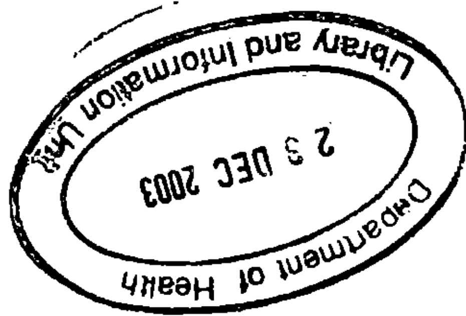
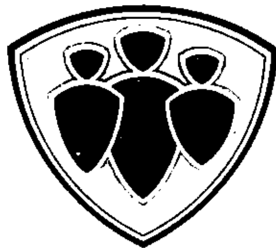
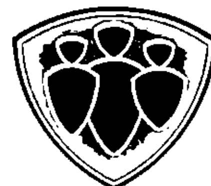
FRIDAY 12TH DECEMBER 2003





BORD SLÁINTE
AN MHEÁN-IARTHAIR

/tf 30/11/03



MID-WESTERN
HEALTH BOARD

CENTRAL OFFICES,
31/33 CATHERINE STREET,
LIMERICK, IRELAND.
TEL 00353 (0) 61 316655
FAX 00353 (0) 61 483350
WEBSITE : http://www.mwhb.ie

To: **Chairman & Each Member**
Mid-Western Health Board

A Chara,

Is mian liom a chur in iúl dhuit go dtionólfar an céad chruinniú eile den mBord, sa t'Seomra Comhairle, 31/33 Straid Caitriona, Luimneach ar **dé hAoine, 12ú, lá de Nollaig, 2003 ag 11.00r.n.** Tá an clár thíosluaite.

I wish to inform you that the next meeting of the Board will be held in the **Boardroom, 31/33 Catherine Street, on Friday, 12th December, 2003 at 11.00a.m.** The Agenda is set out below.

Please arrange to attend.

Le dea mhéin,

S. de Búrca
PRÍOMH OIFIGEACH FEIDHMEACHÁIN

AGENDA

1. a. Urnaí Tosaí

   b. Vote of Sympathy

   c. Confirmation of Minutes of Meeting held on the 14th November, 2003 (herewith)

2. Correspondence

3. Report of the Chief Executive Officer **[BUFF]**

4. Chief Executive Officer's Overview of Financial Results. **[BLUE]**
   (Report No. 59/03 herewith)

5. C & AG Report on the Waiting List Initiative **[WHITE]**
   (Report No. 60/03 attached)

6. Mid-Western Health Board Acute Hospital Annual Report 2002.

7. Review of the Nursing Home Subvention Scheme carried out by Professor Eamonn O'Shea of the National University of Ireland, Galway **(Report No. 56/03 herewith, deferred from the November Board Meeting)** **[PINK]**

8. Healthy Ageing in Ireland: Policy, Practice and Evaluation **(Report No. 61/03 herewith)** **[LILAC]**

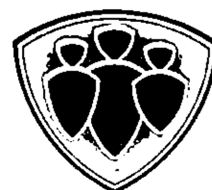
9. Traveller Health Strategy Statement and Action Plan for Mid-Western Health Board 2003 -2005 **(Report No. 62/03 herewith)** **[SALMON]**

10. Review of Child Care and Family Support Services 2002 **(Report No. 63/03 herewith)** **[WHITE]**

11.

a. **Question submitted by L. McNamara:** "That the Mid-Western Health Board would publish the report and recommendations on the review of later life psychiatric services in Limerick. In the context of the 10 year strategy for older persons now being developed I will ask that our most vulnerable elderly – i.e. those with a functional or organic mental illness be given priority."

MINUTES OF THE MONTHLY MEETING OF THE MID-WESTERN HEALTH BOARD HELD IN THE BOARD ROOM, CATHERINE STREET, LIMERICK ON FRIDAY, 14TH NOVEMBER, 2003 AT 11A.M.



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Presiding/ Cllr. S. Marsh, Cathaoirleach

Present/

Dr. Y. Begley	Cllr. J. Bourke
Cllr. P. Bugler	Mr. P. Burke
Cllr. J. Casey	Cllr. B. Chambers
Dr. D. Clinch	Cllr. P. Daly
Cllr./Dr. J. Hennessy	Cllr. S. Hillery
Ms. M. Hogan	Cllr. M. Hourigan
Ms. A. Kenny-Ryan	Cllr. J. Meagher
Mr. D. McAvinchey	Dr. P. McKenna
Mr. L. MacNamara	Ms. M. O'Donnell
Dr. J. O'Riordan	Cllr. K. Walsh

Apologies/

Cllr. R. Butler	Cllr. J. Clifford
Cllr. J. Egan	Ms. N. Fitzpatrick
Dr. J. Mullane	Cllr. K. Sheahan

In Attendance/

Mr. S. deBurca, Chief Executive Officer
Mr. G. Crowley, Assistant Chief Executive Officer
Mr. J. O' Brien, Assistant Chief Executive Officer
Mr. Kevin Kelleher, Director of Public Health
Mr. J. Conway, Assistant Chief Executive Officer
Mr. S. Woods, Regional Manager
Mr. P. McDonald, Director of Finance
Mr. J. Bulfin, Director of Human Resources
Mr. R. McMahon, Director of IT
Ms. T. Fitzgerald, CEO's Department
Ms. C. Shortt, CEO's Department

1(a) Urnaí Tosaí

1(b) Vote of Sympathy A vote of sympathy was extended to staff who had suffered recent bereavements.

1(c) Minutes Minutes of the Meeting of the Board held on the 10th October, 2003, were adopted on the proposal of Cllr. S. Hillery , seconded by Cllr. J. Casey .

2. Correspondence

3. CEO's Report **The Chief Executive Officer briefed the Members on the following:**

Deputation
The Cathaoirleach expressed her dismay that despite repeated requests for a meeting with the Minister for Health and Children, the Board have not yet received notification of a meeting.
A number of Board Members expressed their support for the Cathaoirleach's statement and their disappointment that the meeting had not taken place especially given the serious issues that the Board wish to discuss with the Minister.

Visiting Hours at the Mid-Western Regional Hospital
The CEO briefed the Board that revised visiting hours have been fully implemented and that signs are in place in the hospital to this effect.
Mr. J. O' Brien confirmed that the scheme was working well and is being kept under review.
Dr. D. Clinch stated that he was grateful for the review and suggested that perhaps Intercom announcements informing visitors that visiting hours have ended, would be helpful.

Student Nurse Placements at Ennis General Hospital
The CEO informed the Board that Ennis General Hospital has now been accepted as a training site for Student Nurses.

Refurbishment at Ennis General Hospital
Mr. J. O' Brien stated that the Design Team has been selected and that the Board is awaiting formal approval from the Department of Health and Children.

Nomination to the National Radiation Oncology Group
The CEO informed the Board that Following Dr. R. Gupta, Consultant Medical Oncologist is nominated to the National Radiation Oncology Group. The Board congratulated Dr. Gupta and wished him well.

Report of the National Task Force on Medical Staffing
Cllr. P. Daly advised the Board Members that a protest march has been organised in Ennis for Saturday.
A discussion followed to which a number of members contributed. They expressed their concerns over the future of Ennis and Nenagh General Hospitals, and particularly access to the Accident and Emergency Departments during "out of hours" as

proposed.
The Board supported the proposal sent to the Department of Health and Children by Mr. J. O' Brien on A& E staffing at Ennis and Nenagh General Hospitals and expressed their disappointment at the lack of response.
Cllr. Jim Casey proposed that necessary arrangements should be put in place regarding medical staffing to ensure continuity of service at the A& E Departments at Ennis and Nenagh. This was seconded by Cllr. P. Daly, Cllr. S. Hillery and Cllr. J. Hennessy and Dr. D. McAvinchey.
The CEO stated that the Brennan, Prospectus and Hanly reports are pivotal in the Reform process.
The CEO briefed the Board on draft proposals he has submitted to the Department of Health and Children for the implementation of the Hanly Report
Board Members undertook to express concerns in writing to the CEO on the Hanly Report so that a formal document can be prepared.

Service Plan Meetings In-Committee
The Cathaoirleach proposed that the Service Plan Meetings In-Committee would take place on the same day as Board Meetings in 2004. It was agreed that the Board Meeting would commence at 11 am followed by a light lunch with the Service Plan Meeting In-Committee at 2 p.m.

Stella Maris
The CEO informed the Board Members that the necessary Legal documents have been exchanged.

Private Hospital
The CEO stated that following Board approval to proceed to tender for the disposal of land for the purpose of a Private Hospital, the EU procurement process will commence shortly.

External Review of the Orthodontic Services
Following the Board's approval to an external review of Orthodontic Services, a number of potential candidates have been identified to undertake this review. A candidate will be selected in the coming weeks, and the review will commence as soon as possible.

Minor Capital Funding
The Department of Health and Children notified the CEO that additional Minor Capital Funding has been allocated.

The Civil Registration Modernisation Programme
The new system is on-line in all the Mid-Western Health Board registration offices. There are 10.5 million registration records currently available electronically. Births from 1900 – 2003 and Deaths and Marriages from 1966 – 2003 are now available electronically. The additional years will be uploaded on a phased basis over the next 12-18 months.

Appointment to the Special Residential Services Board
The Board has received notification that Mr. Ger Crowley has been appointed as a member of the Special Residential Services Board.

Dates for the December Board Meetings
The next Board Meeting will take place on the 12th December, 2003 in the Board Room in Catherine Street, Limerick.
The Board Meeting In-Committee to discuss the Service Plan 2004, will take place in Catherine Street on the 19th December at 12 p.m. this will be followed by Christmas Lunch.

Social Welfare Allowances
In response to Cllr. J. Meagher, the CEO outlined that the Board has not yet received the full details of the changes to Social Welfare Allowances announced by Minister C. McCreevey.

4. **Chief Executive Officer's Overview of Financial Results. Report No. 51/03**

Report No 51/03 was noted. The CEO and Mr. P. McDonald gave a brief overview of the financial position year to date.

5. **Waiting List Initiative Report – September 2003 Report No. 52/03**

Mr. J. O'Brien confirmed that the Mid-Western Health Board has performed consistently well in reducing Waiting Lists.

Responding to Ms. M. Hogan concerns over delays in waiting for consultant appointments, Mr. J. O' Brien outlined that a report will be brought forward to the Board on OPD waiting lists.
Dr. Y. Begley expressed her concern that Non- Acute Waiting List were not included in these reports. In response, the CEO outlined that the Waiting List Report was based on the National Initiative for a number of designated specialities as prescribed by the Department of Health and Children.

6.	**Irish Women and Tobacco: Knowledge, Attitudes and Beliefs – Research Report on Tobacco Use in Ireland Report No. 53/03**	The report on Irish Women and Tobacco: Knowledge, Attitudes and Beliefs – Research Report on Tobacco Use in Ireland (Item 6) was discussed with the report on Smoking Prevalence in Ireland from the Office of Tobacco Control (Item 8). Dr. K. Kelleher outlined that the report shows a significant decrease in tobacco use, while the levels of smoking in young people and women need to be addressed. Dr. Y. Begley expressed her concern that not enough is being done to assist young people to quit smoking. In response Dr. K. Kelleher outlined that Education programmes and Smoking Cessation clinics are available to assist people who wish to quit smoking.
7.	**Teenage Smoking, Alcohol and Drug Use in the Mid-West Region 2002 Report No. 54/03**	Dr. K. Kelleher outlined that 23 schools were involved in the survey. Second and Transition years students were surveyed and the results are disturbing. Inhalants are the most immediate danger to young people. A lengthy debate followed to which a number of Board Members contributed. It was agreed that an open day in a public forum would be organised with the City and County Development Boards, the Ambulance Service, Gardai and other relevant social partners. In response to Dr. D. Clinch, Dr. K. Kelleher outlined that this is a Northern European problem, which peaked about 10 - 15 years ago in the UK.
8.	**Report on Smoking Prevalence in Ireland from the Office of Tobacco Control Report No. 55/03**	See Item No. 6
9.	**Review of the Nursing Home Subvention Scheme carried out by Professor Eamonn O'Shea of the National University of Ireland, Galway Report No. 56/03**	This item was deferred to the December Board Meeting.

10.	**Purchase of a site at Carrig Rua, Gortlandroe, Nenagh, Co. Tipperary Report No. 57/03**	The purchase of the site was adopted on the proposal of Cllr. J. Casey, seconded by Cllr. J. Hennessy.
11.	**Adoption of Revised Standing Orders Report No. 58/03**	The revised Standing Orders were adopted on the proposal of Cllr. M. Hourigan, seconded by Cllr. J. Casey.
12.	**Notice of Motion submitted by Dr. D. Clinch:**	**"That this Health Board be made aware of the likely consequences over the coming months of the failure to provide an extra Geriatrician for the Mid-West. It might also discuss possible, interim measures."** Dr. D. Clinch withdrew his Notice of Motion. He wished to highlight his ongoing concern over the lack of funding for an extra Geriatrician posts. A number of Board Members expressed their support. Mr. J. O' Brien suggested that the post might be funded by reconfiguring existing support services. It was agreed to examine the matter and report to the Board at a future date.

Signed/

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Cllr. S. Marsh, Cathaoirleach

____

S. deBurca, Chief Executive Officer

____

Date

31/33 Catherine Street,
Limerick

MID-WESTERN
HEALTH BOARD

Tel: 061-483363
Fax: 061-483516

30/11/03

To: Chairman & Each Member
Mid-Western Health Board

Item No 3 on Agenda

Report for Meeting of the Board to be held on Friday, 12th December, 2003

Report of the Chief Executive Officer

Dear Member,

I propose to brief you on the following items at our forthcoming meeting:-

- Private Hospital
- Service Plan Meeting on the 19th December, 2003
- Orthodontics

Yours sincerely,

S. deBúrca
Priomh Oifigeach Feidhmeacháin

31/33 Catherine Street,
Limerick.

Tel: 061-316655
Fax: 061-483351

MID-WESTERN
HEALTH BOARD

1st December 2003

To: Chairman & Each Member
Mid-Western Health Board

Report No: 59/03
Item No 4

Report of the Meeting of the Board to be held on 12th December 2003

Chief Executive Officer's Overview of Financial Results

Dear Member,

1. Introduction

The Board recorded a positive variance against budget for October 2003 of €2.294k mainly due to changes in budget weightings. Year to date the Board is overspent by (€764k).

2. Outturn to end October 03

The outturn to the end of October is summarised as follows:

	Current Month	Year to Date
	Variance	Variance
	€'000	€'000
Pay	923	733
Superann	189	134
Non-Pay	647	-5,698
Income	533	4,065
Surplus/(Deficit)	**2.294**	**-764**

3. General Commentary

Pay is underspent in the current month by €923k and year to date by €733k. The underspend in the month is mainly due there being no requirement for locum and leave cover in the Acute Hospitals. The year to date underspend is due to the large number of vacant posts in Community Care and Mental Health.

	Pay		Superannuation	
	Current Month	Year to Date	Current Month	Year to Date
	Variance	Variance	Variance	Variance
	€'000	€'000	€'000	€'000
Acutes	304	-1,939	84	60
Elderly Care	95	536	28	18
Mental Health	105	481	18	84
Community Care	396	1,641	47	88
Central Services	21	13	10	51

3 (ii) Non Pay Expenditure

Non-Pay expenditure is underspent in the current month by €647k and overspent by (€5.698m) year to date. The main negative variances recorded were:

	Current Month	Year to Date
Non Pay by Caregroup	Variance	Variance
	€'000	€'000
Acutes	1,172	-663
Elderly Care	-275	-1,200
Mental Health	36	-364
Community Care	262	-3,862
Central Services	177	2,350

	Current Month	Year to Date	
	Variance	Variance	
Non Pay by Category	€'000	€'000	Comments
Demand Led Schemes	-457	-3,021	No Supplementary Estimate
Clinical Costs	-91	-3,259	Historic core underfunding and increased drug costs
Legal Fees	7	-1,296	A specific High Court Case and no of cases in Childcare.
Cleaning	-106	-707	Budget deficit exists and closure of Our Lady's Ennis.
Maintenance	-226	-1,036	Refurbishment contracts in a number of areas.
Energy	-2	-92	Core underfunding, no additional funding received
Education & Training	70	-339	Specialist Nursing courses.

The trends in non pay expenditure are as anticipated are associated with the main demand led cost drivers. Working groups have been established in respect of each of the Demand Led Schemes, however considerable difficulty is expected to keep within the allocation

Travel & Subsistence.

Arrears due in respect of DOHC circular 8/2003 & 07/2002 to end of October 2003 amount to € 1.5m but are not included in the figures above.

Valuation Act (2001)

Demands for rates amounting to €280k in respect of certain health board properties previously exempted from rates have been received from Limerick City Council. Appeals have been lodged where appropriate

Income

Income is positive year to date by €4.065m.

	Current Month	Year to Date
Income	Variance	Variance
	€'000	€'000
Acutes	211	1,435
Elderly Care	43	639
Mental Health	74	393
Community Care	110	1,260
Central Services	93	336

4. Programme Analysis

4(i) Acute Hospitals

	Current Month	Year to Date
	Variance	Variance
	€'000	€'000
Pay	304	-1,939
Superannuation	84	60
Non-Pay	571	-2,219
Income	211	1,435
Surplus/(Deficit)	1,172	-2,663

Commentary

Pay:
Overall positive pay variance for October due to negligible requirement for locum & leave cover for all grades of staff

Non-Pay
Favourable variance is due to adjustments in respect of minor capital works & delays in the commencement of some elements in the Service Plan.
Clinically driven & Pathology costs remain high with 50% - 100% variance from actual budget
Commencement of new consultant posts has contributed to clinical costs.
Waste disposal costs continue to exceed budget as do energy costs which is related to high fuel costs

SUPERANNUATION
Superannuation variance is negative this month & YTD due to payment of lump sums & gratuities

INCOME
Year to date the positive trend in income continues due to payment in respect of blood products

4 (ii) Special Hospitals (Mental Health & Elderly)

	Current Month	Year to Date
	Variance	Variance
	€'000	€'000
Pay	201	1,117
Superannuation	46	-66
Non-Pay	-239	-1,564
Income	113	1,032
Surplus/(Deficit)	129	420

General Commentary

Pay
Pay continues to be favourable overall in Special Hospitals due to unfilled posts in both Mental Health and Older Persons Services. Specific areas within pay are showing a negative variance. These areas have been targeted for corrective action

Non Pay
Overall Non Pay continues to be unfavourable. Certain areas continue to show a negative variance and this is due to the increased costs of clinical waste, drugs & medicines and waste disposal. These core under funding issues have been identified on an on-going basis. Maintenance issues in the long stay facilities continue to impact significantly

Income
Income continues positive year to date but requirements within the service may reduce the favourable position by year end and into the future.

Activity

Mental Health
Acute new admissions and re-admissions in Limerick are below targeted levels due to major refurbishments work in the Acute Unit at the Mid West Regional Hospital. In Clare acute admissions are generally in line with service plan targets.

Day Hospital new referrals are in line with targets but Limerick is under target due to refurbishment work and Clare is over target due to increased demand.

Clinic attendances are over target and this is again due to increased demand in Clare from Asylum Seekers and increased G.P. referrals.

Older Persons
Overall admissions and discharges and in line with targets but some variations exist within the different categories of admissions and discharges.

Day Hospital attendances remain high due to demand in Limerick.

Attendances at Day Centres continue to exceed target levels reflecting the increased demand.

Respite care admissions continue to exceed targeted levels, which reflects the focus on community services and their availability

4 (iii) Community Care (Primary Care, Disabilities, Child Care, Child Health, Child Psychiatry & Community Services)

Overall Financial Position

	Current Month	Year to Date
	Variance	Variance
	€'000	€'000
Pay	396	1,641
Superannuation	47	88
Non-Pay	262	-3,862
Income	110	1,260
Surplus/(Deficit)	816	-872

Analysis by Caregroup

Caregroup: Primary/Community Services

	Current Month	Year to Date
	Variance	Variance
	€'000	€'000
Pay	132	202
Superann	26	(12)
Non-Pay	(313)	(3,941)
Income	71	627
Surplus/(Deficit)	**(84)**	**(3,124)**

Financial Commentary

Pay
Large positive variance in month in comparison with YTD arises from AMO award expenditure versus budget.

Non-Pay
The emerging trends in non-pay expenditure are as anticipated and are associated with demand led cost drivers, principally the Demand Led Schemes. Most of the issues are of a national nature. The Board will not keep the DLS expenditure within budget – there will be large over runs due to core under-funding for schemes. Similarly core funding for Health Centres is inadequate, resulting in significant expenditure excesses.

Income
YTD trend will be maintained.

Activity
Activity across the services is broadly in line to keep within the allocation, as a core underfunding issue exists across a number of schemes

Caregroup:Childcare

	Current Month	Year to Date
	Variance	Variance
	€'000	€'000
Pay	90	695
Superann	56	4
Non-Pay	703	74
Income	12	325
Surplus/(Deficit)	**810**	**1,099**

4 (iii) Community Care (Primary Care, Disabilities, Child Care, Child Health, Child Psychiatry & Community Services)

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Superann	56	4
Non-Pay	703	74
Income	12	325
Surplus/(Deficit)	**810**	**1,099**

Financial Commentary

Pay
The positive variance in pay reflects both vacancies and delays in filling posts

Non-Pay
In non pay significant overspend (€544k) in legal fees and in Foster Care payments (€474k).

Income
Income is ahead of target.

Activity
Activity in this care group is October was broadly in accordance with targets.
The number of children placed in care during October is in excess of the monthly target.
The level of legal activity continues to be a cause for concern by virtue of inadequate core funding.
Pre-school inspections exceeded targets

Caregroup :Disabilities

	Current Month	Year to Date
	Variance	Variance
	€'000	€'000
Pay	59	635
Superann	11	9
Non-Pay	-19	327
Income	-4	55
Surplus/(Deficit)	**47**	**1108**

Financial Commentary

Pay
The positive variance in pay reflects delays in recruiting staff approved for the C.D. C. Service.

Non-Pay
Expenditure on Cash Allowances is running significantly over budget.

Income
Income is ahead of target

Activity

Speech & Language Therapy the number of interventions for the period ending was 22% above target.
Activity in Occupational Therapy continues to show an increase in activity in both Clare & Limerick.
In Physiotherapy the number of interventions for the period ending was 38% above target.

Central Services

	Current Month	Year to Date
	Variance	Variance
	€'000	€'000
Pay	21	13
Superann	10	51
Non-Pay	52	2,013
Income	93	336
Surplus/(Deficit)	**177**	**2,350**

Financial Commentary

Pay
Pay is in line with budget.

