# PEAMOUNT HOSPITAL INCORPORATED



## PRELIMINARY

## DEVELOPMENT PROGRAMME

August 31, 1994

# INDEX

# INTRODUCTION

The Finance and General Purposes Committee of the Board of Management of Peamount Hospital at their meeting in February, 1994 instructed the management to prepare a preliminary development programme.

This programme summarises recent history in the context of activity in the various sections of the hospital. It covers the changes, developments and set-back over the recent past as a prelude to examination of the strengths and weaknesses in the current situation at Peamount.

The Department of Health Strategy for Health Care in the 1990s is analysed with particular reference to its implications for Peamount. Attention is given to the changing pattern of hospital services and its implications. Wide ranging proposals are made for the strengthening of existing services and the development of new services to meet health needs and to ensure high standards of excellence with financial viability.

In accordance with the intentions of the Department of Health Strategy the programme is designed to achieve greater integration of Peamount into the local community services. In addition to the development on a national scale of specialities in respiratory medicine and in services to people with a mental handicap is outlined.

The presentation is provided as a basis for policy in the future. The precise policy to be established is dependent on discussion and agreement with the Health Board/Health Authority and the Department of Health and on the provision of funding. This is suggested as the next stage in the process.

An operational programme must be developed to accommodate the existing and new activities suggested, as they are wide ranging and require considerable reorganisation. Ideally, this would be prepared following agreement on policy so as to ensure effective implementation.

Similarly it will be necessary to examine the organisation and structures required but this also can only be undertaken in a meaningful way when policy has been determined.

# Chapter 1

## BACKGROUND - RECENT HISTORY RELEVANT TO FUTURE DEVELOPMENT

The early 1980's are taken as a logical starting point to review the recent history of Peamount. The changing role of the hospital was emerging at that time. Later the funding arrangements were changed with consequential implications in policy matters. Over the period there were important changes in the climate in which health services were delivered.

In an endeavour to establish basic policy for the Chest Hospital, the Medical Director, provided a document in December 1980 - 'Development in the 1980s', which suggested a role for Peamount in tuberculosis, lung cancer, rehabilitation, asthma, and medical education.

Subsequently discussions were held between the Department of Health and Peamount, leading to the production of a document - 'Peamount Hospital - Its Future Role - A Discussion Document'. This paper was drafted, following a number of meetings, by Mr. Anthony Enright of the Department of Health in October 1983. The document stressed the need for integrated services and the undesirability of having separate specialist hospitals. Despite this, however, because of the capital commitment involved in the transfer of resources, Department policy provided for the retention of specialist hospitals. It was envisaged that Peamount Hospital would be a specialist hospital and be retained as an integrated component in the overall policy for hospital services.

It is of interest that this paper makes specific reference to the provision of services for geriatric patients in the local community as a 'logical progression from the activities of Peamount Hospital'.

Discussion on the above document and further progress in developing the proposals, including the major issue of relationship with other organisations, ceased at the end of 1983. (It is important to note that the document stressed the need to define a role for Peamount). The reason for ceasation was the establishment by the Department of Health of a Committee to determine in-patient requirements for Infectious Diseases. Its remit was extended to include Tuberculosis. The Committee first met at the end of 1983 and also visited Peamount. It did not produce a final report and became defunct after three years.

In the area of Mental Handicap, various meetings between the Department of Health and Peamount took place during the 1980s, leading eventually to the establishment of a Project Team on Peamount's Centre for Adult Mentally Handicapped. The Project Team comprised of representatives of the Department of Health, Eastern Health Board, the Order of St. John of God and Peamount, with Peamount's Chief Executive as Chairman. The inaugural meeting was held in January 1985 and following seven further meetings, an Interim Brief was produced and submitted to the Department of Health in September 1985.

The Brief contained detailed requirements in relation to facilities, staffing, physical structure, training and work opportunity. It also contained proposals for the transfer of 80 residents into community residences.

Protracted discussions took place subsequently with the Department of Health and the Eastern Health Board. The proposals encountered considerable opposition from the EHB and despite commitment from the Department of Health, no progress was made. Major improvements did, however, take place in the reorganisation of the Mental Handicap Section. These involved reorganisation of staff, including the employment of Mental Handicap trained nurses for the first time, the construction of houses for 100 residents, the provision of a new Resource Centre and the development of vocational training and work occupation. These developments were funded from Peamount's resources and the European Social Fund. Neither the Dept. of Health (with the exception of a small workshop subvention) or the EHB provided funding or support.

In 1986, the then Minister for Health, in announcing the abandonment of the Loughlinstown Project for Mental Handicap, decided on a change of funding arrangements. The announcement was made in the context of the development of Mental Handicap Services for South Dublin and Kildare. As a consequence of the changes at Loughlinstown, funding for Peamount and Cheeverstown would no longer be provided directly by the Dept. of Health, but would be paid by the EHB in accordance with the provision of Section 65 of the Health Act 1953. Peamount was notified of this change in relation to the Mental Handicap Unit. Following enquiries from Peamount, the Dept. of Health decided to fund the Chest Hospital also in the same manner.

Various discussions took place between Peamount and the EHB following the above decision. Initially, the EHB expressed their intent of transferring Tuberculosis from Peamount to Cherry Orchard. The intention was to develop limited Geriatric facilities at Peamount as well as the retention of the Mental Handicap activity.

No real progress was achieved in these discussions over the period 1986 to 1993. No role was established for Peamount; its services were not integrated into the general services at local or national level. The development of the Mental Handicap Section was frustrated by inadequate funding. A major issue in the latter regard was the insistence on the part of the EHB that there were unused financial resources within the hospital allocation which could support Mental Handicap development. After six years of argument the EHB eventually accepted that these funds were non-existent.

Despite the best efforts of the Board and Management, the best that was achieved was successful resistance to the attempted closure of the Chest Hospital and limited development of the Mental Handicap service. These achievements were the result of good financial control, reorganisation of the Chest Hospital service, particularly through the development of Out-Patient activity, strong negotiation and some political lobbying. All in all, however, there was an atmosphere of maintaining the status quo at the expense of a number of Ward closures.

In an endeavour to break the deadlock, and following a visit by the then Minister for Health to Peamount in May 1992, a meeting was arranged with the Minister and Assistant Secretary in August of that year. It was agreed at that meeting that talks would take place between the Dept. of Health, EHB and Peamount, with the Dept. acting as facilitators.

Some progress was made in subsequent meetings, resulting in a decision to retain TB at Peamount, a reduction in the size of the hospital to 80 beds, the proposed introduction of the Care of the Chronic Young Sick and a Geriatric service. There was also commitment to the development of the services for the mentally handicapped. These talks continued into 1993 and while subsequent meetings took place separately with the EHB and the Dept. of Health, the new services have not been introduced.

Over the period, two elements of Peamount Hospital Incorporated, which operate independently of the EHB and the Dept. of Health, performed extremely satisfactorily. Peamount Industries was developed primarily as a mechanism for the provision of vocational training, work experience, and meaningful occupation for the handicapped. In the absence of financial input from the State, it was necessary to develop the Industries as a viable, commercial undertaking. It has achieved remarkable growth and generated considerable income. It is now well established and will continue to provide income for developments within the Peamount complex.

The Farm has been developed to a very high level of intensity and efficiency and brought from loss making in the early 1980s to increasing annual surplus over the subsequent years. It represents an extremely valuable asset and is now in the process of providing profits for development of Peamount Hospital Incorporated.

It was against the foregoing background that the Finance & General Purposes Committee, with subsequent approval of the Board of Management, decided to develop a strategic plan for Peamount. Their decision was overtaken by the publication in May 1994 of a Dept. of Health policy document 'Shaping a Healthier Future - A Strategy for Effective Healthcare in the 1990's'.

The Dept. of Health document provides a framework within which to plan and it provides guidelines for the services required. Of fundamental consequence, of course, is the major structural change proposed in the control authority at Health Board level.

The management share the view of the Board that it is essential that Peamount have a strategic plan for consideration in the context of the newly defined Health Authority and the window of opportunity which the Dept. of Health Strategy provides.

# Chapter 2

## LEGAL FRAMEWORK

## OBJECTS AND ARTICLES

The mission and function of Peamount Hospital is defined in the Memorandum and Articles of Association of Peamount Hospital. The Women's National Health Association of Ireland was incorporated under the Companies (Consolidation) Act 1908, in March 1913. It was under this authority that Peamount Sanatorium was established. Subsequently, under the Companies Acts 1908 to 1917, and the Companies Act 1963, Peamount Hospital Incorporated was established as a Company Limited by Guarantee and not having a Share Capital (the change of name being passed by special resolution on 29/3/1962).

The Memorandum and Articles of Association are extremely broad. While many have little relevance to-day, they still facilitate general development in the area of health care. Thus, for instance, it was possible to accommodate the Mental Handicap service at Peamount which was not envisaged at the time of compilation.

The objects range from 'arousing public opinion.....regarding public health to the dissemination of knowledge, the establishment of hospitals, homes and other institutions 'desirable in the interests of public health'. They provided for co-operation with Co. Councils and other Health Authorities. Specific provision is made to 'purchase, sell, rent, let or hold lands, tenements or other real or personal property, as well as the provision of buildings'.

New Articles of Association of Peamount Hospital Incorporated were adopted by resolution on 21st July 1970, covering membership, Board of Management etc., and specifying the powers of the Board of Management, conduct of meetings, voting and the provision of accounts and audits.

It is not necessary for the purpose of the Preliminary Development Programme to examine the Memorandum & Articles of Association in detail. The reason for including reference to indicate that they permit, and indeed encourage, involvement in the provision of health care on a very broad basis. It is clear that a reasonable interpretation would cover involvement in a whole range of activities which are not undertaken at present. They could not be regarded as preventing or inhibiting developments of activities deemed by the Board to be desirable.

Not only are the provisions referred to briefly above consistent with the Dept. of Health policy outlined in their published Health Strategy, but, in fact, contain extraordinary similarity in some respects. Consequently, a revised development policy for Peamount and the inclusion of non traditional activities will not be restricted or limited either by existing authority as defined in the Memorandum and Articles of Association or by conflict between them and Dept. of Health policy.

# Chapter 3

## CURRENT SITUATION

Peamount Hospital Incorporated is to-day a multi-functional organisation and can no longer be regarded in its traditional role. There are four main divisions:

1. The Chest Hospital.
2. The Mental Handicap Section.
3. Peamount Industries.
4. Peamount Farm.

### 1. THE CHEST HOSPITAL

Peamount is now the only hospital in the Republic dealing exclusively with chest patients and retains its role of having a specialised national TB service. Its role has changed radically over the years from its origin as a TB Sanatorium, having in excess of 700 beds. Currently, there are 80 beds with an average occupancy of 66 from 1990 to 1993.

TABLE 1

AVERAGE OCCUPANCY BEDS

| Year | J. | F. | M. | A. | M. | J. | J. | A. | S. | O. | N. | D. | Annual Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1993 | 68 | 64 | 66 | 63 | 67 | 66 | 67 | 63 | 54 | 66 | 73 | 59 | 65 |
| 1992 | 70 | 82 | 78 | 72 | 67 | 65 | 62 | 56 | 57 | 63 | 67 | 57 | 66 |
| 1991 | 67 | 78 | 78 | 77 | 82 | 70 | 64 | 64 | 72 | 72 | 59 | 58 | 70 |

The foregoing, however, does not provide the full picture of hospital activity as there has been a continuous growth in the number of patients treated.

TABLE 2

HOSPITAL ACTIVITY

| Year | Admissions | Out-Patients | Day-Patients | Total Activity |
|---|---|---|---|---|
| 1993 | 947 | 2,480 | 2,631 | 6,058 |
| 1992 | 1,006 | 2,296 | 2,570 | 5,872 |
| 1991 | 1,089 | 1,675 | 2,245 | 5,009 |
| 1990 | 1,012 | 1,711 | 2,259 | 4,982 |
| 1989 | 1,071 | 1,795 | 1,932 | 4,798 |

Table 3 shows a breakdown of diseases treated in 1993.

TABLE 3

DISEASES TREATED 1993 - INPATIENTS

| | Male | Female | Total |
|---|---|---|---|
| New Cases of Tuberculosis* | 64 | 30 | 94 |
| Review on Treatment | 51 | 15 | 66 |
| Review off Treatment | 34 | 11 | 45 |
| Screening for TB | 22 | 7 | 29 |
| COAD | 89 | 35 | 124 |
| Chronic bronchitis & emphysema | 30 | 17 | 47 |
| Respiratory Failure | 7 | 6 | 13 |
| Sarcoidosis | 13 | 3 | 16 |
| Asthma | 49 | 49 | 98 |
| Pneumonia | 49 | 45 | 94 |
| R.T.I. | 20 | 12 | 32 |
| Bronchiectasis | 19 | 2 | 21 |
| Cancer | 51 | 15 | 66 |
| Respite | 13 | 13 | 26 |
| CCF | 42 | 38 | 80 |
| Other | 49 | 52 | 101 |
| TOTALS | 602 | 350 | 952 |

* Includes 5 males and 1 female HIV+

(Peamount Hospital Annual Report 1993)

## 1.1 INFRASTRUCTURE

Peamount Chest Hospital campus is comprised of approximately 50 acres and has very considerable potential for expansion. There are seven Ward units of which three are in use as follows:

1 x 40 bed - Non-Tuberculosis.

1 x 30 bed - Tuberculosis male.

1 x 10 bed (1/2 Ward) - Tuberculosis female.

1 x 1/2 Ward - Out-Patients.

There are four units not in use at present, one of which (St. Theresa's) was upgraded at a cost of £260,000 in 1989 with a view to possible use as a private hospital facility. The latter intention did not proceed. The remaining three units have been well maintained and are available for occupation subject to internal decoration and refurbishment. St. Theresa's has a capacity of 31 beds in semi-private and private accommodation. The remaining units, when in use, provide 50 beds in St. Mary's, 40 in St. Patrick's and 40 in St. Ita's.

In addition to the foregoing, there is a Clinic block (recently refurbished) which accommodates the X-Ray Department, Pharmacy, Dentistry, Clinic facilities, the hospital reception etc.

A modern laundry provides full service for the Chest Hospital and Mental Handicap Unit.

There is a well equipped Laboratory which was relocated in a modern building in 1986. There are two Hostels (2 x 12 bedrooms). The Nurses' Home has 103 bedrooms as well as sitting, dining, recreation and leisure rooms. There is a Church (with shared denominational facilities) and an Administrative centre.

## 1.2 MEDICAL SERVICES

- **A modern Pulmonary Function Laboratory** is equipped with a computer controlled Pulmonary Function machine.

- **The Laboratory** undertakes all routine lab., biochemistry, cytology and microbiological investigations for the hospital. A limited services is provided for local G.P.s.

- **Radiology** - all radiology is performed in this department which has facilities for screening and bronchographs.

- **Bronchoscopy** - flexible endoscopy services.

In addition, a number of services are provided jointly to both the Chest Hospital and the Mental Handicap Unit. Some staff have responsibilities in both areas.

## 1.3 STAFFING

Current staffing consists of :

- Medical Director (part-time).
- Senior Hospital Medical Officer.
- Senior Assistant Medical Officer.
- 5 Senior House Officers.
- Director of Nursing.
- Assistant Director of Nursing.
- Ward Sisters.
- Staff Nurses.
- Cadet Nurses.
- Paramedical, including Laboratory staff and Physiotherapists - sessional
- Radiographer.
- Orderlies.
- Domestics.
- Social Worker.
- In addition, Panel Nurses.
- Visiting Consultants - E.N.T., Ophthalmic, Dentistry.
- Administrative staff

A detailed strategic review of the Chest Hospital, completed by the Medical Director is included at Appendix 1.

Financial detail is provided in Chapter 4 as well as analysis of the financial viability of the hospital.

## 2. MENTAL HANDICAP SERVICE

The Adult Training Centre for people with a mental handicap has been developed from three large Wards in the mid 1960's to a relatively modern complex by continuous up-dating of facilities. It now provides residential, training, occupation, recreation and development facilities for approximately 200 people.

In recent years, one of the original Wards was replaced by family bungalows in a village style complex on the campus, providing modern first class living accommodation for 100 people.

The remaining two Wards have been adapted internally and converted into smaller units each accommodating 30/40 people in small groups with central dining facilities.

A further development in conjunction with the Eastern Health Board led to Peamount's first involvement in community residential care in 1990.

Two houses in Newcastle village accommodating nine people who commute daily to Peamount by public transport. Their training for independent living was undertaken successfully at Peamount.

There are particular problems associated with the unusual age structure of the residents, arising from the fact that some 220 adults were transferred simultaneously to Peamount in the early 1960s, coupled with very few admissions since then. This now necessitated the provision of geriatric facilities for an aging population. It has also limited the benefits of having a community of mixed ages.

The overall situation for the residents has been transformed from an original situation of little more than custodial care to a modern complex providing for individual care and development. This was achieved through the provision of continuously improving facilities ('though still insufficient), the recruitment of Mental Handicap trained nurses (still inadequate in number) and the provision of better recreational and vocational training facilities.

2.1 INFRASTRUCTURE

2.2 Residential Accommodation

| | | |
|---|---|---|
| 10 Bungalows (mixed) | - | 96 |
| 1 Female Unit | - | 33 (St. Anne's) |
| 1 Male Unit | - | 27 (St. Brendan's) |
| 1 Elderly Male Unit | - | 34 (St. Paul's) |
| 2 Houses | - | 9 (Newcastle village) |

2.3 Assembly Hall - a large purpose built facility in regular use as a recreation and social development centre.

2.4 Resource Centre - opened in 1991, it is comprised of a training facility, a central dining facility for residents, those who live in community and day attenders. It also houses an Oratory and vocational training facilities.

2.5 Community Houses.

2.6 Day Care programme facilities.

2.7 STAFFING

- Assistant Director of Nursing M.H. Services.
- Charge Nurses.
- Staff Nurses.
- Care Staff.
- Consultant Psychiatrist - Dr. Vincent Molony, Director of Mental Handicap Services for the Eastern Health Board attends on a regular basis and apart from dealing with behavioural problems, has an advisory and supportive role.

2.8 TRANSPORT

The Friends of Peamount provided a Minibus in 1985 and replaced it in 1992. It is in regular use transporting residents to functions in the community and other outings of value.

## 2.9 SUPPORT ORGANISATIONS

The Association of Parents & Friends of the Mentally Handicapped was established through the initiative of Peamount management in 1985.

This organisation has an outstanding record, not only in fund-raising, but in providing additional comforts for residents, renting of holiday houses and providing entertainment facilities. More importantly there has been a huge personal input in time and commitment.

## 3. PEAMOUNT INDUSTRIES

The Industries consists of a complex of Workshops operating in conjunction with the residential section of the Mental Handicap Service. Its prime function is to provide additional training, work occupation and work experience.

From a small beginning when it catered for 20 residents in the mid 1960s, it was developed to provide for a peak of approximately 130-150. This number has now dropped to approximately 100 because of the aging population. (Those not attending the Workshops are accommodated in an activation centre).

