, whether any additional facilities or staff will be required and the likely savings that would result from their introduction. Proper planning and targetting of patients would be crucial if hospitals were to ensure the effectiveness of this expanded service. The rotation of specialist staff, especially clinical specialist nurses, for in-patients departments to out-patient clinics would be necessary. This highlights the need for careful planning of the out-patients workload through the adoption of the inter-related good practice proposals set out in this report.

1.23 Transport

1.23.1 In our Interim Report, the Group stated that the present routine transport arrangements do not cater adequately for the needs of hospitals and that a specific level of service to hospitals be explored between the relevant authorities.
1.23.2 We further recommend that hospitals review the booking system for appointments to ensure that patients travelling to the Dublin Hospitals from outside the Eastern Health Board area are given suitable appointment times. In addition, hospitals should endeavour to ensure that, where patients are required to wait for some time before being collected by the ambulance service, they are aware of snack bar and other facilities provided in the Department for their comfort.
Table 1
Out-Patient Statistics - 1989

<table>
<thead>
<tr>
<th>Hospital</th>
<th>New</th>
<th>Return</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaumont</td>
<td>18,383</td>
<td>59,466</td>
<td>77,849</td>
</tr>
<tr>
<td>Mater</td>
<td>20,758</td>
<td>71,091</td>
<td>91,849</td>
</tr>
<tr>
<td>J.C.M.H.</td>
<td>8,373</td>
<td>28,931</td>
<td>37,304</td>
</tr>
<tr>
<td>Meath</td>
<td>6,217</td>
<td>26,003</td>
<td>32,220</td>
</tr>
<tr>
<td>St. Vincent’s</td>
<td>14,041</td>
<td>53,436</td>
<td>67,477</td>
</tr>
<tr>
<td>St. James’s</td>
<td>18,652</td>
<td>84,906</td>
<td>103,558</td>
</tr>
<tr>
<td>Adelaide</td>
<td>7,053</td>
<td>24,931</td>
<td>31,984</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>93,477</td>
<td>348,764</td>
<td>442,241</td>
</tr>
</tbody>
</table>
# APPENDIX A

## Illustrative Statement of Out-Patients Standards

<table>
<thead>
<tr>
<th>Episode of Care</th>
<th>Target Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appointment</strong></td>
<td>An appointment should be given within 10 days of request, with opportunity for alternative date.</td>
</tr>
<tr>
<td></td>
<td>First non-urgent appointment to be given within 12 weeks of referral.</td>
</tr>
<tr>
<td></td>
<td>No appointment to be cancelled more than once, and new appointment to be given at once.</td>
</tr>
<tr>
<td><strong>Consultation</strong></td>
<td>Patients should be treated with courtesy by all staff.</td>
</tr>
<tr>
<td></td>
<td>Patient should normally be seen within 30 minutes.</td>
</tr>
<tr>
<td></td>
<td>The patient's notes, complete with relevant reports, should be available.</td>
</tr>
<tr>
<td></td>
<td>No patient should be seen by an SHO alone unsupervised.</td>
</tr>
<tr>
<td><strong>After Consultation</strong></td>
<td>A clear explanation of condition and options for treatment on offer be given to patient.</td>
</tr>
<tr>
<td></td>
<td>A clear explanation be given to patient as to the next step.</td>
</tr>
<tr>
<td></td>
<td>Preventative and health promotion measures to be discussed with patient.</td>
</tr>
<tr>
<td></td>
<td>An appointment be given to patient, if follow-up is decided, before patient leaves.</td>
</tr>
<tr>
<td></td>
<td>The substantive reports to the referring G.P. should be by a Senior Clinician.</td>
</tr>
</tbody>
</table>
Dublin Hospital Initiative Group

Draft Report on In-Patient Waiting Lists
2.1 Introduction

2.1.1 Our Group was established primarily to provide support to the Dublin acute hospitals to operate with maximum effectiveness in balancing the various elements of their workload and in discharging their obligations to different categories of patient. In particular, there was concern that the Accident and Emergency workload was preventing an appropriate level of admission of elective patients, commensurate with patient need and the resources of the hospitals to fulfil their regional and specialty functions.

2.1.2 In our Interim Report, submitted in June 1990, we made various recommendations to increase the effectiveness of the management of patients presenting at Accident and Emergency departments. We also recommended changes in the management of admission and discharge for elective patients. In our report on geriatric services, we propose developments in arrangements for the acute management of geriatric admissions. All of these recommendations would have the effect of reducing the level of inappropriate usage of acute hospital beds, thus facilitating admission of those patients requiring such facilities, particularly patients on waiting lists.
2.1.3 The Group decided that, because of the importance of ensuring that patients have access to necessary treatment within a reasonable time and because of the level of public concern at waiting lists, a special review should be undertaken of arrangements in the Dublin hospitals for dealing with in-patient waiting lists. A Sub-Group was established with the following terms of reference:

- to examine the numbers, categories, priority status and average waiting time of patients on the in-patient waiting list;

- to examine the methodology for placing persons on the waiting list and the frequency and method of review of those on such lists;

- to develop protocols for regular monitoring and validation of the waiting list;

- to develop strategies designed to clear waiting list backlogs efficiently;

- to identify the contribution of computerisation in achieving the above objectives.
2.1.4 To assist the Sub-Group in its work, a questionnaire was issued to each of the admitting consultants in the Dublin hospitals covered by our study. This questionnaire, the responses to which are outlined below, covered current practice on the part of consultants in the management and review of waiting lists and general strategies to improve waiting times for treatment. In addition, members of the Sub-Group visited the Inter-Authority Comparisons and Consultancy at the Health Services Management Centre, Birmingham and the Department of Health Waiting Times Unit, London to discuss experience and practice in relation to waiting lists in the U.K..

2.2 Our Approach to Waiting Lists

2.2.1 Public, political and professional concern about waiting lists relates primarily to the possible impact on patients of having to wait for treatment. Such impact could include:

(a) Varying levels of pain, discomfort or anxiety which treatment could remove or reduce;

(b) Deterioration in the patient's condition, increasing the complexity of treatment or reducing the prospects of recovery;
(c) Irrecoverable loss of patient income because of incapacity or, in the case of children, delays in physical and educational development;

(d) Pressure on alternative and inappropriate forms of treatment, such as Accident and Emergency Departments.

2.2.2 In all of the above-mentioned areas of concern, it is the length of time for which patients await treatment which determines the likelihood and extent of any negative consequence. Public concern is often focussed on the number of patients on waiting lists for treatment. Such figures are meaningless in isolation from the throughput of the service. The proper focus of concern should be the length of time patients spend on waiting lists, the severity of their condition, trends in waiting times and variations between specialties and conditions. For the purposes of this report, therefore, our priority attention is focussed on waiting times and ways of reducing excessive delays, with special emphasis on conditions likely to be adversely affected by long waiting times.

2.2.3 Concern about waiting lists represents a pressure point which may result in crude indices being regarded as indicative of the need for additional resources. If the best possible use is to be made of available resources, it follows that any indicators of delay in patient care should
be accurate and appropriate. Accordingly, waiting times on properly managed and regularly reviewed waiting lists, allied to systematic review of the efficiency with which in-patient treatment resources are used, should be the basis for allocating resources within and between hospitals where the objective is to improve access to elective treatment. Our recommendations in this report are designed to meet these criteria.

2.2.4 It would be widely accepted that an appropriate objective for hospital services is to provide access to necessary treatment in the minimum time possible. It is, therefore, not unreasonable to establish targets for waiting times as a guide to performance. For example, the objective of policy in the U.K., where waiting lists are perceived to be a greater problem than in Ireland, is to reduce to the greatest extent possible the number of patients waiting more than twelve months for treatment and to ensure that, by October, 1992, no patient will be required to wait more than two years for admission. While such general targets are valuable as a guide to action, our concern is that acceptable waiting times should reflect the nature of the condition to be treated. For some cases, waiting times of more than a few weeks may be unacceptable. In other cases, such as some forms of cosmetic treatment, very lengthy delays may be acceptable.
2.2.5 Waiting time for access to necessary treatment is the appropriate focus of policy concern. It is important to clarify that such waiting times should be measured in respect of conditions and patients who are appropriate to be treated immediately, should treatment facilities be available. There are many patients who are diagnosed as requiring investigation or treatment but whose condition is such that they could not be treated immediately even if an immediate admission could be arranged. They should not be included in calculation of waiting lists or waiting times. These include patients suffering from chronic conditions who require periodic review and treatment and who are scheduled for admission at regular intervals. For other patients, their general state of health may make treatment impossible or undesirable in the short term. Such cases should not be included in the calculation of waiting lists when waiting times are a legitimate focus for concern.

2.3 Waiting Lists in Dublin

2.3.1 There is considerable public and professional concern at waiting times for elective treatment in Ireland and in the Dublin acute hospitals in particular. Such waiting times, and the phenomenon of appointments being cancelled as a result of pressure from emergency admissions, were, as mentioned above, part of the context within which our Group was established. Furthermore, in 1989 earmarked funding
was made available to increase the availability of treatment in a number of specialties, especially orthopaedics, ophthalmology and E.N.T., where delays were regarded as unacceptable.

2.3.2 In order to establish current problems and perceptions regarding waiting lists in the hospitals covered by our remit, questionnaires were issued to 240 admitting consultants in these hospitals. Cardiac surgery was excluded from our survey because of the separate review of waiting lists in this specialty which was being carried out by the Department of Health. Consultants were asked for details of current waiting times, practice in relation to management of waiting lists and their ranking of difficulties in dealing with problems of waiting time. Replies were received from 162 or 67.5% of the consultants contacted. We wish to record our appreciation of the assistance given to us by the many consultants who responded to our survey.

2.3.3 Of those replying, 139 or 86%, said that they reviewed their waiting lists regularly. Of those who stated that regular reviews took place, 102 or 63% said this occurred at intervals of one month or less, while a further 31 or 19% said reviews took place at intervals of not more than three months. The management of waiting lists was reported
by 108 or 66% as being a matter for hospital staff, including ward staff, while 33 or 20% said they maintained the lists themselves and a further 21 or 13% said that waiting lists were maintained both by themselves and by hospital staff.

2.3.4 Of those responding to the questionnaire, 84 or 52% said that they used a formal scoring system in reviewing patients on their waiting lists, 49 or 30% said that they reviewed patients at out-patients clinics, 25 or 15% said they carried out such reviews as a result of G.P. contact, while 43 or 27% said that they established patients' continued wish to be treated as a method of reviewing their lists.

2.3.5 Consultants were asked to rank in a semi-quantitative manner the relative importance of a number of factors which affect their capacity to deal with patients on their waiting lists. Of the 162 consultants who responded to the questionnaire, 123 or 76% said that access to beds was a dominant or major factor in such difficulty; 33 or 20% identified access to theatre facilities as a dominant or major factor; 36 or 22% identified staffing levels as a dominant or major factor; 36 or 22% and 40 or 25% identified access to one-day and five-day wards, respectively, as major or dominant factors in their
difficulty in dealing with waiting list patients, while 59 or 36% identified difficulties in discharging patients who no longer require acute hospital care as a dominant or major factor in their problems. It follows that the level of availability of in-patient facilities and the efficiency and effectiveness with which such facilities are used are seen by consultants as central to the prompt treatment of patients requiring care.

2.3.6 The responses to this questionnaire varied by specialty and by hospital. Analysis of the responses by specialty showed no significant variations by specialty in reported frequency of review or the extent of consultant involvement in review of lists. Formal scoring systems were most frequently used as a method of review by general surgeons and were most widely used in such disciplines as neurology, urology, vascular surgery and gastroenterology. Confirmation of a patient’s wish to be treated was reported as a method of review by a minority of consultants in a wide range of disciplines.
2.3.7 Access to beds was widely reported to be a significant problem in dealing with waiting list cases. Only in ophthalmology did it appear not to be regarded as a significant problem. However, access to theatres was reported as a major problem in ophthalmology and also in neurosurgery. Staffing levels were regarded as a major problem in gynaecology, while difficulties in discharging patients was regarded particularly seriously in geriatric medicine, neurosurgery and gastroenterology.

2.3.8 Details of current waiting lists and average waiting times were sought from all admitting consultants. Consultants were asked to categorise their waiting list patients as urgent or non-urgent and, if possible, to distinguish between major, intermediate and minor treatments. Approximately 60% of those replying were in a position to reply, in whole or in part, to this question. Of these, 25 consultants reported that they had no waiting lists or operated primarily an ambulatory care service. The responses from those consultants identifying their waiting lists under some or all of the headings are summarised as follows:
<table>
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<th></th>
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2.3.9. There was considerable variation by specialty in the waiting times reported. Cases regarded as urgent involving major procedures were generally admitted in less than two weeks but delays of 20 weeks or more were reported in general surgery, orthopaedics, urology and vascular surgery. Urology and vascular surgery waiting times were very significantly greater than the average in the other categories of urgent treatment, with vascular surgery significantly skewing the average waiting time in the urgent but minor treatment category. Long waiting times for unclassified urgent cases were reported in E.N.T., plastic surgery and gastroenterology. Long average waiting times were reported for non-urgent cases in urology, E.N.T., endocrinology and orthopaedics.
2.3.10 Our survey reveals that the vast majority of consultants recognise that systematic review of waiting lists is important. It is encouraging that so many report at least some structured arrangements to carry out such reviews. However, it is clear that a formal policy of active validation of waiting lists at regular intervals was not in operation in any of the hospitals covered by our remit. There is a clear acceptance on the part of admitting consultants that the efficient management of cases is central to the achievement of acceptable waiting times for admission of patients. It is clear that some resource constraints are perceived by consultants to limit the extent to which waiting list problems can be addressed.