Non-Pay
The favourable variance in non pay is due to short term savings in Cervical Screening, Public Health and Drugs Project.

Income
Income is ahead of target for the year

Employment Levels
The October WTE return is 6,434.75 and the ceiling is 6,591.
This return excludes the WTE count for homehelps.
A number of issues regarding the board's employment ceiling have been raised with the DOHC.

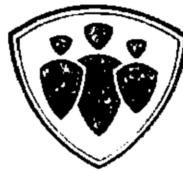
Yours sincerely,

S. de Burca.
Priomh Oifigeach Féidhmeacháin

MID-WESTERN HEALTH BOARD
Summary of Financial Results
October 2003

	Acute Hospitals Euro '000's	Mental Health Euro '000's	Elderly Care Euro '000'	Disabilities Care Grou Euro '000's	Child Care Care Group Euro '000's	Community Services Euro '000's	Central Services Euro '000's	Ambulance Services Euro '000's	Total Euro '000's
PAY									
Budget	117,924	38,785	35,027	5,378	10,130	30,016	9,830	5,406	252,496
Actual	119,802	38,389	34,471	4,651	9,430	29,819	9,766	5,300	251,627
Variance	(1,878)	397	555	727	700	197	65	106	868
Variance -% to Bud	(1.59)	1.02	1.58	13.51	6.91	0.66	0.66	1.96	0.34
Annual Budget	143,908	47,848	42,153	6,628	12,436	36,543	11,638	6,454	307,607
% Annual budget c	83.25	80.23	81.78	70.18	75.83	81.60	83.91	409.00	81.80
NON-PAY									
Budget	43,813	5,935	6,297	68,880	17,435	55,221	11,640	1,323	210,544
Actual	46,033	6,299	7,497	68,553	17,361	59,430	9,691	1,378	216,242
Variance	(2,220)	(364)	(1,201)	328	74	(4,209)	1,949	(56)	(5,698)
Variance -% to Bud	(5.07)	(6.14)	(19.07)	0.48	0.43	(7.62)	16.75	(4.20)	(2.71)
Annual Budget	59,956	7,912	8,341	83,268	23,009	74,325	16,949	1,772	275,532
% Annual budget c	76.78	79.61	89.89	82.33	75.45	79.96	57.17	77.78	78.48
GROSS EXPENDITURE									
Budget	161,737	44,720	41,323	74,258	27,565	85,238	21,470	6,729	463,040
Actual	165,835	44,687	41,969	73,204	26,791	89,249	19,456	6,679	467,869
Variance	(4,098)	32	(646)	1,055	774	(4,011)	2,014	50	(4,829)
Variance -% to Bud	(2.53)	0.07	(1.56)	1.42	2.81	(4.71)	9.38	0.75	(1.04)
Annual Budget	203,864	55,760	50,494	89,896	35,445	110,867	28,587	8,226	583,140
% Annual budget c	81.35	80.14	83.12	81.43	75.58	80.50	68.06	81.19	80.23
INCOME									
Budget	20,052	2,688	5,940	839	263	1,383	790	175	32,129
Actual	21,487	3,082	6,579	894	588	2,239	1,126	199	36,195
Variance	1,435	394	640	55	325	856	337	24	4,066
Variance -% to Buc	7.16	14.65	10.77	6.56	123.88	61.91	42.65	13.51	12.65
Annual Budget	24,054	3,228	7,123	998	311	1,639	946	210	38,508
% Annual budget c	89.33	95.50	92.37	89.58	189.00	136.65	119.07	94.54	93.99
NET EXPENDITURE									
Budget	141,685	42,031	35,384	73,419	27,302	83,855	20,680	6,554	430,911
Actual	144,348	41,605	35,390	72,310	26,202	87,010	18,330	6,480	431,674
Variance	(2,662)	426	(6)	1,110	1,100	(3,155)	2,351	74	(764)
Variance -% to Bud	(1.88)	1.01	(0.02)	1.51	4.03	(3.76)	11.37	1.13	(0.18)
Annual Budget	179,811	52,532	43,371	88,898	35,134	109,229	27,641	8,016	544,632
% Annual budget c	80.28	79.20	81.60	81.34	74.58	79.66	66.31	80.84	79.26

Note 10 months is 83%



Tel: (061) 483277
Fax: (061) 483211

MID-WESTERN
HEALTH BOARD

Date 30th Nov. '03

To: Cathaoirleach & Each Member
Mid-Western Health Board

Report No: [illegible]
Item No 7 on Agenda

Report for Meeting of the Board to be held on Friday 14th November, 2003.
(Deferred to the December Board Agenda – Item No. 7)

Review of the Nursing Home Subvention Scheme carried out by Professor Eamonn O'Shea of the National University of Ireland, Galway

Dear Member,

I set out below a synopsis of the recent report by Professor Eamonn O'Shea, "Review of the Nursing Home Subvention Scheme"

Introduction

The Nursing Home Subvention Scheme was introduced in 1993 under the Health (Nursing Homes) Act, 1990. The Scheme requires Health Boards to pay a contribution to patients towards the cost of care in Nursing Homes. Eligibility is based on the applicants' dependency and means.

Background

This review came about following a Government decision on 25th March, 1997, and in line with commitments made in "Delivering Better Government", wherein a programme of expenditure reviews were initiated by the Department of Finance. These reviews are a key part of the financial management systems that are central to the Strategic Management Initiative and are intended to ensure greater predictability in resource planning. As part of this process the Department of Health and Children contracted with Dr. Eamonn O'Shea of the National University of Ireland, Galway, to undertake a review of the nursing home subvention scheme. The review commenced in March, 2000 and was completed in March, 2001. The objectives of the review were:-

- To examine the objectives of the nursing home subvention scheme and the extent to which they remain valid.
- To estimate the level of need in elderly populations, including inadequately met need.
- To assess the service delivered under the programme in terms of effectiveness, quality and accountability.
- To consider the implications of demographic trends and other relevant changes in the environment that may impact on the programme.
- To evaluate how far the programme objectives have been achieved and how efficiently and effectively this has been done.

- To establish what scope, if any, exists for achieving the programme objectives by other more efficient and effective means.
- To specify the performance indicators that could appropriately be put in place to facilitate future reviews of this type.

Costs of Scheme

When the Nursing Home Subvention Scheme was introduced in 1993 as part of the Health (Nursing Homes) Act 1990, a sum equivalent to €5m. was allocated to cover the cost of the Scheme.

However, due to a range of factors including demographics, increasing demand, increasing dependency, greater availability of private nursing home beds, etc. the cost of the Scheme has risen substantially every year.

This year, funding of over €110m. is being made available to the Health Boards to administer the Scheme.

Principles for Funding Long-Stay Care

The following are the main principles identified within the report for funding Long-Stay Care:-

- Funding should not determine care requirements; rather care requirements should determine funding.
- There should be a built-in bias towards home care solutions while retaining a capacity for financing care in institutionalised settings.
- Access should be on the basis of need and should not be impeded by an inability to pay, or by geography.

Statistics/Data

The tables identified below represent the key findings from all Health Boards in 2000.

Table 1 Non-Acute Care Beds for Older People by Type of Facility in the Long-Stay Sector by Health Board (HB) Region per 1,000 Elderly Population (NCE), 2000

Type of Facility	ERHA	MHB	MWHB	NEHB	NWHB	SEHB	SHB	WHB	Total
HB Extended Care	**17.1**	**26.2**	**19.2**	**18.8**	**21.6**	**25.4**	**23.1**	**23.4**	**20.9**
HB Elderly Mentally Infirm	0.5	4.8	1.0	1.7	3.9	2.4	0.0	0.7	1.3
HB Assessment/Rehab Beds	3.0	1.5	2.5	1.9	3.5	2.2	0.6	2.0	2.2
HB Respite	1.1	1.9	1.2	2.9	1.8	0.3	1.1	0.2	1.1
HB Convalescent	0.8	0.2	0.1	0.0	1.2	0.0	0.0	1.7	0.6
HB Other	0.0	0.6	1.6	0.0	0.0	0.5	0.0	0.0	0.2
Sub-Total: HB Provided	**22.5**	**35.2**	**25.6**	**25.3**	**32.0**	**30.8**	**24.8**	**28.0**	**26.3**
HB Subvented Beds	11.2	13.2	23.1	11.1	12.8	15.1	12.7	21.2	14.3
HB Contract Beds	5.3	0.2	0.0	2.2	6.4	0.0	4.1	0.0	3.0
Winter Initiative Beds	1.8	0.0	0.6	1.0	1.0	0.1	0.5	0.3	0.9
Sub-Total: HB Funded in Private Facilities	**18.3**	**13.4**	**23.7**	**14.3**	**20.2**	**15.2**	**17.3**	**21.5**	**18.2**
Total HB Funded Beds	**40.8**	**48.6**	**49.3**	**39.6**	**52.2**	**46.0**	**42.1**	**49.5**	**44.5**
Private and Voluntary Beds (Non-Subvented)	**14.2**	**11.0**	**16.4**	**5.1**	**2.1**	**9.1**	**9.9**	**11.0**	**11.0**
Total Long-Stay Beds	**55.0**	**59.6**	**65.7**	**44.7**	**54.3**	**55.1**	**52.0**	**60.5**	**55.5**

Table 1 provides information on long-term care facilities in Ireland. These figures are based on National Council for the Elderly population projections for 2001.

Table 2 provides information on the estimated dependency of residents in long-stay units (Public and Private) by Health Board Region, 2000

Table 2 Estimated Dependency of Residents in Long-Stay Units (Public and Private) by Health Board Region, 2000

	Category of Dependency									
HB Region	**Low**		**Medium**		**High**		**Max.**		**Total**	
	N	%	N	%	N	%	N	%	N	%
ERHA	868	15	1,251	21	1,558	26	2,154	37	5,902	100
Midland	152	13	239	20	371	31	446	37	1,208	100
Mid-West	313	15	574	28	616	30	580	28	2,088	100
North- East	81	6	257	20	342	27	588	46	1,267	100
North-West	107	9	256	20	519	41	373	30	1,256	100
South-East	386	17	515	22	582	25	827	36	2,311	100
South	384	13	726	24	900	30	990	33	3,001	100
West	246	10	490	20	946	38	832	33	2,515	100
Total	2,537	13	4,308	22	5,834	30	6,790	35	19,548	100
Ratio H/L	2.8		1.4		1.6		1.6			

As can be seen from the Table, the Mid-West contains the highest proportion of residents in the low to medium dependency categories at 43%.

The Report also provides information in relation to the Private Nursing Home Sector in Ireland. The information is based on a postal survey conducted in June and July, 2000. There was an overall response rate of 40% to the survey.

The occupancy rate in Nursing Homes responding to the survey is detailed in Table 3.

Table 3 Number of Private Beds Currently Occupied by Health Board Region

Beds	ERHA	South-East	West	Mid-West	North-East	Midland	North-West	South	Total
Number of Beds in Survey	1,887	246	620	854	290	400	279	801	5,377
Number of Beds Currently Occupied	1,780	233	566	770	251	358	275	758	4,991
Occupancy Rate (%)	94	95	91	90	87	90	99	95	93

Table 4 Type of Subvention by Health Board Region (%)

Type of Subvention	ERHA	South-East	West	Mid-West	North-East	Midland	North-West	South	Total	N
Medium	20	14	7	23	18	23	10	21	17	433
High	21	28	22	31	21	31	36	30	27	669
Maximum	59	58	71	46	61	46	54	49	56	1,378
Total	100	100	100	100	100	100	100	100	100	
N	526	137	421	471	120	251	193	361		2,480

According to the survey, the main challenges faced by Nursing Homes in the future include staffing, rising costs of care and Health Board regulations. (Table 5)

Table 5 Main Challenges in the Future

Main Challenges in the Future	No. of Nursing Homes	% of all Nursing Homes
Staffing	70	51
Rising Costs of Care	35	25
Health Board Regulations	18	13
Competition from Investors	8	6
Other	7	5
Total	138	100

Current Issues

Within the Report the key challenges for the Scheme and long-stay care in general are:-

- Demand skewed in the direction of the residential option.
- Demands on the Exchequer from the nursing home subvention scheme has made significant calls on the available public resources for all types of dependent older people.
- The absence of an in-built bias towards community care.
- Little by way of innovation and ingenuity in support of community care.
- Family care viewed as free resource.
- Some people denied access to free public long-stay care simply because of where they live and when they have applied.
- Similar regional disparities exist with respect of community care services.
- Location is an important variable in determining the quality of care available to older people.

Recommendations

This report raises a number of important issues, these can be categorised as follows:-

Financial

- Dr. O'Shea's review raises a number of important issues, one being that the Scheme has biased resource allocation in the direction of residential care rather than community care. It further suggests that shortcomings in community support services for older people and their carers forces people to opt for private nursing home care, thereby maintaining constant pressure on the subvention system.

Regulations

- Dr. O'Shea's review stresses the importance of consistency and standardisation across the Health Boards in the application of the Regulations.

Social Economy

- Another recommendation is that the introduction of co-financing arrangements should be considered and it also highlights the import supporting role that the social economy can play in developing a new and vibrant community care sector.

Community Care

- The review questions the justification for the continued public subvention of low and medium dependency residents in either public or private long-stay care, without first of all attempting to care for these people in the community.
- A subvention for nursing home care should never be granted unless it is clear that a community-based subvention would not have succeeded in maintaining the elderly person in their own home.
- The community care subvention could be set at some percentage of the residential care rate if that's what it takes to get it implemented.
- Subvention should be targeted at people on the boundary of in-patient care.
- Needs assessment rather than dependency assessment.
- Packages of care, funded by the new community care subvention scheme, should be negotiated between the relevant Health Board personnel (optimally through a designated care manager) and older people and their families.
- New services should be put in place and all services should be made more flexible to support care in the evenings, at night and at the week-end.

Bed Capacity

- It advocates the provision of more publicly-funded beds for older people through the development of new Community Nursing Units. In particular, beds for assessment and rehabilitation should be provided, not only to control admission to long-stay care, but to change the ethos of the care system away from institutional to one of renewal and restoration.

Home-Based Subvention

- The objective of public policy with respect to the long-term care of older dependent people is to keep them in their own homes for as long as possible in accordance with their wishes.
- The introduction of a home-based subvention is consistent with the policy of successive Governments of maintaining older people in their own homes for as long as they wish.
- The report highlights that this does not mean that nursing home care will no longer be necessary.
- The review emphasises the need to continue to work in partnership with nursing home owners to provide appropriate care to older people.

Dependency and Placement

- Establishment of a common dependency assessment for all of publicly funded long-stay care.
- National guidelines for the measurement of dependency.
- Require assessment of physical and mental dependency.
- People with low or medium dependency should be cared for in an expanded community care system.
- Identify economic and social determinants of dependency.
- For high dependency older people there should be a guarantee that all possible community care strategies will be explored before a decision on admission to residential care is taken.
- One increased subvention payment for dependency instead of the three-tiered payment mechanism currently in use, because only seriously dependent older people should now be in care.

- Retain the potential for enhanced subventions.
- Significant public investment in both rehabilitation and step-down facilities for older people.

Conclusions

Dr. O'Shea identified the following as the main conclusions of his review.

- Without families the community care system for older people would have collapsed a long time ago. Families provide extremely high levels of care, even for relatively low dependent older people. On the margin between community care and residential care, family care has the same significance as nursing care within public and private institutions, with approximately 13,000 high to maximum dependency older people living at home. Families incur significant opportunity costs and health costs in caring for older people but, in general, the commitment to caring is still strong in this country.
- While there is no doubt that the current system of subvention for long-stay care in private nursing homes needs reform, that reform should be part of a wider strategy of keeping older people out of all types of long-stay care. An essential part of any new strategy should be a community-based subvention scheme for the most vulnerable older people living at home. For that reason, there is a need to develop a pilot scheme for community-based subventions immediately to evaluate the optimal approach to planning and developing such a scheme on a national basis.
- Once need for long-term care is established, access to public funding in either public long-stay institutions or private nursing homes should be based on a common assessment of means and assets. This would end the current anomaly whereby a person applying for a subvention to a private nursing home is subject to a more rigorous means assessment than a person seeking admission to a public bed.
- More resources for assessment and rehabilitation are also important, not only to control admission to long-stay care, but to change the ethos of the care system away from institutionalisation to one of renewal and restoration. There seems little justification for the continued public subvention of low and medium dependency residents in either public or private long-stay care, without first of all attempting to care for these people in the community.
- There is a need for significant investment in public beds for older people, particularly in the areas of assessment and rehabilitation.
- The policy context is the desire to recalibrate the current funding of long-term care away from residential care towards care in the community by providing both financial incentives and posthumously collected penalties to encourage people to choose care at home over residential care, whenever possible and practicable. All of this pre-supposes a significant investment in community care by the state if the new system is to work properly.
- There was universal concern about the shortfall between individual applicant's income plus the subvention and the weekly cost of care in a private nursing home.
- The social economy can play an important supporting role in developing a new and vibrant community care sector. There are limitations on how far the state can directly provide the services that are required at local level.
- There has been some experimentation with social economy approaches to the problem of community care provision. As yet, however, the concept of the social economy remains foreign to the health and social services tradition in Ireland. Statutory provision, which is geared to the individual who presents for care, is not sufficiently integrated with local social networks or with local communities. Consequently, important elements of reciprocity, social capital and inter-generational solidarity are neither being nurtured or utilised for the support of older people in the community.

Future Reviews

The Department of Health and Children have launched a review of the Nursing Home Subvention Scheme.

Its objective is to give an opportunity to build on the findings of this report and answer some of the questions posed in this and other reports.

Mid Western Health Board – Current Position

In the Mid Western Health Board area , there are 42 nursing homes providing 1,587 beds. Since the introduction of the Nursing Home Subvention Scheme, the number of people in receipt of subvention has increased from 404 in 1994 to 993 in 2002.
In relation to this report the provision of long-stay care in this region compares favourably with the national averages.
In September of this year, the number of people in receipt of Nursing Home Subvention was 974. Of this number, 34 are categorised as medium dependency, 185 high dependency and 754 maximum dependency. There are 270 people in receipt of enhanced subvention.
The Board's enhanced subvention scheme has been a success and reflects the recommendation in this report with regard to enhanced subventions.
The Board has submitted a proposal to the Department of Health and Children in relation to Home-Based Subvention and is hoping to initiate a pilot scheme before the end of the year. This proposal reflects the recommendations highlighted within the Report of Health Board providing a flexible, community-based service that allows older persons to remain within their home environment.

The Directorate for Older Persons Services has set up a working group to review these findings within the report in the context of the region as a whole. The Board also is represented on the National Group established to review the present Nursing Home Subvention Scheme.

"Review of the Nursing Home Subvention Scheme" Professor Eamonn O'Shea, NUI, Galway.

Full Report available from:

Government Publication Sales Office,
Sun Alliance House,
Molesworth Street,
Dublin 2

Yours sincerely,

James Conway,
Asst. Chief Executive Officer.

Tel: (061) 483277
Fax: (061) 483211

MID-WESTERN
HEALTH BOARD

30/11/03

To: Cathaoirleach & Each Member
Mid-Western Health Board

Report No: 61/03
Item No 8 on Agenda

Report for Meeting of the Board to be held on Friday.

"Healthy Ageing in Ireland: Policy, Practice and Evaluation"

Dear Member,

I set out below a recent report "Healthy Ageing in Ireland: Policy, Practice and Evaluation prepared by the National Council on Ageing and Older People.

Members may be aware that a regional seminar was held in the Mid-West Region in March 2003 in order to contribute to this report.

Introduction

Background to the Study

Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People (Brenner and Shelley, 1998) marked the formal beginning of the Healthy Ageing Programme in Ireland. The objectives of the Strategy are:

- To improve life expectancy at age 65 and beyond
- To improve the health status of people aged 65 and beyond
- To improve the lives and autonomy of older people who are already affected by illness and impairment

The Strategy recognises that the promotion of health for older people is not solely a matter for the Department of Health and Children, but for all Departments and organisations whose policies and actions may potentially have an impact on the health of older people. The implementation of the Strategy requires the development of an information and support network for promoting the health, welfare and autonomy of older people, as well as the identification and promotion of models of good practice for healthy ageing. This Report is part of the process of extending and developing a knowledge-base on healthy ageing activities in Ireland.

Defining Healthy Ageing

Successful ageing is difficult to define (Glass, 2003), and a number of terms are used in the literature (often it seems interchangeably) including 'productive ageing', 'active ageing' and 'healthy ageing'. The term 'productive ageing' came to the fore in the early 1990's and was generally used in relation to promoting economic contributions by older people through

participation in the labour market. Policies concerned with productive ageing dealt mainly with ways to increase the participation of older workers in the labour force, such as the removal of age discrimination in the workplace, and training and re-training programmes (Davey, 2002).

The term 'active ageing' gained prominence during the 1999 United Nations Year of Older People and was subsequently used by the WHO, who currently define active ageing as 'the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age' (WHO, 2002). In 1999 the European Commission held a conference on active ageing and outlined its key elements which included:

- Working longer
- Retiring later
- Being active after retirement
- Engaging in health sustaining activities
- Being as self-reliant and involved as possible

Healthy and active ageing is a global movement supported by the WHO. In its contribution to the Second World Assembly on Ageing in 2002, the WHO recognised that when health, labour market, employment, education and social policies support healthy ageing, there will be:

- Fewer premature deaths in the highly productive stages of life
- Fewer disabilities associated with chronic diseases in older age
- More people enjoying a positive quality of life as they grow older
- More people actively participating as they age in social, cultural, economic and political aspects of society, in paid and unpaid roles and in domestic, family and community life.
- Lower costs related to medical treatment and care services. (WHO, 2002)

Objectives of the Project

The objectives of the project are:

- To generate a comprehensive database of healthy ageing activities in Ireland
- To examine the current situation of health promotion initiatives for older people in Ireland
- To provide criteria for best practice in the planning, operation and development of healthy ageing projects
- To provide criteria for the evaluation of healthy ageing projects.

Methods

The Report is based on extensive consultation with stakeholders in the field of healthy ageing in Ireland and adheres to a participative model of research in keeping with best practice in health promotion investigation. Eight regional seminars on healthy ageing were held over a period of six months in each of the Health Board Regions. The purpose of the regional seminars was:

- To bring together representatives of healthy ageing projects from Health Boards, voluntary groups, community groups, local authorities and older people themselves.
- To generate discussion that would inform national best practice in the field of healthy ageing for older people.
- To obtain a comprehensive list of contact persons and addresses for all healthy ageing projects in that region.
- To facilitate communication and networking in the field of healthy ageing.

Participants at the seminars in each region were asked to consider four major issues in relation to healthy ageing activities as follows:

- Current priorities
- Future priorities
- Issues in the planning, development and operation of healthy ageing projects
- Best practice

The philosophy of the project was to involve all stakeholders in setting priorities for healthy ageing and in establishing criteria for best practice in the field.