Despite the apparent need for this facility and the fact that the State finances sheltered workshops throughout the country, Peamount has been denied funding.

The Industries have been developed without capital or revenue funding from the Dept. of Health or the Health Board. The only exception being a small capital grant towards the cost of a Workshop in 1985.

As as consequence, it has been necessary to operate commercially and this has been done very successfully. Otherwise, the Workshops would not exist and the residents would be denied the many benefits accruing. Clearly, it would not have been possible to operate commercially without the employment of outside staff. This also ensures that residents are not put under any pressure in meeting commercial deadlines in production. The successful integration of the residents working side-by-side with the workforce, while questioned initially, has now been accepted as a model for other organisations. Details of the financial achievements are provided in Chapter 4.

3.1 Infrastructure:

Facilities include:

- Training - vocational and industrial.
- A modern well-equipped corrugated box production unit.
- Cardboard Division Assembly.
- A Shrink-wrap and Packaging facility.
- Die cutting, slotting and slitting cardboard for division making and assembly.
- Reuse of cardboard for pad-making etc.
- A Cardboard Mushroom Chip production unit.
- Waste collection, including bailing waste corrugated material.

3.2 Staff

- Production Manager.
- Training Manager.
- Supervisors.
- Clerical.
- General Operative.

4. PEAMOUNT FARM

The hospital complex is surrounded by a Farm of 435 adjusted acres. In addition, land is leased and rented for silage production and in conjunction with the lease of milk quotas.

The Farm is operated very intensively and ranks among the most efficient farms in the country. It has been brought from a loss-making situation in the late 1970's and early 1980's to a very profitable undertaking (see Chapter 4).

It is now in a position to make increasing contributions to the financial needs of Peamount Hospital Incorporated. In recent years the possibility of developing with the Farm a National Third Level Education Centre, to provide Diploma in Animal Husbandry, for people with a mental handicap has been studied. It is felt that this would be of tremendous value and fulfil a widespread need.

The Farm is recognised under the National Farm Apprenticeship Scheme for training of apprentices and does so on a continuous basis. In addition, the staff co-operate with the Veterinary Faculty at UCD in providing practical animal husbandry training and students visit on a regular organised basis.

The farm is organised on a mixed farming basis having a dairy herd of just under 200 cows with followers, a beef enterprise finishing 250-300 cattle annually, 280 acres of tillage and 80 acres of set-a-side. Additional land is rented for silage production and to provide winter feed requirements on the farm.

## 4.1 Infrastructure

The Farm is extremely well equipped and well provided with buildings and facilities.

## 4.2 Staff

- Farm Manager
- Cowman
- General workers
- Apprentices

## 5. FRIENDS OF PEAMOUNT

The Friends of Peamount has been the organ of the Chest Hospital which raises funds for the benefit of patients and for developments in the hospital. It provides facilities and benefits which are not accommodated within the EHB subvention.

# Chapter 4

## FUNDING - FINANCIAL VIABILITY

Peamount Hospital Incorporated is a voluntary organisation, generating income from some of its trading and fund-raising activities. The provision of services is, however, dependent on funding provided previously through the Dept. of Health and currently through the Eastern Health Board. Peamount depends entirely on State funding for its revenue requirements. While similarly dependent in relation to capital funding, monies generated from other sources e.g., Peamount Industries and Farm, are used to complement funding in this area e.g., the building of houses for the mentally handicapped, the provision of assistance towards equipment for the hospital. It has been Board policy that finance from the latter source should be used for capital development or/and patient comfort rather than be used to replace revenue provided by the State.

The Board and management have succeeded in maintaining the financial viability of the complex. This, of course, is not only essential per se but has also been a major factor in ensuring survival during the period of hospital closures in recent years. Viability has been achieved and maintained through a combination of prudent financial management and adaptation of services, including the closure of Wards. The most notable health service achievement in this regard was the treatment of an increasing number of patients without increased funding. This was achieved by a reduction in the number of in-patients and the maximum conversion of in-patients to out-patients and day-patients. Thus in the period 1989-'93 while the number of in-patients admitted fell from 1,071 to 947, the total number treated rose from 4,798 to 6,058.

It is essential in the compilation of a meaningful development programme to have due regard to financial performance as well as the extent and quality of services provided. For this reason, summaries are provided below of the annual accounts over a period and related to level of activity as a basis for proposals made later in the programme.

The figures presented are broken down on the basis of main activities. Despite this, however, care must be exercised in interpreting them. The admonition of caution arises because of a degree of subsidisation by the Chest Hospital to the Mental Handicap Section e.g. some services are provided centrally. In addition, more accurate attribution of costs following a Board decision in 1991 distorts the trends previously pertaining.

It is proposed to take each of the four main sections of Peamount Hospital Incorporated separately and to discuss the impact of costs, income and net expenditure on current and some future activity.

1. CHEST HOSPITAL

Table 4 shows performance over the period 1983 to 1993.

Perhaps, the most significant feature is that while there was only marginal increase in net expenditure (9%), the number of beds occupied was reduced from 238 to 65.

As a consequence of the reduction, the weekly per bed cost increased from £276 to £1,104 or 400%.

It would be over simplistic to take these figures without regard to the changes in the type of service provided over the years.

The following factors contributed to the increase in the inpatient costs:

- Inflation.
- Type of Patient - Change from long-stay to short stay.
- Duration of Stay.
- Accuity/Dependency.
- Increased drug costs.

## TABLE 4

SUMMARY OF ANNUAL ACCOUNTS AND BED OCCUPANCY 1983 - 1993

| | 31/12/83 | 31/12/84 | 31/12/85 | 31/12/86 | 31/12/87 | 31/12/88 | 31/12/89 | 31/12/90 | 31/12/91 | 31/12/92 | 31/12/93 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| PAY COSTS | 2,294,404 | 2,520,929 | 2,501,121 | 2,513,171 | 2,433,149 | 2,314,392 | 2,495,431 | 2,617,684 | 2,747,046 | 2,599,555 | 2,812,268 |
| NON-PAY COSTS | 1,249,593 | 1,373,697 | 1,360,664 | 1,379,820 | 1,055,376 | 1,177,581 | 997,458 | 970,222 | 1,093,861 | 982,935 | 1,144,641 |
| | 3,543,997 | 3,894,626 | 3,861,785 | 3,892,991 | 3,488,525 | 3,491,973 | 3,492,889 | 3,587,906 | 3,840,907 | 3,582,490 | 3,956,909 |
| INCOME | 132,372 | 212,657 | 206,074 | 207,009 | 233,100 | 235,478 | 214,010 | 217,512 | 213,519 | 206,080 | 225,067 |
| | 3,411,625 | 3,681,969 | 3,655,711 | 3,685,982 | 3,255,425 | 3,256,495 | 3,278,879 | 3,370,394 | 3,627,388 | 3,376,410 | 3,731,842 |
| ALLOCATION | 3,265,905 | 3,386,000 | 3,648,000 | 3,671,757 | 3,252,400 | 3,252,000 | 3,274,100 | 3,364,188 | 3,531,061 | 3,565,000 | 3,728,000 |
| SURPLUS/DEFICIT | -145,720 | -295,969 | -7,711 | -14,225 | -3,025 | -4,495 | -4,779 | -6,206 | -96,327 | 188,590 | -3,842 |
| AVG.OCCUPANCY BEDS | 238 | 187 | 149 | 121 | 96 | 75 | 74 | 66 | 70 | 66 | 65 |
| WEEKLY COST PER BED | 276 | 379 | 472 | 586 | 652 | 835 | 852 | 982 | 997 | 984 | 1,104 |

The figures, despite the limitations mentioned, identify the threat to the viability of the Chest Hospital. Overheads, and to a considerable extent pay costs, are now being carried by one quarter of the number of in-patients as compared to 1983.

A further issue arises in relation to inter hospital cost comparisons. Traditionally, Peamount as a non-acute hospital was, in fact, a low cost activity and comparisons carried out periodically supported this fact. More recently as a consequence of our increasing bed cost the gap between Peamount and other hospitals has narrowed.

The total number of patients treated (i.e. in-patients and out-patients) is greater now, but this does not negate the financial dilemma in relation to funding the in-patient costs.

Table 5 provides detailed analysis of costs at Peamount over the years.

TABLE 5

FINANCIAL ANALYSIS

| | 1984 | 1985 | 1986 | 1993 |
|---|---|---|---|---|
| Average Bed Occupancy | 187 | 149 | 121 | 65 |
| Pay costs | £2,520,929 | £2,501,121 | £2,513,171 | £2,812,268 |
| Pay cost per bed | £13,480 | £16,786 | £20,770 | £43,266 |
| Overheads | £1,373,697 | £1,360,664 | £1,379,820 | £1,144,641 |
| Overheads per bed | £7,346 | £9,132 | £11,403 | £17,610 |
| Employees | 232 | 219 | 212 | 160 |

Despite strict financial control over costs, the pay costs per occupied bed have trebled over the last ten years and the non-pay costs have doubled.

The main financial threat in the situation is that a large portion of our costs, both pay and non-pay, are fixed and in latter years there has been a much smaller base over which these costs can be apportioned.

New or additional services could, to some extent, have to fund only their direct frontline costs as a high proportion of other costs could be absorbed by the current overheads.

The foregoing argument is not invalidated by the increased number of out-patients.

Hospital cost comparisons are made in official statistics, on the basis of in-patient costs, without regard to the number of out-patients. As a consequence, it is necessary to establish whether Peamount is out of line with other hospitals in this regard.

Table 6 provides a comparison between Peamount and the national situation. It will be seen that the ratio of out-patients to others is higher overall than at Peamount.

TABLE 6

HOSPITAL PATIENT STATISTICS 1992

| | Public Vol. Hospitals | Peamount Hospital |
|---|---|---|
| Out-Patients | 1,003,080 | 4,866 |
| Casualty | 556,937 | - |
| Day Cases | 97,345 | - |
| In-patient discharges | 221,094 | 1,002 |
| Ratio of In-patient to others | 1:7.5 | 1:4.9 |

Source - IPA Health fact sheet 8/93

The issue presented above is probably the most fundamental financial matter to be considered in developing a programme for Peamount Chest Hospital over the coming years. Detailed consideration is given to a solution to this problem in the proposals made in this document.

Peamount Chest Hospital becomes less viable financially as in-patient numbers are reduced (the problem is exacerbated by the fall in in-patient numbers in 1994) (see Table 7). It is obvious that financial viability can only be achieved by increasing activity so as to reduce costs per patient.

TABLE 7

MONTHLY BED OCCUPANCY FOR 1994 - CHEST HOSPITAL

| | Jan. | Feb. | Mar. | Apr. | May | June | July |
|---|---|---|---|---|---|---|---|
| Total Bed Days | 2,118 | 1,899 | 2,039 | 1,812 | 1,845 | 1,730 | 1,595 |
| Month Average | 68 | 68 | 66 | 60 | 60 | 58 | 51 |
| Annual Average | 68 | 68 | 67 | 66 | 65 | 63 | 62 |
| % Occupancy | 85 | 85 | 84 | 82 | 81 | 79 | 77 |

Implications of case mix for Resource Management:

The costings used in this chapter are those used traditionally and the comparisons are based on the type of costings used by the Dept. of Health. These represent the only comprehensive data available from official statistics or from the Department.

The Dept. of Health plans to introduce case-mix analysis based on the present Hospital Inpatient Enquire (H.I.P.E.) and Diagnostic Related Groups (D.R.G.). The intention is to use the system as an aid in the allocation of financial resources. Peamount is participating in the programme and an increasing volume of useful information is being generated.

Recent enquiry to the Dept. of Health established that 21 major hospitals are now receiving part of their funding on the basis of diagnostic related groups. In 1993 this amounted to 5% of their allocation and the figure has risen to 10% this year.

The diagnostic related groups are mainly used for surgical procedures and the information is based on the returns made by hospitals in their H.I.P.E. information. There are currently 490 different diagnostic related group costings and within these there are numerous variations.

D.R.G. costs are not available for non-surgical procedures, although the Dept. of Health has recently agreed to use our H.I.P.E. information in conjunction with E.S.R.I. as a pilot project for non-surgical activity.

Since D.R.G.'s are based on individual patient costs rather than on an occupied bed basis a direct comparisons between the two are not valid.

## 2. MENTAL HANDICAP UNIT

The Mental Handicap Unit has never received adequate funding from the time of its establishment. Details of income and expenditure from 1984 to 1994 are set out in Table 8.

TABLE 8

### PEAMOUNT MENTAL HANDICAP UNIT - INCOME & EXPENDITURE

| | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 |
|---|---|---|---|---|---|---|---|---|---|---|
| EXPENDITURE | | | | | | | | | | |
| SALARIES / WAGES | 591,560 | 642,295 | 661,776 | 684,644 | 691,570 | 693,969 | 811,323 | 1,025,159 | 1,095,322 | 1,270,296 |
| PAYMENTS TO PATIENTS | 36,570 | 36,794 | 37,765 | 31,390 | 31,912 | 32,802 | 31,795 | 31,803 | 34,719 | 33,994 |
| PROVISIONS | 132,798 | 132,126 | 132,000 | 139,920 | 139,920 | 139,920 | 144,000 | 144,000 | 152,417 | 154,743 |
| MEDICAL | 18,469 | 20,031 | 19,102 | 20,080 | 19,656 | 20,054 | 20,015 | 20,522 | 33,857 | 40,338 |
| DOMESTIC | 131,584 | 113,130 | 97,643 | 87,016 | 86,293 | 86,370 | 75,528 | 98,663 | 101,609 | 136,660 |
| MAINTENANCE | 28,362 | 22,499 | 11,174 | 23,769 | 24,502 | 29,439 | 22,991 | 31,049 | 32,522 | 46,313 |
| SUNDRY | 18,099 | 16,104 | 19,905 | 24,146 | 14,984 | 12,151 | 13,865 | 15,601 | 21,584 | 26,820 |
| FINANCE | 12,350 | 13,207 | 14,500 | 20,346 | 17,000 | 18,732 | 18,393 | 19,834 | 19,428 | 22,511 |
| | 969,792 | 996,186 | 993,865 | 1,031,311 | 1,025,837 | 1,033,437 | 1,137,910 | 1,386,631 | 1,491,458 | 1,731,675 |
| INCOME | 6,330 | 8,680 | 8,073 | 35,668 | 37,272 | 38,272 | 41,439 | 49,245 | 64,533 | 70,665 |
| DPMA | | | | | | | | | 26,682 | 30,774 |
| EXCESS OF EXPENDITURE OVER INCOME | 963,462 | 987,506 | 985,792 | 995,643 | 988,565 | 995,165 | 1,096,471 | 1,337,386 | 1,400,243 | 1,630,236 |
| ALLOCATION | 925,000 | 955,000 | 974,648 | 985,648 | 985,652 | 993,552 | 1,038,743 | 1,104,176 | 1,160,521 | 1,626,195 |
| DEFICIT FOR YEAR | 38,462 | 32,506 | 11,144 | 9,995 | 2,913 | 1,613 | 57,728 | 233,210 | 239,722 | 4,041 |
| GRANTS FOR PREVIOUS YEARS | | | | 70,968 | | | | | 11,638 | |
| CUMULATIVE DEFICIT | 38,462 | 70,968 | 82,112 | 21,139 | 24,052 | 25,665 | 83,393 | 316,603 | 544,687 | 548,728 |

It will be seen from the figures that the unit has been in deficit over the period, reaching a peak in the years 1991 and 1992. As adverted to in relation to the Chest Hospital, there has been considerable inter-sectional financial support in the organisation. Thus, the Mental Handicap Unit benefited from costs attributed to the Chest Hospital, in particular, up to 1991.

In that year, the Board instructed management to assign costs more precisely to provide a more accurate picture and this is apparent in the figures for the years 1991 to 1993.

The serious under-funding of the Mental Handicap Unit has been the subject of on-going discussion with the Dept. of Health and the Eastern Health Board.

Studies were carried out by Craig Gardner Ltd., on behalf of Peamount in 1988. In addition to suggesting the reallocation of costs referred to above, comparison with other organisations showed that per capita funding at Peamount was less than a half of that provided by the State to other comparable organisations.

The position outlined is recognised by the Eastern Health Board. It is essential not only that funding be provided to eliminate deficits but that it be increased to provide the additional services and benefits.

The current per capita funding at a level of £8,340 is hopelessly inadequate against the national figure believed to be about £14,000. Similarly, capital is required to provide urgently needed facilities, particularly to cope with an increasing geriatric problem.

It is a basic requirement of a development programme that the inadequacy of funding is recognised and that the impact of this situation is realised by the funding authorities.

It is vital that we establish equity of funding as a minimum and we then seek additional funding for further development.

## 3. PEAMOUNT INDUSTRIES

Peamount Industries does not receive any funding from the State and is not recognised by the Eastern Health Board in the financial allocation provided to Peamount Hospital Incorporated. As a consequence, if it is to provide the services necessary for the mentally handicapped, it must be managed on a commercial basis.

There has been a remarkable record of growth in profits from nil in the late 1970's to a peak of £130,000 in 1993. There was a fall in profits in 1992 which was the only year to show a trading loss. This was due to the termination of services being provided to a group of companies which decided to automate their production. These services represented some 80% of the activity at that time.

Steps were taken to acquire alternative business and a corrugated box factory was set up. This business was established very quickly and there was a return to trading profit in 1993. Peamount Industries is securely established and will continue to generate profits on an increasing scale.

TABLE 9

PEAMOUNT INDUSTRIES

SCHEDULE OF SURPLUSES/DEFICITS

| Year | Surplus |
|---|---|
| | £ |
| 1993 | 132,573 |
| 1992 | 92,736 |
| 1991 | 162,517 |
| 1990 | 194,447 |
| 1989 | 173,984 |
| 1988 | 150,283 |
| 1987 | 132,338 |
| 1986 | 112,896 |
| 1985 | 99,474 |
| 1984 | 76,773 |
| 1983 | 112,539 |
| 1982 | 76,953 |
| 1981 | 68,206 |
| 1980 | 48,771 |

4. PEAMOUNT FARM

Peamount Farm is operated as a separate entity within Peamount Hospital Incorporated on a similar basis to Peamount Industries. It is required to operate on an independent basis and is not subsidised in any way by the State funded sections of the organisation. It does, of course, benefit from the various financial aids provided under the Common Agricultural Policy.

The farm has been built up from a loss making situation entering the 1980s to record sizable surpluses in recent years (see Table 10).

Following development and reinvestment of surplus, the farm is now in a position to contribute to the needs of the overall organisation. As mentioned previously, the farm is now geared to providing a National Third Level course in Animal Husbandry for people with a mental handicap.

The Farm represents a major profitable asset appreciating in value. It can provide security against borrowing if necessary. It also represents a valuable financial reserve within the organisation.