2.3.11 It must be pointed out that our remit did not extend to the many specialist hospitals in the Dublin area which provide services of a type where high levels of elective workload apply. In our analysis and recommendations later in this report, we make proposals which are applicable to the management of waiting lists and waiting times generally, and not only in the particular hospitals covered by our terms of reference.
2.4 The relevance of U.K. experience

2.4.1 Waiting lists have been a dominant issue in public debate about the operation of the hospital services in the U.K. for some time. Public concern at this issue resulted in the launch of a Waiting List Initiative in July 1986 by the U.K. authorities. Central, ear-marked funding has been made available since then to deal with particular problems, especially problems of patients waiting very lengthy periods for necessary treatment. Including sums committed for the current year, a total of £154 million has been committed to the waiting list initiative since 1986. Despite this investment and continuing attention, the numbers awaiting in-patient treatment on 30 September 1990 had risen by 2% over the previous twelve months, while those awaiting day-case treatment had risen by 11% over the same period. However, the numbers awaiting in-patient treatment for twelve months or more had fallen by 6% in that period, reflecting the particular focus on long wait patients.

2.4.2 Significant variations exist in the extent of the reduction in waiting lists and waiting times between regions and districts within the National Health Service. In particular, very substantial progress has been made in selected, difficult waiting list problems which have been addressed by a management team, led by John Yates of Inter-Authority Comparisons and Consultancy. This team was
asked to review waiting list and waiting time problems in 22 of England's health authorities with particular waiting time problems. Within these districts, 43 individual specialty waiting lists were selected because of their particular problems. These 43 cases alone represented 10% of England's in-patient waiting lists and 16% of long-wait patients (waiting more than one year). Between December 1988 and March 1990, in-patient waiting lists in these 22 districts fell by 17% and in the 43 specialties selected for particular attention, by 26%. More significantly, the number of patients waiting for twelve months or more fell by 37% in the districts and by 49% in the specialties highlighted. This was against the national trend since, in the remaining 168 English health authorities, the number of long-wait patients rose during 1989.

2.4.3 As a result of this experience, the I.A.C.C. were asked by the U.K. authorities to look at the worst 100 surgical waiting lists in England using the same approach. This exercise, conducted in 1990/91, followed the same general approach as the earlier initiative. The waiting lists selected represented 40% of the long-wait patients in England. By September 1990, the number waiting twelve months or more on these 100 selected waiting lists had fallen by 33%, again in contrast to results achieved elsewhere. Part of the measured reduction was achieved by removing, through validation, patients who were not, in fact, waiting for treatment as indicated on the waiting lists.
2.4.4 While better than average improvements could reasonably be expected from any exercise focussed on worse than average waiting list problems, the scale of the improvement, relative to the national average, clearly suggests that there is much to be learned from the experiences of the I.A.C.C. team. For that reason, representatives of the Group visited the I.A.C.C. in Birmingham and also the Waiting Times Unit of the Department of Health in London. The conclusions and recommendations outlined in subsequent paragraphs draw on that experience and we wish to record our gratitude to the I.A.C.C. in particular for their assistance in sharing with us the fruits of their experience.

2.4.5 The general approach taken by the I.A.C.C. study team in analysing waiting list problems involves a number of stages:

(a) Formal validation of waiting lists to remove patients who are not, in fact, awaiting treatment;

(b) A detailed examination of the content of the waiting list, covering patient details and treatment requirements;

(c) Review of changes in routine activity levels with a view to identifying bottlenecks within the hospital system;
(d) Comparison of performance and activity levels with national trends by specialty;

(e) Discussion with consultants and hospital managers of an interim report reviewing findings;

(f) Preparation of an action plan to deal with problems with, in the case of the I.A.C.C. initiative, allocation of a proportionate share of the national fund provided for waiting list measures tied by contract to specific targeted improvements.

This approach seems entirely applicable in an Irish context.

2.4.6 The re-allocation of resources may be essential to achieve significant improvements in waiting times in particular specialties at particular locations. However, the national experience in England suggests that the allocation of additional funds to a service is not of itself sufficient to ensure improvement in performance. By contrast, the specific contracts in the districts and specialties reviewed by the I.A.C.C. linked additional resources to specific targets for improvement in activity and waiting
times. The contracts were based on rigorous assessment to ensure that additional resources were, in fact, required to secure improvements. This process involved ensuring that waiting list and waiting time figures were thoroughly validated and presented a real picture of the situation. Furthermore, a base line workload measure was agreed in the light of activity levels over the preceding three or four years, and this was compared with the levels of activity to be expected from similarly staffed and competent units elsewhere. Only when this process suggested that additional resources would be required was funding provided, and then in a way which ensured that achievement of the targets led to distribution of additional funds.

2.4.7 The Group is satisfied that these steps in the review of waiting lists constitute an effective model of good practice. In the following paragraphs, we make specific recommendations as to how this good practice model should be applied within the context of the services which we have reviewed in Dublin. We make these recommendations in the light of the conclusion by the I.A.C.C. that the reasons so many patients waited so long for treatment in the areas of study were: a lack of accurate information on the numbers and types of patients awaiting treatment, maldistribution and poor targetting of existing resources and inefficiency in certain aspects of the organisation of hospital activity.
2.5 Monitoring and validation of waiting lists

2.5.1 It is essential that action to deal with unacceptably long waiting times should be based on sound information. Where waiting times are significant, the underlying needs of patients may change. Unless waiting lists are reviewed to take account of such changes, they rapidly become worse than useless as a guide to need or action. We recommend that comprehensive, standardised information be maintained and reviewed by each hospital concerning the numbers and types of patients awaiting admission. Such information, which should be capable of being used in appropriate comparative analyses of waiting times, should (a) clearly distinguish those patients with a planned re-admission from those clearly awaiting an appointment and (b) indicate priorities in terms of urgency.

2.5.2 Of the 162 consultants who replied to our questionnaire, only 43 said that they established patients' continued need or wish to be treated as a method of reviewing their waiting lists. The I.A.C.C. have provided examples of the effects of validation of lists which are not regularly reviewed. The validation of the largest single surgical list in England in 1989 resulted in only 35% of the 4,000 names on the list remaining after removal of the names of patients who had died, moved away or been treated
elsewhere. The need for a clear policy in regard to validation is further indicated by such examples as that of a general surgical waiting list whose patients were written to in two successive years where, on both occasions, the names of all of the patients who had failed to reply were left on the waiting list. It is clear that regular validation of waiting lists is the exception rather than the rule in the areas of difficulty with waiting lists in England and the same is true of Irish hospitals.

2.5.3 Validation of waiting lists can be carried out either (a) through postal review on a particular date to confirm their wish to remain on the waiting list, or (b) by clinical review involving direct contact between patients and medical staff. It is clear from our survey that both methods are employed to varying degrees within the Dublin hospitals. We recommend that validation to establish meaningful waiting list data be adopted as a firm policy in each hospital and that such policies ensure that appropriate management and clinical action is taken on foot of such reviews.
2.5.4 **Postal reviews** can be carried out in bulk or, as part of an ongoing review process, whenever patients reach the point where they have been on the list for a specified period. We recommend that, where this does not already happen, hospitals should immediately carry out a bulk postal review of patients who have been on a waiting list for more than an agreed period of time. The period should relate to the nature of the condition but all patients waiting twelve months or more should be subject to review. Responsibility should be clearly assigned to one staff member to manage the review and to ensure that appropriate management reports are produced. It would be the responsibility of this person to agree the protocol for the review with the consultants concerned. Based on the I.A.C.C. experience, we outline below the main elements to be included in such protocols.

2.5.5 Because of the importance of adherence to a clear protocol in securing the benefits of validation, we feel it appropriate to outline details of the steps which are necessary to be taken in such a review. These are summarised in Appendix A. The first stage is to compile a list of all of the patients on each waiting list who meet the criteria for review in terms of their length of time awaiting treatment (and excluding planned review patients or those with booked dates for admission). An agreed
letter, on the lines given by way of example in Appendix B, should then be issued to these patients with a request for a reply within two weeks. Patients who respond indicating their wish to be treated should have their records noted accordingly, with any changes in patient details that may have arisen.

2.5.6 If a reply is not received within four weeks of issue of the letter, a second letter should issue or, if possible, telephone contact should be made with the patient. If this again fails to evoke a response, the consultant should be informed, requested to review the patient's notes and requested to approve the issue of a letter to the referring G.P. advising that the patient's name has been removed from the list. In the event that consultants do not respond to the latter request within a stated period, hospital policy should authorise the issue of such a letter to the G.P.

2.5.7 Where a patient responds indicating that they have already had the operation or where the hospital are advised that the patient has died or has left the country, this should be noted in the patient record and the name should be removed from the list. Where a patient indicates that they are no longer interested in treatment, the consultant should be asked to review the case notes and, unless the
contrary is indicated, the patient's G.P. should be advised of the patient's response and that the name will be removed from the waiting list unless the G.P. advises to the contrary within two weeks. If a response is not received from the G.P. within that period, the name should be removed from the waiting list and the details recorded in the case notes. In the event that letters are returned by An Post, the patient's G.P. should be advised of this fact and that their name will be removed from the list unless the G.P. indicates within two weeks, with details of new address, that the patient is still awaiting treatment.

2.5.8 It is imperative that clear procedures are followed in dealing with non-responses and indications of loss of interest in pursuing treatment. Without clear guidelines to action, the beneficial effects of validation will be lost. The person assigned responsibility for managing the review process should produce regular reports indicating the status of the review and the numbers of patients responding in various ways, together with the action taken on foot of their response. These reports should be reviewed by hospital management and consultants at regular intervals.
2.5.9 We recommend that, on completion of this comprehensive review and validation of current waiting lists, arrangements should be made by each hospital for the on-going review and validation of lists. This could take the form of either (a) bulk postal review on particular dates each year or, (b) could be spread over the year as patients reach an agreed threshold of waiting time on particular lists. It should be a key responsibility of a designated hospital staff member, either management representative or consultant, to ensure that the hospital's policy on review and validation is followed by all departments.

2.5.10 The on-going review and validation of waiting lists could be based on a clinical review, under which patients awaiting treatment for designated periods would be called for an out-patient appointment. During this appointment the consultant would be in a position to establish the continued need for treatment and to review the prioritisation of patients on waiting lists. Out-patient clinics could be organised specifically to deal with review of waiting list cases or such reviews could be carried out during designated times in routine out-patient clinics. Where patients fail to attend for appointments for review clinics without prior notification, they should be notified
in writing that their names have been removed from the waiting list and their G.P.'s should also be informed. Clinical review is particularly appropriate where the numbers awaiting treatment are manageable and where changes in underlying condition and appropriate treatment might be anticipated. It is also a most effective way of preparing for any special initiative designed to increase activity in the specialty concerned with a view to reducing waiting times.

2.6 Scheduling of Activity

2.6.1 When the dimensions of the waiting time problem are clearly established, through the validation measures proposed above, it is then necessary to consider how admissions can be arranged to reduce waiting times. We recommend that hospitals target waiting lists by ensuring that:

(a) explicit account is taken of waiting times in scheduling admissions, including theatre lists;

(b) specialty teams have reasonable activity targets to guide their attempts to minimise waiting by patients;

(c) the greatest possible use is made of alternative modes of care, especially day care.

The implications of these strategies are set out below.
2.6.2 Priority for admission to hospital is, rightly, regarded as a function of medical need. However, apart from emergency admissions and those non-emergency referrals whose condition is regarded as urgent, judgements must be made about the rank ordering of patients for admission. English experience suggests that specific regard may not always be had to waiting times as an element in the making of judgements as to priorities for admission. Where patients have been waiting for more than an agreed target period, and in most cases certainly for more than twelve months, we recommend that this fact should be given particular weight in the assessment of relative need. For the majority of patients for whom a slight delay in admission would not prejudice their treatment, an increase in average waiting time should be acceptable if it facilitates the admission of patients who have been waiting more than a target period.

2.6.3 In particular, admission of surgical patients in strict order of clinical urgency may consign patients with significant but less urgent conditions to indefinite waits. Such a strategy is unacceptable. Furthermore, it is unlikely that theatre time will be used efficiently if only urgent, major cases are scheduled for operating lists. If, however, a mixture of cases is planned for operating
sessions, those waiting long periods for relatively minor treatment can be accommodated without significantly affecting access to treatment by patients with more serious conditions. Over a period of time, such a strategy should enable waiting times for surgery to be kept to acceptable levels.

2.6.4 In addition to scheduling practices, the organisation of clinical activity can significantly affect throughput and, therefore, the relative availability of treatment. We recommend that hospitals should take steps to establish whether their activity levels, having regard to case mix, are broadly comparable with the productivity levels of similar services in other locations. Clearly, staffing levels, support services and bed availability must be taken into account in making such comparisons. When this is done, any significant variations in activity levels should be a matter for review. Where such comparisons indicate scope for increasing throughput, appropriate action could significantly increase the availability of treatment, thus reducing waiting times.
2.6.5 The data required to make such comparisons are not readily available. Meeting this information requirement would, in our view, be an important task for improving the efficiency of hospital management for the future. However, a start can be made drawing on the work of the I.A.C.C. in England. Based on their detailed analysis of activity levels, they have produced suggestions for average workload for surgical firms. An illustrative outline of possible workload targets drawn from U.K. experience is shown in Table 1. While these, or any other targets, are difficult to apply to specific locations, not least because of variations in case mix, they may be of interest in the course of discussion of strategies for action when the protocols for validation of waiting lists, outlined above, have been applied.

2.6.6 The achievement of throughput targets might be frustrated due to difficulties in access to beds or theatre sessions. Staffing problems may also present. Where these are established to to be the cause of less than target throughput, initial consideration should be given to re-deployment of resources within the hospital. If particular specialties have unacceptably long waiting times for patients, the allocation of additional beds or theatre time should be considered where this would not increase waiting times in other specialties above agreed targets. Such re-deployment could be made either on a permanent basis or for a specific period to enable targetted improvements in waiting times to be achieved.
2.6.7 Activity levels and throughput can also be improved by changing the manner in which patients are treated. The particular scope for increasing the level of day surgery is outlined in the following paragraphs. It is only when the scope for re-deploying beds, theatre time and other resources within a hospital have been shown to be impossible, having regard to target waiting times, and when the scope for increasing day case activity has been maximised, that a valid case for resources can be made on the basis of waiting list problems. In short, we do not consider that waiting times, even when validated, of themselves constitute a basis for requests for additional resources by hospitals. The good practice model which we are putting forward extends to ensuring that all possible measures for increasing efficiency and effectiveness in dealing with elective admissions have been employed.