Lists of contacts for healthy ageing projects were generated at the seminars and subsequently through further communication with participants.

A postal questionnaire was sent to all potential projects identified during the consultation stage of the research. The issues addressed in the questionnaire were similar to those considered in the seminars.

Mid-West Regional Seminar Findings

As part of the consultation process, eight Regional Seminars on Health Ageing were held over a period of six months. The Mid-West seminar took place on the 5th March in Limerick City. It was attended by fifty-two delegates involved in the regions array of services for older persons. These delegates comprised Health Board staff in both hospital and community settings, voluntary organisations and community groups.

Issues identified by the seminar delegates in Limerick included acute care, particularly in relation to cancer and cardiovascular services. Other key discussion issues were Day Centre, Day Care facilities and Mental Health and Illness.

Issue which delegates felt should receive priority in the future included:

- Greater social integration and a home-based services
- Greater choice in relation to services
- Health Promotion should focus on wellness and capabilities
- Greater access to information
- Overcoming negative attitudes in relation to ageing
- The implementation of the Primary Care Strategy and the concept of a "One Stop Shop".

In relation to the planning, development and operation of Healthy Ageing Projects, the seminar delegates felt the following to be important:

- Funding
- Needs Assessment
- Integration
- Dedicated staff
- Best practice
- Consumer consultation
- Equity

The Board's Elderly Directorate are reviewing these findings with in a planning and development context in conjunction with the key findings identified within the report.

Findings & Conclusions

The following outlines some of the main findings and conclusions of the report.

General Findings

- Ireland ranks lowest among European countries in terms of life expectancy at age 65, with a gap of 2.11 years between Ireland and the EU average. The gap appears to be increasing over time, having increased from 1.85 years in 1990.
- In a ranking of healthy life expectancy for 23 developed countries by the WHO, Ireland ranked second last for males and last for females.
- Although 24 goals are specified in *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998), there is no ranking or priority setting, therefore we cannot tell which goal is the most important.
- Evaluation is largely absent from the healthy ageing field in Ireland.
- There is no uniform approach to health promotion for older people across the country.
- A recurring theme at the regional seminars was the acceptability of different options for social interaction offered by community groups and Health Boards. A strong preference was expressed for the development of more community-based social activities that are participative and led by older people themselves.

Regional Seminars

- Active retirement associations (ARAs) are perceived as the most visible face of healthy ageing in local communities.
- Participants in the regional seminars identified the need to change attitudes to ageing as the most important priority for the future in the field of healthy ageing in Ireland.
- At a macro level, people felt that there needs to be a re-orientation from secondary/acute care to primary/community care and this should be reflected in resource allocation and legislation regarding entitlements.
- At a micro level, stakeholders wanted more emphasis on the promotion of health within community care with greater partnership between community care providers and health promotion departments
- The need for greater investment in social housing was emphasised at the regional seminars.

Healthy Ageing Database

- The most common category for healthy ageing projects is that of social environment with 45% of all projects fitting into that category.
- The most popular setting for healthy ageing projects is day care/day centre at 16% followed by ARAs at 15%.
- Almost 70% of projects developed from an initiative taken by the organisation running the project.

- Three quarters of participants in healthy ageing projects are female.
- Projects are small in scale, with two-thirds having less than fifty participants per week and a third having less than twenty.
- Increased funding for social interaction and integration, and the promotion of better attitudes to old age and society were regarded as priority areas for the future by survey respondents.
- Older People living alone were regarded as a priority group by many of the survey respondents.

Building Health Public Policy

- Ageism and inequality have been identified as a major issue affecting the opportunities open to older people to improve their own health and well-being. Combating ageism in public policy and the promotion of better attitudes to older people in society are required in order to maximise the impact of projects promoting healthy ageing.
- A designated and protected Healthy Ageing Fund should be established by the Department of health and Children to encourage innovation and experimentation in respect of healthy ageing.
- A culture of evaluation should be built into community and service-based approaches to promoting healthy ageing, so that the benefits of preventive approaches and supportive environments can be measured.
- The recommendations of the Food Safety Authority on nutrition and older people (FSA, 2000) should be implemented.

Creating Supportive Environments

- Every Government Department needs to build more commitment to keeping older people well and living in their own homes at national and regional level.
- Housing plays an important role in keeping older people well, enabling them to live independently and maintain lifetime social contacts and networks within their community.
- Transport is an important aspect of quality of life for older people.
- Injuries are a major contributor to unhealthy ageing for older people.
- Physical activity can reduce the number of falls, so can designated projects based in the home and in long-stay care to reduce the number of falls.

Strengthening Community Action

- Various attempts have been made to establish a more nationally representative network of older people, representation for older people in the socio-political structure remains under-developed relative to other European countries and especially to the USA.
- There is a need for capacity-building for voluntary groups and ARAs at community level.
- Older people should be placed at the centre of decision-making, both in the community and in residential care.

Developing Personal Skills

- Physical activity can benefit older people at all levels of ability by maintaining musculoskeletal and cardiovascular fitness. Maintaining and extending the Go for Life national programme should be an important component of future healthy ageing policy.

- Specific targeting of vulnerable older people through screening and subsequent social interaction and networking projects can reduce isolation. Community activities, accessible transport and life-long learning courses can also help alleviate isolation and anxiety.

- The participation of older people in life-long learning and creative activities is also supportive of healthy ageing.

Re-Orienting Health Services

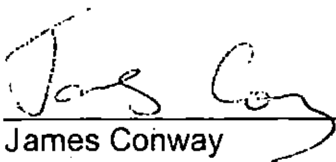
- Healthy ageing should form an integral part of the Primary Care Strategy.

- The re-orientation of treatment and health care from a medical model approach to a bio-psychosocial approach, involving older clients in their own car and tackling issues related to economic, social, psychological, communication, language and cultural barriers which currently impact on access to services.

- Funding for community care services should be enhanced through the provision of person-centred community-based subventions for vulnerable older people.

- Discharge policies are a key factor in determining how well an older person gets on after an episode of illness. Discharge policies could be greatly developed in terms of setting up a plan for the holistic well being of the older person after an acute episode of illness.

Yours sincerely,



James Conway
Assistant CEO

Tel: (061) 483214
Fax: (061) 483211

MID-WESTERN
HEALTH BOARD

Date 25/11/2003

To: Cathaoirleach & Each Member
Mid-Western Health Board

Report No: 62/03
Item No 9 on Agenda

Report for Meeting of the Board to be held on Friday, 12th December, 2003

Traveller Health Strategy Statement and Action Plan for MWHB 2003-2005

Dear Member,

I set out below a recent report "Traveller Health Strategy Statement and Action Plan for MWHB" prepared by Seamus Woods, A/Regional Manager.

Introduction

One of the key objectives of Quality and Fairness, 2001 is about "ensuring that disadvantaged groups get the help and support they need to ensure that everyone in society has an equal chance to achieve his or her full health potential". Specifically for the Mid Western Health Board, this can be achieved by implementing various social inclusion initiatives, which involves working to reduce and, in time, to eliminate the social gradients of health within the region.

One of the initiatives in this regard is the development of a Regional Traveller Health Strategy Statement and Action Plan to support the Traveller Health: A National Strategy (2002-2005), which was launched in 2002. This national strategy places the health of Travellers in Ireland higher on the Government's agenda of priorities than ever before. The strategy is based on a community development ethos that aims to empower Travellers to take responsibility for looking after their health.

Development of Strategy Statement and Action Plan

The key strategic objective of the Mid Western Health Board plan is to improve the health and social gain of Travellers in this region, comparable to that of the general population. The action plan is based on a consultative process that took place over a period of six months. The Board is especially grateful to all the Travellers and Traveller Organisations in the Mid West Region for their cooperation in participating in the development of the plan and also to the Traveller Health Unit for their support and direction. Other Health Board professionals and external agencies had key inputs into the Action Plan, and the Board gratefully acknowledges their support.

The following 3 key Groups were extensively consulted for their perspectives:

a) Travellers and Local Traveller Organisations:
The Traveller Groups consisted of both men's groups and women's groups and the groups varied in size from 3-16. Consultation took place via group sessions, which were jointly facilitated by the local Community Development Worker and the Research Officer (both of the Mid Western Health Board). Ten Traveller Groups were consulted in each of the three main geographical areas of the Mid-Western Health Board region. One-to-one interviews were also conducted with managers, facilitators and co-ordinators of local Travellers groups.

b) Service Providers in the Mid-Western Health boards:
Service providers were consulted across the disciplines and these were either nominated by their head of discipline or volunteered to offer some of their time to discuss their experiences of providing services to Travellers. Fifty service providers in the Mid Western Health Board, who deliver services to Travellers, were consulted individually or within a group.

c) Service Providers Employed by Agencies External to the Mid-Western Health Board:
Eight service providers employed by agencies external to the Health Board who deliver services to Travellers were also consulted. These agencies included various Local Authorities, Limerick County VEC, two Senior Training Centres for Travellers, FÁS, the Visiting Teacher for Travellers' Service and a women's refuge.

Profile of Travellers Health

Research has shown that Travellers are a minority group in Irish society, that do not share similar health status to the settled population. The 2002 Population Census showed that only 3.3% of Travellers were over 65 years compared to 11.1% of the general population, while 42.2% of the young Traveller population were 0-14 years. The equivalent figure in the general population was 21.2%. This compares to an age pyramid of a developing country.

Other alarming statistics relating to the life expectancy of Travellers, which highlight the profile of need, include:

- Traveller men live on average 10 years less than settled men;
- Traveller women live on average 12 years less than settled women;
- Infant mortality rate is 18.1 per 1000 live births compared to 7.4 per 1000 live births in the settled population;
- The still birth rate in the Travelling community is twice the national average;
- The sudden infant death rate is 12 times the national average.

Thus, Travellers are now only reaching the life expectancy that settled Irish people reached in the 1940s.

The findings from the Consultative Process

Similarly to the general population:

- Travellers have a tendency to utilise acute services more than General Practitioner services. Overall, the feedback from Travellers regarding GP services was extremely satisfactory and focused on consultations that were not hurried and where GPs took the time to listen to their patients concerns. A high premium was placed on thorough medical examinations and correct initial diagnoses.
- Travellers also reported positive interactions with Public Health Nurses particularly when they took time to explain health issues clearly and when they took a caring interest in their child's health.

- In regard to acute services, it is documented that the hospital services used most frequently by Travellers are Accident and Emergency (with negligible referral rate by GPs) and Obstetric and Paediatric Services. While Travellers appear to use these services at a greater rate than the rest of the population, they have a lower utilisation rate of other hospital services.

The findings also identify a number of key determinants of health that exist outside the formal healthcare sector which impact on Traveller health. These include accommodation, employment, education and discrimination. While health is the main remit of personnel employed by Health Boards, a stronger role is advocated for more partnerships with external agencies regarding issues.

While much has already been accomplished by the Traveller Health Unit in the past few years, the consultation process and research demonstrated that further initiatives were needed in the following areas:

- The uptake of preventative healthcare by Travellers must be increased through improved information that is accessible and easy to understand so that Travellers can be empowered to take personal responsibility for their health;
- The paramount need to develop accurate data collection methods around Travellers, which would be greatly assisted by an ethnic identifier on medical records to enable efficient planning of health services;
- The need for the development of local, county and regional Traveller networks to enable informed and meaningful participation at Traveller Health Unit meetings;
- The need to develop a number of modules for he Training of Trainers Programme including: i) the appropriate use of Health Services by Travellers; ii) alcohol/substance abuse and iii) the issues of violence against Traveller women;
- The need to develop an information programme regarding Travellers accessing of Mental Health Services;
- The need to enhance inter-agency liaison around issues such as accommodation, discrimination and illiteracy that impinge on Traveller health.

Many improvements in Traveller Health have taken place since the Traveller Health Unit was established in 1998, especially regarding raising awareness around Traveller health issues. The Mid West region has met with success largely due to development of initiatives, in successful partnership with Travellers and Traveller Organisations.

Action Plan

The consultation process has revealed that many successful initiatives had been developed since the Traveller Health Unit of the Mid Western Health Board was established in 1998. Thus, the Mid West Regional Action Plan for Traveller Health builds on these initiatives and will be focused on six main objectives, that will prove beneficial in helping to meet the health needs of Travellers.

I. Appointment of Designated Workers for Travellers

To date a number of designated Community Development Workers and Public Health Nurses have been appointed throughout the region to develop appropriate programmes that are responsive to the needs of Travellers. The Action Plan sets out the need to extend this dedicated support through the employment of Health Promotion Officers, Community Speech and Language Therapists, a Midwife, a Community Mental Health Nurse, an Alcohol and Drug Education Officer, and a Dental team. (Please note that these initiatives will require further funding from the Department of Health and Children).

II. Peer – led initiatives

As noted in the introduction, the National Traveller Health Strategy promotes a community development approach to improving Traveller Health. To incorporate this into practice a permanent role has been developed for peer-led service provision. Training for Traveller women to deliver health services to their community has been established through the development of Primary Health Care Programmes in Limerick City and Roscrea, Co. Tipperary. It is hoped that two Primary Health Care Programmes will also be developed in Co. Clare and Co. Limerick. Pre-development training has also been developed in areas where Primary Health Care Programmes have not yet been developed.

III. Traveller Cultural Awareness/Sensitivity Training Programme

The Action Plan will continue to deliver a Traveller Cultural Awareness/ Sensitivity Training Programme for all front-line staff delivering health services. A group of Traveller women form part of the core team who deliver training to the region. A working group within the Mid-Western Health Board will also be convened to draft an Anti-Racism Code of Practice.

IV. Establishment of active partnerships:

Active partnerships must be established between Travellers, their representative organisations and health service personnel in the provision of health services.
Specific actions are outlined in more detail for GP Services, Public Health Nursing, General Hospital Services, Maternity and Child Health Services, Traveller Women/Men/Youth, Health Promotion Services, Community Services, Childcare, Mental Health, Elderly Services, Disability Services and Dental Services.

V. Complementary Health Services:

This includes a special annual Triage Clinic in Rathkeale, Co. Limerick during the Christmas season to complement local General Practitioner services. As this has proved so successful over the last few years, this initiative will continue to form part of the MWHB Action Plan for Traveller Health. Rathkeale is an area that has the highest number of Travellers in the region, with many more relatives visiting the town during the Christmas period.

VI. Developing a System for Ethnic Identification:

There is currently no systematic or regular gathering of data relating to the health status of Travellers. The major barrier to achieving this is the absence of any specific identification of Travellers within health data-gathering systems in use in hospitals or the community. It is hoped that the results of a pilot project will lead to the implementation of a system that includes ethnic identification during the life of *'Traveller Health: A National Strategy 2002-2005'.*

Action Plan Implementation

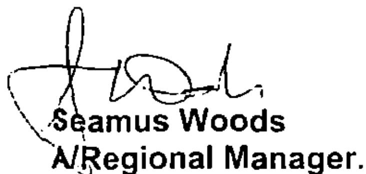
Effective implementation of the regional Action Plan will require change and collaboration between Travellers, Traveller organisation, external agencies and health service providers over the period of the Action Plan (2003-2005). The structuring of services along the continuum of support will require some additional resources to ensure objectives are realised.

Conclusion

Tackling and ultimately reducing the inequalities of health for Travellers is a difficult task. The problems have been long standing and persistent and it must be recognised that many causes of inequalities of health cannot be influenced by the MWHB. The aim of this strategy statement is to maximise the MWHB contribution to improving Traveller Health Status in this region.

Copies of the Strategy Statement and Action Plan are available on request. For further information in relation to Traveller Health Services, please contact Ms Alice McGinley, Co-ordinator of Traveller Health Services, on (061) - 483916

Yours sincerely,



Seamus Woods
A/Regional Manager.

MID-WESTERN
HEALTH BOARD

Tel:
Fax:

4th December 2003

To: Cathaoirleach & Each Member Mid Western Health Board.

Report No: 63/03
Item No 10 on Agenda

REPORT FOR THE MEETING OF THE BOARD TO BE HELD ON FRIDAY 12TH DECEMBER 2003.

ANNUAL REVIEW OF CHILDCARE AND FAMILY SUPPORT SERVICES- 2002

Dear Member

This the 10th Annual Review of Childcare and Family Support Services is circulated for your information and consideration.

The review is produced in response to the obligation placed on the Board by Section 8 of the Childcare Act 1991 to annually review the adequacy of childcare and family support services within the Board's area of responsibility.

Within this context a review process was established which included , feedback from services users, provider agencies, regular internal reviews and the systematic collection and analysis of data on monthly service activities.

Key Developments and Activities in 2002.

The following is a number of the key developments and activities in 2002.

- The strengthening of family support services in Clare.
- Establishment of a Community Mothers Programme in Limerick and Tipperary North.

- The Springboard Family support Programme in Limerick and Tipperary North were mainstreamed.

- The highest proportion of notifications to the child protection notification system related to neglect.

- There was a significant increase in the number of notifications to Gardai, context CPNS.

- Over 400 children were in care of the Health Board of whom over 90% were in Foster Care placements.

- Inspections were carried out of all residential child care units in the region.

The review process highlighted weaknesses and gaps in services which included,

- The need to provide early intervention and preventative programmes for vulnerable families.

- Increased health and safety concerns in relation to frontline staff who are required to deal with children who display extremely challenging and complex behaviour.

- The absence of a national policy on aftercare provision.

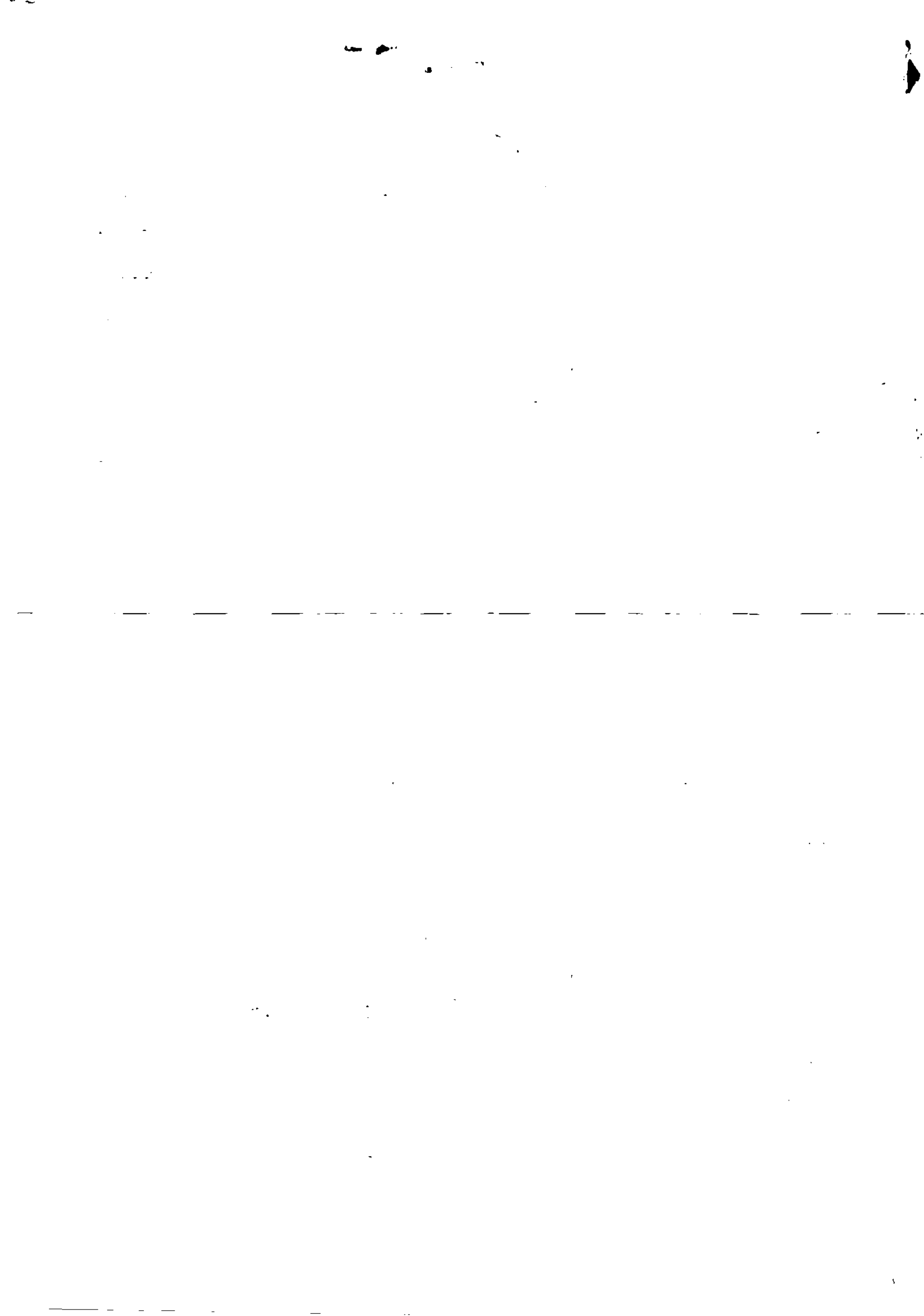
Conclusion

The report is a valuable instrument for service planning and monitoring and in this context the obvious need to further develop services is acknowledged.

The range and complexity of service provision demonstrated in the report presents very significant challenges for the Board. I wish to acknowledge the commitment of all personnel including those in partner agencies who provided these services.

Yours sincerely,

JAMES O GRADY
REGIONAL MANAGER
CHILDREN & DISABILITY SERVICES.



Board Meeting 14th November 2003

RECENT RESIGNATIONS

Name	Grade	Location
Mr. Sean Brodie	Teacher / Instructor	Our Lady's, Ennis
Ms. Philomena Halpin	Senior Physiotherapist	St. Camillus' Hospital
Ms. Anne Nealon	Emergency Medical Technician	Ambulance Control Centre
Ms. Susan Bramley	Grade VIII	St. Joseph's, Limerick
Ms. Bridget Carey	Senior Staff Nurse	St. Ita's, Newcastlewest

RECENT DEATHS

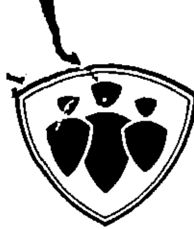
Name	Grade	Location
Ms. Mary Guerin	Laundry Supervisor	St. Camillus' Hospital

RECENT STAFF BEREAVEMENTS

Name	Grade	Location	Death of
Ms. Helen Kirby	Staff Nurse	Mid-Western Regional Hospital	Father
Ms. Kathleen Guerin	Night Sister	Mid-Western Regional Hospital	Father
Ms. Brid O'Connell	A/Grade V	PPARS, Limerick	Father

RECENT RETIREMENT

Name	Grade	Location
Ms. Kathleen Courtney	Senior Staff Nurse	Nenagh General Hospital
Ms. Angela Mary Barry	Staff Nurse	St. Camillus' Hospital
Mr. P.J. Foudy	Clinical Nurse Manager II	Our Lady's, Ennis
Dr. Gerard Burke	Consultant Physician	Mid-Western Regional Hospital
Ms. Catherine P. Sheehan	Senior Psychiatric Nurse	St. Joseph's, Limerick
Mr. Paddy O'Connor	Foreman	Mid-Western Regional Hospital
Mr. James Scanlon	Driver / Porter	St. Joseph's, Limerick
Ms. Kathleen McCaffrey	Attendant	St. Camillus' Hospital



Tel: (061) 483277
Fax: (061) 483211

MID-WESTERN
HEALTH BOARD

Date 30th Nov. '03

To: Cathaoirleach & Each Member
Mid-Western Health Board

Report No: 56/03
Item No 9 on Agenda

Report for Meeting of the Board to be held on Friday 14th November, 2003.