TABLE 10

PEAMOUNT FARM

SCHEDULE OF SURPLUSES/DEFICITS

| Year | Surplus/ Deficit |
|---|---|
| 1993 | 96,377 |
| 1992 | 57,221 |
| 1991 | 20,816 |
| 1990 | 53,288 |
| 1989 | 83,365 |
| 1988 | 80,434 |
| 1987 | 54,113 |
| 1986 | 30,887 |
| 1985 | -1,576 |
| 1984 | 18,215 |
| 1983 | 64,011 |
| 1982 | 46,964 |
| 1981 | 30,825 |
| 1980 | -3,386 |

# Chapter 5

## PEAMOUNT HOSPITAL INCORPORATED AND THE DEPARTMENT OF HEALTH STRATEGY FOR EFFECTIVE HEALTHCARE IN THE 1990's

Peamount Hospital Incorporated is an autonomous voluntary organisation and as such is free to develop whatever policy it wishes to establish.

A future independent of State funding would require large scale financing from other sources. The latter is unlikely to be forthcoming in the foreseeable future.

The foregoing should not rule out private development where this is possible. Indeed, if the opportunity arose, Peamount is very well placed and has the potential to avail itself of such prospect.

In recent years, a number of possibilities for the introduction of independent services have been pursued both on a stand alone basis and as joint ventures e.g. private Nursing Home, Alcohol and Drug Rehabilitation in conjunction with the Ruthland Centre, Hospital and Laboratory services with the Institute of Clinical Pharmacology and others. None of these efforts bore fruit and while the Nursing Home/Convalescent Home possibility still exists, there is no immediate prospect of either a new partner or sizable finance.

The reality is that Peamount is dependent, as indicated in Chapter 4, on the State to fund the services which it provides and is likely to continue to be so. In the foreseeable national economic climate, the State will, of necessity, prioritise spending in the areas where health needs are greatest. It is clearly important for Peamount to identify these services and in as far as possible to influence the Dept. of Health/the Health Boards in their allocation of functions to the organisation. Unfortunately the scope for doing so has been severely limited since 1986 when State responsibility for Peamount, particularly in the area of funding, was transferred to the Eastern Health Board.

The publication earlier this year of the Dept. of Health policy document - 'Shaping a Healthier Future - A Strategy for Effective Healthcare in the 1990's' - together with the changes envisaged in organisation and structure, offer new opportunity.

It is indeed fortunate that the new policy outlined becomes available to coincide with the development of a strategic plan at Peamount. It offers the first real opportunity free from the constraints of the 1980s and early 1990s for Peamount to:

1. develop a realistic long term policy,

2. identify with the health and mental handicap needs of the local catchment area,

3. consolidate its role in providing a supra-regional national role in its hospital specialty,

4. influence the functions to be assigned to it.

It is not intended in this presentation to discuss the Dept. of Health document in detail but rather to identify the issues which will have an impact on the continuation, expansion and development of Peamount as a centre of excellence in the provision of health care and training services. Rather than analyse the broader philosophy on which the Department's document is based, the salient factors likely to impinge on the development of Peamount are extracted and discussed briefly.

## Voluntary Status

The document commits the State to recognition of the autonomous status of the voluntary organisations. It places emphasis on a "strong voluntary sector which provides an integral part of the public system without foregoing the benefits of independence and flexibility".

"A mix of public and private services which facilitates complimentary roles rather than conflict".

## Defects in System

The document lists some of the weaknesses within the above mix, including inadequate focussing of the services on specific goals and consequential difficulty in assessing effectiveness.

## Community Aspects

Inadequate linkage between hospitals, General Practitioners, and other community services.

Organisation and Management

The report stresses the need to up-date organisation and management structures to provide more effective decision making and accountability.

Quality of Service

Achievement of the highest possible quality standards within available resources is emphasised.

Accountability

Accountability is presented as an issue of major consequence as is cost effectiveness. While use of the word 'productivity' has been avoided, quite clearly it is central to the overall objectives.

In discussing the specific role of services and, the framework for their development, a number have immediate and longer term relevance for Peamount.

Linking Community Care and Hospitals

The report stresses the significant problem of lack of integration between services for the elderly in the community and those in hospitals.

Linking G.P.s and Hospitals

Again the necessity for integration in this area is outlined. Specific mention is made of progress in this area. It is indicated that at hospital level 'there will be increased emphasis on the provision an appropriate referral service to General Practitioners'.

Four Year Programme 1994-1997

Within the programme there is provision for :

1. a small number of highly specialised tertiary or supra regional units,

2. self sufficiency in community and regional specialities in each Health Authority.

General Practitioners

Wide consideration is given to the better organisation of General Practitioners service with more organised support and a more integrated role. In this context, providing access to appropriate investigative facilities and other services within hospitals has relevance.

Two areas are of immediate consequence, in the light of the on-going discussions between EHB/Dept. of Health and Peamount - the ill and dependently elderly and the young chronic sick.

Ill and Dependent Elderly

The report states that priority will be given over the next four years to strengthening home, community and hospital services to elderly people. The objective will be to :

1. support the care of older people in community through various services, including hospital based services,

2. to provide high quality hospital and residential care for older people when they can no longer be maintained in community.

Young Chronic Sick

In view of the EHB's undertaking to fund a unit for Young Chronic Sick in Peamount this Autumn, the commitment in the report to provide additional residential facilities is important.

People with Mental Handicap

There is a commitment to the 'development of residential and community based facilities' for the mentally handicapped, with a particular emphasis on 'catering for unmet needs'.

Amongst the key developments to be put in place over the next four years are better assessment of needs, further expansion of residential and day places, and the provision of home support.

Future Organisational Structures

Changes are envisaged in regard to future organisation of services in terms of policy and delivery. While responsibilities, State/Health Board management functions and the role of the Voluntary Sector are outlined, specific detail is not provided. Changes envisaged

are dependent on the introduction of new legislation. The exact format of the new structure will be established following discussion on the strategy document and the receipt by the Dept. of Health of submissions from interested parties.

Many of the proposed changes will have consequences for Peamount:

1. The Minister for Health and his Dept. will be responsible for the development of Health policy and overall control of expenditure but would not be involved in their detailed management.

2. Devolvement of responsibility to executive agencies means that the new Health Authorities will be responsible for the delivery of services.

3. Greater autonomy as envisaged will have the concomitant of increased accountability at all levels and independent monitoring and evaluation.

4. While the Board of the Health Authorities will determine strategic plans within the national framework and agree budgets, the management of the services will be the responsibility of the Chief Executive of the Board who will be given the necessary autonomy.

5. A new Authority will be established to replace the existing Eastern Health Board.

<u>The Voluntary Sector</u>

1. All funding will be provided by the Health Authority and funding will no longer be provided directly by the Dept. of Health.

2. Voluntary agencies will be accountable to the Health Authority for the public funds which they receive.

3. The independent identity of the Voluntary agencies will be fully respected and they will retain their operational autonomy while being fully accountable for the funds which they receive.

4. Larger Voluntary organisations will have service agreements with the Health Authorities.

Summary of Implications for Peamount

Apart from the organisational and structural changes listed, a number of important issues emerge from the overall presentation of policy review, proposed change and short-term action plan. Particularly relevant to Peamount are :

1. The emphasis on delivery of service in community and in conjunction with community services.

2. Provision of national or supra-regional specialities, although these are not specified.

3. Linkage of all services in the Eastern Health Authority area, on a geographic basis, to four or five main acute hospitals. No detail is available although the indications are that Peamount would probably be linked to Tallaght.

4. Access and association of local G.P.s with hospitals and their involvement in services there.

5. The involvement of Peamount in Community Care in hospital, mental handicap and other areas. This will apply to future development of services and can only be advantageous as, for instance, in the integration of the Mental Handicap Unit into both local and national programmes.

6. Provision of residential services for the elderly and day and short-term care services on a community basis.

7. Services for the Young Chronic Sick.

8. Financial aspects of more meaningful budgeting - assurance of funding for services contracted or covered by service agreement, accountability, assessment, productivity and cost effectiveness of service delivery and competitiveness.

The foregoing summary and brief analysis of the Dept. of Health Strategy document provides the background for the preparation of Peamount's Strategic Plan. Many details acquired by the management and obtained at various Dept. of Health, EHB, Voluntary Hospital and other briefings have not been presented. They have, however, been valuable in providing guidelines in anticipating specific health service needs and in assessing the competence and potential which exists or can be developed within Peamount Hospital Incorporated.

# Section Two

# PROPOSALS

# PROPOSALS

The proposals advanced and the possibilities listed in the following chapters have been prepared by the management team on the basis of the following assumptions:

1. Peamount Hospital Incorporated would deliver its service from its existing base. Delivery of services from another base would require a different strategy.

2. Maximum integration into local community services would be achieved in all areas of activity.

3. Supra regional services in a particular speciality e.g. T.B. would be delivered as part of a national programme.

4. Total integration of services currently delivered in isolation e.g., Mental Handicap Service, into the national programme.

Proposals have been developed on the basis of:

1) Existing and anticipated needs.

2) Conformity with the Dept. of Health Strategy.

3) Existing competence and experience as well as the potential to be developed.

4) A number of original concepts geared to meeting urgent needs.

It is important to have regard to the difficulties involved in organising and structuring a diversity of activities into a single organisation and this will be the subject of specific recommendations later.

Sectoral recommendations incorporate a necessary element of appropriate review and presentation of specific background information. This involves the risk of some repetition of comment made in earlier chapters.

# Chapter 6

# THE CHEST HOSPITAL

## INTRODUCTION

The past decade has probably been the most difficult period in Peamount's long and distinguished history. It was a time of unprecedented cut-backs in health care spending. Most of these cut-backs occurred in the acute hospital services. The result was a closure of approximately 1000 acute beds in the Dublin area, all of these in the voluntary care element of the health service. Inevitably this meant intense pressure on all small voluntary acute care hospitals. Most succumbed. There were further problems. There was a strongly held ideology that single specialty hospitals should be abandoned - a view promulgated by Comhairle na nOspideal and accepted by the Department of Health.

The future looks better. Tuberculosis can no longer be ignored. The WHO and the IUATLD have focused the attention of the developed world on what they regard as one of the most important diseases in the world.

The medical establishment in this country are unsure of how to react to this new situation. Most of the Respiratory Consultants returned from the U.S.A. with a firm belief that resource allocated to tuberculosis was largely wasted and now find that the United States has totally changed its outlook. Irish Consultants now cut-off from their American sources however are unsure how to react. The result is that although the world has again changed its mind about tuberculosis we cannot expect an easy ride even now in this country.

It is therefore of great importance to us that we plan for the future, taking note of the changes in the world but clearly needing to apply ourselves to the realities of health care provision in this country.

## PRESENT POSITION

The hospital has consolidated its position as a significant provider of health care. It provides tuberculosis and other respiratory disease services on a supra-regional basis. It has also used every opportunity to expand its range of services in the interests of its local patients. It is conceded nationally and acclaimed internationally as a centre of excellence for the treatment of tuberculosis.

In line with changing health care philosophies the hospital has changed from an almost exclusively in-patient service to a predominantly out-patient/day care service with its in-patient bed numbers reduced from 280 in the early 1980s to the present 80.

During these changes we have - cared for a consistently increasing number of patients, increased medical teaching and research and achieved financial stability despite a drastic reduction in funding. In the future more than in the past it will be necessary to provide services to an agreed quality standard. To do that we must optimise the quantity and range of services provided. Our services must be effective and appropriate.

## MISSION

To continue to create and operate a centre of excellence in the provision of tuberculosis and other respiratory medicine services taking full heed of the changes that have occurred in the health services, particularly the strategy set out by the Minister for Health in 'shaping a healthier future'.

Our objectives should be:

1. To provide the highest quality patient care.

2. To optimise the quantity and range of services provided.

3. To develop additional services through agreement with the funding agency.

4. To provide and support a programme for teaching and research while maintaining financial viability.

## 1. CURRENT ACTIVITY

### 1.1. In-patients

It has been agreed with the Eastern Health Board and the Department of Health that the chest hospital shall consist of a greatly reduced bed number of 80, these being divided almost equally between in-patient accommodation for tuberculosis and non tuberculous respiratory diseases.

It has also been agreed that there be a small number of day beds, and that here will be out-patient facilities to support this activity.

The range and scope of the services provided in this field have not been defined in discussion.

Present out-patient services include:

- New patient and follow up clinics for tuberculosis and other respiratory diseases.

- TB clinics which allow for education and testing of compliance as well as clinical review.

- A special asthma clinic with a particular structure to facilitate the attendance of school-going children.

### 1.2 Day Ward

With the change from in-patient to out-patient based services there has been an increased need for day ward, particularly for patients with chronic lung disease.

This unit offers:

- Rehabilitation for chronic lung disease with support services including physiotherapy, occupational therapy, social support,

- Education particularly with regard to drug compliance. - Treatment modalities during rehabilitation include nebulisation of bronchodilators and oxygen therapy.

Respiratory assessment includes:

- Respiratory function laboratory measurements, observations and education.

- Assessment in particular suitability for longterm domiciliary oxygen treatment.

There are approximately 1000 patients in the country receiving domiciliary oxygen treatment at present, many of them badly controlled and receiving little or no benefit from this expensive treatment. Within our unit they are assessed according to protocol and determination of their suitability and likely benefit from oxygen, objectively tested.

1.3 Bronchoscopy Service

This is available as a day ward activity and is of prime importance in the diagnosis of lung cancer but also tuberculosis, sarcoidosis and interstitial lung disease. The procedures carried out here include bronchoscopy, bronchoalveolar lavage and transbronchial lung biopsy.

1.4 Smoking Cessation

Much of chronic respiratory disease is smoking related. Smoking cessation programmes are part of our activity.

Success rates are at least equal to that in any other programmes.

1.5. Pharmacy

The Pharmacy has stocks of agents commonly required in respiratory and general medicine.

1.6 Radiology Department

This at present is essentially a plain film service with some medium contrast work.

For the development of transbronchial lung biopsy screening facilities are necessary and should be added on.

## 1.7 Laboratory Services

At present we perform routine haematology, biochemistry and microbiology while sending out specimens for rarely used tests, particularly in endocrinology and isotope work.

The TB lab is of course well developed and mentioned earlier.

## 1.8 General Practitioner Services

There are reasonably good working relationships with a number of General Practitioners in south west Dublin and in Kildare. Attempts in the past to structure a service for this area may have clashed with aspirations to deliver and develop the general hospital service at Tallaght. These need to be re-explored now.

We provide local general practitioners with access to:

- The laboratory for routine blood and urine tests.

- Access to X-ray for plain chest radiography.

We have limited direct G.P. access to:

- Physiotherapy services.

- Para-medical services.

- Specialist clinics, e.g. ENT, Psychiatry, Ophthalmology.

## 1.9 TB Telephone Consultancy Service for Public Health Doctors

This is effectively a tuberculosis help line. It has no formal status. Essentially it is an ad hoc service offered by the senior medical personnel at Peamount to Public Health Physicians in all eight Health Boards who have queries about the management of tuberculosis.

It also provides information for other sectors of the health service including teaching hospitals, paediatric units, health screening units etc., in the management of tuberculosis.

This could be a useful area to promote, particularly as we are the constituent member of the International Union against Tuberculosis and Lung Disease, but while it may elevate the profile and perception of the hospital, may reduce hospital activity.

## 1.10 Academic/Research

### Academic

Both the Medical Director and Senior Hospital Medical Officer are on the Trinity College Health Sciences faculty staff and are actively involved in teaching undergraduates from T.C.D. The students from that medical school attend in their final year for instruction in tuberculosis and lung disease.

There is also an active in-house training programme for post-graduate doctors sitting higher examinations including MRCPI and MRCGP.

The hospital is recognised by the Royal College of Physicians and the Royal College of General Practitioners as suitable for higher medical training for these colleges.

### Research

Peamount Hospital has been the main focus of tuberculosis research in this country for the past 10-15 years. It has a national and international reputation in this field and has been responsible for some of the important advances in treatment and diagnosis.

It has published widely on outcome measures in tuberculosis and set standards.

The hospital is the constituent member for Ireland of the International Union Against Tuberculosis and Lung Disease. On the basis of its research and clinical output it is recognised for organising formal teaching seminars and workshops in tuberculosis for specialists in public health medicine.

It was the main focus of a Diploma in Chest Medicine of the Conjoint Royal College of Physicians and Surgeons which as aimed primarily at foreign medical graduates.

Funding for TB Research has increased dramatically in the USA and to a lesser extent in the E.U. as a whole but is entirely without public funding in this country.

## 2. PROPOSED DEVELOPMENTS IN TUBERCULOSIS

### Control and Surveillance

With recognition of the hospital as the main in-patient area for tuberculosis in the country it is important that it take a prime role in the monitoring of control and surveillance programmes for tuberculosis.

To do this in a recognised way it is important to establish formal links with the health authority and with the Department of Health to recognise the work being done and put structures of reporting and analysis in place so that the unit becomes the epidemiological focus for tuberculosis in the country.

### 2.1 TB/AIDS

While Peamount has cared for many of the patients with TB and AIDS, the referral pattern is not established and the process of keeping AIDS/TB patients in general hospitals has not been examined.

The increasing knowledge of the infectiousness of tuberculosis, especially in this setting, has lead to a clear demand for isolation facilities.

The provision of these in general hospitals would be unecessarily expensive and also unnecessarily restrictive on individual patients.

It is therefore essential that clear guidance for the care of these patients should emerge and it is important therefore that formal contact be made with the National AIDS Committee so that this can be agreed.

### 2.2 TB Laboratory

Peamount has the highest number of positive TB specimens of any laboratory in the country and is recognised as a reliable laboratory with good quality control.

BACK-TECH

It should now be recognised as the National Reference Laboratory for Tuberculosis. It is increasingly important that this is done.

As the number of TB cases diminishes, the quality of service in individual hospitals where the chance to develop in this branch of microbiology are very limited, is likely to deteriorate.

Further the worry about the emergence of multi drug resistant tuberculosis (MDR-TB) makes it essential that accurate sensitivity testing is available. If this is carried out in laboratories dealing with a small number of specimens it becomes unreliable as well as very expensive. Peamount has introduced Bactec culture techniques for TB which will give a very quick result which again becomes very important in the AIDS/TB era.

Further development in molecular biology is affording the opportunity of introducing very accurate and speedy examination at a very high cost and the control of this is also important.

It could be efficiently developed by Peamount laboratory in conjunction with the TCD academic department of microbiology.

## 3. NON TB CHEST DEVELOPMENTS

### 3.1 Asthma

Asthma is an important common disease which is increasing. It effects up to 10% of the population and is particularly common in young people.

The need to develop programmes of education in compliance as well as diagnosis and treatment are important and this development should be promoted further in our hospital.

### 3.2 Rehabilitation

While there are respiratory rehabilitation facilities for cystic fibrosis patients Peamount has the only respiratory rehabilitation service for adult chronic lung patients.

This is a deficiency that has been recently identified by the National Rehabilitation Committee set up by the Department of Health. We are already doing this but it needs upgrading and resourcing.

It is an appropriate development for us but to make it successful the catchment areas and referral patterns would have to be structured so that it was not under-used or inappropriately used.

3.3 Longterm Domiciliary Oxygen Treatment

This service is at present available for our own patients but we have estimated that there is some £1 million per year wasted on this treatment because of inadequate assessment, control and usage. If again this role was given to Peamount it could do it very efficiently and should result in big savings as indicated.