2.7 Specific Strategy to Expand Day Surgery

2.7.1 In our Interim Report last June, we identified the benefits of protected one-day and five-day beds in facilitating elective admissions. To maximise the benefit of these facilities, appropriate selection of patients and careful planning of in-patient activity is essential. When these conditions are met, very significant increases in throughput are possible. The experience of the Dublin hospitals indicate that the benefits can be experienced very rapidly.
2.7.2 The problem of waiting times for patients is particularly concentrated in the surgical specialties. It is, therefore, particularly important that the scope for increasing day activity in surgery should be realised. Day cases are defined as patients who do not stay in hospital overnight but who do need to stay for a short time after a procedure for recovery, typically for a half-day. They are formally admitted to the hospital and, as such, are distinguished from out-patients who come for minor procedures, investigations or consultations and leave as soon as these are over. Day surgery has been introduced in the various surgical disciplines in Dublin but there is scope for development.

2.7.3 Day surgery is of benefit to patients because they are treated sooner than in-patients and are less likely to have admission cancelled at the last minute. They spend less time away from home and, through development of specialised facilities, receive high-quality care. Indeed, the Royal College of Surgeons have stated that "day surgery is in no way inferior to conventional admission for those procedures for which it is appropriate, indeed it is better". (Guidelines on Day Case Surgery, 1985). In addition to patient benefits, day surgery in appropriate cases is estimated to cost 25-30% less than in-patient treatment. As a result, more patients can be treated for any given level of resource.
2.7.4 Given these benefits, it may be surprising that the extent of day surgery is rather less than is possible. A review of day surgery in England and Wales carried out by the Audit Commission established possible targets for the proportion of surgery for twenty surgical procedures suitable for day surgery. These targets were based on both current best practice models within England and Wales and on higher, optimistic target figures derived from the literature. These procedures, and the associated targets, are set out in Appendix C.

2.7.5 If these possible targets are to be achieved, with consequent increases in throughput and reductions in waiting times, a number of requirements will need to be met. First among these is the careful selection of patients, having regard to their medical and social circumstances and the distance they may need to travel following discharge. The appropriate organisation of facilities and staffing will also be necessary. In particular, the identification of specific beds for day surgery is essential and, ideally, designated theatres adjacent to such beds should also be deployed for maximum cost-effectiveness. However, the benefits are still substantial even where sharing of theatres is necessary.
2.7.6 When the extent of true waiting time problems are established for the surgical specialties, we recommend that a systematic review of the scope for increasing levels of day surgery for appropriate conditions should be carried out in the hospitals covered by our remit. Ideally, this review should be carried out on a collaborative basis so that variations in practice can be identified and the benefits of good practice generalised. Increasing throughput by greater use of day surgery should, therefore, be a significant element in hospital strategy to reach acceptable levels of waiting time for patients. This will require review of the facilities available to support safe and effective day surgery based on established good practice.

2.8 Information Technology

2.8.1 The efficient management of waiting lists is a task for which information technology is particularly suited. The maintenance of accurate patient data, the routine validation of waiting lists, the scheduling of admissions, the identification of suitable cases for day surgery and the analysis of trends are all made easier and more effective when suitable computer systems are applied. An
integrated patient administration system is the most appropriate basis for such applications. We therefore recommend that the development of appropriate systems and software to support good practice in the management of waiting lists should be given a high priority in the programme of I.T. development in hospitals.

2.9 Conclusions

2.9.1 We are satisfied that waiting lists and waiting times are a legitimate focus for concern. However, we believe that without careful definition of the problem to be addressed, policies and resources may be directed inappropriately and ineffectually.

2.9.2 The protocols for validation of waiting lists outlined in this report are essential if properly targetted action is to be taken. When valid indicators of waiting times are available, a comparative approach to activity and throughput by specialty is necessary. In particular, the development of day surgery should be promoted vigorously as a contribution to reducing waiting times.
2.9.3 Much of the on-going information required to operate the good practice model in this report can be routinely gathered, analysed and reported on the patient administration systems which are now in place or being developed in our hospitals. What is required is a clear hospital policy which will determine that such information is actively used.

2.9.4 We are struck by variations in waiting times, not only between specialties but as between consultants within the same specialty, and even within the same hospital. We believe that, just as consultants should be regularly advised of average waiting times for their patients for admission, so G.P.s should also be regularly advised of average waiting times. In this way, referral behaviour could reflect the relative availability of treatment.

2.9.5 Waiting lists and waiting times can be used as powerful instruments in the debate over resources. The extent to which additional resources need to be targetted at waiting list problems can be clarified only when all of the elements of the good practice model outlined above are seen to be applied. We are satisfied that significant increases in activity levels and consequent reductions in waiting times can be achieved through improved organisation of in-patient activity and re-deployment of resources.
This table outlines the average workload suggested for surgical firms. Many people would argue there is no such thing as an average firm and, clearly, a surgeon working in a district where he only has SHO support will not produce the same volume of surgery as a colleague in a neighbouring district who has support from senior registrars, registrars, housemen, associate specialists and other middle grade surgeons. The figures in this table provide a starting point for discussion. In some instances the level of medical manpower resulted in a lower figure whereas in others a higher figure was agreed. These workloads are now routinely met in the vast majority of districts where IACC has negotiated waiting list contracts and our studies of past performance from routine data suggest that we might be negotiating higher figures next year.

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<th>DC +</th>
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<td>400</td>
<td>1350</td>
<td>650</td>
<td>100</td>
<td>400</td>
<td>1150</td>
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<tr>
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<td>485</td>
<td>150</td>
<td>1100</td>
<td>400</td>
<td>225</td>
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<td>775</td>
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<td>1250</td>
<td>650</td>
<td>200</td>
<td>200</td>
<td>1050</td>
<td>2</td>
</tr>
</tbody>
</table>

+ The balance between cold admissions and day cases varies considerably between surgeons, but we would expect any increase or decrease in the number of day cases to be compensated for by a similar decrease or increase in the number of cold admissions.

* Sessions done by Consultant him/herself. There may be additional sessions undertaken by juniors (in parallel/twin theatres or by juniors on their own).

Appendix A

Summary of Protocol for Validation of Waiting Lists

A. Initial Review: Bulk Postal Review

List of patients selected for Validation

Standard letter issued to confirm treatment needed

2 weeks for reply

Waiting List Status Confirmed

Note records

Patient dead, gone away, treated elsewhere

Remove Name from List

Not interested in treatment

Refer to Consultant

No response within 4 weeks

1st non-response

New address noted

G.P. notified that name will be removed in 2 weeks

Name removed from list

Patient and G.P. notified of removal of name

B. On-going Review

1. As at A on a fixed date or as individual patients reach a target waiting time on the list.

or

2. Clinical Review at out-patient clinics:

Appointment issued for review clinic

Patient attends

Priority Status Noted

Patient fails to attend

Name removed from list

1st non-attendance

Patient and G.P. notified of removal of name

2nd non-attendance
Appendix B
Sample Letter for Postal Validation of Waiting Lists

Dear Patient

Date as postmark

WAITING LIST REVIEW

You are on our in-patient waiting list. Although we are not, as yet, able to offer you an appointment, we would be grateful if you would complete this questionnaire to update our records. This will enable us to plan admissions as efficiently as possible and to minimise delays in treatment. If we do not hear from you, we may have to assume that you no longer wish to be treated in this hospital.

Please amend any of the following information if it is incorrect. (1)

Name ........................ Date of Birth ........................
Address ........................ Consultant ........................
........................................ Unit No. ....................
Telephone No. H ............... G.P. ...........................
W ........................................

1. Do you wish to remain on the waiting list? YES/NO*

2. If no, please state reason:
   [ ] no longer wish to be treated
   [ ] already treated in another hospital
   [ ] no longer resident at this address
   [ ] other, please state reason

Please return this questionnaire in the pre-paid envelope within the next 2 weeks.

Thank you for your co-operation.

Yours sincerely

(1) (preferably the data to be generated from the hospital's patient administration system).

* Delete as appropriate.
Appendix C

Target Levels of Day Surgery for
Common Procedures

BASING UPON THE AUDIT COMMISSION'S "BASKET" OF PROCEDURES

<table>
<thead>
<tr>
<th>Possible target % treated as day cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper (1) quartile</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>1. Inguinal hernia repair</td>
</tr>
<tr>
<td>2. Excision of breast lump</td>
</tr>
<tr>
<td>3. Anal fissure dilatation or excision</td>
</tr>
<tr>
<td>4. Varicose vein stripping or ligation</td>
</tr>
<tr>
<td>5. Cystoscopy, diagnostic and operative</td>
</tr>
<tr>
<td>6. Circumcision</td>
</tr>
<tr>
<td>7. Excision of Dupuytren's contracture</td>
</tr>
<tr>
<td>8. Carpal tunnel decompression</td>
</tr>
<tr>
<td>9. Arthroscopy, diagnostic and operative</td>
</tr>
<tr>
<td>10. Excision of ganglion</td>
</tr>
<tr>
<td>11. Orchidopexy</td>
</tr>
<tr>
<td>12. Cataract extraction, with or without implant</td>
</tr>
<tr>
<td>13. Correction of squint</td>
</tr>
<tr>
<td>14. Myringotomy, with or without insertion of grommets</td>
</tr>
<tr>
<td>15. Sub mucous resection</td>
</tr>
<tr>
<td>16. Reduction of nasal fracture</td>
</tr>
<tr>
<td>17. Operation for bat ears</td>
</tr>
<tr>
<td>18. Dilatation and curettage</td>
</tr>
<tr>
<td>19. Laparoscopy, with or without sterilization</td>
</tr>
</tbody>
</table>

(1) Based on a sample of 54 DHA's in England 1988/89 (see also appendix 4)

(2) These estimates are based on various sources including published literature and data from other countries

Source: A Short Cut to Better Services, Audit Commission, 1990
Chapter Three

Geriatric Services

To be inserted in the form approved by the Group on
20th December 1990.

It will be stated that this report was submitted to the Minister
on 21st December, 1990 in view of discussions then taking place on
developing services. The provision subsequently made in the
Programme for Economic and Social Progress and in the Budget 1991
will be noted in this footnote.
1. **Introduction**

1.1 In our Interim Report, which was submitted to the Minister in June 1990, the Group identified a range of good practice measures designed to improve the overall effectiveness of the Dublin acute hospital service, in particular, in balancing the demands of elective and emergency cases. While not in a position to determine the question of whether additional resources would be required to implement its recommendations, the Group concluded that the overall priority in resource allocation was to improve the geriatric services both within and without the acute Dublin hospitals.

1.2 Following the presentation of our Interim Report, the Group continued in existence to address a range of issues, including a further detailed examination of the appropriate deployment of resources to the geriatric services. In carrying out this examination, the Group had available to it "The Years Ahead - The Report of the Working Party on Health and Welfare Services for the Elderly" which was published in 1988 and which was accepted by the Government as the basis of policy in relation to services for the elderly. In addition, the Eastern Health Board's response to this report "Services for the Elderly" - a policy document - was also available to the Group.
2. **Demographic Changes**

2.1 An assessment of the appropriate provision to be made for the needs of the elderly should be based on an analysis of the level of demand for services. A number of studies have been carried out in recent years aimed at projecting the population and estimating the numbers of elderly within these projections. "The Years Ahead" makes reference to a number of studies which based their estimates on differing assumptions and base data as outlined in that report. It is clear that, on all plausible assumptions, the number of elderly in the population is set to increase significantly and that the rate of increase in the numbers of women reaching advanced old age is particularly marked.

2.2 "The Years Ahead" also highlights the fact that the increase in the elderly will be most uneven around the country. The National Council for the Aged estimated that the numbers over 65 years of age in the Eastern Health Board area will increase by almost 31% between 1981 and 2006 and that in the case of Dublin county the number of those aged over 75 years is expected to double in that period.

2.3 Because of the scale of this increase, the implications for services are considerable. "The Years Ahead" considered that the objectives of public policy in relation to the elderly should be:
to maintain elderly people in dignity and independence in their own home;

- to restore those elderly people who become ill or dependent to independence at home;

- to encourage and support the care of the elderly in their own community by family, neighbours and voluntary bodies in every way possible;

- to provide a high quality of hospital and residential care for elderly people when they can no longer be maintained in dignity and independence at home.

A broad range of services are required to achieve these objectives, both in the community and in the hospital setting. These are clearly identified in "The Years Ahead".

3. Development of services

3.1 In January 1990, the Government, in recognition of the need to develop further services for the elderly in line with the recommendations of the Working Party on Health and Welfare Services for the Elderly, made available an additional £5 million to the health services. Of the £5 million allocated, £500,000 was retained to assist in the implementation of the
Health (Nursing Homes) Act, 1990. The remaining £4.5 million was allocated so as to enable the health boards to strengthen services for the elderly at home and in the community and was allocated to each board in accordance with their share of the national elderly population. The additional monies have been used to expand home nursing and home help services, to provide day centres and hospitals, to increase the number of physiotherapists and speech therapists in the community and to develop services for the elderly with dementia.

4. **A changing workload**

4.1 The elderly at present account for a very substantial proportion of the demands placed on the acute hospital system. Such demands are likely to grow in line with the projected increase in the elderly population.