Review of the Nursing Home Subvention Scheme carried out by Professor Eamonn O'Shea of the National University of Ireland, Galway

Dear Member,

I set out below a synopsis of the recent report by Professor Eamonn O'Shea, "Review of the Nursing Home Subvention Scheme"

Introduction

The Nursing Home Subvention Scheme was introduced in 1993 under the Health (Nursing Homes) Act, 1990. The Scheme requires Health Boards to pay a contribution to patients towards the cost of care in Nursing Homes. Eligibility is based on the applicants' dependency and means.

Background

This review came about following a Government decision on 25th March, 1997, and in line with commitments made in "Delivering Better Government", wherein a programme of expenditure reviews were initiated by the Department of Finance. These reviews are a key part of the financial management systems that are central to the Strategic Management Initiative and are intended to ensure greater predictability in resource planning. As part of this process the Department of Health and Children contracted with Dr. Eamonn O'Shea of the National University of Ireland, Galway, to undertake a review of the nursing home subvention scheme. The review commenced in March, 2000 and was completed in March, 2001. The objectives of the review were:-

- To examine the objectives of the nursing home subvention scheme and the extent to which they remain valid.
- To estimate the level of need in elderly populations, including inadequately met need.
- To assess the service delivered under the programme in terms of effectiveness, quality and accountability.
- To consider the implications of demographic trends and other relevant changes in the environment that may impact on the programme.
- To evaluate how far the programme objectives have been achieved and how efficiently and effectively this has been done.

- To establish what scope, if any, exists for achieving the programme objectives by other more efficient and effective means.
- To specify the performance indicators that could appropriately be put in place to facilitate future reviews of this type.

Costs of Scheme

When the Nursing Home Subvention Scheme was introduced in 1993 as part of the Health (Nursing Homes) Act 1990, a sum equivalent to €5m. was allocated to cover the cost of the Scheme.

However, due to a range of factors including demographics, increasing demand, increasing dependency, greater availability of private nursing home beds, etc. the cost of the Scheme has risen substantially every year.

This year, funding of over €110m. is being made available to the Health Boards to administer the Scheme.

Principles for Funding Long-Stay Care

The following are the main principles identified within the report for funding Long-Stay Care:-

- Funding should not determine care requirements; rather care requirements should determine funding.
- There should be a built-in bias towards home care solutions while retaining a capacity for financing care in institutionalised settings.
- Access should be on the basis of need and should not be impeded by an inability to pay, or by geography.

Statistics/Data

The tables identified below represent the key findings from all Health Boards in 2000.

Table 1 Non-Acute Care Beds for Older People by Type of Facility in the Long-Stay Sector by Health Board (HB) Region per 1,000 Elderly Population (NCE), 2000

Type of Facility	ERHA	MHB	MWHB	NEHB	NWHB	SEHB	SHB	WHB	Total
HB Extended Care	**17.1**	**26.2**	**19.2**	**18.8**	**21.6**	**25.4**	**23.1**	**23.4**	**20.9**
HB Elderly Mentally Infirm	0.5	4.8	1.0	1.7	3.9	2.4	0.0	0.7	1.3
HB Assessment/Rehab Beds	3.0	1.5	2.5	1.9	3.5	2.2	0.6	2.0	2.2
HB Respite	1.1	1.9	1.2	2.9	1.8	0.3	1.1	0.2	1.1
HB Convalescent	0.8	0.2	0.1	0.0	1.2	0.0	0.0	1.7	0.6
HB Other	0.0	0.6	1.6	0.0	0.0	0.5	0.0	0.0	0.2
Sub-Total: HB Provided	**22.5**	**35.2**	**25.6**	**25.3**	**32.0**	**30.8**	**24.8**	**28.0**	**26.3**
HB Subvented Beds	11.2	13.2	23.1	11.1	12.8	15.1	12.7	21.2	14.3
HB Contract Beds	5.3	0.2	0.0	2.2	6.4	0.0	4.1	0.0	3.0
Winter Initiative Beds	1.8	0.0	0.6	1.0	1.0	0.1	0.5	0.3	0.9
Sub-Total: HB Funded in Private Facilities	**18.3**	**13.4**	**23.7**	**14.3**	**20.2**	**15.2**	**17.3**	**21.5**	**18.2**
Total HB Funded Beds	**40.8**	**48.6**	**49.3**	**39.6**	**52.2**	**46.0**	**42.1**	**49.5**	**44.5**
Private and Voluntary Beds (Non-Subvented)	**14.2**	**11.0**	**16.4**	**5.1**	**2.1**	**9.1**	**9.9**	**11.0**	**11.0**
Total Long-Stay Beds	**55.0**	**59.6**	**65.7**	**44.7**	**54.3**	**55.1**	**52.0**	**60.5**	**55.5**

Table 1 provides information on long-term care facilities in Ireland. These figures are based on National Council for the Elderly population projections for 2001.

Table 2 provides information on the estimated dependency of residents in long-stay units (Public and Private) by Health Board Region, 2000

Table 2 Estimated Dependency of Residents in Long-Stay Units (Public and Private) by Health Board Region, 2000

	Category of Dependency									
HB Region	**Low**		**Medium**		**High**		**Max.**		**Total**	
	N	%	N	%	N	%	N	%	N	%
ERHA	868	15	1,251	21	1,558	26	2,154	37	5,902	100
Midland	152	13	239	20	371	31	446	37	1,208	100
Mid-West	313	15	574	28	616	30	580	28	2,088	100
North- East	81	6	257	20	342	27	588	46	1,267	100
North-West	107	9	256	20	519	41	373	30	1,256	100
South-East	386	17	515	22	582	25	827	36	2,311	100
South	384	13	726	24	900	30	990	33	3,001	100
West	246	10	490	20	946	38	832	33	2,515	100
Total	2,537	13	4,308	22	5,834	30	6,790	35	19,548	100
Ratio H/L	2.8		1.4		1.6		1.6			

As can be seen from the Table, the Mid-West contains the highest proportion of residents in the low to medium dependency categories at 43%.

The Report also provides information in relation to the Private Nursing Home Sector in Ireland. The information is based on a postal survey conducted in June and July, 2000. There was an overall response rate of 40% to the survey.

The occupancy rate in Nursing Homes responding to the survey is detailed in Table 3.

Table 3 Number of Private Beds Currently Occupied by Health Board Region

Beds	ERHA	South-East	West	Mid-West	North-East	Midland	North-West	South	Total
Number of Beds in Survey	1,887	246	620	854	290	400	279	801	5,377
Number of Beds Currently Occupied	1,780	233	566	770	251	358	275	758	4,991
Occupancy Rate (%)	94	95	91	90	87	90	99	95	93

Table 4 Type of Subvention by Health Board Region (%)

Type of Subvention	ERHA	South-East	West	Mid-West	North-East	Midland	North-West	South	Total	N
Medium	20	14	7	23	18	23	10	21	17	433
High	21	28	22	31	21	31	36	30	27	669
Maximum	59	58	71	46	61	46	54	49	56	1,378
Total	100	100	100	100	100	100	100	100	100	
N	526	137	421	471	120	251	193	361		2,480

According to the survey, the main challenges faced by Nursing Homes in the future include staffing, rising costs of care and Health Board regulations. (Table 5)

Table 5 Main Challenges in the Future

Main Challenges in the Future	No. of Nursing Homes	% of all Nursing Homes
Staffing	70	51
Rising Costs of Care	35	25
Health Board Regulations	18	13
Competition from Investors	8	6
Other	7	5
Total	138	100

Current Issues

Within the Report the key challenges for the Scheme and long-stay care in general are:-

- Demand skewed in the direction of the residential option.
- Demands on the Exchequer from the nursing home subvention scheme has made significant calls on the available public resources for all types of dependent older people.
- The absence of an in-built bias towards community care.
- Little by way of innovation and ingenuity in support of community care.
- Family care viewed as free resource.
- Some people denied access to free public long-stay care simply because of where they live and when they have applied.
- Similar regional disparities exist with respect of community care services.
- Location is an important variable in determining the quality of care available to older people.

Recommendations

This report raises a number of important issues, these can be categorised as follows:-

Financial

- Dr. O'Shea's review raises a number of important issues, one being that the Scheme has biased resource allocation in the direction of residential care rather than community care. It further suggests that shortcomings in community support services for older people and their carers forces people to opt for private nursing home care, thereby maintaining constant pressure on the subvention system.

Regulations

- Dr. O'Shea's review stresses the importance of consistency and standardisation across the Health Boards in the application of the Regulations.

Social Economy

- Another recommendation is that the introduction of co-financing arrangements should be considered and it also highlights the import supporting role that the social economy can play in developing a new and vibrant community care sector.

Community Care

- The review questions the justification for the continued public subvention of low and medium dependency residents in either public or private long-stay care, without first of all attempting to care for these people in the community.
- A subvention for nursing home care should never be granted unless it is clear that a community-based subvention would not have succeeded in maintaining the elderly person in their own home.
- The community care subvention could be set at some percentage of the residential care rate if that's what it takes to get it implemented.
- Subvention should be targeted at people on the boundary of in-patient care.
- Needs assessment rather than dependency assessment.
- Packages of care, funded by the new community care subvention scheme, should be negotiated between the relevant Health Board personnel (optimally through a designated care manager) and older people and their families.
- New services should be put in place and all services should be made more flexible to support care in the evenings, at night and at the week-end.

Bed Capacity

- It advocates the provision of more publicly-funded beds for older people through the development of new Community Nursing Units. In particular, beds for assessment and rehabilitation should be provided, not only to control admission to long-stay care, but to change the ethos of the care system away from institutional to one of renewal and restoration.

Home-Based Subvention

- The objective of public policy with respect to the long-term care of older dependent people is to keep them in their own homes for as long as possible in accordance with their wishes.
- The introduction of a home-based subvention is consistent with the policy of successive Governments of maintaining older people in their own homes for as long as they wish.
- The report highlights that this does not mean that nursing home care will no longer be necessary.
- The review emphasises the need to continue to work in partnership with nursing home owners to provide appropriate care to older people.

Dependency and Placement

- Establishment of a common dependency assessment for all of publicly funded long-stay care.
- National guidelines for the measurement of dependency.
- Require assessment of physical and mental dependency.
- People with low or medium dependency should be cared for in an expanded community care system.
- Identify economic and social determinants of dependency.
- For high dependency older people there should be a guarantee that all possible community care strategies will be explored before a decision on admission to residential care is taken.
- One increased subvention payment for dependency instead of the three-tiered payment mechanism currently in use, because only seriously dependent older people should now be in care.

- Retain the potential for enhanced subventions.
- Significant public investment in both rehabilitation and step-down facilities for older people.

Conclusions

Dr. O'Shea identified the following as the main conclusions of his review.

- Without families the community care system for older people would have collapsed a long time ago. Families provide extremely high levels of care, even for relatively low dependent older people. On the margin between community care and residential care, family care has the same significance as nursing care within public and private institutions, with approximately 13,000 high to maximum dependency older people living at home. Families incur significant opportunity costs and health costs in caring for older people but, in general, the commitment to caring is still strong in this country.
- While there is no doubt that the current system of subvention for long-stay care in private nursing homes needs reform, that reform should be part of a wider strategy of keeping older people out of all types of long-stay care. An essential part of any new strategy should be a community-based subvention scheme for the most vulnerable older people living at home. For that reason, there is a need to develop a pilot scheme for community-based subventions immediately to evaluate the optimal approach to planning and developing such a scheme on a national basis.
- Once need for long-term care is established, access to public funding in either public long-stay institutions or private nursing homes should be based on a common assessment of means and assets. This would end the current anomaly whereby a person applying for a subvention to a private nursing home is subject to a more rigorous means assessment than a person seeking admission to a public bed.
- More resources for assessment and rehabilitation are also important, not only to control admission to long-stay care, but to change the ethos of the care system away from institutionalisation to one of renewal and restoration. There seems little justification for the continued public subvention of low and medium dependency residents in either public or private long-stay care, without first of all attempting to care for these people in the community.
- There is a need for significant investment in public beds for older people, particularly in the areas of assessment and rehabilitation.
- The policy context is the desire to recalibrate the current funding of long-term care away from residential care towards care in the community by providing both financial incentives and posthumously collected penalties to encourage people to choose care at home over residential care, whenever possible and practicable. All of this pre-supposes a significant investment in community care by the state if the new system is to work properly.
- There was universal concern about the shortfall between individual applicant's income plus the subvention and the weekly cost of care in a private nursing home.
- The social economy can play an important supporting role in developing a new and vibrant community care sector. There are limitations on how far the state can directly provide the services that are required at local level.
- There has been some experimentation with social economy approaches to the problem of community care provision. As yet, however, the concept of the social economy remains foreign to the health and social services tradition in Ireland. Statutory provision, which is geared to the individual who presents for care, is not sufficiently integrated with local social networks or with local communities. Consequently, important elements of reciprocity, social capital and inter-generational solidarity are neither being nurtured or utilised for the support of older people in the community.

Future Reviews

The Department of Health and Children have launched a review of the Nursing Home Subvention Scheme.

Its objective is to give an opportunity to build on the findings of this report and answer some of the questions posed in this and other reports.

Mid Western Health Board – Current Position

In the Mid Western Health Board area , there are 42 nursing homes providing 1,587 beds. Since the introduction of the Nursing Home Subvention Scheme, the number of people in receipt of subvention has increased from 404 in 1994 to 993 in 2002.
In relation to this report the provision of long-stay care in this region compares favourably with the national averages.
In September of this year, the number of people in receipt of Nursing Home Subvention was 974. Of this number, 34 are categorised as medium dependency, 185 high dependency and 754 maximum dependency. There are 270 people in receipt of enhanced subvention.
The Board's enhanced subvention scheme has been a success and reflects the recommendation in this report with regard to enhanced subventions.
The Board has submitted a proposal to the Department of Health and Children in relation to Home-Based Subvention and is hoping to initiate a pilot scheme before the end of the year. This proposal reflects the recommendations highlighted within the Report of Health Board providing a flexible, community-based service that allows older persons to remain within their home environment.

The Directorate for Older Persons Services has set up a working group to review these findings within the report in the context of the region as a whole. The Board also is represented on the National Group established to review the present Nursing Home Subvention Scheme.

"Review of the Nursing Home Subvention Scheme" Professor Eamonn O'Shea, NUI, Galway.

Full Report available from:

Government Publication Sales Office,
Sun Alliance House,
Molesworth Street,
Dublin 2

Yours sincerely,

James Conway

pp **James Conway,**
Asst. Chief Executive Officer.

Mid Western Health Board - Determination of Health Expenditure for 2004

Summary

The 2004 Non-Capital Determinations has been calculated as follows:

	€m
2003 Revised Determination of Non-Capital Expenditure	556.745
Less: Once-off funding in 2003	31.336
2003 Revised Base Determination	525.409
Approved Additional Expenditure in 2004	57.952
2004 Original Determination	583.361

The approved additional expenditure in 2004 of €57.9m can be categorised as follows:

Category	€m
Pay	47.3
Non-Pay	5.1
Savings Required	-5.5
Specific Allocations	11.0
Demand Led Schemes	3.0
Increased Income Target	-2.4
Hipe/Casemix	-0.6
Total	57.9

The above table indicates that over 80% of the additional funding provided for 2004 will be required to meet the cost of various pay agreements. The non-pay increase has been cancelled out entirely by the requirement to achieve value for money and other savings. Additional funding has been provided for specific services including cancer, renal, disability and services for older people.

Pay

The allocation of €47.3m is to provide for the following pay awards:

- Sustaining Progress agreement in 2004,
- Benchmarking, 50% of the award,
- Parallel Benchmarking, full year cost of award,
- Increments,
- PRSI,
- Superannuation,
- Public Health Doctors agreement, on-going costs
- Nurses Pay - A&E, on-going costs.

Non-Pay /Savings Required

A sum of €5.1m was provided for non-pay inflation.
This however was offset by:

• required VFM savings	(€2.40m),
• administration savings	(€0.35m),
• a general reduction of	(€2.20m),
• DPS scheme reduction of	(€0.60m).
Total	(€5.55m)

Income

The 2004 allocation is based on projected additional income of €1.8m in respect of the increases in Bed Charges as announced in the Budget and additional €0.4m from inpatient charges.

Specific Allocations

The main additional allocations received were as follows:

Intellectual Disability & Autism Services

A total of €2.2m was provided to meet:

- the full year cost of the provision of residential services for emergency cases which arose during 2003,
- the extension of the inspection process by the SSI and the health board to residential services for children with disabilities,
- the provision of emergency placements in 2004,
- the provision of additional services, including rehabilitative training places, for those young adults who will be leaving school in June 2004.

Waiting List Initiative

A sum of €1.75m for permanent consultant posts and associated costs which was previously funded form the WLI. This will now become part of the base funding for the Board.

Cancer Strategy

Funding of €0.94m has been allocated from National Cancer Strategy funding to address service pressures in oncology/haematology, including oncology drug treatments.

Child Care Services

Funding of €0.9m has been provided for foster care allowances (€0.45m) and legal services (€0.45).

Services for Older People

Funding of up to €0.987m will be available to the Board for the Nursing Home Subvention Scheme (€0.322m), Personal Care Packages (€0.125m), Home Help Service (€0.34m), Elder Abuse Programme (€0.075m) and Palliative Care Services (€0.125m).

Services for People with Physical / Sensory Disabilities

Funding of €0.803m has been provided for priority services, alleviation of under resourcing and the continued roll out of the NPSDD.

Other Specific Funding Allocated

Community Optometric Services (Adult)	€0.592m
Health Amendment Act 1996 (Services for persons with Hepatitis C)	€0.483m
Dental Services	€0.369m
Renal Services	€0.270m

Draft Press Release **December 3, 2003**

Board comments on waiting list initiative

The Mid-Western Health Board has replied to the recent report on the Waiting List Initiative by the Comptroller and Auditor General, Mr John Purcell.

The Health Board said it had achieved the second best results under the Initiative of any health authority in the country and its record spoke for itself. "We can provide full information on the euro 10,019 million allocated to us and the 4,653 operations carried out in cardiology, general surgery, ENT, gynaecology, orthopaedics and opthalomogy from 1998 to December 31, 2002", said assistant chief executive Mr John O'Brien.

"The C&AG's own report shows that we received just 6% of all funds allocated under the Initiative but managed to reduce the waiting lists for the targeted specialities by 91%. Only one other health board managed to do better with a reduction of 92%. Mr Purcell's report clearly states that the lowest rates of long waiting, relative to population, for the specialities are in the Mid-West.

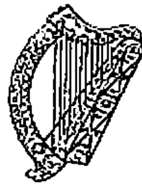
"Of course we used some of the funding to employ extra frontline staff in our hospitals but how else were we expected to do extra operations without them?", said Mr O'Brien.

Target waiting times have been reduced to six months for adults and three months for children in 2003, the target set out in the National Health Strategy. All patients in the Mid-Western Health Board area who have been waiting more than twelve months, and who are available for treatment, are offered treatment either in the Board's Hospitals or in outside Hospitals under the National Treatment Purchase Fund.

In the past four years, the number of Waiting List Initiative patients in the Mid-West was reduced from 1,608 to 337. The current position is that there has been an overall reduction of 17% in the waiting lists in the period from January to September 2003 and at the end of September 189 people were waiting less then six months for elective surgery with only 148 people waiting more than six months.

Ends

Queries : Michael Walsh
087-2556494



Comptroller and Auditor General
Report on Value for Money Examination

Department of Health and Children

The Waiting List Initiative

August 2003

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This report was prepared on the basis of information, documentation and explanations obtained from the public bodies referred to in the report. The draft report was sent to the Department of Health and Children, the Eastern Regional Health Authority, the Midland Health Board, the Mid-Western Health Board, the North Eastern Health Board, the North Western Health Board, the South Eastern Health Board, the Southern Health Board and the Western Health Board and comments were requested. Where appropriate, the comments received were incorporated in the final version of the report.

Report of the Comptroller and Auditor General

The Waiting List Initiative

I have, in accordance with the provisions of Section 9 of the Comptroller and Auditor General (Amendment) Act, 1993, carried out a value for money examination of the Waiting List Initiative between 1998 and 2002.

I hereby submit my report on the above examination for presentation to Dáil Éireann pursuant to Section 11 of the said Act.

John Purcell
Comptroller and Auditor General

14 August 2003

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Glossary

Acute hospital	A hospital providing medical and surgical treatment of relatively short duration
Day case admission	A person admitted to hospital for elective treatment who is discharged on the same day
Elective treatment admission	A planned or non-emergency admission of a patient on a day case or inpatient basis
HIPE (Hospital Inpatient Enquiry)	A health information system that collates data about each inpatient and day case hospital discharge, including diagnostic and treatment information
Inpatient	A patient admitted to hospital for elective or emergency treatment, who stays for at least one night
Outpatient	A patient who attends a hospital clinic for treatment or for a consultation with a specialist and who is not admitted to hospital
Procedure	Operation or treatment carried out on a patient by medical staff
Treatment specialty	The treatment area under which the patient is categorised (e.g. cardiac surgery, orthopaedics). Each consultant generally specialises in one of these treatment specialties.
Public voluntary hospitals	Publicly funded hospitals not under direct control of health boards

Abbreviations

CSO	Central Statistics Office
ERHA	Eastern Regional Health Authority
GP	General Practitioner
WLI	The Waiting List Initiative

Summary of Findings

The Department of Health and Children introduced the Waiting List Initiative (WLI) in 1993 to deal with a persistent waiting list problem in the acute hospitals. This problem involved significant numbers of public patients waiting long periods for elective (non-emergency) hospital treatment. In setting up the Initiative, the Department set targets for the maximum length of time patients should have to wait for treatment in specialties with the longest waiting lists. The targets were that adults would not have to wait longer than 12 months and children would not have to wait longer than 6 months.