3.4 Lung Cancer

At present we are involved in the diagnosis of lung cancer. Thoracic surgery being carried out in St. James's Hospital and the chemotherapy of oat cell carcinoma is performed at Peamount.

Increasingly the case for chemotherapy of inoperable non small cell lung cancer is being advocated. The number of patients that this would yield is very high and the need for Peamount to become involved would increase greatly.
However, the decision to extend this treatment modality to these patients should not be taken unilaterally but it will emerge in the near future as a real possibility.

3.5 Respiratory Function Laboratory

This laboratory carries out a range of tests including:

- Spirometry.
- Lung volumes by helium dilution.
- Gas diffusion by carbon monoxide transfer
- Reversibility testing.
- Cardiac output.
- Histamine challenge testing.

There is potential for expansion in the activities in this unit, particularly by taking on exercise assessment and challenge.

The industrial implications of challenge testing with the increasing number of agents recognised as causing occupational asthma is major.

### 3.6 Potential Development of Extended Role in Chest Medicine

Peamount is well placed to supply a specialist respiratory service to the new Tallaght hospital and in the intervening period to the cardio-respiratory unit at St. James's.

These developments can only take place by deliberate planning and negotiating.

## 4. GENERAL MEDICINE

It is entirely inappropriate that when there is an under-provision of beds for emergency medicine that Peamount is not incorporated into an acute admission service probably linked with Naas but also ideally suitable for its surrounding areas.

## 5. RESPIRATORY MEDICINE

The programme for continuation of respiratory medicine at Peamount is based on the 'Strategic Review' paper prepared by Dr. Clancy last May. Proposals for the expansion of that service are outlined in this section. Some new activities in other health service areas are presented. The latter are discussed in greater detail in the section - Community Hospital.

# Chapter 7

## NEW DEVELOPMENTS

The development of health services other than the respiratory service raises new and important issues. Integration of new activities into the existing programme at Peamount require careful study. The basic motivation comes from:

a) the necessity for new services to meet community needs,

b) the potential which exists in Peamount for the delivery of these services,

c) the expansion of hospital activity to overcome the financial problems outlined in Chapter 4.

The approach taken by the management team included:

i) discussion with individual Health Boards and others to identify needs,

ii) visits to Community Hospitals and Health Centres and other organisations to obtain first hand knowledge. Day-to-day operation of these facilities were seen at first hand and discussed in detail with the providers.

Following analysis of the information gathered and the experience of observing the delivery of relevant services as outlined above, proposals to develop a Community Hospital at Peamount are presented. This would not be a substitute for existing services but would be an integrated activity of Peamount Hospital Incorporated.

# COMMUNITY HOSPITAL

In examining its future role within the health services the management has considered how it will best serve the local community in providing services aimed at supporting and meeting the needs of an increasing and mixed age population within a suburban/rural setting.

Smaller hospitals have an important positive role and that role is clearly linked to local needs. Other small hospitals within our locality are few, namely Naas Hospital, St. Loman's Psychiatric Hospital and Cherry Orchard Hospital: the latter is almost full with a mixture of services.

It is necessary to give consideration to the needs of our immediate communities. Local population trends show an expanding young population while retaining an elderly population of approximately 7.5%. This is due to the development of old well established villages.

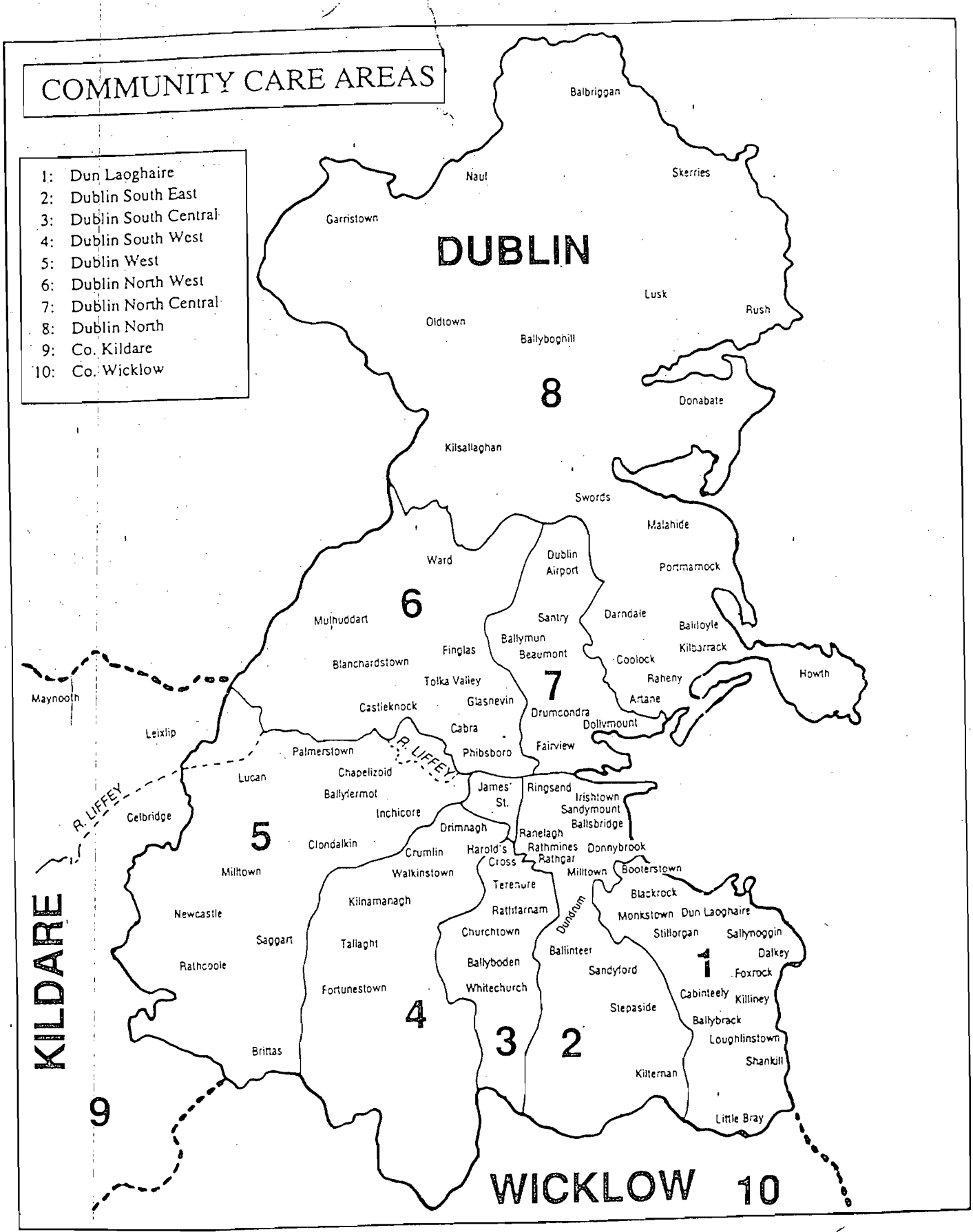
The national census of population of 1986 shows the population of for Community Care Areas 4, 5 and 9 as follows:

Area 4 population of 148,781 - Dublin south west

Area 5 population of 103,264 - Dublin west

Area 9 population of 116,247 - Co. Kildare

The principle impact affecting the Eastern region health services will be the projected increase of 30% of the elderly population over 65 years of the greater Dublin area by the year 2000.


COMMUNITY CARE AREAS
1: Dun Laoghaire
2: Dublin South East
3: Dublin South Central
4: Dublin South West
5: Dublin West
6: Dublin North West
7: Dublin North Central
8: Dublin North
9: Co. Kildare
10: Co. Wicklow
DUBLIN
KILDARE
WICKLOW
Balbriggan
Naul
Skerries
Garristown
Lusk
Rush
Oldtown
Ballyboghill
Donabate
Kilsallaghan
Swords
Malahide
Portmarnock
Dublin Airport
Ward
Mulhuddart
Santry
Darndale
Baldoyle
Ballymun
Beaumont
Kilbarrack
Finglas
Coolock
Howth
Blanchardstown
Tolka Valley
Raheny
Artane
Maynooth
Castleknock
Glasnevin
Drumcondra
Dollymount
Leixlip
Cabra
Fairview
R. LIFFEY
Palmerstown
Phibsboro
Chapelizoid
Lucan
James' St.
Ringsend
Irishtown
Ballyfermot
Sandymount
Inchicore
Ballsbridge
Celbridge
Drimnagh
Ranelagh
Clondalkin
Crumlin
Harold's Cross
Rathmines
Donnybrook
Rathgar
Milltown
Booterstown
Walkinstown
Terenure
Blackrock
Kilnamanagh
Monkstown
Dun Laoghaire
Newcastle
Rathfarnam
Dundrum
Churchtown
Stillorgan
Sallynoggin
Saggart
Tallaght
Ballinteer
Dalkey
Rathcoole
Ballyboden
Sandyford
Foxrock
Fortunestown
Whitechurch
Cabinteely
Killiney
Stepaside
Ballybrack
Loughlinstown
Britas
Shankill
Kilternan
Little Bray

The 'Services for the Elderly' report gives details of size of population and age structure. (see Table 11).

TABLE 11

STATISTICAL ANALYSIS SHOWING OVER 65 AGE GROUPS

FOR COMMUNITY CARE AREAS 4, 5 and 9.

| Community Care Area | Total Population | Over 85 | 75-84 | 65-74 | Total Over 65 | % of Area | % Of EHB |
|---|---|---|---|---|---|---|---|
| 5 | 103,264 | 405 | 1,803 | 4,315 | 6,520 | 6.5% | 6.0% |
| 9 | 116,247 | 459 | 2,410 | 5,216 | 8,035 | 7.0% | 7.5% |
| 4 | 148,781 | 487 | 3,084 | 6,337 | 9,908 | 6.6% | 9.2% |

Of the 1.25 million people living in the Eastern Health Board area some 120,000 are aged 65 or older.

28,000 live in the St. James's catchment area,

15,000 in the proposed Tallaght catchment area,

8,000 in the Naas General Hospital catchment area.

Thus, in the nominal sub-division of the Eastern Health Board area, giving sub-divisions of approximately 250,000, an estimate will be that 20-25,000 residents of each area will be in the geriatric (older than 65 years) age group.

The development of a Community Hospital at Peamount would be the most appropriate activity to serve the local community.

The Minister's Health Strategy emphasis the need for community based services with improved integration into the services of the hospital.

Activity at Peamount's Chest Hospital already provides a service locally and is a popular referral centre for many General Practitioners. Their involvement in this development would be important for its future success.

What is a Community Hospital?

A Community Hospital, a primary referral hospital (others being secondary and tertiary referral hospitals) is one where the day-to-day medical cover is provided by General Practitioners with the co-operation of consultants. It is complimentary to the General Hospital.

No two Community Hospitals are alike because activity responds to local need. The ideal model, however, comprises accommodation for General Practitioners, health and social services, day facilities and in-patient accommodation.

A full range of integrated facilities are provided at community level serving the needs of a defined population. The level of in-patient activity in the Community Hospital should be that which can be supervised by a General Practitioner.

The Community Hospital and Peamount.

Various models of the community hospital have been examined with no ideal model identified to suit our needs or the needs of the local community. The "Peamount Model"will evolve through future discussions with the new health authority in determining local needs.

Recent discussions with the Eastern Health Board have included many suggestions for a range of activities for Peamount i.e. services for the elderly, a stepdown unit, a rehabilitation unit, day hospital activity and the young chronic sick.

Current trends within the health Services are that many of these activities are provided within the Community Hospital for a locally identified population.

Peamount Hospital in having a Community Hospital would serve the non-consultant treatment needs of the local population mainly Area 5 and North Kildare. It would be staffed by General Practitioners with medical cover provided by the Chest Hospital.

Patients would also be accepted from acute hospitals at their request.

The community hospital could also facilitate outreach clinics.

Services Required

Activities required locally are related to the needs of a younger population group, older people and General Practitioners.

In the Services for the Elderly Report (E.H.B. 1989) it was proposed that for areas 4, 5, and 9 an additional 951 beds/places would be needed to care for the elderly as follows:

155 Extended care / respite.
48 Day hospital.
135 Assessment/rehabilitation.
613 Welfare.

We have identified areas of activities that Peamount can offer in order to address some of the above as follows:

1. Inpatient Accommodation

Long Stay Elderly Care.

Short Stay Elderly Care:

- Respite Care.
- Intermittent Care.
- Convalescence Care.

Elderly mentally infirm Unit:

- Long term care
- Respite care

Terminal Care.

Young Chronic Sick:

- Long stay care.
- Respite care.

Independent Living Units.

2. Outpatient services

Specialists clinics.

Investigations.

Industrial health.

Nursing Clinics.

Day Activities for the elderly.

3. General Practitioner Services

4. Rehabilitation

## 1. IN-PATIENT ACCOMMODATION

### 1.1 Long Stay Elderly Care

35 beds would be allocated to long term nursing care for elderly people too ill or unable to return home.

Admission would follow consultation with a Geriatrician and the team for the elderly in accordance with the admission policy for the unit.

Each patient would continue to be cared for medically by his General Practitioner or where this is inappropriate be allocated to the medical team within the hospital.

### 1.2 Short Stay Care

A variety of care options would be available for short stay including:

**Respite Care** - admissions to be prearranged for up to a maximum of three weeks.

Reasons for admissions are varying and include; holiday relief, carer relief, living alone.

Admissions may be once only or every 4-6 weeks depending on individual needs.

Number of beds available in Peamount range from 5 to 20.

**Intermittent Nursing Care** - admissions to be arranged for frequent monitoring or provision of nursing care for 2/3 days per week (floating bed system).

**Convalescence Care** - for people recovering from acute illness but too ill to return home i.e. patient postoperative, orthopaedics, general surgery etc.

Care will be provided the patient's General Practitioner and will be integrated with the rehabilitation team.

## 1.3 Elderly Mentally Infirm Unit

The need for this type of accommodation for the over 85's cannot be ignored in addressing local needs. It is proposed that a small unit of 10 - 15 beds should be allocated for this group of people.

A combination of long term care and respite care would be offered.

The provision of medical cover for this unit will need further consideration. The requirement of the services of a psychogeriatrician is essential.

## 1.4 Terminal Care/Palliative Care

It is important when providing palliative care that the philosophy of the Hospice movement is adapted.

Palliative Care aims to provide a variety of services including:

- Pain relief as an In Patient or outpatient.
- In patient care.
- Home team care.

A special palliative care unit would be provided with approximately 8-10 beds allocated for this purpose. This unit could offer continuity of care and active symptom control by staff with expertise in palliative care.

The palliative care unit would address the needs of the local community through active involvement as members of a steering committee. The client group will be people from our catchment area who have been diagnosed as having a terminal illness and who are no longer in need of curative treatment.

Staff numbers would be sufficient to provide a high staff/patient ratio.

## 1.5 Young Chronic Sick

We would provide In Patient accommodation for people with physical disabilities from the Eastern Region. Medical conditions include; stroke, head injuries, spinal injuries, multiple sclerosis.

25 beds would be allocated five of which are for respite care. Admission to the unit will be in consultation with the rehabilitation centre in Dun Laoghaire with whom close links are essential.

On-going assessment of those availing of respite care would ensure they are maintained at a level fit for community care.

Emphasis of care would be on individual living, daily occupation/employment, and social activity.

Integration into the community would be an essential part of this service.

## 1.6 Independent Living Units

The existence of Peamount's large land bank presents the possibility of new innovations.

When caring for people with disability, whether old or young, the request to live independently will inevitably arise.
Independent living units provide specially adapted individual apartments for those individuals who have potential to live alone or in shared accommodation but need the security of medical, nursing and allied support.

## 2. OUT-PATIENT SERVICES

A full range of Out Patient services would be provided and would include those currently available in the Chest Hospital.

A range of Consultant staffed Out Patient clinics could be developed if needed. These Outreach Clinics could offer easy access to patients from the catchment areas.

Other non consultant clinics would be developed to include nursing, psychology, family planning, counselling, continence care, stoma care etc.

### 2.1 Investigation Facilities

Investigation facilities are already available and are outlined in Chapter 5, dealing with the Chest Hospital.

### 2.2 Industrial Health

As part of the Community Hospital a service would be offered to local industrial activity. This would compliment any current Occupational Health programmes they have already been established or provide total industrial medical/nursing needs of individual companies.

### 2.3 Day Activities

Day care facilities should be available to cater for 25 people.

Services to be offered:

- Physiotherapy
- Occupational
- Nursing Care
- Meals
- Chiropody
- Hairdressing
- Education

## 3. GENERAL PRACTITIONER SERVICES

New developments for general Practitioners at Peamount could involve the active participation on site of General Practitioners or just services provided by the hospital to the G.P.'s .

Approximately 25 beds would available for General Practitioners. Patients would be admitted for a variety of conditions not requiring admission to the Acute General Hospital, The General Practitioner would visit patients while in hospital and will be involved in case conference.

The services most sought are those mentioned for the Chest Hospital Services. Those most frequently requested but not available at Peamount are assessment/placement of the elderly or young dependent patients.

In order to define clearly what the General Practitioner demand would be, we propose doing a survey.

## 4. REHABILITATION

This is an essential part of the activities of the new developments relating to the Community Hospital and could be established following the appointment of a Consultant Geriatrician for Tallaght Hospital.

Rehabilitation will aim to promote activity, restore mobility, adapt environments, provide aids and be part of the assessment process of patients.

Physiotherapists/Occupational Therapists would be integrated from the Community Services into the hospital Rehabilitation Team and would be familiar with the needs of individual patients from their involvement with them in the community prior to admission.

Case conferences could be held and would integrate hospital and community personnel.

The liaison nurse has an important role to play in the rehabilitation team. This service is already available at Peamount.

GENERAL

The management team recognise the problems of operating a Community Hospital in conjunction with the existing Chest Hospital. It will be necessary to prepare a detailed working plan if the proposal is accepted in principle.

Since the Community Hospital would not operate on a stand alone basis, it would not follow the exact pattern of existing hospitals.

The aim would be to provide services similar to those developed elsewhere with, for example, the same type of GP access.

Unlike other Community Hospitals the location at Peamount requires different internal organisation and management. This must ensure:

1. Smooth operation.

2. Maximum utilisation of existing services and staff to achieve efficiency and economy.

3. Active involvement of outside interests delivering important elements of the new service e.g. a General Practitioners and might extend to include a local G.P. on the management team.

4. Retention of control of Peamount management while providing the facilities for the achievement of the stated objectives of the Community Hospital. This is necessary in relation to delivery of service and accountability.

# Chapter 8

## MENTAL HANDICAP

A Draft Development plan for the Mental Handicap Services at Peamount - 1993-1999 - was completed by the management and staff in April 1993. (see Appendix 2). This programme was prepared when the management became aware that other organisations had been invited to submit their seven year needs and proposals to the Central Planning Committee for Mental Handicap within the Eastern Health Board. Peamount were not invited to do so.

The draft development plan was submitted to the Finance & General Purposes Committee on 4th May 1993 and subsequently to the Board. The Finance & General Purposes Committee directed that the plan be forwarded to the Central Planning Committee, eventhough it had not been requested. The plan was given to that Committee on 13th December 1993.