4.2 The elderly comprise over 25 per cent of admissions and over 40 per cent of bed days in acute hospitals, although they constitute only 11 per cent of the population. Almost 36% of all admissions through the Accident and Emergency Departments of the Dublin hospitals are aged over 65 years and most of these are referred by their General Practitioners. Of this 36%, 19% are over 75 years of age. An Eastern Health Board survey of A & E practice which was carried out in December 1989 found that 77% of those patients referred aged over 75 years required admission.
4.3 The Group’s Interim Report stated that part of the current difficulties in the hospitals result from a lack of sufficiently flexible strategies to adapt to their changing workload. Most of the general hospitals in Dublin are geared to deal with patients with specific acute illnesses. Such an orientation does not regard the management or care of the elderly patient, who may be admitted with multiple-pathology and whose recovery may be slow, as a core element of the hospital’s work. As a result, the dominant approach to organising the acute hospital system is at variance with a major element of its workload. The provision of appropriate care for the elderly must be planned and managed as an integral and indeed central function of the acute hospital, on a par with planning and managing the A & E workload.

4.4 A low priority has been given to the development of a properly staffed and resourced geriatric service in some of the major acute hospitals in Dublin. This has resulted in large numbers of "inappropriate" patients remaining in the acute hospital when they might have been discharged earlier or been cared for more appropriately either in the community or in an extended care setting. A survey was carried out earlier this year on behalf of the Group to identify all patients who had been over 21 days in the hospitals covered by our work. It showed that 194 patients were regarded as being inappropriately placed in an acute hospital, accounting for 7.7% of all available beds. Of these patients, 145 or 75% were over 65 years of age. 62% of the total over 65 were in Northside hospitals, despite the fact that there are almost twice as many people over 65 years of age on the Southside (including Kildare and Wicklow) than the Northside.
When one considers that one of the primary objectives of public policy is to restore those elderly people who become ill or dependent to independence at home, it is clear that the first priority in the future development of the services for the elderly is properly resourced Departments of Geriatric Medicine. The presence of a consultant in geriatric medicine with appropriate support services, including assessment beds and an effective role in managing a range of services for the elderly, can make a very significant difference to the efficient use of existing acute beds. In hospitals where specialist Departments of Geriatric Medicine have been established, the geriatric department "ensures prompt admission of elderly patients to hospital, specialist diagnosis and treatment, skilled nursing and rehabilitation and, in many cases, continuing support in a day hospital on discharge. Geriatric departments tend to encourage close liaison between domiciliary, community and extended care facilities in the interest of a comprehensive response to the problems of vulnerable elderly people." (The Years Ahead)
4.6 The specialist Department of Geriatric Medicine encompasses

- Out-patient services.

- Access to beds for acute admission of elderly patients with multiple pathology as well as for assessment and rehabilitation, with access to the full range of specialist and diagnostic facilities of the acute hospital so that a comprehensive treatment programme can be instituted.

- A day hospital where all of the services of the acute hospital can be offered to suitable patients on a day basis.

4.7 Transport to out-patients departments and the day hospital is crucial to the success of these two services which can prevent unnecessary admission to an acute bed. Discharge of patients from the acute hospital requires that each physician in geriatric medicine has access to support facilities, including secondary rehabilitation beds and extended care beds.

4.8 "The Years Ahead", in dealing with the subject of the development of Departments of Geriatric Medicine, stated:
"the facilities for these departments need not be additional to those existing in general hospitals. The patients treated by physicians in geriatric medicine are not 'new' patients to the health services. They are a group of patients who were previously treated by general physicians. We consider that there are sound medical and economic reasons for the redeployment of resources for specialist geriatric departments in acute hospitals in recognition of the medical needs of an increasingly elderly population. ... The experience of the existing specialist geriatric departments shows that they restore the overwhelming majority of patients to independent living quickly, reduce admissions to long-stay beds and reduce pressure on other acute hospital beds. For these reasons; the geriatric department is cost-effective by ensuring the most efficient use of scarce resources".

5. **Discussions with Physicians in Geriatric Medicine**

5.1 Following the submission of its Interim Report, the Group established a Sub-Group (Implementation Sub-Group) to oversee the implementation of the best practice recommendations in the Interim Report. The Implementation Sub-Group also gave consideration to the priority developments in geriatric services within the acute hospital setting. The Sub-Group approached this aspect of its remit initially by requesting the physicians in geriatric medicine in Dublin to complete a problem-oriented questionnaire.
5.2 The questionnaire, in addition to requesting details of the existing hospital-based facilities for the elderly, also featured a problem-list relating to structured access to services outside the acute hospital setting and a semi-quantitative scoring system in relation to difficulties experienced with admission and discharge. The scoring system was also supplemented by a brief commentary. Respondents were also asked to list what they considered to be the top three priority service developments. All six physicians in geriatric medicine responded to the questionnaire and, following its receipt, met with the Implementation Sub-Group.

5.3 There was a clear consensus among the respondents in identifying existing problems which related to the need for additional consultant manpower and support staff, the lack of assessment and day hospital facilities, difficulties in accessing extended care and rehabilitation facilities and the inadequacy of the psycho-geriatric service.

6. Consultant Manpower

6.1 We pointed out in our Interim Report that there are six physicians in geriatric medicine for a population of over 1 million in Dublin. This compares extremely unfavourably with the position in Northern Ireland and Wales. All respondents considered that there is a pressing need for the appointment of additional consultants on both sides of the city.
6.2 We have referred earlier to expected demographic changes in the Dublin area in the next two decades and to the increasing demands which this will place on the acute hospitals. The contribution which departments of geriatric medicine can make to the planning, organisation and management of acute hospital services makes a compelling case for the immediate appointment of these consultants. We consider that an effective department of geriatric medicine in a large acute hospital, with appropriate access to support services off-site, requires the appointment of at least two consultants. While there is a clear need for the appointment of additional consultants in South-East Dublin and in St. James's Hospital, the Group recommend that physicians in geriatric medicine should be appointed as a matter of extreme urgency in both the MANCH and the Northside Hospitals (Mater/Beaumont/J.C.M.H.). These appointments should be full-time physicians in geriatric medicine rather than physicians with an interest in geriatrics. The Group also recommend that, in view of the scale of the service need, these appointments should be given priority over all other consultant appointments in the Dublin Hospitals.

6.3 The appointment of consultants alone, without the provision of adequate support staff and facilities, will not have the desired effect of improving the efficiency and effectiveness of services for the elderly. As we have already stated, a range of services are required to allow these consultants to provide a comprehensive and efficient service.
7. **Assessment/Day Facilities**

7.1 Despite the large number of elderly admissions to the general hospitals in Dublin and the high number of elderly patients attending their Accident and Emergency Departments, some of these hospitals do not have Departments of Geriatric Medicine. The advantages of developing such departments have already been highlighted.

7.2 The Department of Geriatric Medicine in St. James’s Hospital has been a particularly successful model. The Group considers that significant progress could be made in the development of geriatric services if each major general hospital had

- a major commitment from at least two physicians in geriatric medicine;
- an acute geriatric assessment unit;
- an active geriatric day hospital;
- an efficient transport system.
7.3 A multi-disciplinary support team providing intensive nursing, occupational therapy, physiotherapy, speech therapy and medical social services would also be a prerequisite. In the case of the South-East Dublin area, such provision should be made on a co-ordinated basis by St. Vincent's, St. Michael’s and St. Colmcille’s Hospitals. The Group therefore supports the thrust of the joint proposals for development in this area.

7.4 Many of these facilities and personnel already exist and cater for many elderly patients. Where proper departments of geriatric medicine exist, these resources can be more effective in avoiding acute admission and in facilitating early discharge. Day hospitals, in particular, enable investigation, treatment and rehabilitation of dependent elderly patients to be carried out without in-patient treatment or at least with short periods of in-patient care.

8. Extended Care

8.1 One of the major problems identified by the physicians in geriatric medicine and also highlighted by the Eastern Health Board in its report "Services for the Elderly" is the clear shortfall in the provision of extended care beds in the Dublin area. The physicians felt that there was an immediate need for approximately 150 places in Dublin, distributed in accordance with current need levels by area, and for a planned increase over the years ahead in line with the demographic trend.
8.2 "The Years Ahead" had indicated that, nationally, there was a significant proportion of patients in extended care who were inappropriately placed. This, coupled with the fact that extended care beds may be accessed in many areas without structured assessment, indicated that some improvement in the availability of extended care beds to those who require them could be achieved. However, the gross under-provision in the Dublin area is such that there is very little contribution to be made by a more intensive management of available places.

8.3 The Group acknowledges that the provision of any additional extended care facilities has major resource implications. However, the projected high proportion of elderly persons in the Dublin area for the next two decades, together with the serious shortage of extended care facilities, is a matter of serious concern for the future. The Group considers that the provision of these additional facilities is a matter of the highest priority. While 85%-90% of patients treated in a department of geriatric medicine are discharged home, the remainder require admission to an extended care place. To ensure that these patients can be discharged to the appropriate setting, it is essential that the expansion of extended care facilities takes place in tandem with the development of departments of geriatric medicine.
9. Rehabilitation

9.1 It is generally accepted that rehabilitation facilities for the elderly should ideally be located on a hospital campus. However, this is not always possible. There are particular problems with the operation of rehabilitation facilities in isolation from the acute hospital in that

- there is no immediate access to diagnostic facilities
- patients need to be stabilised in an acute unit before transfer
- should the rehabilitation programme fail, there is great difficulty in placing the patient in another appropriate setting.

There is also a problem in attracting medical staff to such a programme (but this could be overcome by an appropriate rotation system).

9.2 The Group endorses the recommendations of Comhairle Na nOspideal for greater integration of general hospital and rehabilitation facilities for the elderly but acknowledges that the problems associated with off-site rehabilitation facilities will continue for the foreseeable future. The priority is to provide each department of geriatric medicine with access to sufficient rehabilitation beds to enable it to function efficiently.
10. Psycho-geriatric Services

10.1 The provision of psycho-geriatric services are divided broadly into two main areas, viz.

- services for elderly patients with functional mental illness, and
- services for elderly persons with varying degrees of dementia.

10.2 The report on psychiatric services "Planning for the Future" and "The Years Ahead" form a comprehensive planning framework for the development of these services. While it is generally agreed that the provision of services for elderly patients with functional mental illness should be provided in high support hostels, such hostels have not been provided to a sufficient degree in the Dublin area.

10.3 One of the problems emphasised in "The Years Ahead" and again highlighted in our discussions with the physicians in geriatric medicine was the lack of adequate provision for the long-term care of elderly persons with dementia. If the needs of such patients are to be dealt with in a comprehensive fashion, it is clear that a co-ordinated multi-disciplinary approach is required.
10.4 The Group considers that the recommendations contained in the "The Years Ahead" for the future development of psycho-geriatric services form a concrete basis for this approach. While acknowledging the progress made by the Eastern Health Board in developing psycho-geriatric services, the Group are concerned that development should be accelerated and, in particular, that adequate in-patient facilities are made available for use by the psycho-geriatricians.

11. Conclusion

11.1 We are satisfied that the development of properly structured departments of geriatric medicine with adequate consultant staffing are vital to the efficient management of acute hospital services. While recognising that the majority of patients over 65 years may not require specialist geriatric services and that most consultants will continue to cater for large numbers of elderly patients, the needs of the very elderly with high dependency and multiple pathology are such that a structured approach is needed. That need is all the greater in the Dublin area, given the demographic trends which are already apparent.
11.2 The Group considers that each major general hospital should have a major commitment from at least two consultants in geriatric medicine. Within this target, the immediate need, in the Group's view, is for the appointment of additional consultants in geriatric medicine to the Mater and Beaumont and the Meath/Adelaide and subsequently to Dublin South-East, MANCH/Naas and St. James's. Acute beds for treatment and assessment are already in use for the treatment of elderly patients so we do not consider that additional beds are required. However, additional investment is required to provide day hospital facilities with appropriate multi-disciplinary staffing and transport support. Additional long-stay places - of the order of 150 places - should also be provided, i.e. 50 places for each of the three major catchment areas in Dublin (Dublin North, Dublin South-East and Dublin South-West). The planning for additional consultants and support facilities, including extended care places, should also commence now, in line with the known increase in demand which the hospitals will face in coming years.

11.3 The Group accepts that the overall framework provided by the report "The Years Ahead" provides an appropriate guide for action and the Eastern Health Board's plan covers the areas of priority need for care in the community. The Group welcomes the fact that the needs of the elderly have been recognised by the provision of a development budget in 1990. The Group considers that such ear-marked funding is desirable but feel that the particular needs of the Dublin area, notably the serious shortfall in long-stay places, should be
reflected in the distribution of such funds. Furthermore, the development of properly structured departments of geriatric medicine with appropriate structural links to rehabilitation and long-stay facilities is the vital element in the operation of an effective and efficient service for the elderly at both primary and secondary care levels. Such services must be planned and developed as an integral part of the acute hospital service but their wider contribution to the care of the elderly warrants support from such ear-marked development funds as may be available.
Arrangements for referrals from outside the Eastern Health Board area to Dublin Hospitals

1. Introduction

1.1 Following the completion of the Interim Report and the Report on Structural Arrangements, it was considered that a number of other issues should be examined by the Group. As the number of referrals from outside the Eastern Health Board area to the Dublin hospitals constitutes a significant element of the workload in those hospitals, a Sub-Group of the Group was established with the following terms of reference:

- to examine and consider the extent and appropriateness of current referrals from outside the Eastern Health Board area;

- to review the present arrangements, including transport, for the referral and discharge of such patients;

- to develop protocols for the future organisation of access by referrals from outside the Eastern Health Board area to services in the Dublin hospitals.
2. **Approach to Work**

2.1 The Sub-Group identified a range of data requirements which they considered would help in their examination of this issue. Initially, each hospital covered by the initiative was asked to supply details of admissions/discharges in each specialty from outside the Eastern Health Board functional area in 1989.

2.2 Each hospital was also asked to supply details of such referrals by consultant for a particular six-week period in 1990. It was hoped that the Sub-Group would then be in a position to consider the extent and appropriateness of such referrals. However, although most of the hospitals were in a position to supply details of referrals by specialty in 1989, many did not have a breakdown by consultant readily available.