WLI funding which was provided in addition to normal hospital funding was intended to

- incentivise hospitals and health boards to perform extra elective procedures
- be targeted specifically at patients waiting longer than target times in the selected specialties
- be ring-fenced i.e. kept separate from other funding of elective procedures.

Although initially intended to be a short-term initiative, the WLI has been funded each year since 1993 at a total cost of €246 million. Over two-thirds of this funding (€172m) was spent in the five-year period focused on by this examination, 1998 to 2002. The examination considered

- how the WLI funding was used
- what the impact of the WLI has been on the target group of long waiting patients
- how the waiting time and waiting lists are monitored and managed.

Use of the Funds

The funding provided to individual hospitals under the WLI was used in a wide variety of ways. This included increased use of hospitals' own capacity to treat patients or using other hospitals' facilities to perform extra procedures.

Many hospitals used part of the available WLI funds to pay for extra waiting list administration and bed management staff. In hospitals visited in the course of this examination, initiatives in these areas appear to have resulted in more active management of waiting lists and waiting times, and better hospital bed utilisation.

WLI funding has been used in many hospitals to fund temporary consultant posts on an ongoing basis. Many of these posts are now being made permanent. This has resulted in a situation where, by 2002, the application of up to half of WLI funds to staffing has reduced the level of flexibility available to the Department to target the WLI funds to long waiting patients in other hospitals.

One factor not directly taken into account in allocating the available WLI funding to hospitals was the number of long waiting patients in each hospital. In fact, those health boards and hospitals that have performed well in reducing their numbers of long waiting patients, have tended to attract increasing shares of funding.

Impact on Patient Treatment

Between the start of 1998 and the end of 2002, the reported number of patients waiting longer than the target maximum waiting times for elective treatment decreased by 39% — from just over 14,100 to 8,700.

The reduction in the target group in the period 1998 to 2002 did not affect all target specialties equally.

- The target groups for the ear, nose and throat, vascular, orthopaedic and, in particular, cardiac surgery specialties declined significantly in this period.
- The number waiting in the ophthalmology and urology specialties varied but were about the same at the start and end of this period.
- The plastic surgery and general surgery target groups increased by a quarter during this period.

The extent to which WLI funding succeeded in achieving extra elective activity cannot be reliably established. Although the extra funding under the Initiative was intended to be ring-fenced from core funding, in practice, the activity it generated cannot, in most cases, be distinguished separately from core funded elective activity. Consequently, while the WLI aimed to result in additional elective activity, it is not possible to ascertain if, or to what extent, this was achieved, or if this activity benefited long waiting patients as intended.

Prioritisation of the Target Group

Although it was planned that WLI funding would result in the provision of treatment for long waiting patients, the Department has not specified that they should be given priority in receiving treatment paid for under the Initiative. While the Department does not wish to interfere with clinical independence, in order to ensure that the funding is applied for the purposes intended, there should be, at a minimum, formal shared criteria and standards adopted for the prioritisation of patients for elective treatment, as recommended by a 1998 Review Group of the WLI.

Between 1998 and the middle of 2001, the number of patients in the target group moved broadly in line with the number of other patients waiting for elective treatment, which suggests that there was little prioritisation of target group patients over that period. It was only from mid-2001 that the numbers in the target group began to decline relative to those of other patients. The relative prioritisation of target group patients has continued, in part, as a consequence of the introduction in mid-2002 of the National Treatment Purchase Fund which also targeted long waiting patients.

Current Status of the Target Group

The problem of long waiting is highly concentrated. At the end of 2002, over 70% of long waiting patients were waiting for treatment in hospitals in the Eastern region. While some progress was made in reducing the scale of the problem in the region during the period 1998-2000, progress was significantly slower than in most other regions.

Analysis of data collected by the ERHA from hospitals in the region indicates that, at the end of 2002, the average waiting time of over 15 months for elective inpatient treatment of adults was significantly greater than the target maximum waiting time of 12 months. Similarly, the combined

average waiting time for both inpatient and day case treatment for children was 8.9 months compared to the target maximum waiting time of 6 months.

Even within the Eastern region, the scale of the problem in individual hospitals varies greatly.

- St James's Hospital had almost eliminated waiting longer than the target maximum waiting times for elective treatment at the end of 2002.
- Four Eastern region hospitals (Beaumont, Mater, St Vincent's and Tallaght) together accounted for half of the national target group at the end of 2002.
- More than 50% of all patients reported as waiting for elective treatment at the end of 2002 in Tallaght Hospital, Temple Street Children's Hospital and Our Lady's Hospital for Sick Children in Crumlin were waiting longer than the target maximum times.

Resolving the waiting problem in hospitals such as these will involve a co-ordinated response between the initiatives that now focus on long waiting patients, the WLI and the National Treatment Purchase Fund.

Measuring and Managing Waiting Time

Improvements are required in the performance measurement and management systems in relation to waiting lists and waiting times.

- The Department reports numbers of patients waiting, while measures of average waiting time and maximum waiting time would be more relevant.
- Greater accuracy and consistency between hospitals in reporting waiting lists and waiting times is required.
- The Department should begin to measure and monitor the time a patient waits for an outpatient appointment.
- Existing waiting time targets set by the Department are largely aspirational. In managing waiting time under an initiative like the WLI, milestones and deadlines should be set and periodically reviewed if they are to function as clear and achieveable performance targets.
- Waiting time for public patients in public hospitals should be benchmarked against waiting time for private patients in those hospitals.
- The Department's public reporting of data about waiting for elective treatment could be significantly improved to assist GPs in making choices about referrals for consultations.

The Waiting List Initiative

1 Introduction

1.1 The Waiting List Initiative (WLI) was introduced in 1993, initially as a short-term measure to tackle the problem of significant numbers of public patients waiting excessively long periods for elective (i.e. non-emergency) hospital procedures.

1.2 The Department of Health and Children (the Department) allocated funding under the WLI to individual health boards and voluntary hospitals to pay for procedures for long-waiting patients on the waiting lists for a number of selected treatment specialties. The money provided under the Initiative was additional to the normal funding for acute hospital services and the procedures funded were to be additional to procedures performed using normal funds.

1.3 The Initiative has been renewed every year since 1993. Total expenditure from 1993 to 2002 was €246 million.

Targets for Waiting Time

1.4 Prior to the WLI, there were no national targets in relation to waiting time for elective treatment. Under the Initiative, specific targets were set. The objective was that adults would not have to wait longer than 12 months for treatment in certain specialties and that children would not have to wait longer than 6 months.

1.5 Surgical procedures were specifically targeted under the WLI (see Figure 1.1). They were selected because they had the largest reported numbers of patients waiting for treatment at the time the Initiative was launched. The target specialties have not changed since January 1994.

Figure 1.1 Targeting of treatment specialties under the Waiting List Initiative

Treatment specialties targeted under the WLI	Cardiac surgery Ear, nose and throat (ENT) General surgery Gynaecology Orthopaedics	Ophthalmology Plastic surgery Urology Vascular surgery
Treatment specialties not targeted under the WLI	Cardiology Dental Dermatology Endocrine procedures Endocrinology Gastro-enterology Genito-urinary Gerontology Infectious diseases Haematology Maxillo-facial General medicine	Metabolic Nephrology Neurology Neurosurgery Oncology Radiotherapy Rehabilitation Respiratory Rheumatology Paediatrics Pain management Psychiatry

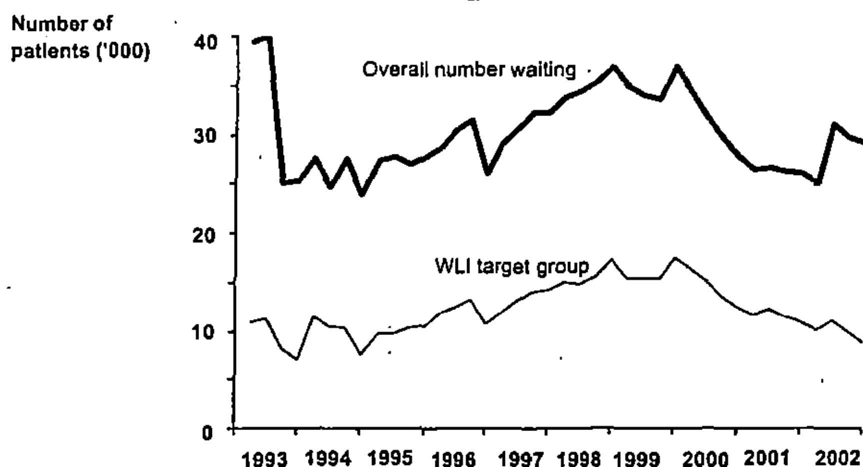
Source: Department of Health and Children

1.6 When the WLI was launched, the perception was that there was not a significant problem of long waiting for other specialties and they were not included under the Initiative. Consequently, the target maximum waiting times specified for the WLI specialties did not apply to patients waiting for treatment in other specialties.

Trend in Numbers Waiting for Treatment

1.7 As part of the WLI, the Department began to compile national statistics about the number of patients waiting three months or more for treatment, from data supplied by individual hospitals. Figure 1.2 shows the total number of patients reported as waiting and those waiting longer than the target times in the target specialties (the target group) each quarter from March 1993 to December 2002.

Figure 1.2 Reported number of patients waiting for elective treatment, quarterly, March 1993 to December 2002



Source: Analysis by the Office of the Comptroller and Auditor General

1.8 A significant proportion of the dramatic fall in the reported number of patients waiting in 1993 was due to the results of extensive validation exercises carried out by individual service providers at the time. From the end of 1994, there was an upward trend in the reported number of patients waiting, despite repeated funding under the WLI. This trend continued into 1999 when the overall total number waiting peaked at around 37,000. The number reported dipped to 26,000 by the end of 2001 and rose again to 29,000 by 31 December 2002.

1.9 For most of the period 1994 to 2002, the numbers of long waiting patients moved broadly in line with the overall numbers waiting.

Developments since the Introduction of the Waiting List Initiative

1.10 As a result of the upward trend in the numbers waiting, the Minister for Health and Children established a Review Group in April 1998 to examine the operation of the WLI and to make recommendations on how best to maximise its effectiveness.

1.11 The Review Group reported in July 1998, and presented a set of immediate, medium-term and long-term recommendations which they believed were required if waiting lists and waiting times were to be reduced substantially.[1] Some of the recommendations related specifically to the WLI; others related to factors in the wider health system that contributed to the waiting list problem. The Group proposed that all the recommendations should be implemented in the period 1998-2001.

1.12 In guidelines relating to the WLI issued in 1999 and 2000, the Department stated that the objectives of the Initiative were to

- achieve a significant reduction in the number of public patients awaiting elective procedures
- increase the numbers of persons receiving elective procedures (inpatient and day cases)
- reduce the maximum times patients are waiting for elective procedures in target specialties to 12 months for adults and 6 months for children
- improve the management of elective procedures, waiting lists and waiting times.

However, in sending the 2000 guidelines to the Chief Executive Officers of health boards and hospitals, the Department pointed out in a covering letter that the overall objective of the Initiative was to ensure that the target maximum waiting times were not exceeded.

1.13 A number of proposals for the acute hospital service, which may potentially impact on the priority for the treatment of long waiting patients, were announced in the health strategy document, *Quality and Fairness — A Health System for You,* published in November 2001.

- The capacity of the acute hospital service is to be expanded through the provision of 3,000 extra beds designated for public patients by 2011. The planned extra beds represent a 25% increase on the 2000 acute hospital bed capacity level.
- The National Treatment Purchase Fund was established in 2002 to pay for the treatment, either in hospitals in Ireland or abroad, of public patients who had been waiting longer than maximum target waiting times. The Department stated that 1,920 patients were treated using resources provided by the Fund from its inception in July 2002 to the end of that year.
- A National Hospitals Office will carry out functions relating to the coordination of actions to reduce waiting lists and waiting times.

---

1 The recommendations of the Review Group are summarised in Appendix A.

Scope and Objectives of the Examination

1.14 In order to eliminate waiting beyond the target times, it was intended that the WLI funding would be managed in a particular way. It was planned to be

- **ring-fenced** i.e. kept separate from other funding of elective procedures
- **targeted** specifically at people waiting longer than target times in the selected treatment specialties which had the longest waiting lists
- **performance-related** i.e. it was designed to incentivise the performance of extra procedures.

1.15 This examination was carried out to establish the extent to which the WLI was successful in achieving its objectives. The specific questions addressed include

- How was the WLI funding used?
- What has been the impact of the WLI on the target group of long waiting patients?
- How is the problem of long waiting time for elective patients being monitored and managed?

1.16 The examination focused mainly on the period 1998 to 2002, when a total of €172 million was spent under the Initiative. This is also the period during which the Review Group's recommendations were expected to change the operation and impact of the WLI.

1.17. It is too early to assess the effect of the acute hospital service proposals presented in the November 2001 health strategy document.

Examination Methodology

1.18 The examination was carried out by staff of the Office of the Comptroller and Auditor General. Advice on the development of examination issues and analytic approaches was provided to the examination team on a consultancy basis by a member of the School of Management, Trinity College, Dublin.

1.19 Work on the examination included analysis of statistical data compiled by the Department about the number of patients on waiting lists. In addition, other departmental information about the allocation and monitoring of WLI funding was examined. Information was also gathered from the Eastern Regional Health Authority (ERHA) and all health boards. More detailed information about the use of WLI funding and the management of waiting lists was gathered during visits to St Vincent's Hospital (Elm Park) and St James's Hospital in Dublin, Cork University Hospital and Tullamore General Hospital.

Structure of the Report

1.20 Chapter 2 examines how WLI funding was allocated and spent. Chapter 3 looks at the extent to which the target group for the WLI – patients waiting longer than the target maximum times – have benefited from the Initiative. Chapter 4 considers how performance in relation to the measurement and monitoring of waiting time could be improved.

2 How Waiting List Initiative Funding Was Used

2.1 The WLI is a hospital-focused initiative. In the main, it aims to provide extra resources to individual hospitals, allowing them to increase the level of elective procedures above that achievable through their normal, core funding. This, in turn, is intended to reduce the number of long-waiting patients.

2.2 This chapter examines how the funding provided under the WLI was spent. In particular, it examines

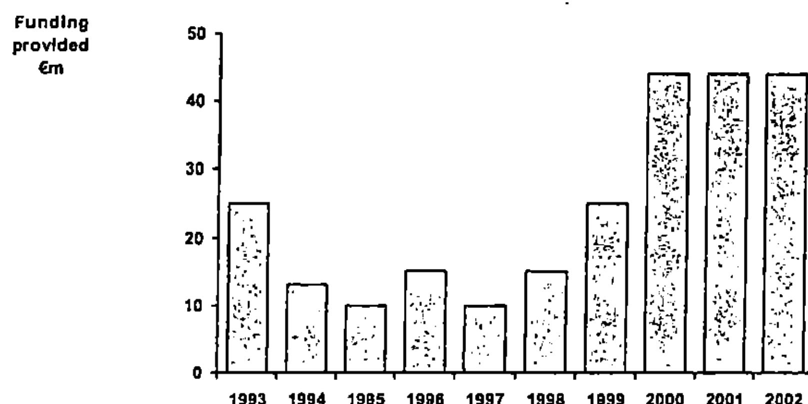
- the basis for allocation of WLI funding to acute hospital service providers
- the types of strategies and activities service providers undertook using the WLI funding they received
- the extent to which the funding succeeded in generating additional elective treatment.

Allocation of Funding to Service Providers

2.3 Figure 2.1 shows the levels of funding provided under the WLI each year from 1993 to 2002. Spending in the period 1994 to 1998 averaged around €12.6 million a year. The annual funding level increased significantly between 1998 and 2000 and has remained constant at around €44 million a year since then.

2.4 Between 1993 and 1998, the Department allocated WLI funding around July each year. The 1998 Review Group report recommended dividing the available annual funding under the Initiative into two phases, with an early phase allowing service providers to plan activities better to address the problem of long waiting. It was also recommended that the (smaller) second phase of funding would be awarded to the service providers with the best performance record, so as to increase the positive incentive effect of the funding. As a result, almost three-quarters of the WLI funding in recent years was allocated at the start of each year, along with general acute hospital funding allocations. The remaining funding is awarded mid-year.

Figure 2.1 Expenditure under the Waiting List Initiative, 1993 to 2002



Source: Department of Health and Children

2.5 Funding provided under the WLI is channelled down through the normal system for funding acute hospitals. As a result, the process of decision-making about how WLI funding is used is effectively shared between various levels of health service administration.

- The Department allocates WLI funding to the Eastern Regional Health Authority (ERHA) and to the health boards and is responsible for overseeing the overall impact of this funding.
- The ERHA [2] and the health boards allocate the WLI funding available to them to individual hospitals, collate information about the use of the funding and about waiting times and report back to the Department.
- Management in hospitals identify strategies and activities to tackle the long waiting problem in the context of overall management of admissions and waiting lists.
- Ultimately, consultants select the patients who are to receive treatment using the resources provided with WLI funding.

2.6 As with other areas of the health services, this layered decision-making process creates a management challenge in ensuring that scheme objectives are aligned across all relevant levels of administrative and clinical management, and that there is accountability for performance.

2.7 Figure 2.2 sets out the total allocations of WLI funding to individual service providers over the period 1998 to 2002, and shows the percentage of total funding received by each service provider. Allocations on a year-by-year basis are shown in Appendix B.

2.8 Half of the WLI funding in the period 1998 to 2002 went to service providers in the Eastern region. This was mainly supplied to voluntary hospitals, which provide most of the acute hospital services in the region.

Allocation Criteria

2.9 In allocating WLI funding, service providers are required by the Department or by the ERHA (as appropriate) to set out their proposals for how they would use WLI funding. The proposals typically specify the expected number of additional elective procedures to be carried out. In certain cases, the types of activities proposed to achieve these extra procedures are also outlined. In some cases (especially where procedures are to be outsourced to other hospitals), the expected unit cost of the additional procedures may be specified in the proposals. Many of the proposals submitted are based on the continuation of activities and strategies previously funded under the WLI, with occasional proposals for new initiatives.

2.10 In response to the proposals submitted, the Department/ERHA notifies the service providers of the amount of funding that will be provided, and approves (explicitly or implicitly) the elements of the proposals that are acceptable. The related projected numbers of procedures to be carried out are regarded as performance targets to be achieved.

---

2 The ERHA has been involved in the allocation of funding to hospitals in the Eastern region since its establishment in 2000.

Figure 2.2 Allocation of WLI funding to service providers, 1998 to 2002

Service provider/region	€'000	% of total
Voluntary hospitals in Eastern region		
St James's Hospital	19,444	11%
Mater Misericordiae Hospital	14,576	9%
Beaumont Hospital	12,764	8%
Our Lady's Hospital, Crumlin	10,079	6%
St Vincent's Hospital, Elm Park	9,219	5%
Tallaght Hospital	5,673	3%
Royal Victoria Eye & Ear Hospital	4,138	2%
St Mary's Hospital, Cappagh	3,954	2%
Temple Street Children's Hospital	717	*
Other	831	1%
External service providers		
Mater Private Hospital	3,486	2%
Blackrock Clinic	1,107	1%
Other	28	*
Eastern region	**86,016**	**50%**
Midland Health Board	9,643	6%
Midland region	**9,643**	**6%**
Mid-Western Health Board	10,019	6%
St. John's Hospital, Limerick	1,104	*
Mid Western region	**11,123**	**6%**
North Eastern Health Board	8,584	5%
North Eastern region	**8,584**	**5%**
North Western Health Board	8,808	5%
External service providers	1,346	1%
North Western region	**10,154**	**6%**
South Eastern Health Board	13,153	8%
South Eastern region	**13,153**	**8%**
Southern Health Board	13,103	8%
Mercy Hospital, Cork	3,754	1%
South Infirmary/Victoria Hospital	2,250	2%
Southern region	**19,107**	**11%**
Western Health Board	14,248	8%
Portiuncula Hospital, Ballinasloe	98	*
Western region	**14,346**	**8%**
Totals	**172,126**	**100%**

Source: Analysis by the Office of the Comptroller and Auditor General
Note: *indicates percentage is less than 0.5%

2.11 The Department has stated that, in general, it took into account the following factors in the allocation of WLI resources in the period 1998 to 2002

- the population of the health board area
- the reported total number of patients on the waiting list in each hospital
- the capacity of each hospital to increase the elective procedures activity level, internally or through purchasing services from external sources
- past performance of the hospital in reducing its waiting list
- temporary consultant posts in the hospital funded under the WLI.

2.12 The ERHA has stated that it applied criteria similar to those used by the Department in deciding funding allocations to the hospitals in its region.

2.13 In general, the specific reasons for allocating amounts of funding to individual service providers are not formally recorded at Departmental or ERHA level. Consequently, it is difficult to discern the precise factors which were influential in the allocation decisions and the weighting given to each.

Allocations and Numbers Waiting in the Target Group

2.14 Although the primary objective of the WLI was the elimination of the problem of long waiting patients, whether through directly delivered or outsourced treatment, the number of those patients has not been taken directly into account in making funding allocations. Analysis of the amounts allocated to regions and to individual hospitals shows that, in practice, there was no direct relationship between funding and the number of patients in the target group.

- The proportionate share of WLI funding allocated to the Eastern region fell by 5% in the period 1998 to 2002. During the same period, this region's share of the waiting list target group increased from 49% to 72%.
- By contrast, while the share of the target group of all other regions combined decreased by 23%, their share of the WLI funding increased by 5%.

2.15 In the Dublin area this divergence between funding and numbers waiting in the target group is also evident when major hospitals are compared.

- St James's Hospital reported a reduction of around 90% in the number of long waiting patients between the end of 1997 and the end of 2001. As a result, the number of long waiting patients reported by the Hospital at the end of 2001 represented only 1% of the national target group. By contrast, the Hospital received 13.5% of the total national WLI funding in 2002 — up from 11.6% of the national total in 1998.
- The Mater Hospital reported the biggest target group (over 1,600 long waiting patients) at the end of 2001 — up 4.5% from the end of 1997. Despite this, its share of national WLI funding fell from 15.5% of the total in 1998 to 9.5% of the total in 2002.
- St Vincent's Hospital reported an 82% increase in its target group (to a total of over 1,300 long waiting patients by end 2001). Despite this increase, the share of funding provided to the hospital decreased from 7.6% of the total in 1998 to 5.7% of the total in 2002.