The Central Planning Committee did not respond to the proposals. The management learned subsequently that it had been sent by the Committee to the Dept. of Health.

In compliance with the request of the Finance & General Purposes Committee at the February 1994 meeting for a development programme, the management reconsidered the draft plan for the Mental Handicap Unit.

There has always been a problem in the calculated isolation of Peamount Mental Handicap Unit. The service had not been integrated into the general Mental Handicap Service. Some progress was made in recent years e.g. through the community residences at Newcastle, but inadequate integration is still a problem.

The Finance & General Purposes Committee authorised the management to seek the assistance of outside consultants in the preparation of the Development Programme. Dr. Vincent Molony was requested to examine the Mental Handicap Unit and to advise on the reorganisation of services. He was asked to have particular regard to the problem of integration into the local and national services for the mentally handicapped. It was felt that he was an appropriate person to do so being Director of Mental Handicap for the Eastern Health Board and familiar with the needs and inadequacies in the existing services. Since he is the Visiting Psychiatrist to Peamount he knows the client population and the services provided.

He had been consulted in the preparation of the Peamount Draft Development Plan for the Mental Handicap Services at Peamount in 1993. There has been further consultation and discussion with Dr. Molony and his report entitled 'Peamount Project 2000' is incorporated into the Preliminary Development Project with his agreement.

Many proposals in Peamount's 1993-1999 programme are included in 'Peamount Project 2000' with other suggestions. In addition, proposals are made for the reorganisation of the Peamount services. Basic changes are proposed to up-date the services. Fundamental changes in funding procedure are stressed so as to cost service delivery on the basis of individual client needs.

Some preliminary discussions have taken place with the EHB to establish the system for new admissions. Specific provision is made for the provision of community services with a view to overcoming the isolation of the Peamount service. Recognition of the proximity of the Chest Hospital to the Mental Handicap Unit provides the basis for his proposals for co-operation between the two sections in interesting joint developments.

The proposals have been combined into a comprehensive programme with the novel title - 'Peamount Project 2000'. As a consequence, the Peamount Plan 1993-1999 is now included as an Appendix to this report rather than being revised or included in addition to 'Peamount Project 2000'.

# PEAMOUNT PROJECT 2000

V. MOLONY, LRCPSI. D.P.M. L.M.
DMMH. M.M.M.H. MRC Psych

# PEAMOUNT PROJECT 2000

## Section One: Service Review

- Introduction.

- The Historical Perspective.

- The Present Facilities.

- Client Base.

- Location and Services within the Area.

- Census of Population.

# PEAMOUNT PROJECT 2000

## INTRODUCTION

The aim of this project is to look at the mentally handicapped services in Peamount in the context of the total services on the campus. We will look at the services at Peamount against the background of the overall strategy for effective health care in the 1990's as outlined by the Minister for Health in his document 'Shaping a Healthier Future', published in summer 1994.

This document noted that in 1993 residential services were being provided for 6,582 people and day services for 6,817 people.
The information currently available indicates that about 1,300 people are wait listed for residential services and 1,500 for day services.

In addition, this document noted that 942 people were inappropriately placed in psychiatric hospitals and needed to be rehoused in more suitable accommodation. I would see Peamount as having a major role in the further expansion of residential and day services. This would help meet at least in part the Minister's aims for the handicapped in the 1990's.
To do this I would envisage Peamount becoming more involved in the local Mental Handicapped Services by linking up with the community care teams in Areas 5, 4 and 9. Peamount should continue in the provision of services at national level. I note that some 87 clients out of a complement of 191 clients in residence are from outside the EHB area. These include representatives from the other seven Health Board areas.

The provision of the flexible home support schemes and respite care services are areas where we could expand. Mentally Handicapped persons with disturbed behaviour continue to be a source of concern. The provision of a small unit for about ten disturbed persons on the campus at Peamount should be considered. These places would help in coping with persons who become disturbed while already receiving residential care in Peamount. This care would be on the basis of crisis intervention. It the unit was not filled from the complement already resident in Peamount then short term placement for disturbed persons in the community could be considered. This would be a very high cost service and could include short term placement for persons with Autism.

This document would hope to address the suggestions put forward in the health strategy which was based on the recommendations of the review group of mentally handicapped services 'Needs & Abilities 1990'.

## PEAMOUNT THE HISTORICAL PERSPECTIVE

### THE CHEST HOSPITAL

Peamount Sanatorium for the treatment of tuberculosis was set up in 1912. Lady Aberdeen, wife of the Marquis of Aberdeen, while President of a voluntary body known as the Women's National Health Association, publicly campaigned against the prevailing scourge of tuberculosis. Peamount was set up as part of this campaign and continues to treat tuberculosis on a national basis up to the present day. In 1962 the Annual Report noted that there was a marked reduction in tubercular patients presenting for treatment. This resulted in spare bed capacity becoming available at Peamount. To utilise this bed capacity a decision was made to set up a Mental Handicap Service in 1963.

### MENTAL HANDICAP SERVICES START UP

Approximately 140 male mentally handicapped persons were transferred from the St. John of God Services in Celbridge and Drumcar between 1963 and 1974. In 1976 approximately 80 females from the Daughters of Charity services at St. Vincent's, Navan Road, and St. Joseph's Clonsilla, were transferred to Peamount.

To provide occupation for this group of persons extensive Workshops were developed in 1964 and have operated on a commercial basis on the campus at Peamount since that time. These services were unique in that mentally handicapped persons worked side-by-side with persons of normal intelligence in w hat was a real factory environment.

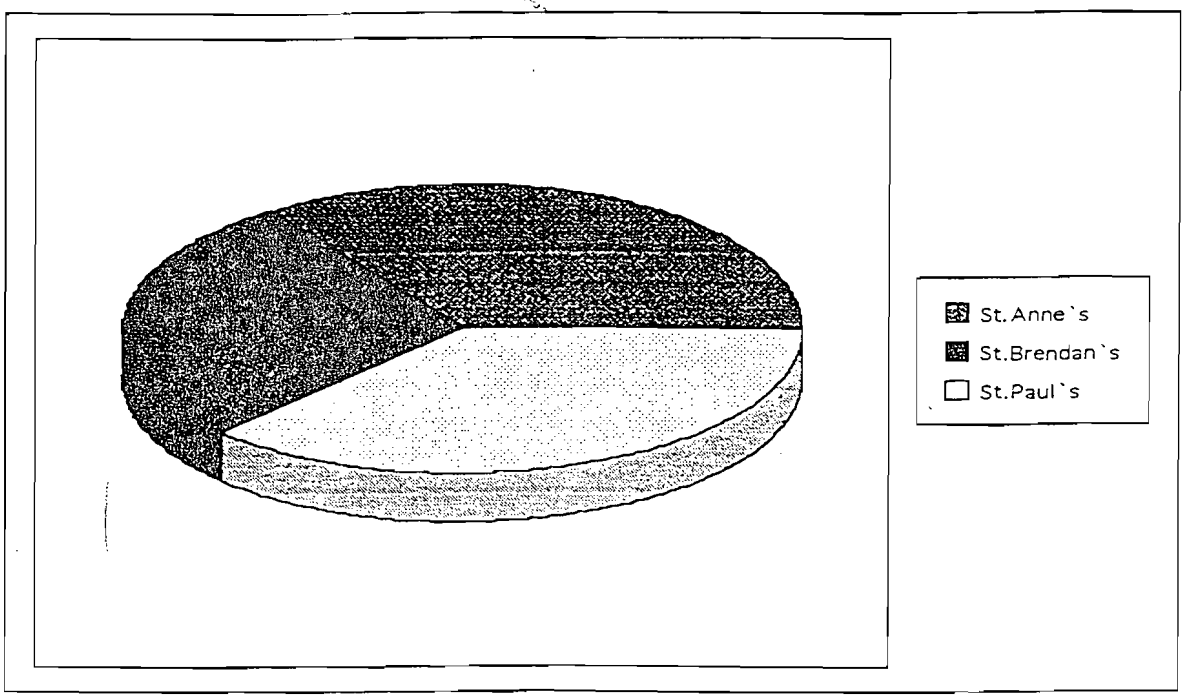
### THE RECENT PAST

In 1983 funding became available from the European Social Fund for the education of the mentally handicapped. New instructors were employed because of the new emphasis on skills training. In 1984 in a further development the social skills programme was introduced. An important part of this programme included the acquisition of a seventeen seater minibus for use on social outings and annual holiday outings.
A Consultant Psychiatrist was contracted to provide sessional services in that year. In 1988 the new village complex was started. This was to replace a wooden dormitory structure. The complex consisted of six bungalows which housed a total of 58 persons. In 1990 a new core building was erected for vocational training and training in catering. Four additional bungalows were built in the Peamount village complex in the early 1990's. In recent times, two houses were acquired in the local village of Newcastle to accommodate nine handicapped persons. This was the first step in Peamounts move into the community.

THE PRESENT FACILITIES

1 Three dormitory units housing approximately 100 high dependency persons.

| | | |
|---|---|---|
| A | St Anne`s unit | Residental care for 33 Females. |
| B | St Brendans unit | Residental care for 27 Males. |
| C | St Pauls unit | Residental care for 36 Males. |




2 Peamount village complex

ten Bungalows housing 95 persons mixed Male & Female

3 Dav services on campus.

A One sheltered factory - six units.
B One Activation unit.
C One Core Building for training & catering.
D One Assembly Hall for recreation & physical education.

4 Communitv Services.

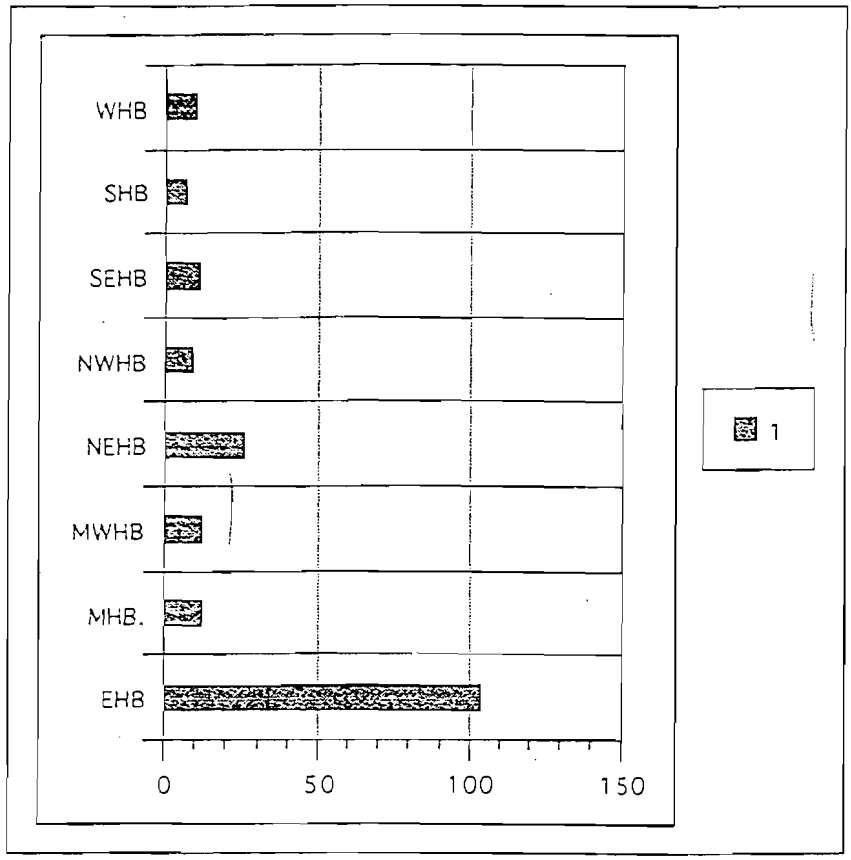
A Two houses in Newcastle Village coping with 9 Clients.

## Client Base.

Distribution of Mentally Handicapped Persons - based on the Health Boards of origan.

## Peamount total numer of Residents. 191.

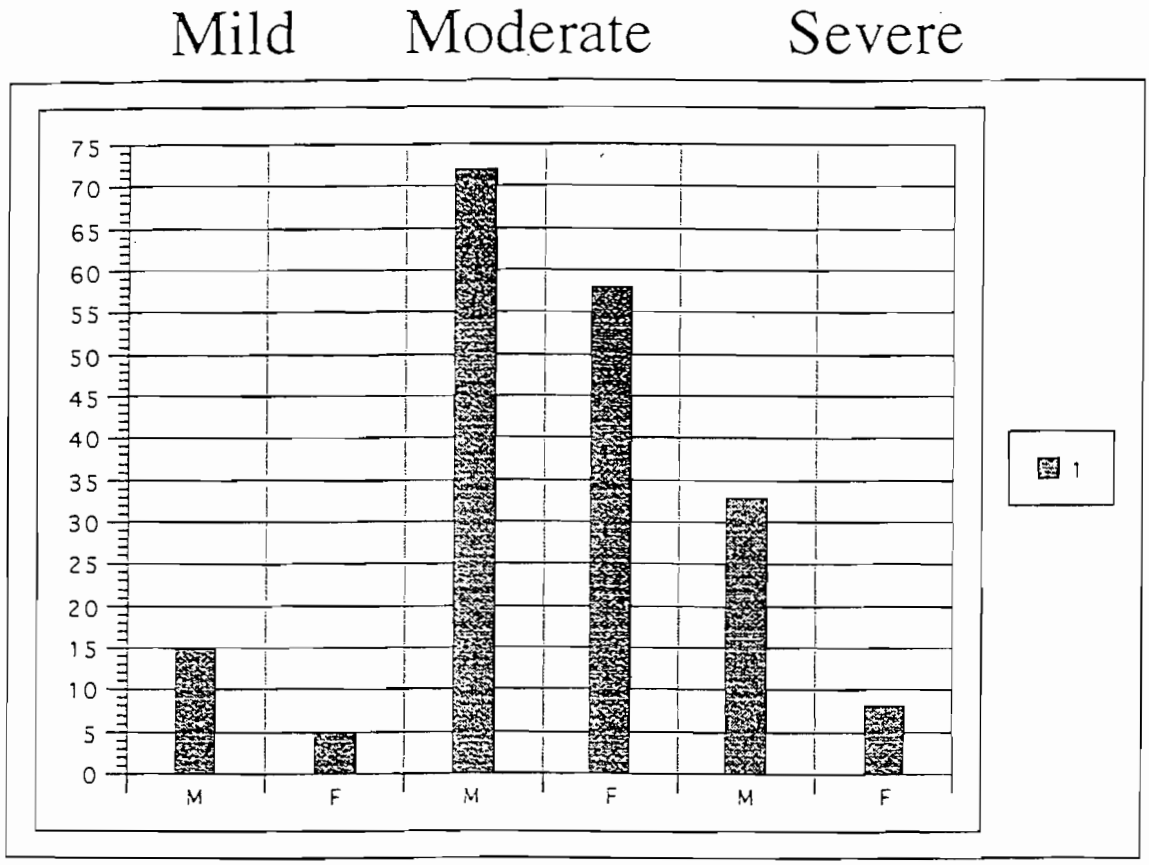
| | |
|---|---|
| Western Health Board | 10 |
| Sothern Health Board | 7 |
| South Eastern Health Board | 11 |
| North Western Health Board | 9 |
| North EasternHealth Board | 26 |
| Mid Western Health Board | 12 |
| Midland Health Board | 12 |
| Eastern Health Board | 104 |




## Distribution of Mentally Handicapped Persons on the basis of age, gender & degree of handicap.

| | Mild | | Moderate | | Severe | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | |
| 24 years | | | | | | | | | |
| 25-34 years | 2 | 1 | 3 | 2 | | | 5 | 3 | |
| 35-44 years | 6 | 2 | 28 | 28 | 9 | 7 | 43 | 37 | |
| 45-54 years | 2 | 2 | 29 | 23 | 11 | | 42 | 25 | |
| 55-64 years | 1 | | 7 | 6 | 6 | | 14 | 6 | |
| 65-74 years | 2 | | 4 | | 6 | | 12 | | |
| 75-84 years | 2 | | 2 | | | | 4 | | |
| 85 & over | | | | | | | | | |
| Total | 15 | 5 | 73 | 59 | 32 | 7 | 120 | 71 | |

# Bar chart giving the distribution of Mentally Handicapped Persons based on gender and degree of handicap.




| | | |
|---|---|---|
| Total number of | males 120 | females 71. |
| Degree of handicap. | | |
| Mild | 15 male | 5 female. |
| Moderate | 72 male | 58 female. |
| Severe | 33 male | 8 female. |

## PEAMOUNT LOCATION AND SERVICES WITHIN THE AREA

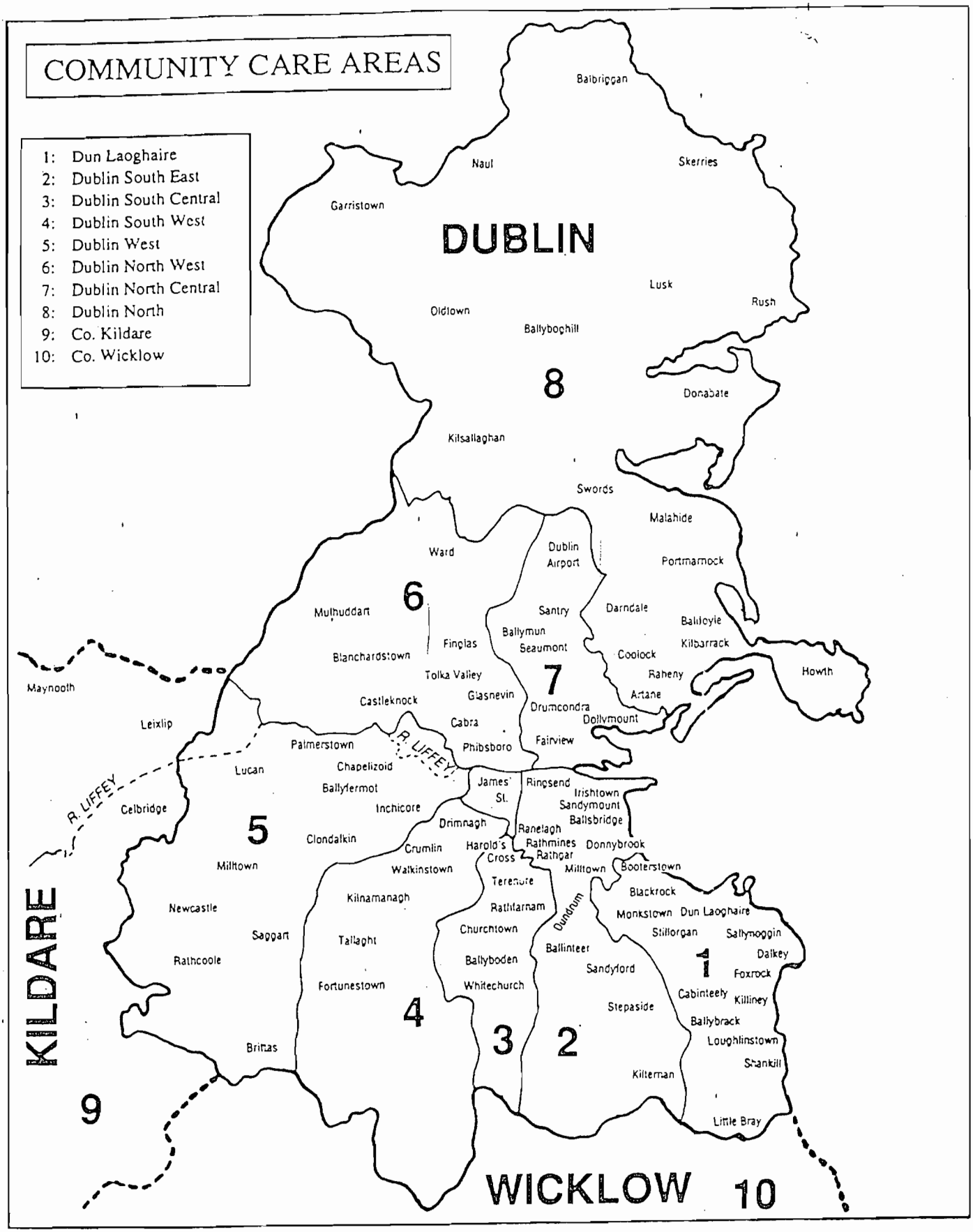
Peamount is situated about 1 mile from Newcastle village and 3 miles from the village of Lucan. It is in Community Care Area 5. It has a public bus service coming to and from the hospital.