2.3 In order to identify and review the current arrangements for such referrals, each hospital was also asked to complete a short questionnaire. The questionnaire focussed on the same six-week period in 1990 and the hospitals were asked to indicate
- 3 -

- the numbers discharged to addresses outside the E.H.B. region;

- the problems experienced in discharging these and similar patients;

- the number of bed-days lost because of these problems;

- the current arrangements, including transport, for the acceptance and discharge of such patients.

The questionnaire, which was completed by the Bed Managers, Medical Records Officers and Ward Sisters, also asked for suggestions on how the organisation of such referrals could be improved.

2.4 Finally, the Sub-Group supplied each of the Chief Executive Officers in the other seven health boards with copies of the questionnaire. They were also given the total number of referrals by health board area in 1989 and for the six-week period in 1990. The CEOs were asked for their views on overall access to services in Dublin and on problems which may have been experienced in referring patients to the Dublin hospitals, including those in need of day, diagnostic and O.P.D. treatment.
3. **Extent of Referrals to Dublin Hospitals**

3.1 The information supplied by the hospitals on the volume of referrals in 1989 showed that a total of 19,972 patients were referred to the Dublin Hospitals from outside the Eastern Health Board functional area. This equates to 19.8% of the total number of patients treated in that year. Details of the referrals are given in Table 1. The North-Eastern Health Board referred the largest number of patients, 6,311 (31.6%), followed by the South-Eastern Health Board at 4,818 (24.1%). The results of the survey carried out for the six-week period in 1990 confirmed that the overall referral rate remained at approximately 20% of total patients treated.

3.2 The returns from the questionnaire showed that a total of 2,382 patients were discharged from the Dublin hospitals to areas outside the Eastern Health Board in the six-week period in 1990. Details are given in Table 2. The North-Eastern and South-Eastern Health Boards again had the highest number of discharges with 705 (29.6%) and 558 (23.4%) respectively.

3.3 The returns also identified a range of problems and delays experienced by the hospitals in attempting to discharge these patients to their respective functional areas. These included
- delays in obtaining ambulance/other transport services;

- difficulties in co-ordinating transport with bed availability in the receiving hospitals;

- ambulance services from other health boards only available on certain days of the week;

- difficulties in admitting patients to other levels of care, e.g. long-stay institutions, nursing homes, etc.;

- inadequate community care services in some health board areas prevented early discharge.

3.4 Although all of the hospitals continue to experience some of these difficulties in discharging such patients, none regarded them as major problems. While delays still occur, the number of bed-days lost is minimal. While each of the hospitals stated that no major difficulties are experienced in discharging such patients, most considered that an efficiently organised and co-ordinated transport system would improve the existing situation.
3.5 The hospitals were also asked to indicate the standard arrangements which exist for the acceptance and discharge of such patients, either with particular hospitals or health boards. The returns show that, while most of the hospitals have ad hoc arrangements with other health boards/hospitals for the acceptance and discharge of these patients, no formal structures or protocols are in place.

4. National Role of the Dublin Hospitals

4.1 The acute general hospitals in Dublin are required to play a number of roles in the health care system. The successful balancing of these roles, with their competing demands, is a major challenge to management and to clinical practice. The establishment of our Group reflected, fundamentally, a concern to ensure that this balancing of responsibilities should be as effective as possible.

4.2 In particular, hospitals are required to provide a service to their immediate catchment population in respect of accident and emergency facilities and general, community specialties; to the entire region or a sub-region in respect of particular specialties offered at the hospital; a regional service to patients outside the E.H.B. area where such specialties are not available and, in some cases, a national service where,
within each of these services, a balance must also be struck between emergency and waiting list admissions. In our Interim Report in June 1990, we identified a range of measures to ensure that elective admissions would be protected, to the greatest extent possible, from the impact of emergency requirements.

4.3 Given the demanding tertiary role of the Dublin hospitals, it is clearly desirable that unnecessary admission to secondary care beds should be avoided. Equally, duration of stay beyond what is clinically necessary can directly reduce the availability of specialist services which are in particular demand. In our Interim Report, we recommended approaches to the management of admission and discharge to minimise such negative effects. Similarly, in our report on geriatric services, we have proposed developments to ensure that appropriate and effective responses are made to the growing numbers of elderly patients in acute beds.

4.4 The appropriate management of workload by Dublin hospitals is also of great importance to patients outside the region. In so far as regional services or national specialties are provided to such patients by Dublin hospitals, patient access to these services will reflect the extent to which appropriate use is made of beds in the Dublin hospitals.
4.5 Given the possibility that patients referred to Dublin hospitals may require a period of care for which the specialist facilities of a tertiary referral centre are not required, concern has from time to time been expressed that delay in discharging patients to their referring hospital or region may result in inappropriate use of beds. Our survey of Dublin hospitals indicates that this is not a significant problem. It follows that the main focus for concern in ensuring that patients, whether from Dublin or elsewhere, who require the services of the Dublin hospitals have access to them is the appropriateness of the referrals to the Dublin hospitals. This is considered below.

5. Appropriateness of Referral to Dublin Hospitals

5.1 In our Interim Report, we have recommended procedures designed to ensure that admission and discharge of patients are managed in such a way as to make the most effective possible use of in-patient facilities. Such procedures apply equally to Dublin residents and patients referred from elsewhere. However, particular considerations arise in the case of referral of patients from outside Dublin, since a very significant level of acute general hospital services are provided throughout the country, although clearly many specialist services are not generally available.
Appropriateness in this context refers to the availability of a specialty or service in a Dublin hospital which is not available in the referring area. This may be a permanent feature because of the highly specialised nature of the service. It may also give rise to appropriate referral on an exceptional basis when the service is normally available in the referring region but, by reason of exceptional demand or lack of resources, is not available at a particular time. Furthermore, even where a specialist service, such as a diagnostic facility, is available in a regional centre, clinical indications may require the referral of individual patients to a particular centre in Dublin.

5.2 Apart from such referrals which would be regarded as appropriate on objective criteria, referral can occur in circumstances which are less clearly appropriate. One such pattern arises from the particular relationships developed over time between referring doctors, particularly G.P.s, and consultants in Dublin hospitals. Such referrals could involve by-passing local services which are capable of dealing with the condition referred to Dublin. In addition, individual patients may exercise a choice and request referral to a particular hospital or consultant in Dublin from their referring G.P. Again, such referrals could involve the by-passing of adequate and more local services.
We are not suggesting that patient and G.P. choice should be restricted. However, where conditions are capable of being treated in less specialised centres, their referral to Dublin acute hospitals can be at the expense of the care of the patients, including patients from outside Dublin, whose condition does require the more specialised facilities of the receiving hospitals.

5.3 In order to examine the extent to which these problems may arise, the Dublin hospitals were asked to provide details of referral levels by consultant and by specialty. Unfortunately, a breakdown of referrals by consultant was, in most cases, unavailable. In the time available, a detailed breakdown by specialty was not able to be supplied by all of the hospitals either. From the partial information supplied, it would appear that a substantial proportion of referrals - of the order of 40% - are in respect of specialties which are not formally designated as national or regional services for the referring regions. However, a significant proportion of these referrals would be in respect of treatments and procedures which form part of sub-specialties or particular expertise which is available within the Dublin hospitals, though not formally designated as providing supra-regional services. It is, unfortunately, impossible to measure the residual level of referral which would not be regarded as appropriate according to the objective criteria set out above. However, it is clear that such referrals constitute a relatively minor element - we estimate it to be of the order of 4% - in the activity levels of Dublin hospitals in respect of non-E.H.B. patients.
5.4 While most referrals may be regarded as appropriate by current criteria, the question arises as to whether such levels of referral are necessarily desirable. In particular, we are concerned at the level of dependence on the Dublin hospitals for specialist services which could, in principle, be developed more locally. For example, the level of referral to E.N.T. and Gastroenterology services in Dublin is particularly high. Our measured referral activity excludes services provided in specialised hospitals in Dublin and thus underestimates the level of usage of Dublin hospitals. In the case of such services, where complexity levels do not require super-specialisation and where a significant proportion of procedures can be performed on a day surgery basis, there is a prima facie case for greater development of more local services. Considerations of patient convenience and comfort, particularly in the case of children, would tend to support such a case.

5.5 It is beyond the range of our terms of reference and our information to indicate what services should be re-located. Our findings suggest, however, that there is an urgent need to review the overall level and distribution of activity in specialties where there is currently a high level of dependence on referral to Dublin. In particular, the development needs of the Dublin hospitals for the years ahead
may be met more effectively through investment in secondary care services outside Dublin which are targeted at relieving pressure on acute beds in Dublin. It follows that the national and regional role of the Dublin hospitals must be defined in the context of the overall profile of services to be provided throughout the country. This is a planning and management role at national level which we have already indicated requires urgent development.

6. **Views of other health boards**

6.1 We invited the Chief Executive Officers of the health boards outside Dublin to comment on their general experience in accessing services, both in-patient and out-patient, for their patients in Dublin hospitals. Constraints of time did not permit a detailed examination of the situation on their part. However, the general view conveyed to us was that they did not perceive there to be significant difficulty in having patients referred or treated in Dublin hospitals where this was necessary. Their concern was that maximum use should be made of local services and that these should be developed to reduce the need for referral to Dublin, where this was viable and capable of being resourced. A view was expressed that alternative funding arrangements for the referral of such patients to Dublin would result in a more balanced provision of services.
6.2 A number of specific procedural difficulties with referrals were mentioned, such as the need to refer patients through the accident and emergency department even where prior contact was made with the admitting consultant. Similarly, the possibility of having follow-up of patients carried out locally rather than by recall to Dublin out-patients departments was mentioned as an area for possible improvement.

6.3 An area of particular concern which was mentioned was the cost implication of the treatment of patients referred to Dublin hospitals. While the cost of their treatment within the Dublin hospitals is met from their own budgets, the follow-on costs at both in-patient and community care levels fall to be met by the referring health board. Without adequate planning and liaison arrangements, such costs, even in the case of individual patients, can be very substantial. A mechanism to improve communication and planning would be desirable.

6.4 On balance, it did not emerge that health boards outside Dublin perceived major difficulties with the operation of current arrangements. While specific operational improvements could be made, these did not suggest that present arrangements were unsatisfactory. Overall, there would appear to be acceptance on the part of health boards nationally that a review and definition of the service role of the Dublin hospitals in the context of balanced development of services in general hospitals throughout the country was desirable.
7. **Conclusions and Recommendations**

7.1 Our survey of the Dublin Hospitals has shown that no significant problems occur in delays in discharge of patients referred from outside Dublin. The main focus of our concern, therefore, has been to examine the appropriateness of such referrals which we have outlined in section 5.

7.2 We have already referred to the need to review the overall level and distribution of activity in specialties and the need to define explicitly the national and regional role of the Dublin Hospitals. While these objectives should be met through consultations at national level, the **Group recommend that:**

- referrals by specialty to Dublin hospitals from outside the region should be monitored regularly;

- discussions should take place on a regular basis between hospitals and referring health boards on all aspects of the process of referral and discharge of patients;

- the development of some specialist services which are highly dependent on referral to Dublin in hospitals outside Dublin should be considered as a matter of urgency.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Others</th>
<th>Eastern</th>
<th>Midland</th>
<th>Mid-West</th>
<th>North-East</th>
<th>North-West</th>
<th>South-East</th>
<th>Southern</th>
<th>Western</th>
<th>Total</th>
<th>% admission outside EHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. James's</td>
<td>89</td>
<td>16,383</td>
<td>629</td>
<td>300</td>
<td>1,080</td>
<td>321</td>
<td>1,114</td>
<td>121</td>
<td>309</td>
<td>20,346</td>
<td>19%</td>
</tr>
<tr>
<td>Mater</td>
<td>472</td>
<td>14,767</td>
<td>590</td>
<td>368</td>
<td>1,901</td>
<td>447</td>
<td>612</td>
<td>157</td>
<td>271</td>
<td>19,585</td>
<td>22.2%</td>
</tr>
<tr>
<td>Beaumont</td>
<td>86</td>
<td>15,557</td>
<td>543</td>
<td>369</td>
<td>1,397</td>
<td>849</td>
<td>971</td>
<td>142</td>
<td>485</td>
<td>20,399</td>
<td>23.7%</td>
</tr>
<tr>
<td>Meath *</td>
<td>10</td>
<td>8,387</td>
<td>193</td>
<td>112</td>
<td>171</td>
<td>145</td>
<td>325</td>
<td>92</td>
<td>77</td>
<td>9,512</td>
<td>11.7%</td>
</tr>
<tr>
<td>Adelaide *</td>
<td>7</td>
<td>3,972</td>
<td>105</td>
<td>53</td>
<td>138</td>
<td>63</td>
<td>208</td>
<td>24</td>
<td>82</td>
<td>4,652</td>
<td>14.5%</td>
</tr>
<tr>
<td>St. Vincent's *</td>
<td>72</td>
<td>14,856</td>
<td>688</td>
<td>348</td>
<td>655</td>
<td>425</td>
<td>1,548</td>
<td>98</td>
<td>159</td>
<td>18,849</td>
<td>20.8%</td>
</tr>
<tr>
<td>J.C.M.H. *</td>
<td>23</td>
<td>5,975</td>
<td>67</td>
<td>23</td>
<td>969</td>
<td>128</td>
<td>40</td>
<td>19</td>
<td>41</td>
<td>7,285</td>
<td>17.6%</td>
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<tr>
<td>TOTAL</td>
<td>759</td>
<td>79,897</td>
<td>2,815</td>
<td>1,573</td>
<td>6,311</td>
<td>2,378</td>
<td>4,818</td>
<td>653</td>
<td>1,424</td>
<td>100,628</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