- Although it reported over 1,100 patients waiting longer than the target maximum waiting times at the end of 2001, an increase of over 60% on the end-1997 figure, Tallaght Hospital received no WLI funding in 2002. The ERHA have stated that funding was not allocated to Tallaght because the hospital reported that it would not have sufficient capacity to carry out WLI procedures during the year, due to pressures on existing services. The Hospital did not achieve the level of extra activity it had projected with WLI funding in 2001.

2.16 A fixed policy of allocating funding solely or mainly on the basis of the reported number of long waiting patients could result in funding being provided to hospitals that are unable, due to capacity or other constraints, to increase the level of elective activity to provide treatment for long waiting patients. For example, the comparatively high levels of utilisation of available inpatient beds in the larger Eastern hospitals would have affected the ability of these hospitals to use WLI funding in-house.

2.17 Furthermore, there is the risk — recognised in the 1998 Review Group report — that allocating funding in line with the reported numbers of long waiting patients could be a negative incentive, and potentially encourage service providers to maintain waiting lists at a particular level in order to secure continued funding. In making funding allocation decisions, the Department and the ERHA appear to have avoided that type of negative incentive.

2.18 In order to provide a positive incentive to service providers to reduce the number of long waiters, the Review Group recommended that good performers in previous periods should receive priority in the allocation of WLI funding. The current pattern of allocation of funding seems to go beyond that, with a significant amount of WLI funding being directed on a more or less permanent basis to some service providers that have consistently succeeded in reducing their reported number of long waiting patients and maintaining this reduction. As a result, it appears that those service providers are being rewarded for previous success, rather than being incentivised to achieve further success. Correspondingly, this reduces the potential to use WLI funding to provide a positive incentive to those that still have a long waiting problem.

2.19 Reducing the funding allocated to some service providers because they did not meet previous activity targets or because they do not have sufficient capacity to carry out extra procedures puts the long waiting patients concerned at a disadvantage. As a result, approaches other than the WLI will be needed to deal with the waiting time problem in those hospitals. In this respect, the National Treatment Purchase Fund, which funds long waiting patients on an individual basis, potentially complements the WLI in meeting the needs of the patients affected.

WLI Activities

2.20 Individual service providers report that they used the funding they received under the WLI in a wide range of ways. A summary of the main kinds of activities undertaken in using the available WLI funding in selected hospitals in recent years is shown in Figure 2.3.

2.21 The main strategies and activities in using WLI funding include

- **Waiting list management**

  WLI funding was used in all the hospitals visited to hire additional staff to administer waiting lists, to centralise (partially or fully) waiting list management, to develop waiting list recording systems, and to carry out waiting list validation procedures to ensure that the waiting lists were accurate, comprehensive and up-to-date.

- **Hospital bed management**

  The hospitals visited used WLI funding to employ bed managers, combined in some cases with a waiting list co-ordination function. Typically, the bed managers have senior nursing experience, and have responsibility to manage the allocation of hospital beds between competing demands, in particular between emergency and elective admissions. They are also responsible for developing and managing patient admission and discharge initiatives. These initiatives include advance patient discharge planning and management of the discharge of patients who no longer require acute care but for whom rehabilitation, long-term care beds or adequate home support are not readily available. In some cases, they are also involved in ensuring that long waiting patients are actively considered when appointments are being made for elective procedures and in the selection of patients for out-sourced procedures funded under the WLI.

Figure 2.3 Main types of activities funded under the Waiting List Initiative in selected hospitals, 1998 to 2002

	St James's Hospital	St Vincent's Hospital, Elm Park	Cork University Hospital	Tullamore General Hospital
Amount of WLI funding received	€19.4m	€9.2m	€9.7m	€8.5m
Activities funded through WLI				
Appointment of a Waiting List Coordinator/Committee	✓	✓	✓	✓
Employment of staff to manage and validate elective waiting lists	✓	✓	✓	✓
Bed management initiatives (e.g. later admission, earlier discharge, patient selection for treatment)	✓	✓	✓	✓
Extra weekend/evening theatre sessions	✓	✓		
Employment of temporary consultant/medical staff	✓	✓	✓	✓
Employment of temporary nursing staff	✓	✓	✓	✓
Dedicated in-house facilities (theatres/wards) to treat elective patients	✓	✓		✓
Use of treatment facilities (theatres/beds) in other hospitals	✓	✓	✓	
Outsourcing of elective procedures in other hospitals	✓	✓	✓	✓
Outpatient monitoring, screening, extra clinics	✓	✓	✓	✓

Source: Analysis by the Office of the Comptroller and Auditor General

- **Increased output from existing capacity**

  Some hospitals tried to achieve higher levels of output from the existing capacity of staff, beds and operating theatres. Strategies adopted included weekend or late-night working on overtime, and the keeping open of wards that might otherwise be closed for periods to achieve expenditure savings. Some hospitals increased their output of elective procedures by using WLI funds to pay for overnight accommodation for patients outside the hospital.

- **Expansion of in-house hospital capacity**

  Some of the hospitals applied the available funding to increase their existing capacity. This included, in particular, the recruitment of extra medical, nursing and associated administrative and support staff on temporary contracts, and equipping of theatre or other treatment facilities in a few cases.

- **Purchasing external capacity and procedures**

  Some hospitals used WLI funding to outsource treatments for some of their own patients in other hospitals, within the State or abroad. Hospitals also hired treatment facilities, theatres and wards in other hospitals and used their own medical and nursing staff to carry out procedures in the hired facilities.

Activity Costing

2.22 There was no routine comprehensive reporting of the cost of WLI activities in any of the hospitals visited. While there was separate accounting for some of the WLI activities, the cost of activities was generally included in existing cost centres, and could not be distinguished from core-funded activities.

Outsourcing of Treatment

2.23 In the hospitals visited, it was possible to identify the extent to which expenditure on externally commissioned procedures was funded from WLI resources.

- In St Vincent's, Cork University Hospital and Tullamore General Hospital, the procedures invoiced by external service providers were carried out at a cost in the region of €1,000 to €3,000 per patient.
- St James's Hospital outsourced some relatively serious and complex cardiac surgery procedures for elective patients. The hospital stated that the cost of these outsourced procedures was around the estimated average unit cost of carrying out similar procedures in-house.

2.24 The National Treatment Purchase Fund operates by commissioning mainly private sector hospitals to carry out procedures on long waiting patients selected from the lists in individual public sector hospitals. There is therefore a risk that, in outsourcing treatment, individual public sector hospitals may end up competing with the Fund. The Department should bear this risk in mind in coordinating the operation of the two schemes. It could, for example, consider restricting the use of WLI funding to pay for in-house treatment of long waiters, and allow most external purchasing of procedures for the treatment of long waiting patients to be managed by the National Treatment Purchase Fund.[3]

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[3] This could involve purchasing by the National Treatment Purchase Fund of procedures for public hospital patients either in private hospitals or in other public hospitals where spare capacity is available in the relevant specialty area.

Hire of Temporary Staff

2.25 The Department's records indicate that recruitment of additional consultants and associated nursing and support staff on a temporary basis was a feature of the WLI strategies adopted in many hospitals. The cost of employing temporary staff in this way was equivalent to almost half of WLI funding allocated in 2002. Some of the staff were hired to provide treatment in specialty areas targeted under the WLI. Other staff were recruited to provide 'across-the-board' increases in treatment capacity, such as in anaesthetics.

2.26 When the Department approved the employment of staff on a temporary basis, funded by the WLI, it did not specify that the staff were required to provide services primarily or only for patients waiting longer than the target maximum waiting times. However, it was noted that in Tullamore General Hospital, temporary consultants were required initially to take on and treat a number of long waiting patients on the existing consultants' lists before their own patient lists began to build up.

2.27 The Department received representations from Comhairle na nOspidéal, the statutory body which regulates consultant appointments, recommending that temporary posts created and repeatedly funded using WLI money should be made permanent. The Department is currently implementing this recommendation and it intends to continue funding the posts through the WLI. This reduces the level of discretion available in allocating WLI funding and implies that prior-year allocation has effectively become the most significant allocation criterion for the funding. In this way, what was intended as ring-fenced discretionary WLI funding has, in fact, become part of core hospital funding, used to fund ongoing elective treatment capacity.

Selection of Patients for Treatment

2.28 In most cases, public patients waiting longest for treatment are classified medically as being in need of 'routine' procedures. These typically deal with medical conditions that, at the time of diagnosis, are not considered to be life threatening, although in many cases they may have serious impacts on the quality of patients' lives. In drawing up lists of patients for treatment, medical staff in most public hospitals first identify the number of treatment places for public and private patients. Thereafter, patients are selected for treatment on medical grounds, for example, acuteness of the patient's medical condition, and likely effectiveness of treatment. Duration of waiting time is also considered, but it is not clear what weight it carries in the selection process.

2.29 In order to effectively administer a targeted initiative like the WLI, it would have been necessary, in applying the extra funds, to specify that, as a general rule, all patients waiting longer than target times should be treated before patients waiting less than the target times. No rules were set with the aim of prioritising long waiting patients in this way. The Department has stated that it would have been impossible to absolutely direct that those waiting longer than a particular period should be treated without reference to clinical decision-making or prioritisation.

2.30 The overall objective of the Initiative cannot be achieved unless the moneys are applied for the purposes intended. Consequently, to achieve this, systems must be put in place that are designed to reconcile the aim of reducing long waiting patient lists with the selection by consultants of patients for treatment on the basis of medical considerations and priorities.

2.31 While the 1998 Review Group report recommended that formal shared criteria and standards should be adopted in all public hospitals for prioritisation of patients for elective

treatment, this has not been achieved to date. However, it is intended that the National Hospitals Office will lead the development of guidelines for referral and prioritisation of patients.

Reporting WLI Output

2.32 To assess the extent to which the WLI succeeded in impacting on the target group, WLI-funded procedures would have to be both distinguishable from core-funded procedures, and related to treatment of target group patients. In the hospitals visited, there were no effective systems either

- to distinguish the procedures undertaken with WLI funding from core-funded procedures or
- to relate the movement in the target group to the funding sources.

Reporting Extra Procedures

2.33 One of the stated objectives of the WLI is to increase the number of people receiving elective treatment. In measuring output for the WLI, the Department and the ERHA requested service providers to supply information on the number of elective procedures carried out in addition to those achievable through core funding.

2.34 The examination found that hospitals used a variety of approaches in estimating the number of extra procedures funded under the WLI. Only in the case of outsourced procedures is the number readily identifiable in most cases.

2.35 The number of procedures attributable to other types of WLI-funded activity is estimated in a range of ways.

- In St James's Hospital, an estimate of the number of additional cardiac procedures carried out in-house as a result of WLI funding is based on the same service design, staffing and cost structure as for baseline activity in this specialty; for other specialties, the number of elective inpatient procedures in the target specialties[4] carried out in a five-day 'WLI' ward is used.
- In Cork University Hospital, WLI-funded activity is estimated as the difference between actual activity and projected baseline activity in each of the target specialties.
- In the other hospitals visited, a complex estimation method, devised originally by the Department, is used to estimate the number of procedures attributable to WLI funding. This relies on a mix of actual and estimated figures, including projected baseline elective activity in the target specialties.

2.36 The estimation methods used in the hospitals reviewed do not provide reliable estimates of the level of elective activity supported by WLI funding.

- Elements of the estimation model used by some hospitals are not internally consistent — some of the elements relate to individuals waiting 3 months or more; others include those waiting less than 3 months.

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4 St James's regards maxillo-facial surgery as a target specialty for WLI purposes, although it has not been defined as such by the Department.

- The practice in deriving baseline or core activity estimates for use as an input in calculations varies from hospital to hospital and is not clear and reliably based.
- Attributing all extra activity over and above core activity levels to WLI funding ignores the effect of other initiatives on elective activity.

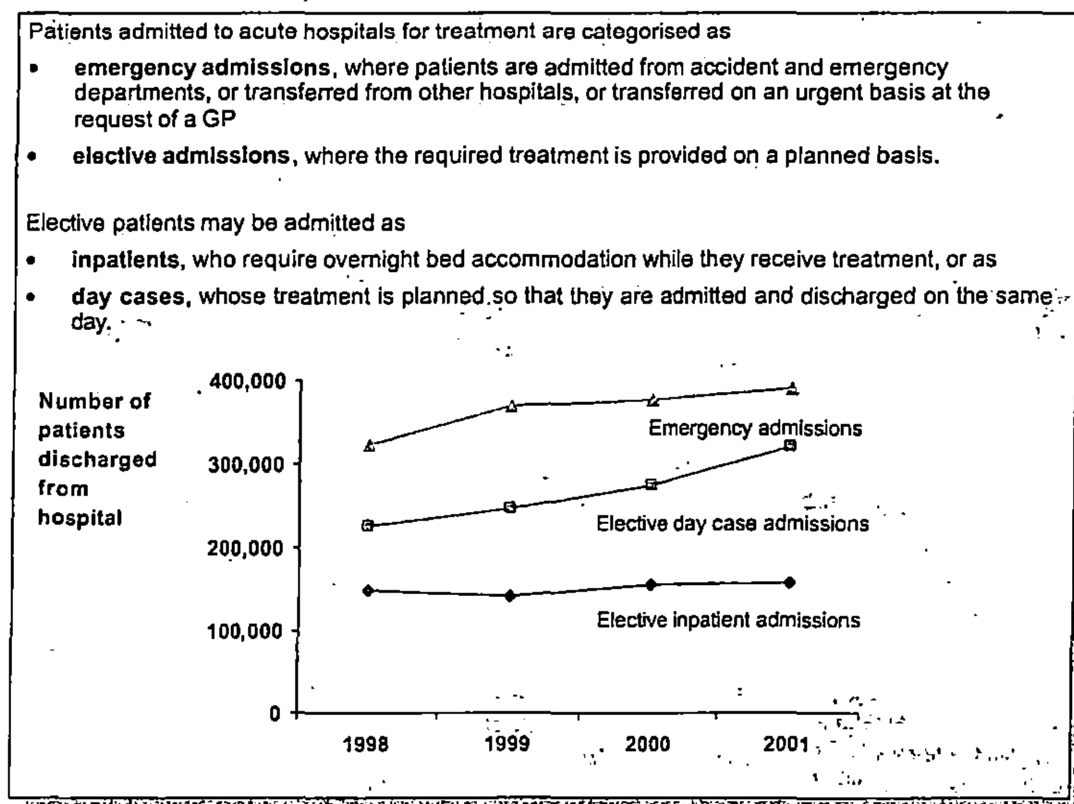
2.37 Inconsistency in reporting can occur even in cases where dedicated facilities are provided out of WLI funding. In St James's, all patients other than emergency cases admitted to a five-day ward funded by the WLI are counted as WLI procedures, irrespective of how long they have been waiting. This does not give a true measure of WLI-funded activity in the hospital.

2.38 The reported estimates of activity are not formally audited for accuracy and completeness by the Department or by the ERHA. As a result, it is difficult to verify the reported number of procedures carried out under the WLI and to ascertain the extent to which they are over and above core-funded activity.

Effect of WLI on Overall Elective Activity

2.39 The total number of patients (public and private) treated by the acute hospital system increased rapidly in recent years, reflecting the very substantial increases in overall funding provided for the system. The number of patients discharged after receiving treatment grew from 697,000 in 1998 to 871,000 in 2001 — an increase of 25%.

Figure 2.4 Number of patients treated in acute hospitals, by route of admission and nature of treatment, 1998 to 2001



Source: Analysis by the Office of the Comptroller and Auditor General
Note: Based on HIPE data. Last available data relates to 2001

2.40 The bulk of the increase occurred in emergency and day case treatments (see Figure 2.4). There was a 21% increase in the number of emergency patients treated and a 43% increase in the number of elective day case patients treated. In comparison, the number of planned inpatient treatments increased by 6% nationally. In some hospitals, the number of elective inpatient treatments decreased.

2.41 While it is acknowledged that some of the WLI funding could have been used to fund day case treatment[5], it was clear that most of the WLI-funded activities in the hospitals visited were aimed, directly or indirectly, towards the provision of public elective inpatient treatment. Despite this, in the hospitals visited, the overall level of inpatient elective activity actually decreased between 1998 and 2001, as shown in Figure 2.5.

Figure 2.5 Number of elective inpatients discharged[a], selected hospitals, 1998 to 2001[b]

Hospital	1998	1999	2000	2001
St James's Hospital	7,400	7,200	7,500	6,200
St Vincent's Hospital	6,800	4,600	5,000	5,000
Cork University Hospital[c]	13,600	12,000	11,300	11,400
Tullamore General Hospital	2,800	2,100	2,600	2,700

Source: Analysis by the Office of the Comptroller and Auditor General, based on HIPE data

Notes: a Includes public and private patients. Excludes procedures outsourced to other hospitals.
b Latest available data relates to 2001.
c Includes elective inpatient procedures carried out at St Mary's Orthopaedic Hospital, Gurranebraher.

2.42 Apart from the increased treatment of patients on a planned day case rather than inpatient basis, as a result of advances in treatment, the decline in the level of elective inpatient treatment in the hospitals may be attributable to

- increased competition for resources from emergency admissions, particularly in large urban areas, in a context of overall hospital capacity constraints
- increasing incidence of overholding of beds by patients who are medically fit for discharge but for whom there are no suitable rehabilitation, long-term care beds, or adequate support in the community.

2.43 The decrease in the overall volume of elective inpatient procedures performed suggests that, while WLI may have funded inpatient activity in the hospitals examined, it was not additional activity as originally envisaged. Instead, it may in effect have partly compensated for a reduction in core-funded elective inpatient activity, which might have fallen more had WLI funding not been available. In practice, this has the effect of further blurring the distinction between WLI procedures and core-funded elective inpatient procedures.

5 There was considerable confusion about the status of day cases during the period up to mid-2002 (see paragraph 3.4).

Conclusions

2.44 The examination found that allocations from WLI funds were, by 2002, out of line with the number of long waiting patients in each region. While a feature of the allocation method was the rewarding of good performance, a high level of provision is continuing even in instances where the list has been virtually eliminated. It is acknowledged that capacity constraints may have reduced the ability of some hospitals in the Eastern region to deliver treatment to patients directly. However, in order to impact on the numbers in the target group in each hospital, whether through directly provided or outsourced treatment, it will be necessary to allocate funding broadly in line with numbers of long waiting patients. There appears to be scope for coordinating the WLI and the National Treatment Purchase Fund more effectively to focus on the needs of long waiting patients and to address them quickly.

2.45 Visits to hospitals indicated that, while WLI funds appear to have been applied to activities designed to achieve the general aims of the Initiative, clear traceability was largely lost because

- hospital accounting systems did not track the application of the funds and
- the reported number of procedures could not, therefore, be linked to those funds. The number of procedures reported was found in some cases to have been inaccurate due to inconsistencies in the estimation methods used to determine them.

There is a need to ensure that, where tranches of public funds are provided for specific purposes, systems are put in place that can demonstrate that these funds have been applied for the purpose intended and that the output resulting from any such initiative is captured.

2.46 While WLI funding was found to be targeted at inpatient lists in the hospitals visited, the overall level of elective inpatient treatment actually fell between 1998 and 2001. This suggests that the Initiative did not result in an increase in elective inpatient activity over and above existing levels in those hospitals.

2.47 The administration of an initiative such as the WLI through the layered decision-making process that exists in the health service, presents a challenge in reconciling the objective of fund providers to target a category of long waiting patients and the process of consultants selecting patients for treatment on the basis of medical priority. This has remained an unresolved issue throughout the Initiative to date. The Department needs to examine how systems, procedures and practices within the health service can be aligned so as to ensure that these specific allocations of public funds are applied and seen to be applied to treat the intended beneficiaries of the funding, the long waiting patients.

2.48 The application of almost half of the funds to pay for permanent staff posts limits the discretion of the Department to redistribute the funds to meet changing demands in the system. In order to avoid blurring the distinction between the Initiative and the core work of hospitals, core requirements should be funded from the core budget.

3 Impact of the Waiting List Initiative

3.1 From the commencement of the WLI in 1993, the primary objective of the Initiative was to ensure that no public patient waiting for elective treatment in certain specialties would have to wait longer than the specified target maximum waiting times — 12 months for adults and 6 months for children.

3.2 This chapter examines

- the extent to which reported waiting list figures are reliable
- the trend in the figures reported for the target group
- whether the planned targeting of long waiting patients resulted in their prioritisation, relative to other patients waiting.

Trends in the target group by specialty, region and hospital and the extent to which these trends differ from the overall national pattern are also examined.

Reporting the Number of Patients Waiting

3.3 National figures for the number of patients in the target group are compiled by the Department from data reported by individual hospitals.

3.4 In compiling and reporting on numbers waiting for elective treatment, there has been considerable confusion about whether or not elective day case patients (i.e. those where it is planned that the patient will be admitted to the hospital, treated and discharged on the same day) should be included. Between 1993 and 2002, the Department requested reporting of the number of persons waiting for 'elective inpatient treatment'. In some contexts, the term 'inpatient' is used to refer to any formal admission of a patient to a hospital. However, the more general usage of the term is in relation to patients who spend at least one night in hospital. Consequently, some hospitals reported only those waiting on their inpatient lists and excluded patients waiting for treatment on a day case basis.

3.5 In mid-2002, the Department began publishing day case numbers for certain hospitals. This resulted in an adjustment in the number of patients reported in June 2002. Some hospitals have not yet started to report their long waiting day case patients — this may result in some further upward adjustments as all hospitals move to a common reporting basis.

3.6 The net result of these factors is that changes in the reported numbers of long waiting patients have to be interpreted carefully. Furthermore, analysis of national trends needs to be supplemented by analysis of trends at individual hospital level.

3.7 At individual hospital level, patients usually leave the waiting list when they receive the required treatment, whether as a result of normal core funded activity or as a result of WLI-funded or other initiatives. However, they may also cease waiting for other reasons: they may no longer wish to have the treatment or may become unfit for treatment; they may have the procedure carried out elsewhere; or they may become un-contactable. Hospitals periodically review their waiting lists to identify patients in these categories for removal from the list, subject to direction by the consultant concerned and often in consultation with the patients' GPs. In the hospitals visited, this list validation process was funded mainly through the WLI.

3.8 There is also a perception that some individual patients may be on waiting lists for the same treatment in a number of hospitals. While this would lead to double counting of such patients in the reported number of patients waiting, there is no reliable statistical evidence of the scale of this phenomenon.