It draws its client base from the major centres of population in Area 5. These include Newcastle, Rathcoole, Saggart, Clondalkin, Ballyfermot, Lucan, Palmerstown, Chapelizod and Inchicore.

On its west side it is bounded by the River Liffey.

To the north it is bounded by Area 4 which includes the huge population base of Tallaght.

To its south it is bounded by Area 9 which includes the whole of County Kildare.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Naul
Skerries
Garristown
Lusk
Rush
Oldtown
Ballybochill
Donabate
Kilsallaghan
Swords
Malahide
Ward
Dublin Airport
Portmarnock
Mulhuddart
Santry
Darndale
Baldoyle
Ballymun
Finglas
Seaumont
Kilbarrack
Blanchardstown
Coolock
Howth
Tolka Valley
Raheny
Maynooth
Glasnevin
Artane
Castleknock
Drumcondra
Dollymount
Leixlip
Cabra
Palmerstown
Fairview
R. LIFFEY
Phibsboro
Lucan
Chapelizoid
James' St.
Ringsend
Irishtown
Ballyfermot
Sandymount
Celbridge
Inchicore
Ballsbridge
Drimnagh
Ranelagh
Clondalkin
Crumlin
Harold's Cross
Rathmines
Donnybrook
Rathgar
Milltown
Walkinstown
Booterstown
Terenure
Blackrock
Kilnamanagh
Rathfarnam
Monkstown
Dun Laoghaire
Newcastle
Churchtown
Dundrum
Stillorgan
Sallynoggin
Saggart
Tallaght
Ballinteer
Dalkey
Ballyboden
Sandyford
Foxrock
Rathcoole
Whitechurch
Cabinteely
Killiney
Fortunestown
Stepaside
Ballybrack
Loughlinstown
Britas
Shankill
Kilternan
Little Bray
1
2
3
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10

## PROXIMAL RESIDENTIAL AND DAY SERVICES

1. Stewarts Hospital Palmerstown.
   Day Centre at Balgaddy.

2. St. John of God's, Island Bridge.

3. St. John of God's, Celbridge.

4. Walkinstown Day Centre.

5. Cherry Group Workshops.

## CENSUS OF POPULATION 1991

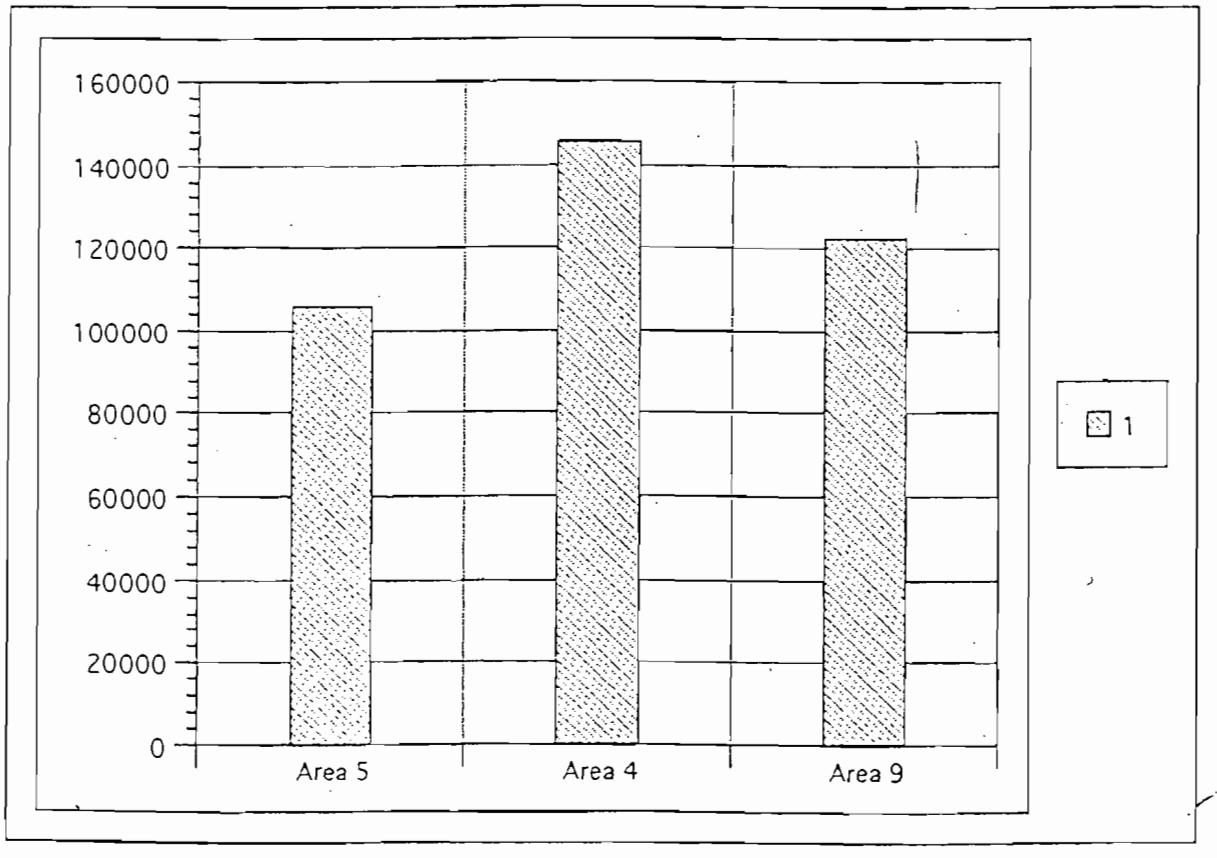
In the National Census of Population in 1991 the population of Community Care Areas 5 and 9 showed an increase from the 1986 census and Area 4 showed a very slight decrease. The exrapolation from national figures to the Community Care Areas of Eastern Health Board was made in the preliminary report of the 1991 census of population for the EHB area.

The mentally handicapped population would be estimated at one to two percent of the total population of the areas.

Area 5 population of 105,740.
Area 4 population of 145,227.
Area 9 population of 122,645.

The population in Areas 5 and 9 showed an increase of 2.5% each on the 1986 population census.

Bar Chart of Population in Areas 5, 4, and 9.



# PEAMOUNT PROJECT 2000

## Section Two: Proposal for Change

- Service - Overview of Expansion.
- The National Respiration Service.
- New Plan Introduced.
- The Peamount Village Complex.
- The Aberdeen Frail - Elderly Service.
- Peamount Enterprises.
- Peamount Outreach Services.
- The National Special Animal Husbandry College.
- Peamount Education and Research Services.
- Conclusion.
- References.
- Centres Visited.
- Appendix.

## PROPOSALS FOR CHANGE

1. The monolith which is Peamount Mental Handicap Service is outdated and must be broken down into a number of independent services based on specialised functioning.

2. The non-differentiation of mental handicapped persons which has been a feature of the delivery of services to-date is now outmoded and has to change.

3. The costing of the delivery of services to individual clients where the unit cost is the same for all clients is financially unsound. This should be rectified as a matter of urgency.

4. The failure to use the agricultural land bank which is part of Peamount's physical and fundamental philosophical structure is to deprive the handicapped of a unique training facility. Proposals are included to change this situation.

5. The failure to take up the major challenge for the provision of community services is a situation which needs to be rectified urgently.

6. The isolation of the services at Peamount from the community services in Area 5 needs to be changed through closer contact with the Community Care team.

7. The publicising of the excellent residential and unique day facilities already in existence has to be taken up as a matter of urgency.

8. The use of the expertise present in Peamount as a local and national educational resource needs promoting.

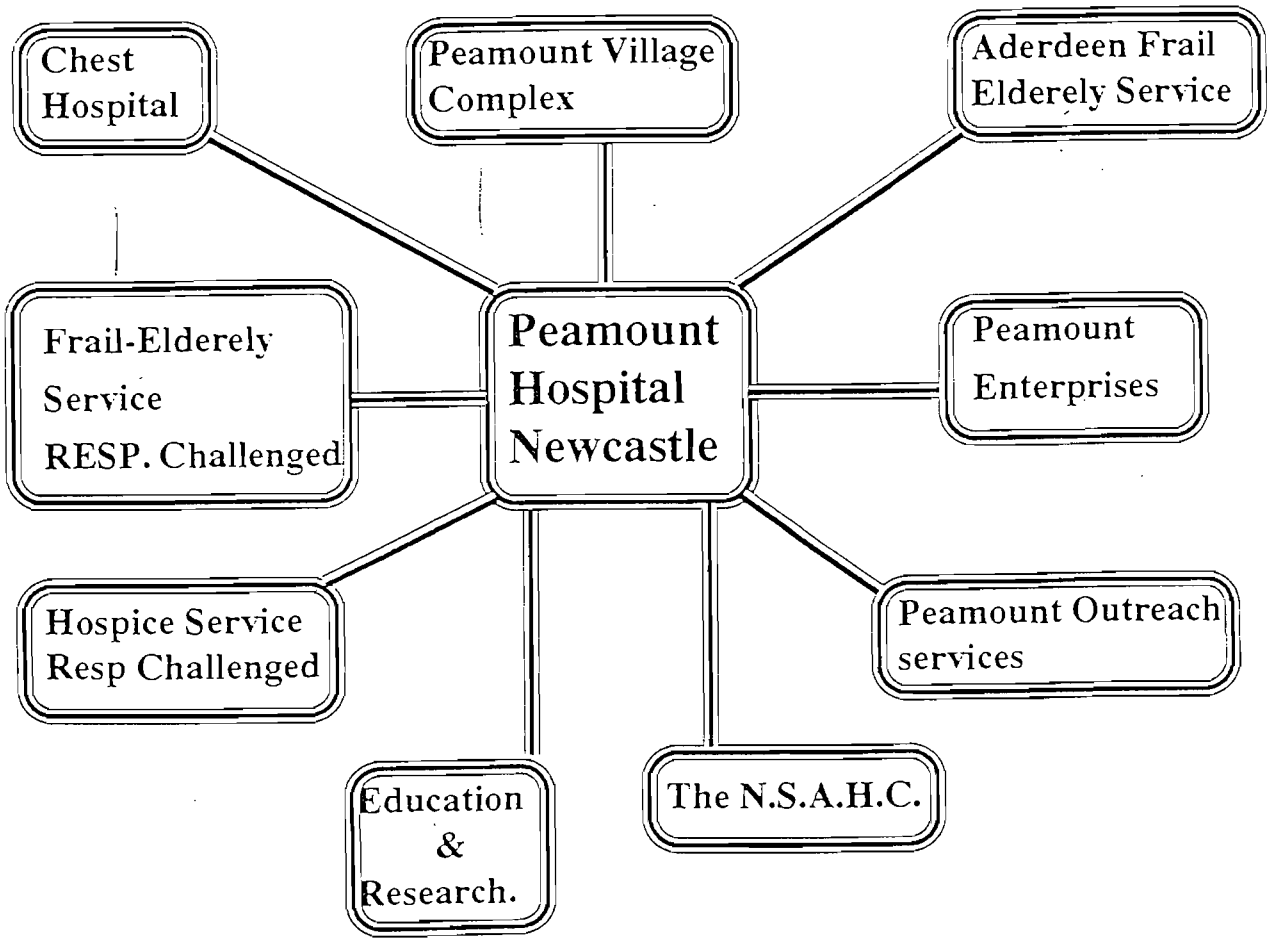
9. The unique position of the National Respiratory service on the same campus as the mentally handicapped services to be exploited for the benefit of both services.

10. The need for research both prospective and retrospective is recognised. To promote this, a special research fund should be set up even if it is very limited in scope.

# Service - Overview of Expansion

Chest Hospital Service

Mentally Handicapped Service




This Diagram outlines the new service structure at Peamount Hospital.

## THE NATIONAL RESPIRATORY SERVICE

### PRESENT SITUATION

The service at Peamount Chest Hospital which deals with Tuberculosis and other major chest conditions has a reservoir of expert knowledge in this area of health care management. I feel that as a Cost Centre this area could benefit from expansion in related respiratory areas.

### EXPANSION 1:

### Frail Elderly Unit for the Respiratory Challenged

The establishment of a Frail Elderly unit for the respiratory challenged who have major chest conditions like Chronic Bronchitis, Emphysema, Asthma etc. The catchment area could be based on the Eastern Health Board or on the country as a whole for frail-elderly persons.

The client complement could be in the region of thirty persons.

### EXPANSION 2:

### Hospice Foundation - Terminally Ill Respiratory Challenged

A Hospice foundation specifically geared towards those who are terminally ill with major chest conditions such as Tumours, Tuberculosis etc.

The hospice would have day and residential services together with counselling for patients and relatives, especially in the area of the grief reaction.

Payment would be on a capitation basis as holds in other services. The whole emphasis is on the specialised respiratory services.

The costings of these services to be based on up-to-date costing in similar units throughout the country. The client complement could be in the region of thirty persons. This would be a national service.

## THE MENTALLY HANDICAPPED SERVICES

The division of the present Mentally Handicapped Services would form the basis for five new discreet services. These would include:

1. The Peamount Village Complex.
2. The Aberdeen Frail Elderly Service.
3. Peamount Enterprises.
4. Peamount Outreach Services.
5. The National Special Animal Husbandry College.

### NEW PLAN INTRODUCED

From now on each of these five services for the mentally handicapped should be regarded as an individual service under the general umbrella of Peamount Hospital.

Each Unit would be an independent cost centre with its:

1. Own Budget.
2. Client Costing.
3. Front Line Management.
4. Policy with regard to client admission.
5. Range of services provided.

The Unit Managers would be chosen from the present personnel in charge. The frontline management would come forward with ideas for flexible utilisation of the day or residential accommodation available.

Clients would be assessed before admission and only those whose needs could be met by the particular unit would be admitted.

The charge per client would have to reflect the needs of the client, from a staffing and services point of view.

The service would be Client Focused and Needs Driven.

The administration function of the entire service would remain centralised but separate budgets would be prepared for each cost centre as defined above. Each cost centre would pay its own way and try if possible to make a profit. In each budget a proportion would be allocated for the central administration costs of the organisation.

A suggested budget format for the whole organisation if not already in place would be the rolling method of budgeting because of the quick financial management of cost variation eradication.

In the National Special Animal Husbandry College, a new position of Co-Ordinator of the facility should be established.

1. THE PEAMOUNT VILLAGE COMPLEX

The ten bungalows which comprise Peamount Village Complex should have a realistic costing structure inline with similar services. These bungalows would house the mildly handicapped with good social skills. They could have a semi-independent existence. Two units could be used as Training Centres for persons being prepared to move into houses in the community.

If places became available in any of the ten bungalows they could be offered to the EHB or other Health Boards at realistic market prices. This in no way should interfere with the continued pressure for realistic payments for those already in residential placement in these bungalows.

If suitably funded, long stay replacements cannnot be found for those who move out, then the whole area of short-term care could be investigated.

Realistic costings for short-term care might be a more viable proposition.

A second possibility for one or two of the bungalows would be to incorporate them should they become empty into the separate outreach programme as holiday accommodation or respite accommodation.

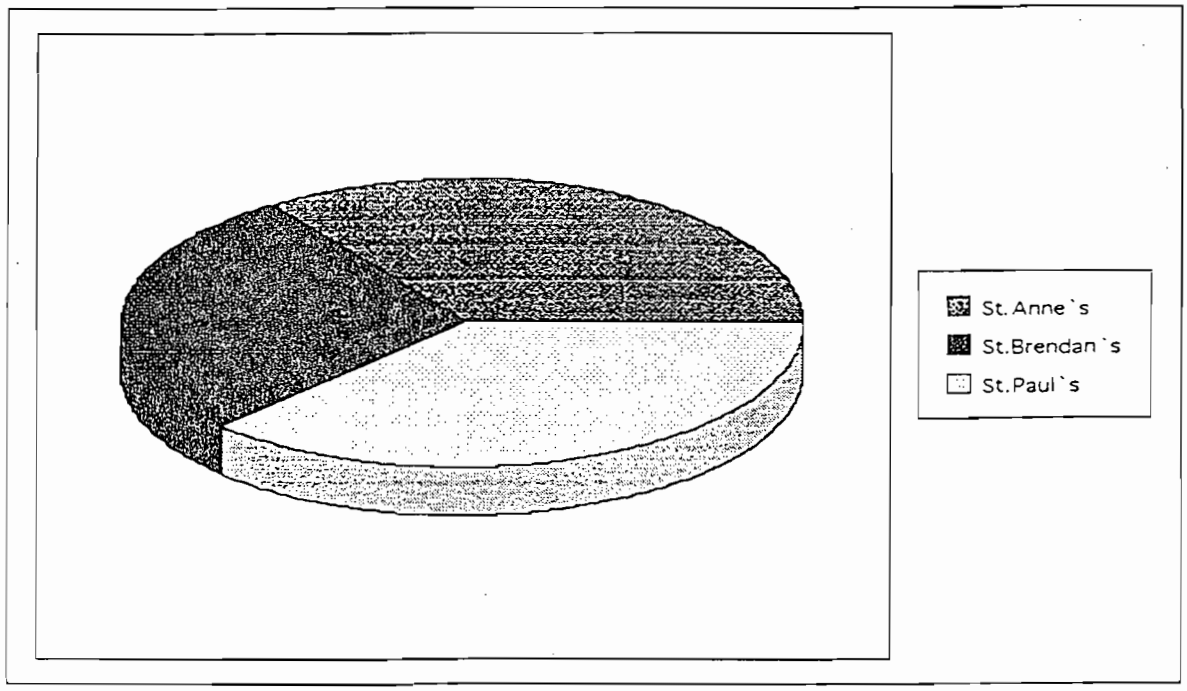
2 THE ABERDEEN FRAIL ELDERLY SERVICE

This service, which includes the three units St. Anne's, St. Brendan's and St. Paul's, should now be officially recognised as the Frail-Elderly Service.