* approximate figures
### TABLE 2

**Referrals from Outside the Eastern Health Board area**

1st October 1990 – 16th November 1990

<table>
<thead>
<tr>
<th></th>
<th>Beaumont</th>
<th>Mater</th>
<th>J.C.N.H.</th>
<th>Meath</th>
<th>St. Vincent’s</th>
<th>St. James’s</th>
<th>Adelaide</th>
<th>Total</th>
</tr>
</thead>
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<tr>
<td><strong>Number of discharges</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>by health board</td>
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<td></td>
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<td>area from 1st Oct.-</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>16th Nov. of</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>patients resident</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>outside EHB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N.E.H.B.</td>
<td>128</td>
<td>219</td>
<td>119</td>
<td>19</td>
<td>103</td>
<td>86</td>
<td>31</td>
<td>705</td>
</tr>
<tr>
<td>N.W.H.B.</td>
<td>103</td>
<td>63</td>
<td>12</td>
<td>24</td>
<td>56</td>
<td>28</td>
<td>15</td>
<td>301</td>
</tr>
<tr>
<td>W.H.B.</td>
<td>33</td>
<td>34</td>
<td>6</td>
<td>13</td>
<td>25</td>
<td>43</td>
<td>2</td>
<td>156</td>
</tr>
<tr>
<td>M.W.H.B.</td>
<td>43</td>
<td>43</td>
<td>6</td>
<td>15</td>
<td>61</td>
<td>36</td>
<td>10</td>
<td>214</td>
</tr>
<tr>
<td>S.H.B.</td>
<td>6</td>
<td>22</td>
<td>8</td>
<td>10</td>
<td>17</td>
<td>15</td>
<td>3</td>
<td>81</td>
</tr>
<tr>
<td>S.E.H.B.</td>
<td>55</td>
<td>79</td>
<td>2</td>
<td>43</td>
<td>225</td>
<td>123</td>
<td>31</td>
<td>558</td>
</tr>
<tr>
<td>M.H.B.</td>
<td>58</td>
<td>73</td>
<td>6</td>
<td>13</td>
<td>107</td>
<td>86</td>
<td>24</td>
<td>367</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>426</td>
<td>533</td>
<td>159*</td>
<td>137</td>
<td>594</td>
<td>417</td>
<td>116</td>
<td>2382</td>
</tr>
</tbody>
</table>

* approximate figure
# Membership of Sub-Groups

## 1. Implementation Sub-Group
- **Professor M. FitzGerald (Chairman)**
- **Professor D. Coakley**
- **Dr. L. Vella**
- **Dr. J. Mason**
- **Dr. J. Ennis**
- **Mr. L. Dunbar**
- **Dr. B. O’Herlihy**

## 2. Sub-Group examining Waiting Lists/Out-Patient services
- **Professor M. FitzGerald (Chairman)**
- **Professor D. Coakley**
- **Dr. B. O’Herlihy**
- **Mr. D. Rogan**
- **Dr. C. Burke**
- **Dr. J. Mason**
- **Mr. D. Magee**
- **Dr. L. Vella**

## 3. Sub-Group examining referrals from outside the Eastern Health Board area to the Dublin Hospitals
- **Mr. L. Dunbar (Chairman)**
- **Dr. G. Hurley**
- **Mr. M. McLoone**
29 January 1991

Dear Member,

I am enclosing for your consideration a copy of that section of the Report on Implementation and Follow-Up of the Group’s Recommendations which relates to the Pilot Projects.

As the final reports are to be circulated on Wednesday, 30th January 1991, it would be appreciated if any comments/amendments could be advised to Paul Griffin or myself at extensions 2661/2662 before 11.00 a.m. on that date.

Yours sincerely,

Shay McGovern
1.5 Areas requiring further research

1.5.1 In the Interim Report, the Group identified the desirability of pilot schemes to develop and test models for structuring the relationship between acute hospital and community services and for developing more effective arrangements to provide rehabilitation services to patients no longer requiring the services of tertiary referral hospitals.

1.5.2 In the case of the proposed study of hospital/community relations, among the issues which, in the light of the Group's analysis of the process of admission and discharge of patients, require further investigation are:

- the factors which influence general practitioners to refer patients to hospital for various types of service;

- the perception of referral behaviour of G.P.s within the hospital system;

- the opportunities which exist to improve liaison with community services, including G.P.s, on admission and prior to discharge;
- the scope for improving physical arrangements for communication between hospitals and community services (liaison personnel, FAX machines, etc.);

- the potential to develop treatment plans for patients which integrate the in-patient and community-based elements of their care;

- the extent to which access to hospital-based resources could enhance the community care of patients and the extent to which specification of community service needs by hospital personnel could enhance more effective use of resources.

1.5.3 The exploration of these issues would require a project which was rooted in a particular hospital and its catchment area and would require an appropriate research design to evaluate the effectiveness of various aspects of the issues to be examined.

1.5.4 The Group became aware of a research project which was being developed in the Department of Preventive Medicine/Cardiology in St. Vincent's Hospital. The study, whose pilot phase has been supported by the Health Research Board, was designed to look at integration of hospital and community services. The focus of the study was patients in designated G.P. practices in the catchment area of St. Vincent's Hospital who are considered by their family doctor to require hospital care or who, otherwise, received hospital care.
1.5.5 The essential question being considered by the Study Group was the natural history of patients who are considered to require admission to an acute general hospital. With that in view, the pilot phase developed methods for recording details on all patients referred to hospital and patients from the study G.P. practices actually admitted to hospital. Having reviewed this material, we are satisfied that the study design can be extended to address the question of what community resources might obviate the need for admission to an acute general hospital or reduce the length of stay in hospital.

1.5.6 We therefore recommend that steps be taken to expand the scope of this study to address, in the light of evidence on the nature of patients' needs, the organisation of services which might obviate admission or reduce length of stay in that catchment area. The active co-operation of a significant number of G.P. practices, the development of patient recording systems in both hospital and general practice within the study and the availability within the catchment area of a broad range of support services should make an action research programme both viable and useful. We recommend that the study team be expanded to enable this wider range of issues to be incorporated in the design. The Eastern Health Board are already actively
collaborating in this study and we recommend that, with the support of the Department of Health, all necessary steps be taken to enable changes in the level and type of community service to be assessed in the interests of a more effective division of labour between primary care and acute hospital care.

1.5.7 The second area where additional research is required relates to rehabilitation of patients. The concern which gave rise to the proposal for pilot arrangements in this area arose from the survey of inappropriately placed in-patients who were awaiting specialist rehabilitation services. The scope of a research project in this area would have particular application to the needs of elderly patients, for example, stroke victims, but would not be confined to the elderly. Areas of particular concern identified in the survey related to limb fitting and patients recovering from skin grafts.

1.5.8 On this basis, the Group "recommended that, on a pilot basis, a comprehensive rehabilitation service geared to the needs of such patients and drawing on the appropriate range of disciplines should be introduced in a special unit. The purpose of the pilot scheme would be to establish the level of intervention which patients with appropriate levels of incapacity require and the most effective means of supplying such services."
1.5.9 In approaching the question of design of a pilot project, the Group were in a position to draw on its experiences when meeting the various hospital staffing groups, including the Physicians in Geriatric Medicine in addition to reports from Comhairle na nOspideal and the Irish Association of Rheumatology and Rehabilitation. The Group, in association with the various institutions involved, drew up an inventory of existing rehabilitation facilities in Dublin and made contact with the Royal Hospital, Donnybrook and Our Lady’s Hospice, Harold’s Cross.

1.5.10 Our information shows that a wide range of rehabilitation facilities exist for the treatment of various categories of patients, including geriatric, spinal injuries, head injuries, multiple sclerosis, spina bifida, rheumatic, stroke, etc. However, although some shared clinical appointments exist, it is clear that, generally, services are provided in stand alone institutions without any formal structural links to the major acute general hospitals.
1.5.11 In the case of geriatric patients, we have already referred to the need for the development of specialist Departments of Geriatric Medicine. In that Chapter, the Group, while acknowledging that the problems associated with the operation of rehabilitation services in isolation from the acute general hospital would continue for the foreseeable future, also endorsed the recommendations of Comhairle na nOspideal for a greater integration of general hospital and rehabilitation facilities. It is the Group's view that the development of specialist Departments in Geriatric Medicine in general hospitals, which would include a rehabilitation unit and day hospital facilities, would represent a significant improvement in the co-ordination and integration of rehabilitation services for the elderly.

1.5.12 In our discussions with the various clinical and para-medical staff groupings, it was represented to the Group that staffing levels and facilities for the treatment of patients in need of rehabilitation services were inadequate. While the inventory of facilities and staffing levels shown on Table 1 indicates that the numbers of staff in some disciplines are low, the Group considers that it is the organisation and direction of rehabilitation services which require priority attention. This applied both to the overall structure of services, as well as to the specific direction of services targeted at specific catchment populations.
1.5.13 The immediate priority is to identify what organisational and staffing changes would most effectively improve the prospects for early discharge of patients from acute beds. This can most effectively be done in the context of a specific acute hospital and its catchment area. One option would be to focus on the Dublin South-East area, where we have recommended an action research programme on acute hospital/community service linkages. There are a number of agencies in this area providing a range of rehabilitation services. However, we leave the selection of the location to the Department of Health and the Eastern Health Board. Our concern is that the existing activity be reviewed and focussed on the particular problems which the Group’s work has shown to apply in relation to rehabilitation of patients who do not require acute hospital care.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>No. of beds (not all currently funded)</th>
<th>Category of patient</th>
<th>Consultant Staff</th>
<th>Physiotherapists</th>
<th>O/Ts</th>
<th>Speech Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaumont</td>
<td>7 (elective)</td>
<td>Neurological</td>
<td>1 x Consultant Physician 1 Grade 3 1 Grade 2 1 head</td>
<td>1 senior 1 basic 1 sessional</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 x Consultant Rheumatology/Rehabilitation 5 senior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 x Grade 3 1 Grade 2 15 basic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. James's</td>
<td>48</td>
<td>Geriatric</td>
<td>2 x Consultant Physicin 2 (WTE 1) 2</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our Lady's Hospice, Harold's Cross</td>
<td>70</td>
<td>Rheumatic</td>
<td>2 x Physician Rheumatologists 3</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Connolly Memorial</td>
<td>28</td>
<td>Geriatric</td>
<td>2 x Consultant Geriatricians 2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 x Grade 3 Geriatricians (shared) 2</td>
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<td></td>
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</tr>
<tr>
<td>St. Vincent's</td>
<td>Day-care only</td>
<td>Stroke, Rheumatic, Neurological, etc.</td>
<td>Rheumatologist 3</td>
<td>2 W.T.E. 1</td>
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<tr>
<td>St. Colmcille's</td>
<td>30</td>
<td>Geriatric</td>
<td>1 x Consultant Geriatrician (shared) 1</td>
<td>N/A</td>
<td></td>
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<tr>
<td>N.M.R.C.</td>
<td>140</td>
<td>Spinal Injuries M.S., Spina Bifida, Neurological, Stroke</td>
<td>2 x Consultants Rheumatology/Rehabilitation 16 7</td>
<td>3.5 WTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Hospital, Donnybrook</td>
<td></td>
<td></td>
<td>1 x Geriatrician 2</td>
<td>1 (sessional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Mary's, Phoenix Park</td>
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<td>Geriatric</td>
<td>2 x Consultant Geriatricians 1</td>
<td>N/A</td>
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<td></td>
</tr>
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</table>
30 January 1991

To Each Member of the Dublin Hospital Initiative Group

Dear Member

I enclose documentation for the next plenary meeting of the Group, to be held in the Conference Room, 4th Floor, Corrigan House, Fenian Street at 5.00 p.m. on Friday, 8th February.

The documents enclosed are:

(a) a draft third report incorporating reports on out-patient services, waiting lists and implementation of our recommendations prepared by a Sub-Committee chaired by Professor Muiris FitzGerald, and on referrals from outside Dublin prepared by a Sub-Committee chaired by Mr. Liam Dunbar;

(b) an outline of a proposed final report from the Group, containing an over-view of our work and conclusions.

In order to assist discussion at the meeting, it would be very helpful to have comments or drafting amendments in advance. It would be particularly helpful to have such suggestions in advance if you will be unable to attend the meeting.

I look forward to seeing you on 8th February.

Yours sincerely

Dermot McCarthy
Secretary
Final Report

Overview of the Work of the Group

Draft Summary of Contents
1. Introduction and Background

2. Significant achievements by the Group

(a) The Group received full co-operation from hospital managements and staff of all grades; access to data and open sharing of views and experiences.

(b) The Group demonstrated that there is a capacity to identify models of good practice in dealing with common problems which can be of general application.

(c) The Group demonstrated that there is a clear willingness to learn from other institutions' experiences and ideas, where tangible benefits can be expected.

3. Strengths of the Group in carrying out its Tasks

(a) The Group consistently applied a multi-disciplinary approach, reflecting the variety of backgrounds of its members.

(b) The Group's work was based on an inter-sectoral approach, with valuable inputs from the areas of public health and general practice, as well as the variety of hospital experience.
(c) The Group was able to bring, and was seen to bring, a degree of independence to the analysis of problems and formulation of responses.

(d) The Group benefited from access to information and support from the Department.

4. **Difficulties experienced by the Group**

(a) There is generally an absence of clearly defined objectives and roles for hospitals and other services.

(b) There is a striking absence of reliable and comparative data on performance, costs, etc. on most key areas of operation of the hospital services.

(c) The extent of certain problems in the hospital system reflects the absence of analytical skills in comparing and evaluating many aspects of activity.
5. General Conclusions

(a) Hospital services are not organised to identify and respond explicitly to many of the key demands placed upon them. Specification of service objectives and targets must be central to planning and management.

(b) The autonomy of the Dublin hospitals has tended to result in an unnecessary and unhelpful degree of isolation.

(c) Planning and evaluation should be based on an integrated approach, embracing acute, community and continuing care services.

(d) There is a policy and management vacuum at national level in relation to some key issues affecting hospital services which needs to be addressed.

(e) Structural arrangements in the Dublin region need radical overhaul, as per our second Report.

(f) Management development, for both lay managers and clinicians, is an urgent priority.
(g) Regular service reviews on a cross-disciplinary and cross-sectoral basis should be a feature of management, pursuing important issues in-depth.