Trend in the Target Group

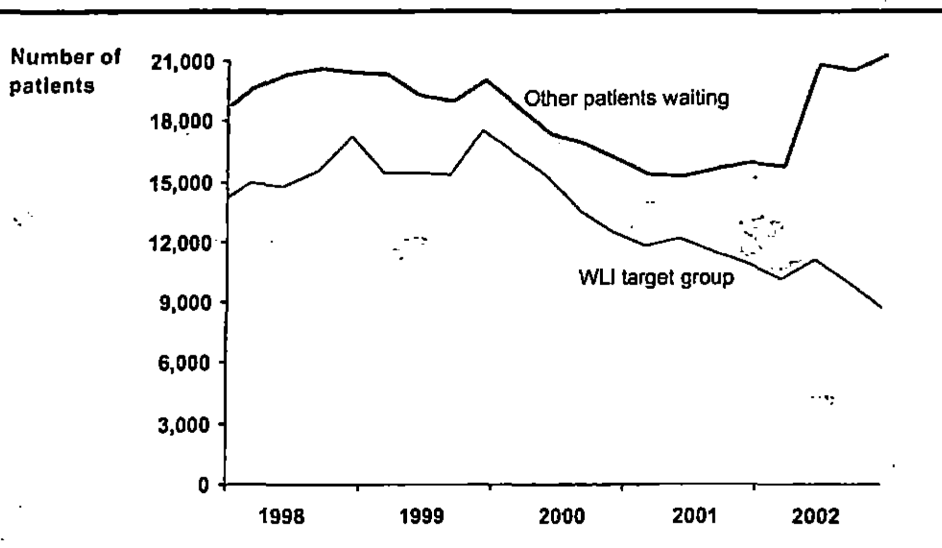
3.9 The total number of patients reported in the target group increased from just over 14,100 at the beginning of 1998 to around 17,500 at the end of 1999 (see Figure 3.1). Thereafter, it decreased to reach a level of around 8,700 by the end of December 2002. This represents a net decrease of 39% over the period.

3.10 Fastest progress in reducing the number of patients in the target group was made during 2000. This occurred following an increase in the amount of funding provided under the WLI from €25 million in 1999 to €44 million in 2000. The decline halted temporarily in 2001, despite repeat funding of €44 million, but the downward trend resumed thereafter.

3.11 Identifying the separate impact of the WLI on the reported number of patients in the target group is difficult because other influences may impact on this number. Until the middle of 2002, the influence of the WLI is potentially more obvious. It becomes more complex to separate the influences from June 2002 onwards because

- the Department began reporting day cases for a number of hospitals for the first time
- the National Treatment Purchase Fund began to treat long waiting patients[6].

Figure 3.1 Reported number of patients in WLI target group and in the WLI non-target group nationally, by quarter, 1998 to 2002



Source: Analysis by the Office of the Comptroller and Auditor General

6 The National Treatment Purchase Fund provided resources for the treatment of over 1,900 patients from its inception in July 2002 to the end of that year.

3.12 Figure 3.1 shows that, until around September 2001, the number of patients in the target group moved broadly in line with the number of other patients waiting. This suggests that the target group was not prioritised before this date.

3.13 If the WLI were to operate in a way that prioritised long waiting patients, the numbers in the target group should decrease as a proportion of the total number waiting. While the number of patients in the target group fell significantly, it generally mirrored the decline in the reported overall number of patients waiting for treatment. In March 1998, 44% of all patients reported by hospitals as waiting 3 months or more for treatment were in the target group; the corresponding figure at the end of 2001 was 42%.[7]

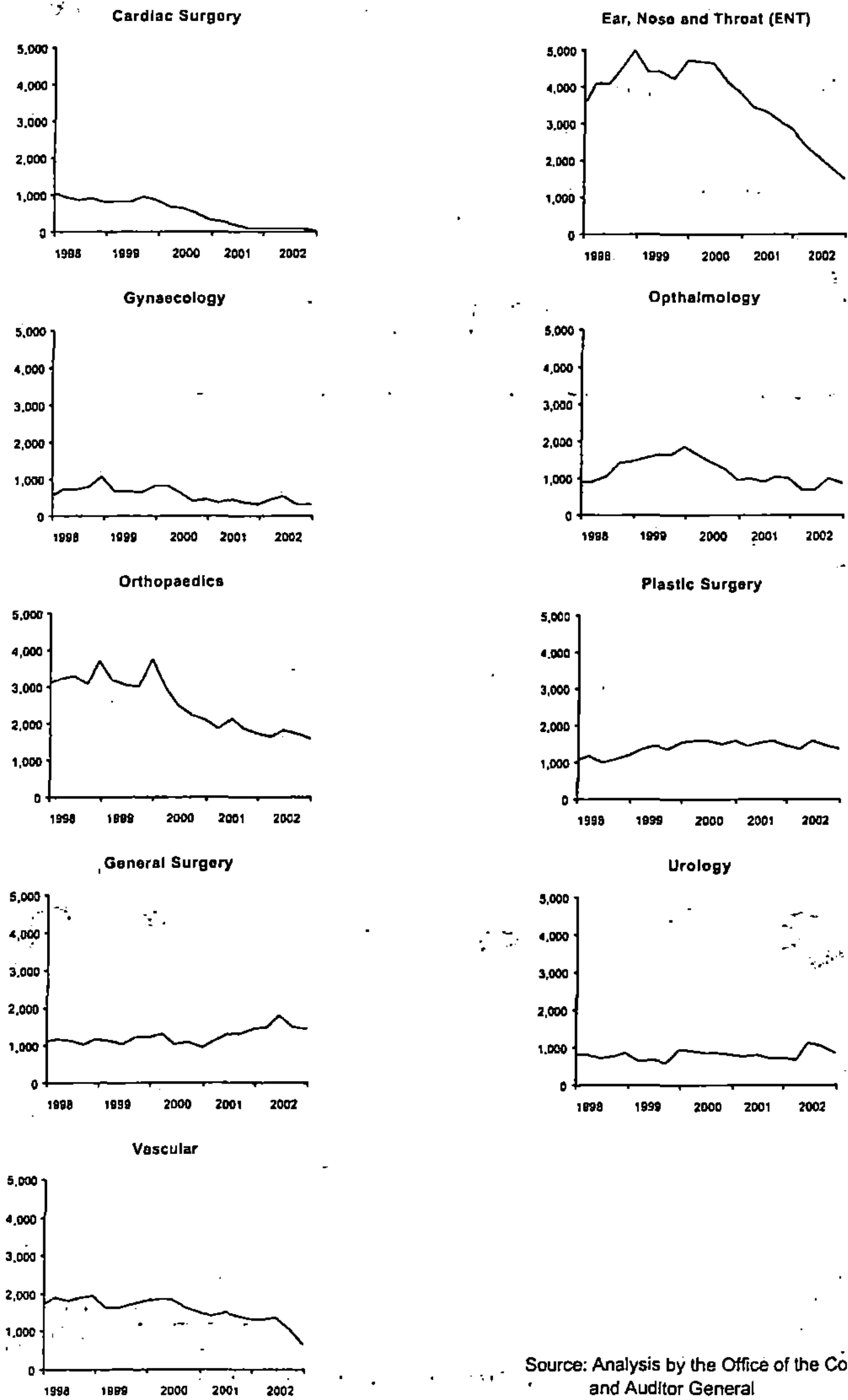
Target Group by Treatment Specialty

3.14 There was considerable variation in the trends in numbers waiting longer than the target maximum waiting times for the different treatment specialties in the period 1998 to 2002 (see Figure 3.2).

- The ENT and orthopaedics specialties consistently had the largest reported number of patients in the target group, but the numbers reported began declining significantly from the beginning of 2000.
- Hospitals reported that the number waiting longer than the target maximum waiting time for cardiac surgery treatment decreased from around 1,000 at the start of 1998 to 55 by the end of 2002. However, this reduction is not attributable in full to the WLI since there was also a significant increase in the acute hospital capacity for this specialty during this period.
- The number of patients in the target group for vascular surgery reduced by over 60%; the number of patients in the target group for gynaecology procedures reduced by around a half.
- While there was some fluctuation in the target groups of patients waiting for ophthalmology and urology procedures throughout the period, the number of people waiting longer than the target maximum waiting times at the end of the period was about the same as at the beginning.
- The target group in both the plastic surgery and general surgery specialties increased by a quarter over the period.

[7] The figures for June, September and December 2002 are not directly comparable with previous quarters because, for those dates, more hospitals reported the number of day case patients waiting.

Figure 3.2 Number of patients in the target group, by treatment specialty, 1998 to 2002



Source: Analysis by the Office of the Comptroller and Auditor General

Regional Variations in the Target Group

3.15 The overall reduction in the total number of patients in the WLI target group in the period 1998 to 2002 masks significant regional variations (see Figure 3.3).

- In the Eastern region, the number of patients in the target group decreased by around 10%, when the overall national reduction was 39%. As a result, while those waiting longer than the target maximum waiting times in hospitals in the Eastern region accounted for around half of the total target group at the beginning of 1998, they accounted for more than 70% of the total at the end of December 2002.
- In the North Western region, the increase of 50% in the size of the target group relates to the first reporting in 2002 of long waiting day case patients at Letterkenny General Hospital.
- In the North Eastern region, there was a 16% increase in the reported number of patients waiting longer than the target maximum waiting times.
- In all other regions, the reported numbers waiting longer than the target maximum waiting times decreased significantly.

Figure 3.3 Reported number of patients in target group, by region, 1998 to 2002

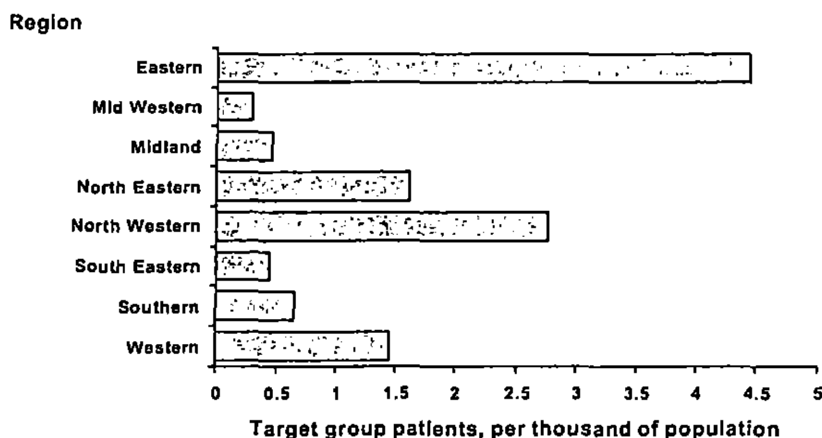
Region	Number waiting at end		Share of waiting list at end		% change in number waiting 1998-2002
	January 1998	December 2002	January 1998	December 2002	
Eastern	6,914	6,210	49%	72%	-10%
Mid Western	1,102	98	8%	1%	-91%
Midland	1,242	102	9%	1%	-92%
North Eastern	476	554	3%	7%	+16%
North Western	408	614	3%	7%	+50%
South Eastern	966	181	7%	2%	-81%
Southern	1,437	376	10%	4%	-74%
Western	1,619	548	11%	6%	-66%
Totals	**14,164**	**8,683**	**100%**	**100%**	**-39%**

Source: Analysis by the Office of the Comptroller and Auditor General

3.16 The relative scale of the waiting time problem in the Eastern region is illustrated in Figure 3.4. An estimated 4.4 patients per 1,000 of population were recorded as waiting longer than the target maximum times for treatment at hospitals in the Eastern region at the end of 2002. The lowest rates of long waiting, relative to population, were in the Mid Western, Midland and South Eastern regions.

3.17 Figure 3.4 is based on the number of patients listed as waiting for treatment in hospitals in each of the regions, rather than on the place of residence of the patients. The high rate of long waiting for treatment in the Eastern region reflects, in part, the inclusion of patients from other regions in the waiting lists for treatment in Dublin hospitals, many of which are designated national or regional centres for provision of particular forms of treatment. (In 2002, 32% of patients who received elective inpatient treatment in Eastern region hospitals were resident in other regions; 17% of patients who received day case treatment were resident elsewhere.)

Figure 3.4 Number of patients waiting longer than target maximum times per thousand of population, by region, end-December 2002



Source: Analysis by the Office of the Comptroller and Auditor General

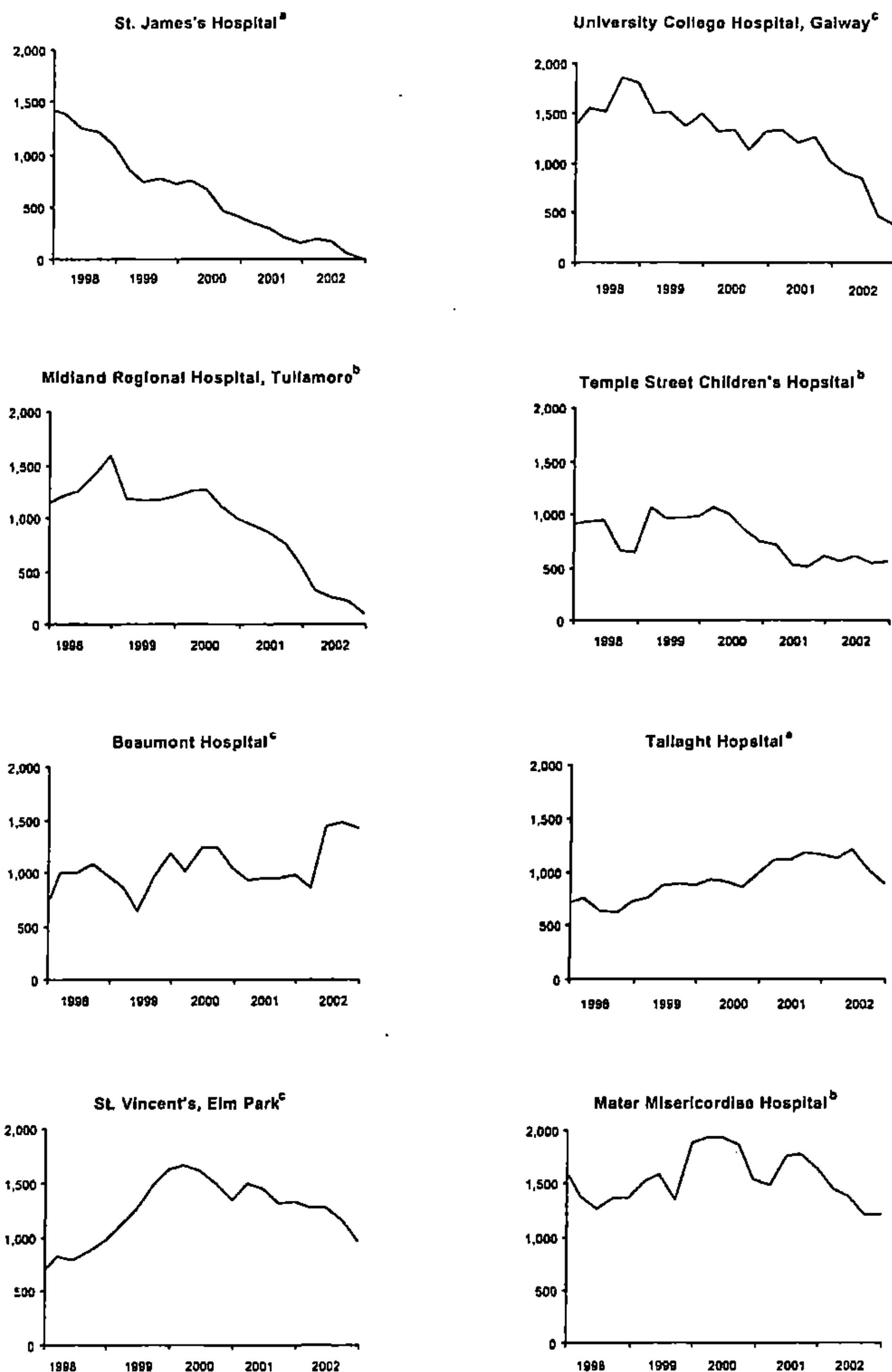
3.18 Patients may seek treatment in hospitals in regions other than where they reside for a variety of reasons. This arises particularly where regional or national specialties are provided in other regions or if the types of procedures they seek are not available in local hospitals. Patients may also seek treatment in hospitals in other regions, on the advice of their GPs or for personal reasons, even though the kind of treatment they require may be available in hospitals in their own region. If their GPs refer them to a number of consultants for the same condition, they may also be listed for the same treatment in hospitals both in their own and in another region.

Target Group by Hospital

3.19 Variations in the trends in numbers of long waiting patients reported are also evident at individual hospital level. Figure 3.5 shows how the numbers reported in the target groups changed over the period 1998 to 2001 in the eight hospitals reporting the biggest target groups during that period.

- St James's Hospital reported that it had only 4 patients remaining in the target group by the end of December 2002.
- Tullamore and University College Hospital Galway also reported significant reductions in the numbers of long waiting patients.
- The reported numbers in the target group in Beaumont Hospital increased by over a quarter between the beginning of 1998 and the end of December 2001. The further increase in the reported number in the target group in the end-June 2002 quarter reflects the first reporting by the Department of patients waiting longer than the target maximum time for day case treatments.
- There were significant increases in the reported number of long waiting patients in St Vincent's and Tallaght Hospitals. (In the case of Tallaght, this relates only to elective inpatients — the Hospital does not report on day case patients waiting.)
- Four Eastern region hospitals (Beaumont, Tallaght, St Vincent's and the Mater) together accounted for half of the reported national target group in December 2002.

Figure 3.5 Number of patients reported in the target group, selected hospitals, 1998 to 2002



Source: Analysis by the Office of the Comptroller and Auditor General

Notes:
- a inpatients only.
- b inpatients and day case patients.
- c inpatients only up to the quarter ended March 2002; inpatients and day cases figures thereafter.

Size of Target Group Relative to Total Patients Waiting

3.20 Figure 3.6 shows the size of the target group as a percentage of the total number of patients waiting in certain hospitals at the end of 2002.

- Of the 14 hospitals listed, 11 hospitals had a higher percentage of people waiting in the target group than the national average of 30%.
- In Temple Street, Tallaght and Crumlin hospitals, more than half of those reported as waiting are long waiting patients.

Figure 3.6 Target group as a percentage of total reported patients waiting, selected hospitals, end December 2002

Hospital	Total number of patients waiting	Target group	Target Group as a % of Total Waiting
Temple Street Children's Hospital	756	552	73%
Tallaght Hospital	1,440	885	61%
Our Lady's Hospital, Crumlin	1,034	523	51%
Our Lady's General Hospital, Navan	604	293	49%
South Infirmary/Victoria Hospital	175	73	42%
University College Hospital, Galway	950	371	39%
Merlin Park Regional Hospital, Galway	472	177	38%
Cavan General Hospital	609	208	34%
Beaumont Hospital	4,240	1,423	34%
James Connolly Memorial Hospital	706	225	32%
Mater Misericordiae Hospital	3,878	1,217	31%
St. Vincent's Hospital, Elm Park	3,287	953	29%
Royal Victoria Eye and Ear Hospital	976	271	28%
St. Luke's Hospital, Kilkenny	180	46	26%
Other hospitals	9,852	1,466	15%
National totals	**29,159**	**8,683**	**30%**

Source: Analysis by the Office of the Comptroller and Auditor General

Note: Hospitals listed are those with a waiting list of 100 people or more and with a percentage of long waiting patients of 25% or greater. All hospitals with a waiting list in excess of 100 people are shown in Appendix C.

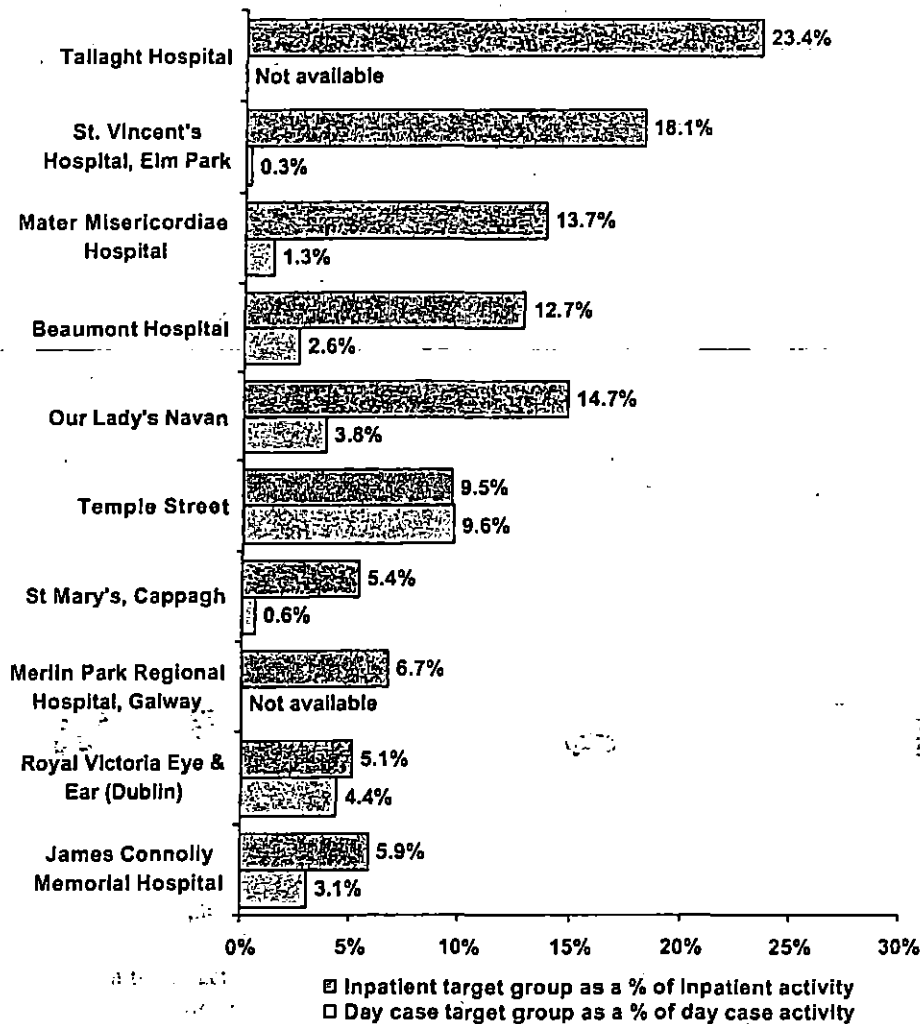
Size of Target Group Relative to Volume of Elective Activity

3.21 The number of patients reported nationally as waiting longer than the target maximum times — just under 8,700 at the end of December 2002 — is significant in absolute terms. On the other hand, relative to the overall output of elective procedures by the acute hospital system (almost half a million inpatient and day case procedures in 2001), the number of long waiting patients is small – less than 2% of output. The number of long waiting patients may be capable of being addressed by more efficient allocation of WLI funds and the use of the National Treatment Purchase Fund to treat cases backlogged due to capacity constraints.

3.22 Since the long waiting problem is highly localised, a first step in addressing it would be to identify the extent of both the inpatient and day case list in terms of hospital capacity.