Admissions there could be from the other services on the campus. They could also come form the community, either from the EHB or from other Health Board areas. The costings should be based on services provided for elderly people in regular Nursing Home accommodation in the community.

Respite care for elderly mentally handicapped persons could be provided on a short-term basis and at substantially higher rates. In all respite accommodation higher costing will ensure that respite care does not become long-term care which would defeat the whole purpose of the exercise.

| Diagram: | St. Anne's Unit | - | 33 Females |
|---|---|---|---|
| | St. Brendan's Unit | - | 27 Males |
| | St. Paul's Unit | - | 34 Males |
| | Total | - | 94 Mixed |




Pie Chart: Representing the numbers in the three units which make up the Frail-Elderly Service.

## 3. PEAMOUNT ENTERPRISES

Peamount Enterprises were known previously as Peamount Industries. Originally they consisted of a complex of six workshops which were established in the 1960's. The main activities over the years consisted of:

a) Mushroom chip carton manufacture.

b) The assembly of cardboard boxes.

c) Subcontracts in various products, including:

- Light Engineering.
- Packaging.
- Assembly work.

d) Shrink-wrapping of various subcontract work.

Up to 130 clients were occupied in this setting. The work was arranged at a series of skill levels by the workshop management.

Due to the ageing population the number of clients attending the workshop has fallen in recent yeas.

Peamount Enterprise would now be expanded to include the core building where there is a self-service canteen. This would be ideal for adding a catering module to the vocational training programme. In addition, the core building includes a vocational training centre for Picture Framing, Woodwork, Sewing and a Remedial education department where literacy and numeracy classes are carried on.

It would continue to provide day services for those who are presently in residential care as it has done over the years.

### New Client Base

New clients to be actively sought from the community, by establishing contact with local day schools for the mildly handicapped. As a source of new trainees contact would be established with Scoil Eoin in Crumlin and St. Patrick's in Tallaght.

## 4. PEAMOUNT OUTREACH SERVICES

In addition to its two hostels, the service would expand through acquiring further houses in the community.

One of these houses could be geared towards respite care and holiday placement. A Drop-in Unit in the community where mildly handicapped students from special schools could drop in for an hour or two after tea would be useful.

This could be based on the organisation of an Arch Club at the drop in centre and function one or two nights per week.

It would establish family contact early on with the training centre and would help through-put in our training programme at a later date.

An advisory service for parents could also be sited at this centre.

## 5. THE NATIONAL SPECIAL ANIMAL HUSBANDRY COLLEGE

The purpose of this College is three fold:

1) To make available to handicapped persons the training and expertise in animal husbandry which is already available to students from University College Dublin. The programme set up should be similar to that at the Special Equestrian Training Centre at Kilternan.

2) To use the agricultural land bank which is an inherent resource in Peamount for the benefit of the handicapped. This land bank is near the city and in an ideal situation to contribute to training for our largest national industry - agriculture.

3) To give a national profile to the service at Peamount and to provide training for mildly handicapped people from all over the country for realistic and useful jobs in their family farm enterprise.

I would suggest that the Nurses' Home which is on the right hand side of the road as you travel from Newcastle to Lucan be used for the setting up of this College. It would be seen as totally separate from the Peamount complex and is on the proper side of the road for access to the land bank. The entrance to the building would need to be up-dated. This would be a third level education setting for mentally handicapped persons. The training would be over a three year period based on the academic year. The programme would follow the animals from birth right through to departure from the farm.

Certification

Recognition for the programme would be sought from Teagasc. A certification body could be set up with S.E.T.E.C. if recognised by Teagasc. An American system of credits would be put in place. Peamount might provide a second level skills programme for those certified in Special Equestrian Skills from Spruce Lodge. Spruce Lodge, in turn, might provide a second level training for those qualified in animal husbandry from Peamount.

Funding

To start the programme scholarships could be sought from Agricultural enterprises, the ACC, the Ireland Fund etc. Once the College was in place we would expect that students would be sent by the major referral agencies with EU funding. Extra funding would have to be provided by the Health Boards for residential aspects of the course.

The College buildings when not in use during the summer time could be used for:

1) Holiday placements.

2) Respite Care.

3) Summer School - residential.

4) Summer School - day.

## PEAMOUNT EDUCATION AND RESEARCH SERVICES

1. I propose that the House Doctors who work in the Chest services get training in mental handicap during their six month placement at Peamount. This would take the form of a foundation course in mental handicap. They would share this course with Doctors from community care, Registrars in Psychiatry and Registrars in the Psychiatry of mental handicap.

2. Nursing staff inservice training including seminars, lectures and visits to other centres be provided on a continuing basis.

3. Untrained staff. A supervisors course similar to that run in 1993-'94 be provided on the campus at Peamount. Other centres are invited to send representatives to the course. This would last over one academic year.

4. Reservoir of casual untrained staff. A panel of mature people to do part-time work should be formed together with a short course in Mental Handicap to familiarise them with the handicapped on a need to know basis.

5. A research fund should be established to provide some finances for small research projects. This fund might be topped up by grants from interested firms.

6. An annual Seminar to be held at Peamount on major aspects of Mental Handicap.

7. An academic library to be established with books, journals, videos and audio tapes.

# CONCLUSIONS

## OBJECTIVES OF THE REPORT

The purpose of this report is to examine fully the services on the campus at Peamount. This would include both the Chest service and the Mental Handicap service. The changes are designed to meet the needs expressed in the New Health Care Strategy put forward by the Minister for Health in the summer of 1994.

## THE CHEST HOSPITAL

The service provided by the Respiratory Unit at the moment would be expanded to include a unit for the Frail-Elderly who were challenged in the Respiratory area. A hospice unit for the terminally ill with major chest complications would be a logical extension to the existing service.

## THE MENTALLY HANDICAPPED SERVICE

The monolith which is the Peamount Mentally Handicapped Service must be broken down into independent constituent services with separate budgets and zero based independent costing. A total of five financial cost centres is envisaged for the Mental Handicap Services. Each unit would deal with specific clients who would have their own funding. The service in future should not be referred to as the Peamount Mentally Handicapped service. Each centre would be called by its own name. It would have its own admission policy and its own client cost structure. The team from each centre would have as a major part of its policy increased productivity by maximising its day and residential resources. Each cost centre would contribute a fixed proportion of its budget to the central administration costs.

## STAFF TRAINING

On-going staff education would be funded in a similar manner to central administration. Staff education would take place not as an in-house function but as a joint venture with other mental handicapped facilities or community care services. The National Special Animal Husbandry College would form the flagship for Peamount's contribution towards the care of the handicapped at a local, Health Board and national level.

V. MOLONY, LRCPSI., D.P.M., LM DMMH M.R.C. Psych.

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12. 'Community Care: People with Mental Handicap. N.A.M.H.I. Policy Document - 1988.

13. 'Experiments on the Rehabilitation of the Mentally Handicapped', London, Gunzberg, H.C. 1974.

## CENTRES VISITED

Daughters of Charity Services

a) Navan Road.
b) St. Joseph's, Clonsilla.

St. John of Gods Services

a) St. Raphael's, Celbridge.
b) Islandbridge.
c) St. Mary's, Drumcar.
d) Dunmore House.

The Eastern Health Board

a) Counsel Centre, Ballyboden.
b) Ashling Hostels, Maynooth.
c) Maryfield Industries.

Sunbeam Services

a) Sunbeam Training Centre.
b) Wicklow, A.T.E.C.
c) Ballyraine Rural Industries.

KARE Services

a) Baltinglass Garden Centre.

Other Services

a) Fingal Workshops.
b) Pilgrim House Residential Centre.
c) Duffcarrig Centre, Camphill.

APPENDIX ONE

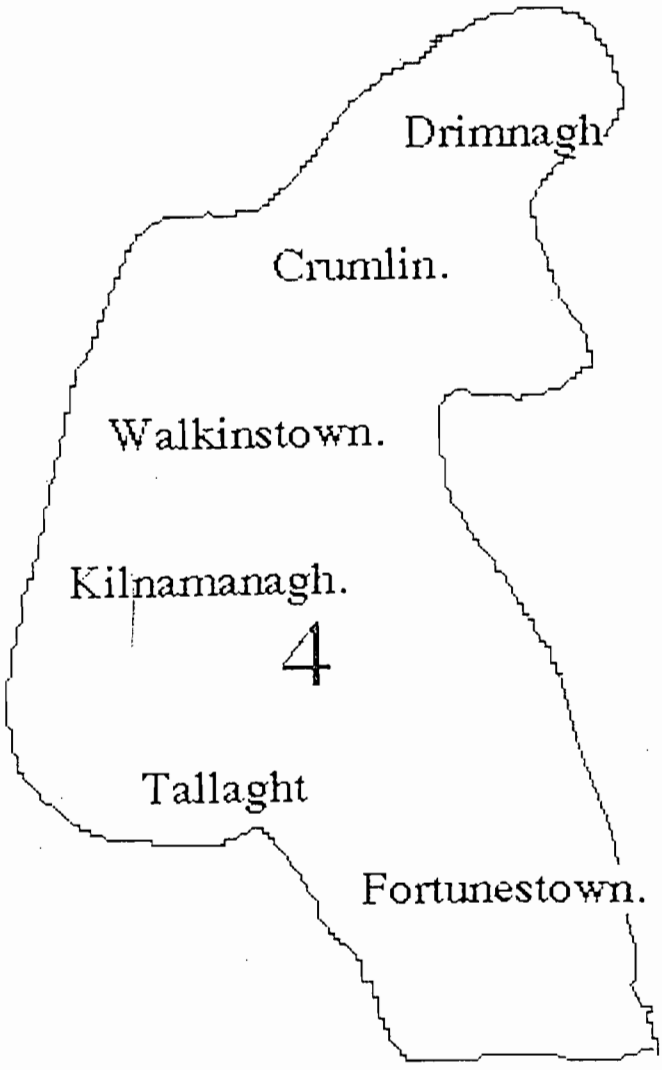
- Map of Area 4

- Map of Area 5

- Map of Area 9

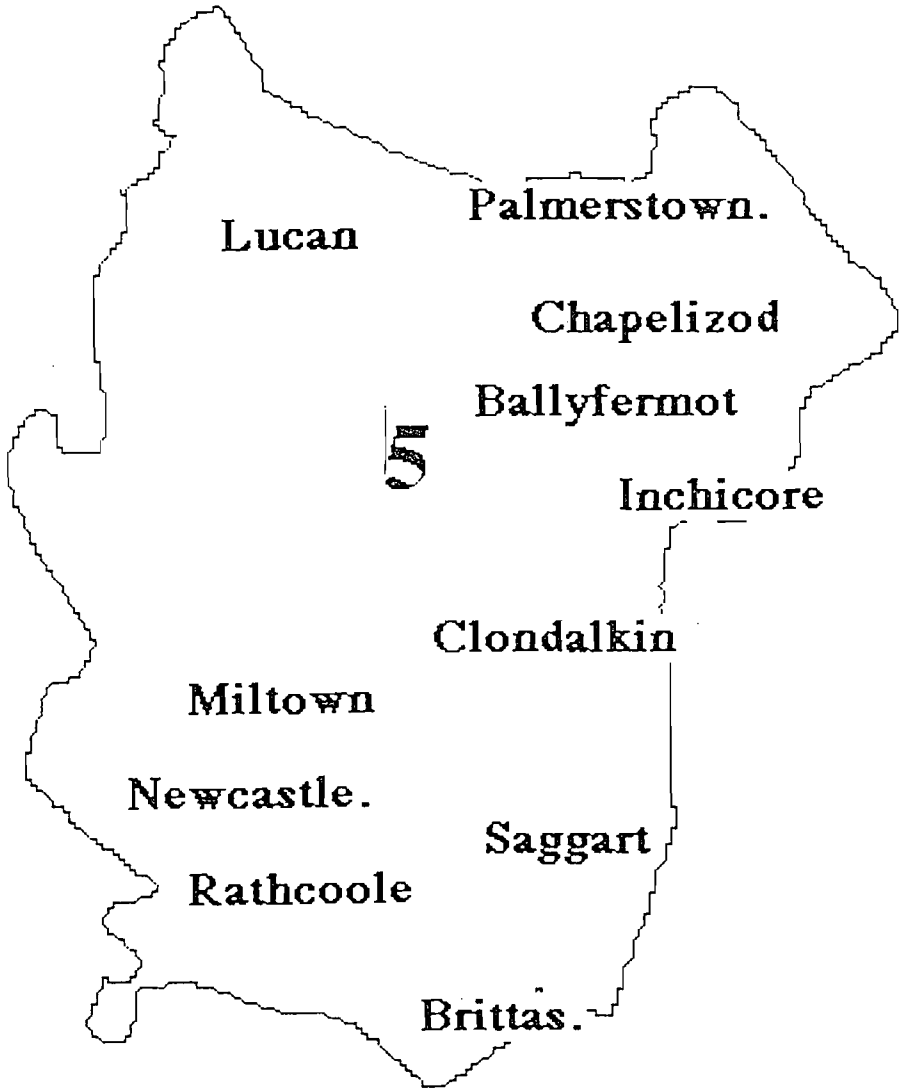
# Area 4

Population - 145227 - Census 1991.



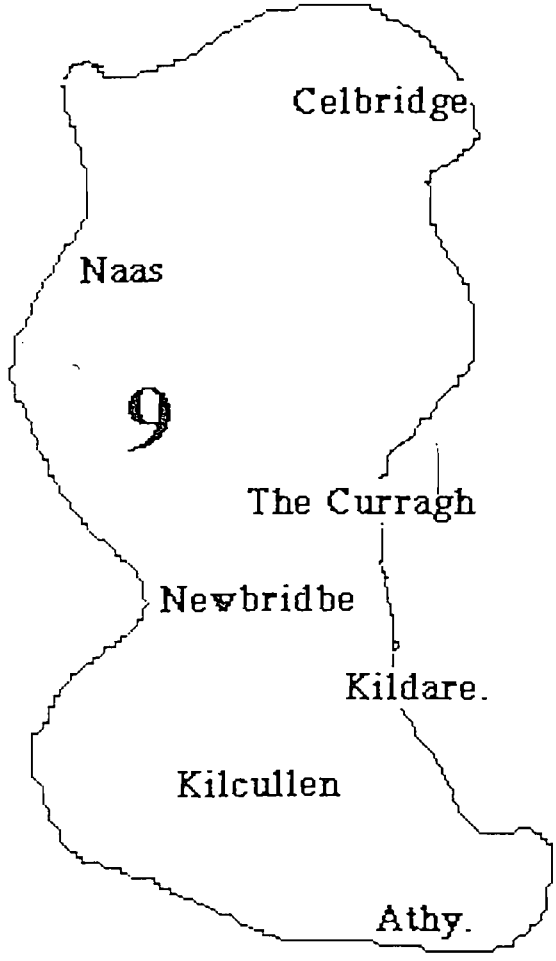
# Area 5

**Population - 105740 - Census 1991.**



# Area Nine - County Kildare.

**Population - 122645 - Census 1991**



GENERAL

As outlined in relation to the Community Hospital, the proposal for Mental Handicap Services at Peamount will require extensive organisational and structural change.

Similarly, responsibility must remain with the management team and community representation will need to be considered. It will be necessary in this case also to produce a detailed working plan if the proposals are agreed in principle.

# Chapter 9

## PEAMOUNT INDUSTRIES

Peamount Industries would be renamed Peamount Enterprises as proposed in Chapter 8 and reorganised. Its identity would be established as one of the five separate services outlined:

In the future Peamount Industries would:

1. continue to provide training, occupation and work experience for mentally handicapped;

2. attract day-attenders from the community and provide transport, if necessary, to bring this to fruition;

3. provide of work experience of trainees from other Training Centres;

4. expand its four main areas of operation, namely:

    a) Shrink wrapping and hand packing,
    b) Assembly,
    c) Corrugated box manufacture,
    d) Mushroom chip manufacture.
    e) Develop other suitable activities as the opportunity arises,.

5. actively pursue funding for the services provided to the mentally handicapped;

6. build on the relationships that exist between Peamount and the large companies in the corrugated industry;

7. develop and expand the customer base to avoid over reliance on a small number of customers;

8. subdivide one of the existing units into smaller activation areas for the elderly and more feeble residents;

9. continue to provide resources for development within Peamount Hospital Incorporated.

Organisation and management changes will be necessary, and, as with the other new services proposed, an operational programme will be provided when outline agreement has been reached.

# Chapter 10

## PEAMOUNT FARM

Peamount Farm will continue to operate on a commercial basis contributing income to Peamount Hospital Incorporated.

There is potential for considerable further expansion as the benefits of reinvestment of profits over recent years materialise.

Peamount operates under a Farm Plan which has been designed in conjunction with E.U. requirements under the Common Agricultural Policy. This also ensures eligibility for the payment of Farm Aids and the production premia.

The National Special Animal Husbandry College would be developed as set out in Chapter 8. This programme would establish a special status for the Mental Handicap Service on a national basis. Since the Farm is accepted under the National Farm Apprenticeship Scheme and provides a service to the Veterinary Faculty of University College Dublin, it is well qualified to provide the necessary training.

The altered management requirement would also be incorporated into the operational programme referred to in previous chapters.

# SUMMARY OF CONCLUSIONS & RECOMMENDATIONS

1. Peamount Hospital Incorporated has become a multi-functional organisation and should develop and expand on that basis.

2. Proposals are made for the further development of existing traditional and core activities.

3. An extensive range of new activities is suggested as a basis for future policy.

4. The proposals are framed in conformity with the Dept. of Health's 'Strategy for Effective Healthcare in the 1990's'.

## HOSPITAL

1. The projected expansion is seen as necessary for:

   a) the delivery of additional health services to meet local and national needs,

   b) so as to ensure continued viability of core activities in light of the reduction in bed numbers in the Chest Hospital and increasing per bed costs.

2. Peamount Hospital Incorporated, while retaining and further developing its respiratory role, should incorporate a Community Hospital.

3. The Community Hospital concept, modified to operate alongside the Chest Hospital, is seen as the best way of delivering the additional new services within the local community.

4. Some new services e.g. the Young Chronic Sick, might appropriately be delivered from either hospital or on a shared basis.

5. Specific proposals are made on the national role of respiratory medicine with particular emphasis on tuberculosis.

MENTAL HANDICAP UNIT

1. Major reorganisation of the Mental Handicap Unit is recommended in the Peamount Project 2000.

2. It is recommended that the pursuit of equitable funding should be intensified.

3. The division of the unit into five financial cost centres is proposed:

   a) to modernise the facility,
   b) achieve full integration into the national service.
   c) ensure maximum involvement in the local community,
   d) to develop and enhance training facilities.

4. A number of new services are proposed for the benefit of existing residents and the community.

5. A specialised national role is proposed in the establishment of a National Special Animal Husbandry College in conjunction with the Farm.