(h) Resource allocation to hospitals and other agencies should be used as an instrument for clarifying objectives and securing performance.

(i) The consumer perspective on performance should receive much more attention through appropriate feedback mechanisms.

6. **Appendix: Overall Summary of the Group’s Recommendations**
Introduction

The Group was established to identify tangible improvements which could be made in the operation of the Dublin hospitals so that patients could have the best possible access to the highest level of care that available resources could provide. The Group’s work must, therefore, be judged on the basis of action rather than analysis. The impact of our recommendations on the day-to-day running of the acute hospital system is, therefore, the main focus of our concern.

Within our terms of reference, our approach to our work focussed very specifically on the areas of greatest difficulty in meeting hospitals’ service roles and in identifying realistic measures to produce improvements. We have been able to draw more general conclusions – about overall structures and policies – based on insights gained from this approach.

The emphasis on identifying workable solutions to common problems was facilitated by:
(a) the fact that our membership included a wide range of backgrounds with many different perspectives on the problems experienced by hospitals and their staff;

(b) on each issue, we consulted in detail with the hospital staff most directly involved and assessed the relative significance of the issues they raised;

(c) we focussed on identifying models of good practice already operating in some centres;

(d) we have framed our recommendations in such a way as to emphasise tangible, measurable steps which can be taken by hospitals.

1.1.4 We believe that implementation of our recommendations is enhanced by the fact that they are grounded in the experience and priorities of the hospital personnel with practical experience of the difficulties which gave rise to our establishment. Furthermore, we have proposed remedies for these difficulties which are based on proven benefits experienced by those already operating the good practice models which we outline. Our conclusions are, therefore, neither academic nor speculative; they derive from the real world of the busy acute hospital. The benefits to be expected from their implementation can be seen and verified.
1.1.5 Despite these structural elements which are conducive to implementation, we recognise that change can be difficult in any organisation. Many of the recommendations which we have made involve changing long-established and widely-observed practices. More importantly, many of them require a change in attitude and orientation. It follows that the issue of a report of itself, no matter how compelling the case for its conclusions, is unlikely to be sufficient to bring about change. We, therefore, recognise the need for a specific implementation strategy. This is not to say that hospital staff have been unwilling to change. On the contrary, we have been impressed by the openness with which our analysis and conclusions have been received and the readiness of hospitals to review and adapt their policies when provided with models of good practice.

1.1.6 In the following section, we outline our experience in regard to implementation of the recommendations of our Interim Report, submitted in June 1990. Drawing on that experience, we subsequently make recommendations on the implementation strategy which should apply in respect of the recommendations contained in this report. Finally, we deal with a number of areas where further analysis and research are required.
1.2 Implementation of the Interim Report

1.2.1 The Interim Report of the Group was presented to the Minister on 22nd June. Recommendations were made under three main headings:

- proposals for more effective management of the hospitals' workload;

- proposals which have resource implications. The main recommendation was that there should be an improvement in geriatric services, both within and without the acute hospital system;

- critique of existing organisational structure in Dublin.

Following the presentation of the Interim Report, the Group continued in existence to complete a number of tasks, including overseeing the implementation of the recommendations in relation to best practice.
1.2.2. In July, the Department of Health wrote to each of the hospitals covered by the exercise and to the Eastern Health Board, enclosing a copy of the Interim Report and asking them to implement the series of recommendations which were designed to enhance the performance of the acute hospital system. Implementation was sought not later than 1st October, which was the target date given in our Report. Each hospital was asked to prepare a plan to give effect to these recommendations and to submit it to the Department.

1.2.3. A Sub-Group of the Dublin Hospital Initiative Group was set up to provide advice and support to these hospitals and to the Eastern Health Board in developing their plans and to ensure that they had taken all possible measures to implement fully the recommendations.

1.2.4. The proposals for better management of the hospital workload recommended that each hospital

(a) should introduce, if it did not already have, an effective admissions policy involving the active co-operation of consultants, nursing staff and management;
(b) should have an effective bed management policy in operation to ensure maximum utilisation of available bed stock, including the appointment of senior nursing personnel as bed managers to operate this policy;

(c) should arrange its bed complement so as to reflect demands made as a result of its case mix and, in particular, to introduce an appropriate number of protected 1-day and 5-day wards;

(d) should arrange, where necessary, for an increase in the ratio of senior to junior medical staff in A & E Departments;

(e) should arrange that senior members of the "on-take" team become more involved in decision-making in A & E with clear protocols to expedite and rationalise the assessment and admission process in A & E;

(f) should ensure that teams rostered for A & E duties are sufficiently free of other commitments to meet the increasing needs of A & E Departments;
(g) should have an observation ward adjacent to the A & E Department under the overall administrative control of the A & E consultant;

(h) should develop better communications with General Practitioners. Every A & E Department should have available the services of a medical social worker;

(i) should ensure that expert interpretative radiology and pathology skills are available to the A & E Department, proportionate to its workload, to facilitate prompt decision-making;

(j) should ensure that discharge planning begins at the point of admission and is a structured process involving the key disciplines as appropriate.

1.2.5 On 30th July 1990, the Implementation Sub-Group met with representatives of the hospitals covered by the exercise in the Royal College of Physicians in Ireland. The purpose of the meeting was to outline the background to the "best practice" recommendations and to discuss ways in which the Sub-Group could be of assistance. Papers were delivered by representatives of those hospitals where certain best practice models were operating. Following the meeting, detailed summaries of the presentation were circulated to each of the hospitals to assist them in preparing their plans.
1.2.6 The Sub-Group has surveyed the hospitals and met with hospital representatives on a number of occasions since July. It is clear that a considerable amount of discussion has taken place, both within and between hospitals, to give effect to the recommendations. This has required, in some instances, their addressing complex problems, some of which are unique to the circumstances of individual hospitals.

1.2.7 The Sub-Group decided in September, 1990 to provide hospitals with a summary of the implementation plans received from each hospital, as it was felt that these might indicate possible lines of action to those hospitals which had yet to adopt policies in respect of particular recommendations. The Sub-Group also stressed that the recommendations were based on best practice profiles which had already been introduced and were working successfully in certain hospitals. All the hospitals were urged once again to introduce best practice policies based on

(a) alteration of the configuration of existing bed stock;

(b) re-deployment of existing human resources;

(c) flexible rostering arrangements; and

(d) other appropriate strategies that do not depend on additional monetary allocations.
1.2.8 It is clear that, for the most part, hospitals took steps to put in place all possible measures in advance of the anticipated pressure of the Winter season. It is recognised that some of the recommendations will require a longer period for full implementation. However, it is also clear from the contents of the hospitals' implementation plans that the discussions and consultations have, in some instances, failed to result in clear-cut decisions or policies, for instance:

- the absence to date of agreed admission/discharge policies in the Mater Misericordiae Hospital;

- the lack of progress in opening a 5-day ward in Beaumont and the Adelaide Hospitals. The Adelaide Hospital do not propose to open such a ward;

- the lack of observation beds in both St. Vincent's and the Meath Hospitals.

While accepting that some of these recommendations may have resource implications, their proven benefits in other hospitals justify their introduction as a matter of urgency.

A summary table outlining progress to date in implementing these recommendations is attached.
1.3 Implications of the Follow-Up to the Interim Report

1.3.1 The implementation of the good practice recommendations in our Interim Report has been broadly satisfactory. Most of the specific, tangible actions recommended to hospitals have been taken. There is also evidence that the implications of active management of bed stock, admissions and discharge are more widely appreciated within the hospitals.

1.3.2 It is difficult to quantify the impact which various elements of the implementation strategy had in securing this result. Our judgement is that a number of significant elements were of particular significance:

(a) The recommendations were targeted at widely shared problems (such as the impact of A & E activity on waiting list admissions);

(b) The good practice recommendations were outlined in quite specific terms;

(c) The benefits of good practice models were clear from those already operating them, particularly from those who had participated in the general meeting for hospital staff;
(d) Implementation was given a high priority by the Department of Health;

(e) The Implementation Sub-Group actively pursued hospitals for details of progress made and circulation and discussion of these reports undoubtedly influenced the priority given to action within the various hospitals.

1.3.3 The Group concludes that the implementation of good practice in hospitals generally, and in particular the good practice recommendations made elsewhere in this report, will be facilitated if: the benefits can be proven from experience elsewhere; the action to be taken is specific and measurable and some external stimulus to change is provided by a structured review of action taken and progress made. In our report on organisational structures in the Dublin area, we made recommendations designed to enhance the process of development of good practice models and of structured, on-going review of the performance of hospitals and other agencies. In the rest of this Chapter, we focus on the action which we feel should be taken, within present organisational arrangements, to ensure implementation of our recommendations on management of waiting lists and out-patients departments.
1.4 Developing a quality service

1.4.1 It is clear that our health services, and in particular the hospitals covered by our remit, are committed to excellence in patient care. This is reflected in the ethos of teaching hospitals in particular, where emphasis is placed upon research and utilisation of the most modern and effective therapies and procedures. This commitment by medical, nursing and other staff is a fundamental resource which must be valued and developed.

1.4.2 The primary orientation of this commitment to excellence has been to the care of individual patients. The care of patients is, of course, the fundamental criterion for assessing clinical performance. Within the various professional disciplines, there is a growing realisation that such excellence is best promoted in an atmosphere of critical appraisal of performance. For that reason, audit procedures have been introduced in most disciplines. The operation of an audit programme is increasingly regarded as a criterion for recognition of a hospital for training purposes by the relevant professional body. Such audit requires review of activity and outcome on a comparative basis. In this way, the highest standards of achievement within a particular discipline are taken as the target for development of clinical practice.
1.4.3 Our good practice recommendations, both in this and earlier reports, are designed to broaden the scope of the concern for quality. Our focus has been upon the efficiency and effectiveness with which hospital resources are organised. Our concern has been with the way in which hospitals approach the management of their workload and the management of the flow of patients, both out-patients and in-patients. If this management task is not addressed properly, the resulting inefficiencies can result in too few patients or the wrong mix of patients being dealt with for any given level of resource. A concern for quality patient care must, therefore, extend to a concern for all aspects of the hospital's service to patients. This includes aspects of hospital activity which are not immediately clinical in nature, such as the organisation of out-patient clinics. However, as we have shown in Chapter One, organisational problems in this area can have clinical consequences through, for example, the impact of high levels of recall of patients to clinics and the anxiety experienced by patients if they are unable to have the time and privacy to discuss their concerns about their condition and treatment.
1.4.4 Our central conclusion regarding implementation of the good practice recommendations on management of out-patients and waiting lists is for hospitals to develop an effective quality assurance programme. Such an explicit commitment to the review of the care of patients would serve to broaden and deepen the existing strong commitment to provision of the highest possible quality of care.

1.4.5 The main elements of a quality assurance programme are:

(a) A clear statement of objectives about processes and outcomes;

(b) Availability of measures of performance reflecting the targets;

(c) Structured, on-going arrangements for review of performance and feedback;

(d) Staff development and training to support specified targets.
With regard to targets to be attained, we have suggested some specific targets in relation to both out-patients and waiting lists. For example, maximum acceptable waiting times for the issue of an out-patients appointment or for admission from an elective waiting list should be specified for particular disciplines or conditions. Operational targets in relation to the issue of appointments or delays experienced by patients within the hospital can also be specified. What is important is that these targets should reflect an attainable standard of performance when elements of good practice are operating. They should also reflect a mix of what is clinically desirable with standards of patient service, such as might apply in any consumer-based organisation. The process by which standards are generated should involve participation by, and therefore active support from, all relevant interests within the hospital. Ideally, performance relative to these standards would be assessed in respect of all relevant departments and personnel.

If quality care is to be provided on a sustained basis, hospitals must be able to establish how they are performing relative to their own targets and relative to other, similar institutions. Performance indicators are measurements of some process or activity which enables the achievement of a hospital or department to be measured.
Indicators should be reliable guides to the area of activity in question. Clear definitions, adequate validation procedures and regular feedback are essential if they are to be useful measures of activity. Standardisation of the indicators to be used is also essential if comparative assessments are to be made. Our experience to date suggests that the stimulus provided by better performance in another institution can be a very powerful contributor to change in a hospital. Ideally, the performance indicators should be comprehensive and cover all aspects of hospital activity, from clinical case mix through to average waiting times for patients attending out-patient clinics. The development of adequate information systems is essential if these basic aids to quality service are to have full effect.

1.4.8 The review of targets and the gathering of information on performance will be effective only if it is undertaken in the context of a clear and structured commitment on the part of the hospital authorities. We have proposed the creation of mechanisms, such as the Out-Patient Services Group, to provide a focus for this commitment in certain areas. Overall, however, there is a need for hospitals to develop a corporate arrangement for ensuring that all aspects of the commitment to quality are pursued. The particular structures may vary but all should involve
opportunities for particular participation by the relevant interests and staff. They should also involve the allocation of specific responsibility to named individuals for ensuring that various elements of the quality assurance programme are, in fact, operated. In particular, they should ensure that patient complaints and feedback are given a high priority in the review of the performance of the hospital.

1.4.9 Hospital policies can be successful only if they are applied on a day-to-day basis by the relevant hospital personnel. This is likely to happen on a sustained basis only if these personnel are committed to the objectives of the policy and recognise that the action taken to implement policy are appropriate. We have already emphasised the importance of participation by relevant staff groups into the formulation of policy and of feedback on performance to departments and staff concerned. We also recognise the importance of staff development and training. At one level, such training can take the form of specific support for staff dealing with the public as a major element in their work. There are well-established staff development programmes operating in other service sectors designed to improve the quality of consumer contact. At another level, this development effort can be focussed on those, including consultants, who have a major role in shaping hospital performance.
This would be designed to strengthen the process of quality assurance by helping to develop the range and effectiveness of the quality assurance programme overall. Commitment from senior hospital personnel, in line with a perceived commitment from the Department of Health, would be crucial to the effective application of these initiatives, including training initiatives.