6. New and expanded activities are suggested for Peamount Industries - to be renamed Peamount Enterprises.

FARM

1. Proposals are made for the continuation and development of Peamount Farm.

2. A national role is proposed in the training of people with a mental handicap.

GENERAL

1. It is proposed that policy when agreed be discussed with the Dept. of Health and the Health Board/Health Authority.

2. Implementation of the proposals would necessitate preparation of an Operational Plan and detailed costings as the logical sequence to the general programme.

3. Requisite funding would be sought from the Health Authority.

4. Organisation and structures would then be developed to meet the needs of the expanded functions of the organisation.

APPENDIX 1 : **Strategic Review**

APPENDIX 2 : **Draft Development Plan for the Mental Handicap Service 1993 - 1999**

APPENDIX 3 : **Extract from Farm Plan**

APPENDIX 1

# STRATEGIC REVIEW - 1994

Peamount Hospital
Newcastle
Co. Dublin.

Luke Clancy, FRCPE,FRCPI,FCCP
Medical Director

9/5/1994

INTRODUCTION

The past decade has probably been the most difficult period in Peamount's long and distinguished history. It was a time of unprecedented cut-backs in health care spending. Most of these cut-backs occurred in the acute hospital services. The result was a closure of approximately 1000 acute beds in the Dublin area, all of these in the voluntary care element of the health service. Inevitably this meant intense pressure on all small voluntary acute care hospitals. Most succumbed. There were further problems. There was a strongly held ideology that single specialty hospitals should be abandoned - a view promulgated by Comhairle na nOspideal and accepted by the Department of Health.

Of all the institutions threatened by these changes, the most vulnerable was Peamount. It was a single specialty hospital, a voluntary organisation, in a rural setting without a large local community whose prime focus was on a disease, tuberculosis, which was considered eradicated or at worst a minor problem. Our weakness was compounded when the then Minister for Health without discussion effectively cut-off our access to the Department of Health by directing funding for the institution through a hostile Health Board. The battle for survival in this setting has been painful and debilitating but against the odds we have survived.

The future looks better. Tuberculosis can no longer be ignored. The WHO and the IUATLD have focused the attention of the developed world on what they regard as one of the most important diseases in the world. The medical establishment in this country are unsure of how to react to this new situation. Most of the Respiratory Consultants returned from the U.S.A. with a firm belief that resource allocated to tuberculosis was largely wasted and now find that the United States has totally changed its outlook. Irish Consultants now cut-off from their American sources however are unsure how to react. The result is that although the world has again changed its mind about tuberculosis we cannot expect an easy ride even now in this country. It is therefore of great importance to us that we plan for the future, taking note of the changes in the world but clearly needing to apply ourselves to the realities of health care provision in this country.

PRESENT POSITION

The hospital has consolidated its position as a significant provider of health care. It provides tuberculosis and other respiratory disease services on a supra-regional basis. It has also used every opportunity to expand its range of services in the interests of its local patients. It is conceded nationally and acclaimed internationally as a centre of excellence for the treatment of tuberculosis. In line with changing health care philosophies the hospital has changed from an almost exclusively in-patient service to a predominantly out-patient/day care service with its in-patient bed numbers reduced from 280 in the

early 1980s to the present 80. During these changes we have - cared for a consistently increasing number of patients, increased medical teaching and research and achieved financial stability despite a drastic reduction in funding. In the future more than in the past it will be necessary to provide services to an agreed quality standard. To do that we must optimise the quantity and range of services provided. Our services must be effective and appropriate. To enable us to start this process it is important that we recognise our strengths and weaknesses.

Among our most obvious strengths are:

- Dedicated, appropriately trained staff
- Integrated management with full involvement of medical and nursing personnel
- A pleasant environment
- A position in the health services which is entirely compatible with the Department of Health strategy for effective health care in the 90s:-
  - Because of our history in health promotion and disease prevention, treatment and continuing care. Specifically we have a long history in efforts to prevent tuberculosis and prevent lung cancer.
  - We have a prime role in the treatment of one of the potentially fatal diseases which can be cured - tuberculosis.
  - We have been prominent in supporting those who are dependant or disabled both in the chest hospital in our rehabilitation programme and of course in the mental handicap services.

<u>Weaknesses</u>

- Image problems as a sanatorium
- Geographically remote
- Politically weak
- Small single specialty institution
- Under-funded.

MISSION

To continue to create and operate a centre of excellence in the provision of tuberculosis and other respiratory medicine services taking full heed of the changes that have occurred in the health services, particularly the strategy set out by the Minister for Health in 'shaping a healthier future'.

Our objectives should be:-

1. To provide the highest quality patient care

2. To optimise the quantity and range of services provided

3. To develop additional services through agreement with the funding agency

4. To provide programmes for staff training and development

5. To provide and support a programme for teaching and research while maintaining financial viability

To enable us to achieve our objectives we must describe the scope of the hospital in terms of its resources.

Corporate Support

- Medical Administration
- Finance
- Personnel
- Information
- Technology
- Technical Services
- Occupational health

General Support

- Supplies
- Catering
- Porters
- Laundry
- Security
- Housekeeping
- Maintenance
- Records
- Biophysics
- Bio-engineering

Clinical Support

- Imaging
- Pathology
- Pharmacy
- Physiotherapy
- Occupational Therapy
- Speech Therapy
- Social Work
- Nutrition

Patient Access

- Day Ward
- Theatre
- O.P.D.
- Wards

Scope - Personnel

- Medical
- Nursing
- Attendants
- Paramedics
- Secretaries/Clerks

OBJECTIVE 1 - QUALITY OF PATIENT CARE

The new emphasis on the quality of patient care rather than quantity as outlined in the Department of Health document is welcome to Peamount. Quality in health care is usually meant to be a combination of selecting the appropriate activity and performing these activities in a manner that produces the best outcome. In many acute hospitals very little attention is paid to outcome other than length of stay. We have, over the last decade, measured and published our outcomes in the most relevant aspects of our activity viz efficacy of treatment regimens, mortality, prevention of the emergence of drug resistance and the management of toxic effects of drugs. These have been produced not only in annual reviews but in peer reviewed scientific papers in national and international journals. The result is that our outcomes in the treatment of tuberculosis are not only the best in this country and the best documented but also in many aspects the best in the world. However, in order to improve our performance we must formalise our quality of care estimates by the introduction of medical and nursing audits. The processes for which includes the setting of standards, measuring current performance against standards, making of recommendations and implementing changes to ensure further improvements. The quality of care also includes other dimensions such as structure, process and outcome.

Structure

Structure includes the availability of suitable buildings, equipment and numbers of adequately trained staff.

Process

We have had to consider process but usually in the negative sense of the use of inadequate resource. This has the danger of influencing the choice of investigation, the use of out-patient or in-patient facilities, the number of in-patient days. It is important however that the quality aspects rather than the financial should dictate.

Outcome

Attention to outcome is in our interest because we usually improve the present and future health of our patients. This is unlike the outcome in many acute hospital situations where there are often fine structures and careful processes with outcomes which make the activity meaningless and yet are often given much higher priority than we are.

There are other dimensions which we have to monitor carefully and be in a position to make our case. These concern efficacy, effectiveness and efficiency. They also concern appropriateness of care and relevance to the needs of the community. I feel we have never been accused of ineffective delivery of care and therefore we welcome it. Nevertheless as I have suggested in our weaknesses we can be criticised on accessibility and on our social acceptability. These are important considerations that will have to be explored and we will probably need outside assistance in formulating plans to deal with these problems.

## OBJECTIVE 2 - OPTIMISE QUANTITY AND RANGE OF SERVICES PROVIDED

The services we are best placed to provide form the basis of the document produced in the 80s and remain - tuberculosis, lung cancer, obstructive airways disease and respiratory rehabilitation. These fit very well with "shaping a healthier future" involving as they do prevention, treatment and care services in the fields of infectious diseases, smoking and rehabilitation.

It should be noted here however the 'shaping a healthier future' in its Chapter on HIV/AIDS is the only document published in the world of recent times which does not link tuberculosis to HIV/AIDS in its planning.

OBJECTIVE 3 - DEVELOP ADDITIONAL SERVICES

The hospital has spare capacity and suitable setting for the development of further services particularly in care of the elderly, community services and the chronic young sick. Since none of these are traditional services to the hospital and all are directly planned through the Health Board, initiatives taken by the hospital with regard to these services is unlikely to be funded without prior agreement of the funding agency.

OBJECTIVE 4 - PROGRAMME FOR STAFF DEVELOPMENT

Staff development at all levels and in all departments needs to be formalised. This becomes even more important in a time of dramatic change and is probably best developed in our hospital among the nurses. Staff development for other departments is very limited because of our size and lack of links with other institutions. To achieve this objective I believe a review of our management structures and our external links are essential.

OBJECTIVE 5 - PROVIDE AND SUPPORT PROGRAMMES FOR TEACHING AND RESEARCH

Peamount has a position in research and teaching far in excess of its size or its financial commitment to these activities. This has been due to the vision, ability, energy and commitment of the medical staff. More recently the nursing department has begun to assume its important role in these activities and I expect it to become as successful in this aspect of the activity as in the extraordinary high quality of care that they already deliver.

OBJECTIVE 6 - MAINTAINING ECONOMIC VIABILITY

Maintaining economic viability has been the major preoccupation of the hospital over the last decade. This has been necessary because any reading of the allocation of resource to the health care in that period would show that we have been singled out for special deprivation. Protracted discussions and negotiations with the Health Board which was facilitated by the Department of Health has I believe resulted in the possibility of fair treatment in the future. The Department of Health strategy particularly alludes to accountability and we welcome this while accepting that it will mean a further burden on our hard worked finance department.

## THE FUTURE

### 1. Organisation and Management Structures

'Shaping a healthier future' states that there will be a new health authority to replace the Eastern Health Board and that the new authority will operate through a number of management areas within the region. Also that the emphasis at area level will be to achieve the maximum integration of hospital and community services and to reflect local needs and priorities. The precise geography of these areas has not been defined. It is widely expected that there will be some five areas each with a full range of services including a major teaching hospital. It is likely that we will be in the same area as St. James' Hospital.

Our tuberculosis service however is provided not only to a single area within the eastern region but also to other regional health boards. This position will probably have to be negotiated with the new regional health authorities.

As regards our non-TB respiratory service it is proposed that this be negotiated with St. James' Hospital and that an integrated service be formulated. This would need the support and approval of Peamount board, St. James' Hospital board, the area and regional health authority and prior to legislation, the Department of Health. If such an agreement were successfully negotiated there would be direct management implications for the chest hospital.

### 2. Medical Information Systems

The computerisation and development of medical information technology is proceeding at a rapid rate. This is encouraged by the Department of Health which has heavily invested in information technology and has facilitated the computerisation of the hospital in-patient enquiry (HIPE) system. They are also engaged in developing models based on diagnostic related groupings (DRG) which they intend to use as a basis for funding. There is an urgent need therefore for us to up-date our information systems. At present finance (budgeting and finance) is the department furthest advanced but it also includes word processing for all secretaries and the HIPE system.

The immediate areas needing attention are:-

(a) Patient administration system (PAS) linked with the clinical system linked with the facility to down load demographic data to word processing systems for discharge and referral letters.

This should facilitate the development of methods for collection of statistics which will be needed for further analysis and collection of activity data and ultimately funding. It should be possible by linking pay-roll to examine absenteeism and rostering.

(b) If links with St. James' are established then it should be possible to avail of the development work which has already been done and pick ready made systems. If we are going it alone considerable resource and time will have to be applied.

(c) Private facility. The mixture of public and private service provision is an established and accepted position in the Irish health care system. The provision of private facilities at Pe mount has traditionally been under-developed. Formerly this was regarded as an important element of equity. Today it can be regarded as an obstacle to equity representing an under-provision to the one-third of the population who carry Voluntary Health Insurance. It is also a negative factor in the noted poor image of the hospital and it represents a loss of potential finance resource.

At the insistence of the Department of Health the VHI has recognised the hospital for a private facility. It will prove very difficult to succeed in this sector and needs planning, marketing and managing.

APPENDIX 2

P E A M O U N T  H O S P I T A L  I N C O R P O R A T E D

# DRAFT DEVELOPMENT PLAN

# FOR THE MENTAL HANDICAP SERVICES

# AT PEAMOUNT

# 1993-1999

May 4, 1993

CONTENTS

# PROPOSAL FOR THE PROVISION OF SERVICES

# TO PEOPLE WITH A MENTAL HANDICAP BY PEAMOUNT HOSPITAL

## 1. INTRODUCTION

### 1.1 Background

Peamount Mental Handicap Unit was established in 1963 with the transfer of adult male mentally handicapped residents from St. John of God Services in Drumcar and Celbridge. In 1972, a further eighty five females were admitted from centres run by the Daughters of Charity.

The total population of over 200 people were accommodated in three large units. These comprised of people ranging from mild, moderate to severe intellectually disabled.

Over the years, few changes have taken place in the client population.

### 1.2 Developments

Over the last number of years, one large institutional unit has been replaced by family style bungalows in a village type complex facilitating one hundred residents. The remainder of our residents are accommodated in three ward type units of between 30-40 people each.

In addition to the improved accommodation, we have also built an Assembly Hall which is in constant use as a recreation and social development centre. A new Resource Centre was opened late in 1991. This provides a permanent training facility, a central dining facility for residents, those who live in the community, and day-attenders. Peamount in conjunction with the Eastern Health Board opened two community houses in Newcastle village.

### 1.3 Existing Facilities

a) Residential accommodation.

b) Workshops, sheltered employment.

c) Training, vocational and industrial.

d) Community Houses.

e) Day care programme.

## 2. PHILOSOPHY AND AIMS

2.1 Our aim is to provide the best possible professional care, coupled with an approach that benefits and, at all times, promotes the dignity, self-respect and individuality of our residents.

2.2 The range of services provided in Peamount should safeguard the dignity and rights of all the residents, and be so arranged to provide the maximum advantage for the individual to grow and develop, without creating unnecessary dependence.

2.3 In keeping with Departmental policy, the services are structured to provide the required range of facilities, community and residential, to best meet individual needs.

2.4 Those of the present residents who, after professional assessment and training, may be more appropriately housed in the community, will be resettled.

2.5 For those residents who continue to reside in Peamount we will endeavour to provide a community environment, rather than an institutional one by ensuring that all people live in small, family-sized units.

2.6 Peamount, with its specialist staff and facilities, will become the resource centre for residents, day attenders and community based units.

2.7 Peamount will also provide specialist vocational training in animal husbandry and industrial work experience for young adults.

2.8 An acute health care service for the intellectually disabled will be provided at Peamount.

## 3. CATCHMENT AREA

3.1 Peamount will provide services for the Western region, Community Care Areas 4, 5 and North Kildare.

3.2 The main service providers in this area are Peamount Hospital, Cheeverstown House, Hospitaller Order of St. John of God, and Stewart's Hospital.

## 4. CLIENT GROUPS

Peamount will provide services for people with an intellectual disability under the following categories:

4.1 Young adults, both severe and profound over the age of 18.

4.2 Young adults with a mild/moderate handicap who have additional physical/sensory disabilities.

4.3 Young adults with potential for second and third level training and education, excluding people with challenging behaviour problems.

4.4 The elderly.

## 5. SERVICES

Peamount will provide services in the following areas:

1. Residential care for 160 people.
2. Community living for 40 people.
3. Day-Services.
4. Respite and Crisis Care.
5. Sheltered workshops.
6. Satellite Workshops.
7. National third level educational programmes.
8. Industrial work experience programmes.
9. Regional Health Care Services.

### 5.1 Residential care

Accommodation will be 'domestic in scale' and as 'homelike as possible'.

-- Bungalow Complex: for 80 people.

To accommodate some of our existing clients, minor adaptations will be required to cater for a more dependent client group. This will involve improvement in accessibility and versatility of accommodation.

-- Residential Units: for 80 people.

Existing units will be renovated and restructured to cater for the needs of the elderly and those with a profound intellectual disability.

## 5.2 Community living

The expansion of this service will follow in line with Departmental policy re-emphasised in their most recent report 'Needs and Abilities', 1990. We would envisage an additional eight houses to cater for four to five persons per house. This will be developed at the rate of one to two per year, over the seven year plan with the necessary support services.

Housing options:

- Houses purchased by Peamount.
- Houses purchased by the Eastern Health Board.
- Houses purchased by the Parents & Friends Association.
- Houses provided by Local Authority.
- Renting.

## 5.3 Day Services

We will provide day services under the following headings:-

- sheltered workshop.
- factory/industrial unit.
- day care/activation.

A transport network appropriate to the needs will be developed. Public transport will be utilised where possible.

## 5.4 Respite and Crisis Care

Respite care will be planned to give relief to carers.

Crisis care will be available to facilitate emergencies.

Three to four beds would be set aside in different locations.

## 5.5 Sheltered workshops

We will provide sheltered workshops in the community as well as in our residential centre. These will be complemented by a wide range of programmes including educational and social skills development.

## 5.6 Satellite Workshops

We will provide satellite workshops suitably located to facilitate those living in the community.

## 5.7 National third Level Education Programme

A national educational programme in animal husbandry and crop production which will be organised on a modular basis and will :--

1. Provide education/ training.

2. Provide work experience.

3. Assist course participants to gain open employment.

## 5.8 Industrial Work Experience Programme

The industrial work experience programme will :--

1. Provide training in an industrial environment.

2. Assist trainees attain open employment.

3. Provide trainees with work experience.

5.9 Regional health care services.

Peamount with it's acute hospital service will provide the following for the Eastern Health Board region.

| | |
|---|---|
| Dental: | Dental, dental Hygienist and anaesthetic service. |
| Medical: | Management of acute and non-acute medical problems. |
| Surgical: | Post operative surgical care. |
| Infectious Diseases: | The diagnosis and management of people with infectious diseases. |

APPENDIX 3

# EXTRACT FROM FARM PLAN 1994-'99

1. Milk a herd of 240 pedigree holstein friesian cows to produce a total of 360,000 gallons of milk for sale.

2. Retain all heifer calves for rearing to produce herd replacements and surplus stock for sale.

3. Purchase 300 beef cattle/young stores to mature within 12 months for sale.

4. Cropping Programme:

   - Grow 365 acres of cereal crops (including set-a-side at 20%).
   - Grow 180 acres of grazing grass at Peamount Farm.
   - Grow 122 acres of grazing grass on milk leased land.
   - Grow 486 acres of silage on leased land.

   Adjusted Acres: 1,153.

5. Retain sufficient grain and silage for stock winter feeding and sell the remainder.

6. Qualify for and collect all E.U. C.A.P payments for livestock headage and extensification premia. Collect E.U. area aid on 365 acres of cereal etc.

7. Sources of Farm Income:

   - Sale of 360,000 gallons milk.
   - Sale of 180 calves.
   - Sale of 40 cull cows.
   - Sale of 80 breeding stock.
   - Sale of 300 beef cattle.
   - Sale of 700 tons approx. cereals.
   - Sale of 200 acres straw.
   - Sale of 5,500 tons silage.
   - E.U. subsidy payments on cereal acreages and livestock premia.