1.4.10 The adoption of internal policies by hospitals to promote quality care is of vital importance. Our experience to date suggests that some degree of external monitoring and stimulus will be required if progress is to be sustained and reasonably uniform. In part, this role can be played by the Department of Health in its dealings with the individual hospitals concerned. In the long term, structural changes may provide a more effective basis for this review of performance.

1.4.11 In the short term, however, we feel that a specific follow-up is required in regard to the particular recommendations contained in this Report. We envisage that this might take the following form:
(a) circulation of this Report to all the hospitals concerned;

(b) the organising of a seminar on out-patient departments and waiting lists so that the models of good practice can be developed, with opportunity for questions, with a sufficiently large representation from the hospitals participating;

(c) a period of, say, six months during which each hospital will be asked to furnish a progress report on the steps taken to apply the specific recommendations contained in this Report.

We recommend that the Department of Health should establish a small advisory group to assist in this implementation exercise and to review the progress made by hospitals on the specific recommendations regarding out-patients and waiting lists.

1.4.12 With regard to the broader strategy of quality assurance, we feel that there are a variety of possible means of reinforcing external stimulus to action by hospitals. One of the options which we would recommend for careful consideration is the adoption by hospitals of a commitment to taking action to have their services either in whole or in part (such as in respect of out-patients services) -
put forward for compliance with international standards for quality service. The National Standards Authority, based in Eolas, is the national agency entitled to award certification of compliance with Irish standards. While such standards have typically been developed in respect of certification of products and processes, the international quality standard is now applicable to services. Certification of compliance with this quality standard for services involves audit of the steps taken by organisations to specify and achieve quality performance. The organisation itself, to a large extent, specifies the substantive component of the quality service being attempted. The external audit, carried out by or on behalf of the National Standards Authority, measures the extent to which the organisation's own objectives are being achieved. It is a process which is eminently applicable to health care and, in particular, to patient service activities, such as the operation of out-patients departments. It would enable independent verification of quality programmes to be carried out without creating new organisational structures. This process could extend over time to a wider range of hospitals' activities but we recommend that serious consideration be given to making a start in the patient care area of out-patients departments.
1.5 Areas requiring further research

1.5.1 In the Interim Report, the Group identified the desirability of pilot schemes to develop and test models for structuring the relationship between acute hospital and community services and for developing more effective arrangements to provide rehabilitation services to patients no longer requiring the services of tertiary referral hospitals.

1.5.2 In the case of the proposed study of hospital/community relations, among the issues which, in the light of the Group's analysis of the process of admission and discharge of patients, require further investigation are:

- the factors which influence general practitioners to refer patients to hospital for various types of service;

- the perception of referral behaviour of G.P.s within the hospital system;

- the opportunities which exist to improve liaison with community services, including G.P.s, on admission and prior to discharge;
the scope for improving physical arrangements for communication between hospitals and community services (liaison personnel, FAX machines, etc.);

- the potential to develop treatment plans for patients which integrate the in-patient and community-based elements of their care;

- the extent to which access to hospital-based resources could enhance the community care of patients and the extent to which specification of community service needs by hospital personnel could enhance more effective use of resources.

1.5.3 The exploration of these issues would require a project which was rooted in a particular hospital and its catchment area and would require an appropriate research design to evaluate the effectiveness of various aspects of the issues to be examined.

1.5.4 The Group became aware of a research project which was being developed in the Department of Preventive Medicine/Cardiology in St. Vincent's Hospital. The study, whose pilot phase has been supported by the Health Research Board, was designed to look at integration of hospital and community services. The focus of the study was patients in designated G.P. practices in the catchment area of St. Vincent's Hospital who are considered by their family doctor to require hospital care or who, otherwise, received hospital care.
1.5.5 The essential question being considered by the Study Group was the natural history of patients who are considered to require admission to an acute general hospital. With that in view, the pilot phase developed methods for recording details on all patients referred to hospital and patients from the study G.P. practices actually admitted to hospital. Having reviewed this material, we are satisfied that the study design can be extended to address the question of what community resources might obviate the need for admission to an acute general hospital or reduce the length of stay in hospital.

1.5.6 We therefore recommend that steps be taken to expand the scope of this study to address, in the light of evidence on the nature of patients' needs, the organisation of services which might obviate admission or reduce length of stay in that catchment area. The active co-operation of a significant number of G.P. practices, the development of patient recording systems in both hospital and general practice within the study and the availability within the catchment area of a broad range of support services should make an action research programme both viable and useful. We recommend that the study team be expanded to enable this wider range of issues to be incorporated in the design. The Eastern Health Board are already actively
collaborating in this study and we recommend that, with the support of the Department of Health, all necessary steps be taken to enable changes in the level and type of community service to be assessed in the interests of a more effective division of labour between primary care and acute hospital care.

1.5.7 The second area where additional research is required relates to rehabilitation of patients. The concern which gave rise to the proposal for pilot arrangements in this area arose from the survey of inappropriately placed in-patients who were awaiting specialist rehabilitation services. The scope of a research project in this area would have particular application to the needs of elderly patients, for example, stroke victims, but would not be confined to the elderly. Areas of particular concern identified in the survey related to limb fitting and patients recovering from skin grafts.

1.5.8 On this basis, the Group "recommended that, on a pilot basis, a comprehensive rehabilitation service geared to the needs of such patients and drawing on the appropriate range of disciplines should be introduced in a special unit. The purpose of the pilot scheme would be to establish the level of intervention which patients with appropriate levels of incapacity require and the most effective means of supplying such services."
1.5.9 In approaching the question of design of a pilot project, the Group were in a position to draw on its experiences when meeting the various hospital staffing groups, including the Physicians in Geriatric Medicine in addition to reports from Comhairle na nOspídale and the Irish Association of Rheumatology and Rehabilitation. The Group, in association with the various institutions involved, drew up an inventory of existing rehabilitation facilities in Dublin and made contact with the Royal Hospital, Donnybrook and Our Lady’s Hospice, Harold’s Cross.

1.5.10 Our information shows that a wide range of rehabilitation facilities exist for the treatment of various categories of patients, including geriatric, spinal injuries, head injuries, multiple sclerosis, spina bifida, rheumatic, stroke, etc. However, although some shared clinical appointments exist, it is clear that, generally, services are provided in stand-alone institutions without any formal structural links to the major acute general hospitals.
1.5.11 In the case of geriatric patients, we have already referred to the need for the development of specialist Departments of Geriatric Medicine. In that Chapter, the Group, while acknowledging that the problems associated with the operation of rehabilitation services in isolation from the acute general hospital would continue for the foreseeable future, also endorsed the recommendations of Comhairle na nOspideal for a greater integration of general hospital and rehabilitation facilities. It is the Group’s view that the development of specialist Departments in Geriatric Medicine in general hospitals, which would include a rehabilitation unit and day hospital facilities, would represent a significant improvement in the co-ordination and integration of rehabilitation services for the elderly.

1.5.12 In our discussions with the various clinical and para-medical staff groupings, it was represented to the Group that staffing levels and facilities for the treatment of patients in need of rehabilitation services were inadequate. While the inventory of facilities and staffing levels shown on Table 1 indicates that the numbers of staff in some disciplines are low, the Group considers that it is the organisation and direction of rehabilitation services which require priority attention. This applied both to the overall structure of services, as well as to the specific direction of services targeted at specific catchment populations.
1.5.13 The immediate priority is to identify what organisational and staffing changes would most effectively improve the prospects for early discharge of patients from acute beds. This can most effectively be done in the context of a specific acute hospital and its catchment area. One option would be to focus on the Dublin South-East area, where we have recommended an action research programme on acute hospital/community service linkages. There are a number of agencies in this area providing a range of rehabilitation services. However, we leave the selection of the location to the Department of Health and the Eastern Health Board. Our concern is that the existing activity be reviewed and focussed on the particular problems which the Group's work has shown to apply in relation to rehabilitation of patients who do not require acute hospital care.
<table>
<thead>
<tr>
<th>J.C.M.H. Hospital</th>
<th>St. James's Mater Hospital</th>
<th>Beaumont Hospital</th>
<th>St. Vincent's Meath Hospital</th>
<th>Adelaide Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed Manager</strong></td>
<td><strong>Operational.</strong></td>
<td><strong>Had previously been appointed.</strong></td>
<td><strong>Had previously existed.</strong></td>
<td><strong>Bed Manager appointed on 7.1.91.</strong></td>
</tr>
<tr>
<td><strong>Bed Management Committee</strong></td>
<td><strong>Operational.</strong></td>
<td><strong>Had previously existed.</strong></td>
<td><strong>Already in existence.</strong></td>
<td><strong>Has been appointed.</strong></td>
</tr>
<tr>
<td><strong>Admissions Policy</strong></td>
<td><strong>Has been circulated to all appropriate staff.</strong></td>
<td><strong>New policy agreed.</strong></td>
<td><strong>Has yet to be agreed by the Executive Committee of the Medical Council.</strong></td>
<td><strong>Circulated and agreed.</strong></td>
</tr>
</tbody>
</table>


Admissions Officer acts as bed manager.

Beaumont Hospital Bed Manager appointed on 17.12.90. Awaiting approval from Department for permanent post.

St. Vincent's Meath Hospital Bed Manager appointed on 7.1.91.

Admissions Officer acts as bed manager.

Admissions Policy:
- J.C.M.H.
  - Has been circulated to all appropriate staff.
- St. James's Mater Hospital
  - New policy agreed.
- Beaumont Hospital
  - Has yet to be agreed by the Executive Committee of the Medical Council.

Current status:
- J.C.M.H.: Not yet completed.
- St. James's Mater Hospital: In place.
- Beaumont Hospital: Currently being revised to a specialty by specialty approach.
- St. Vincent's Meath Hospital: In place.
- Adelaide Hospital: Now in place. Circulated to all appropriate staff.
<table>
<thead>
<tr>
<th>J.C.M.H.</th>
<th>St. James's Hospital</th>
<th>Mater Hospital</th>
<th>Beaumont Hospital</th>
<th>St. Vincent's Hospital</th>
<th>Meath Hospital</th>
<th>Adelaide Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Protected 1-day and 5-day beds</strong></td>
<td>27 1-day beds open. 5-day ward - principle agreed. Conflict of opinion between medical and surgical consultants as to format. Hospital hopes to have ward in place by early February.</td>
<td>1-day beds previously existed. A 5-day ward (18 beds) opened on 5th November.</td>
<td>1-day ward to be opened on 1st March. 5-day ward (31 beds) has also been opened.</td>
<td>1-day ward (12 beds) currently in operation. A proposal to open a 5-day ward still under consideration.</td>
<td>Have been established and are in use.</td>
<td>Have been established.</td>
</tr>
<tr>
<td><strong>Observation Beds</strong></td>
<td>8 observation beds available.</td>
<td>Had previously existed.</td>
<td>A revised bed schedule is at present being drawn up which includes 15 observation beds.</td>
<td>Had already existed.</td>
<td>Not possible to open observation beds due to lack of resources.</td>
<td>Available but not applicable.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Discharge Planning Policy</th>
<th>J.C.M.H.</th>
<th>St. James’s Hospital</th>
<th>Mater Hospital</th>
<th>Beaumont Hospital</th>
<th>St. Vincent’s Hospital</th>
<th>Meath Hospital</th>
<th>Adelaide Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has been circulated to all appropriate staff.</td>
<td>New policy agreed.</td>
<td>This is currently under consideration by the medical staff.</td>
<td>New policy being developed.</td>
<td>In place. Has been circulated to all appropriate staff.</td>
<td>In place but limited success as there are no support staff - para-medical.</td>
<td>Previously existed. Has been circulated to all appropriate staff.</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>No. of beds (not all currently funded)</td>
<td>Category of patient</td>
<td>Consultant Staff</td>
<td>Physiotherapists</td>
<td>O/Ts</td>
<td>Speech Therapists</td>
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<tr>
<td>Beaumont</td>
<td>7 (elective)</td>
<td>Neurological</td>
<td>1 x Consultant Phys.</td>
<td>1 Grade 3</td>
<td>1 head</td>
<td>1 senior</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 Grade 2</td>
<td></td>
<td>1 senior</td>
<td>1 basic</td>
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<td></td>
<td></td>
<td></td>
<td>5 senior</td>
<td></td>
<td>2 basic</td>
<td>1 sessional</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>15 basic</td>
<td></td>
<td></td>
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<tr>
<td>St. James's</td>
<td>48</td>
<td>Geriatric</td>
<td>2 x Consultant Geriat.</td>
<td>2</td>
<td>2</td>
<td>N/A</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(WTE 1)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Our Lady's Hospice, Harold's Cross</td>
<td>70</td>
<td>Rheumatic</td>
<td>2 x Physician Rheumatologists</td>
<td>5</td>
<td>3</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>James Connolly Memorial</td>
<td>28</td>
<td>Geriatric</td>
<td>2 x Consultant Geriat. (shared)</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>St. Vincent's</td>
<td>Day-care only</td>
<td>Stroke, Rheumatic, Neurological, etc.</td>
<td>Rheumatologist</td>
<td>3</td>
<td>2 W.T.E.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>St. Colmcille's</td>
<td>30</td>
<td>Geriatric</td>
<td>1 x Consultant Geriat. (shared)</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>N.M.R.C.</td>
<td>140</td>
<td>Spinal Injuries M.S., Spina Bifida, Neurological, Stroke</td>
<td>2 x Consultants Rheumatology/Rehabilitation</td>
<td>16</td>
<td>7</td>
<td>3.5 WTE</td>
<td></td>
</tr>
<tr>
<td>Royal Hospital, Donnybrook</td>
<td></td>
<td></td>
<td>1 x Geriatrician</td>
<td>2</td>
<td>2</td>
<td>1 (sessional)</td>
<td></td>
</tr>
<tr>
<td>St. Mary's, Phoenix Park</td>
<td>51</td>
<td>Geriatric</td>
<td>2 x Consultant Geriat.</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
<td></td>
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