3.23 Using the most recent output figures as an indication of capacity, Figure 3.7 presents the reported number of long waiting patients for elective treatments at the end of December 2002 as a percentage of the output of elective treatments in selected hospitals in 2001 (the latest year for which the information is available). Separate percentages are shown for day case and inpatient elective treatment. Hospitals are included in the figure where the percentages for inpatient or day case patients (or both) exceeded 5%.

Figure 3.7 Long waiting patients as a percentage of annual output of elective day case and inpatient treatment, selected hospitals, December 2002



Source: Analysis by the Office of the Comptroller and Auditor General
Note: Tallaght and Merlin Park Regional Hospitals did not report long waiting day case patients.

3.24 In six of the hospitals, the number of patients waiting longer than the target maximum times for elective inpatient treatment exceeded 10% of the annual throughput of elective activity.

- In Tallaght Hospital, the reported number of long waiting patients for inpatient treatment was 23% of the number of elective inpatient procedures carried out.
- In St Vincent's, long waiting patients were equivalent to 18% of annual inpatient activity.
- Given the relative scale of the problem, it would be a considerable challenge for these hospitals to increase the output of elective procedures sufficiently in the short to medium term in order to have an impact on the number of patients waiting long periods for inpatient treatment, without significantly reducing the level of day case or emergency admission treatment.

3.25 The problem of patients waiting longer than the target times for day case procedures is, in most cases, much less acute than for inpatients. However, some major hospitals are not yet reporting the number of patients waiting for day case treatment.

Conclusions

3.26 The numbers reported in the target group of long waiting patients reduced by 39% from just over 14,100 in January 1998 to 8,700 in December 2002. However, it was not until 2001 that the reduction of the target group began to be achieved at a faster rate than the reduction of the waiting list for other patients.

3.27 The problem of long waiting is highly concentrated in the hospitals in the Eastern Region. At the end of December 2002, the hospitals with the worst problems of long waiting for elective inpatient treatment nationally, in both absolute and relative terms, were Beaumont, the Mater, St. Vincent's and Tallaght Hospitals in Dublin. Between them, they account for over half of the national target group. There is also a significant long waiting problem in Temple Street Children's Hospital, both for inpatient and day case treatment. The concentration of the problem in these hospitals suggests that in allocating funds, whether from the WLI or the National Treatment Purchase Fund, there will be a need for co-ordination and the targeting of resources in a way which takes account of

- the internal capacity of these hospitals and
- the scope for using outsourced treatment options.

3.28 Despite the move to reporting the target group on the basis of both the inpatient and day case elements, full consistency has not been achieved since some hospitals still only provide figures for those awaiting inpatient treatment. The effective administration of the Initiative, which has now been running for 10 years, is dependent on accurate information. The Department needs to address this matter urgently.

4 Monitoring and Managing Waiting Time

4.1 Waiting lists are a feature of any situation where the demand for a service is greater than the availability of that service. In the hospital system, people who require elective treatment may have to wait because resources such as beds, staff or operating theatres have to be rationed or because the available resources are not used in the most efficient way.

4.2 From an efficiency viewpoint, the existence of a waiting list does not, in itself, indicate that a problem exists within the system. In fact, achieving optimum efficiency in the provision of public services may inevitably result in the creation of waiting lists. The alternative to requiring patients to wait is to provide spare capacity in the system to deal with peaks in demand. This could be expensive and wasteful, particularly in the health service where any excess resources can always be used productively. However, the objective of being efficient in the use of resources in the health system has to be balanced with the requirement to deliver treatment to patients within a reasonable time.

4.3 As the Department acknowledges in its November 2001 Health Strategy document, active and effective management of waiting lists generally and of initiatives (such as the WLI) to address waiting time problems will require the development of sound performance measurement systems.

4.4 This chapter examines

- how waiting time is measured, including the suitability of the measures used by the Department and how the consistency, reliability and comprehensiveness of the data collected could be improved and
- the management of waiting lists and waiting time in terms of the targets set and the reporting and benchmarking of performance.

Measuring Waiting Time

4.5 Targets for waiting times were first set by the Department when establishing the WLI. Since then, the number of patients waiting for elective treatments has been compiled by the Department from quarterly reports supplied by the service providers. The waiting list definition adopted by the Department for measurement and reporting purposes required service providers to report the number of public patients waiting three months or more for elective treatment.

4.6 At the end of each quarter, hospitals are required to report the number of patients listed as waiting in each of the following categories

- **Target specialties**
  - adults waiting 3 to 12 months; and adults waiting 12 months or more
  - children waiting 3 to 6 months; and children waiting 6 months or more
- **Other specialties**
  - adults waiting 3 months or more
  - children waiting 3 months or more.

4.7 To be useful in decision-making, point-in-time reports such as these need to be supplemented with additional information because

- in the target specialties, they report only those cases that fall into two time categories (3 months to target time; patients waiting longer than target time)
- they do not give the average length of time patients are waiting or the time spent waiting by the patient waiting longest
- they do not measure the rate of turnover of cases on the waiting list or in the target group.

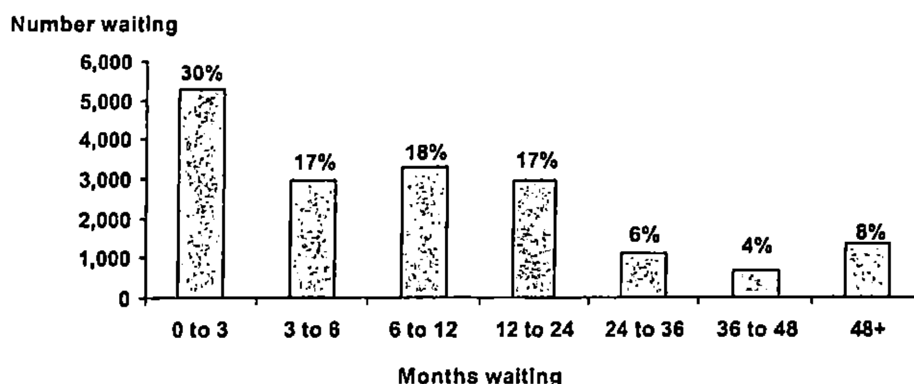
In addition, they do not give any details of persons waiting until they pass the lower threshold of 3 months. This information would be useful to identify emerging patterns.

Distribution of Numbers Waiting

4.8 From the patient's point of view, the time spent waiting for treatment is the most relevant consideration.

4.9 The ERHA has begun to compile information about the waiting time distribution of patients on waiting lists for all treatment specialties in hospitals in the Eastern region (see Figure 4.1). This shows that the total number of patients reported by hospitals as waiting for elective inpatient treatment in the Eastern region at the end of December 2002 was almost 17,600. Almost 30% of these patients were waiting less than three months for treatment and, consequently, they are not included in the waiting list figures published by the Department.

Figure 4.1 Public patients in the Eastern region waiting for elective inpatient treatment, all specialties, by duration of wait, end December 2002



Source: Eastern Regional Health Authority

4.10 At end December 2002, almost 6,100 patients in the Eastern region had already waited twelve months or more for elective inpatient treatments — over a third of all those waiting for elective treatment. Over 1,300 patients (8% of the total) had been waiting longer than four years.

4.11 The data gathered by the ERHA provides a basis for estimating the average length of time public patients had been waiting for inpatient care in the Eastern region at the end of December 2002 (see Figure 4.2). This indicates that adults were, on average, waiting an estimated 15 months for treatment. This average is very high, considering that the target maximum waiting time for adults is 12 months.

Figure 4.2 **Estimated average waiting times[a] for elective inpatient treatment in the Eastern region, adults and children, end December 2002**

	Adults	Children[b]
Inpatient admissions	15.1 months	n.a.
Day case admissions	7.8 months	n.a.
All elective admissions	12.6 months	8.9 months

Source: Analysis by the Office of the Comptroller and Auditor General

Notes: a Averages are based on mid-point value for patients in each time band; patients waiting 48 months or more are assumed to be waiting an average of 60 months.

b Average waiting times cannot be calculated separately for children waiting for inpatient and day case treatment because the numbers waiting in Our Lady's Hospital, Crumlin cannot be categorised in this way.

4.12 Using the ERHA data, it is not possible to separately estimate inpatient and day case waiting time averages for children. However, the overall average for children reported as waiting for elective treatment is estimated at almost 9 months. This is significantly greater than the target maximum waiting time of 6 months.

4.13 The Department (or the National Hospitals Office, when it is established) should consider collecting national waiting time data along the same lines as the ERHA, and including an analysis of the distribution of waiting time and waiting time averages in its periodic reports on waiting time. Furthermore, because the number of patients in the '48 months or more' category is so significant, both the Department and the ERHA should use a more disaggregated time categorisation. They should also consider asking all service providers to report the longest waiting time for an individual patient in each of the targeted specialties.

Data Collection and Validation

4.14 The Department has had considerable difficulties in ensuring the completeness, accuracy and reliability of the data it collects and publishes in relation to numbers of patients waiting. We examined data collection and reporting in four hospitals.

Patient Record Administration Systems

4.15 Three of the four hospitals visited in the course of this examination (St James's, St Vincent's and Tullamore General) use the same system to manage patient administration details — the Patient Administration System (PAS), developed on behalf of the Department as a generic system for Irish acute hospitals. While individual hospitals have developed some localised modules, the same kinds of basic information are captured in all hospitals. A different computer system (the Patient Information Management System) is used in Cork, but it has a similar functionality to the PAS, and holds similar information.

4.16 Practice in the use of the patient record systems varies from hospital to hospital. In all the hospitals visited, all elective patients are registered on the systems from the date of first contact with the hospital (e.g. receipt of a GP referral letter, date patient was seen in accident and emergency, etc). All the hospitals visited have waiting lists for the WLI target specialties, but three of the four do not have centralised waiting lists for some of the non-target specialties.

4.17 Typically, a waiting list is not kept if all patients in a specialty area are immediately given an appointment date for their elective treatment. Hospital managements regard this as acceptable if the appointment date is in the near future, but separate monitoring systems are required in such cases to ensure waiting times do not begin to extend. The preferable approach — employed in Tullamore General Hospital — is to record all elective patients for all specialties on waiting lists, and use the computerised reporting system to generate comprehensive waiting time information.

4.18 Following on a recommendation of the 1998 Review Group report, the Department introduced a reporting mechanism so that average waiting time by specialty and by consultant would be calculated at hospital level, and collated and published by the Department. This kind of data is routinely collected in other health services and is published so that GPs can take account of the information in referring patients for consultations or treatment. However, the Department judged that the quality and reliability of the information returned by service providers was poor and decided not to publish it.

4.19 The patient administration systems in the hospitals visited are potentially capable of producing waiting time distributions and reliable average waiting times for each hospital, by specialty and by consultant. However, the Department has also pointed out that some other hospitals do not have sufficiently sophisticated patient administration systems to allow them to produce the necessary data. A first step in providing this information will be the clear definition by the Department of the measures it seeks to generate and of a methodology that will ensure the production of comprehensive and consistent data across all hospitals.

4.20 In this regard, there may be scope for applying the lessons learned from a major information technology project commissioned in the Eastern region to address the recording of waiting lists in the major Dublin acute teaching hospitals. It is expected that the project will identify and resolve inconsistencies in the management of waiting list data, as well as improving access to waiting list information.

Reporting Day Case Procedures

4.21 The Department has stated that, from the outset of the WLI, it intended to include in its waiting list count both those waiting for inpatient treatment and those waiting for treatment as day cases. However, its guidelines and data collection instruments refer specifically in some places only to inpatients. Because this term has two different meanings in practice, some hospitals reported numbers waiting including both groups, while others reported only those waiting for inpatient treatment.

4.22 In mid-2002, the Department began to categorise numbers waiting as either day case patients or inpatients for all those hospitals that report day case numbers. In June 2002, hospitals reported that almost 9,500 patients were waiting three months or more for day case procedures. By December 2002, the same hospitals were reporting that over 10,500 day case patients were waiting three months or more. The Department plans in the future to report the numbers waiting in each of the categories separately.

4.23 Some hospitals had not begun reporting the number of patients waiting for day case treatment up to December 2002. These included Tallaght Hospital and St. James's Hospital. Our Lady's Hospital for Sick Children reports inpatient and day case numbers together.

4.24 The Department does not have separate waiting time targets for inpatients and day case patients.

Suspended and Return Patients

4.25 In their counts of patients on their waiting lists, practices differ between hospitals in the manner of treatment of two small but significant categories of patient.

- Patients listed for particular kinds of treatments may require a certain amount of assessment and pre-operative work before the planned procedure can be carried out. This process may reveal that the patient is not medically fit to have the treatment e.g. achievement of a weight loss target may be necessary before joint replacement or anaesthesia. In Tullamore, patients who are long term medically unfit (particularly for major joint replacement) are temporarily suspended from the waiting list count. Thereafter, they are routinely assessed and, when judged to be medically fit, are restored to the active list and shown as waiting from the time they were originally listed for treatment. In the other hospitals visited, unfit patients may remain on waiting lists. While the numbers involved are unlikely to skew the estimation of average waiting times significantly; retaining them in a distribution analysis may give an incorrect measure of longest waiting time.
- For some types of elective treatment, patients may require a procedure to be repeated at planned intervals. Typically, patients are given their next appointment at the time they are discharged. Strictly, they are not waiting for the treatment. In some cases, they are counted as waiting patients; in other cases, they are excluded from the count. These patients should be excluded from the count in all cases, unless the planned treatment is deferred.

Validation of Waiting Lists

4.26 In the earlier years of the WLI, list validation exercises by individual service providers reduced the reported numbers waiting significantly. There has been more systematic validation of lists on an on-going basis in recent years, resulting in correspondingly smaller adjustments to the lists.

4.27 In general, the validation exercises carried out have been of an administrative nature, including writing to patients to ascertain that they still wish to have the treatments for which they are listed. In some cases, validation has involved recall of long waiting patients for a medical re-assessment.

4.28 Considering the length of time some patients have waited for treatment, it seems reasonable that the medical condition and suitability for treatment of patients waiting longer than the target times should be assessed periodically as part of a list validation strategy.

Waiting for an Outpatient Appointment

4.29 From an individual patient's perspective, waiting time for treatment includes the time between the referral by the patient's GP and the initial appointment with the consultant as an outpatient.

4.30 The Department has not set waiting time targets for outpatient consultations. It does not collect national statistics about the number of patients waiting for outpatient appointments, nor about the length of time they wait. In other health services, these aspects of patient waiting time are measured routinely, and performance targets are set for these measures, as well as for time spent waiting for elective treatment.

4.31 A CSO survey carried out in mid-2001[8] suggests that for every 10 public patients reporting that they were waiting for elective treatment, a further 14 public patients said they were waiting for an outpatient appointment.

4.32 In view of the numbers of patients waiting for outpatient consultations, the Department (and, in due course, the National Hospitals Office) should gather data and set waiting time targets for outpatient appointments as well as for elective treatments.

4.33 In most cases, patients attend a consultant's outpatient clinic before being placed on the relevant waiting list for elective treatment.[9] Irrespective of the length of time they have waited for an outpatient appointment, patients are not eligible for consideration for treatment under the National Treatment Purchase Fund until they have been waiting on the list for elective treatment longer than the target maximum waiting times.

Managing Waiting Time

4.34 Initiatives such as the WLI need to be managed on the basis of clear objectives and targets, with performance benchmarked against comparable results. The compilation and reporting of waiting time information is a basic requirement for effective management. In this regard, it is planned that the National Hospitals Office will, upon its establishment, introduce and manage a national waiting time database and coordinate actions to reduce waiting lists and waiting times.

Target Setting

4.35 Achievable deadlines are important in motivating and focusing management in the pursuit of objectives. An initiative such as the WLI should be managed as a programme and deadlines set for the achievement of key milestones. Without target dates for achievement, standards set in terms of waiting time remain aspirational and imprecise for performance management purposes.

4.36 When the WLI was launched, a deadline was not set for meeting its overall aim of treating all long waiting patients. Subsequently, the Health Strategy 2001 specified both waiting time targets and deadlines for their achievement, as indicated in Figure 4.3.

4.37 The aim is that by the end of 2004, no patient should have to wait longer than 3 months for elective treatment in any specialty, whether on a day case or inpatient basis. The end-2002 performance target has not been achieved, and the Department has not set revised deadlines for achievement of its waiting time targets. As a result, the targets have again become aspirational and imprecise.

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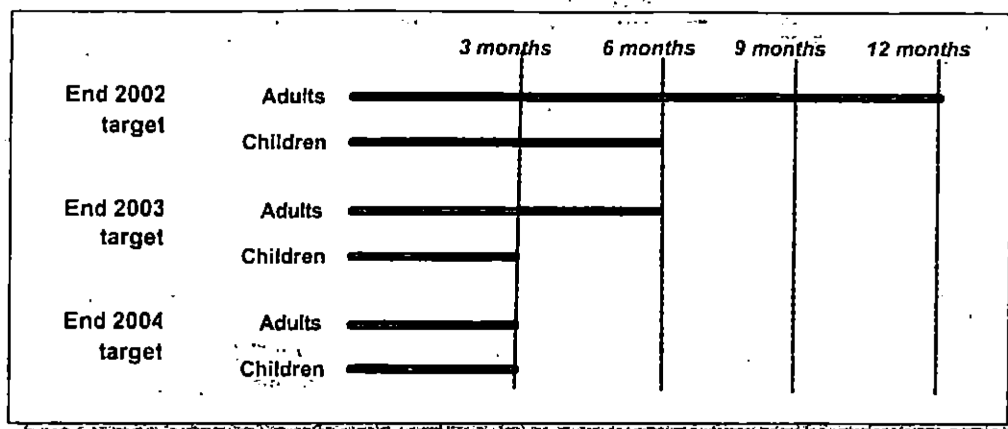
8 CSO, Quarterly National Household Survey, June – August 2001, published May 2002.

9 In Tullamore General Hospital, a patient may be placed on a waiting list on the direction of the relevant consultant, based on the GP's referral letter and without an outpatient consultation, where the GP refers the patient in line with medical assessment protocols laid down by the Hospital's consultants.

Figure 4.3 National target maximum waiting times for elective treatment



Source: Department of Health and Children

Benchmarking Public Waiting Times

4.38 Public hospitals provide services to both public and private patients. Approximately 20% of beds in public hospitals are formally designated for private use.

4.39 It is frequently suggested that waiting times for private patients treated in public hospitals are lower than those for public patients but little comparative analysis is available. Similar details are recorded about public and private patients in public hospitals, so statistical analysis of relative waiting times is possible. While this, potentially, provides a highly relevant performance benchmark in the context of management of public patient waiting times, the Department does not collect any information about waiting times for private patients.

4.40 In the absence of health service data about comparative waiting times for public and private patients, the results of a Central Statistics Office (CSO) survey carried out in 2001 provides a basis for benchmarking waiting times for public and private patients (see Figure 4.4). In drawing comparisons from the survey results, it should be noted that private patients might have been waiting for treatment in private beds in public hospitals, or in private hospitals.

4.41 The CSO data can be used to compare the distributions of time waited for both elective treatment and outpatient appointments reported by those with private health insurance and by those who rely mainly on the public health system for treatment.

4.42 The survey suggests that

- while 29% of private patients reported they had been waiting more than 3 months for elective treatment, almost twice that percentage of public patients reported they had been waiting more than 3 months
- a quarter of private patients had been waiting more than 3 months for an outpatient appointment, whereas 46% of public outpatients had been waiting more than 3 months.

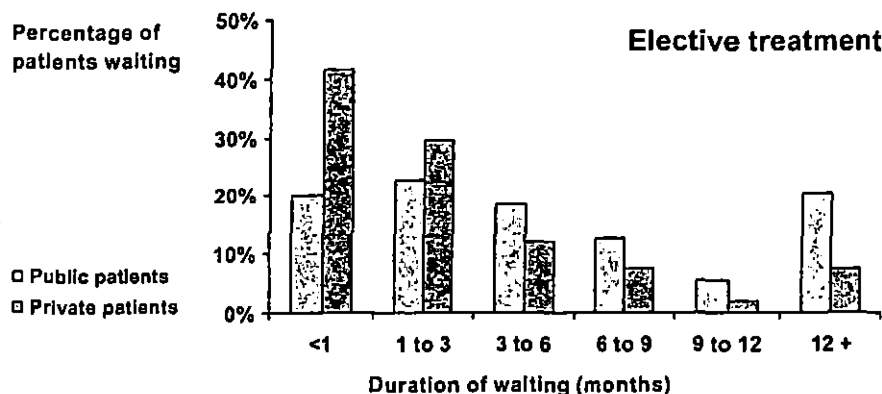
4.43 The monitoring of performance in public hospitals in terms of relative waiting time for public and private patients could provide valuable information to help managers benchmark performance in the management of waiting time for patients treated using public funds.

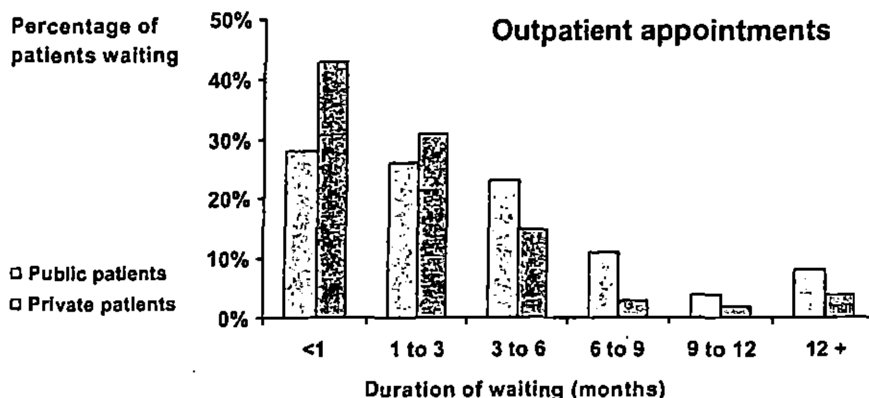
Figure 4.4 Benchmarking waiting time for elective treatment and outpatient appointments, June-August 2001

As part of its Quarterly National Household Survey in the three months from June to August 2001, the Central Statistics Office (CSO) asked respondents a number of questions about their use of health services and about waiting for services. The results of the survey in relation to health issues were published in May 2002.

The survey results cannot be fully reconciled with the Department's reported waiting list numbers, because the CSO used different definitions and the timing of the survey did not coincide exactly with the Department's reporting period. Furthermore, the CSO's results are based on patients' perceptions of the services they are awaiting and on the length of time they have been waiting. Despite these differences, comparison of relevant parts of the CSO results with the Department's figures indicates that the two sets of data are reasonably consistent.

The survey distinguished between respondents on the basis of the type of medical cover they hold. The survey found that 48% of respondents had private medical insurance. (This includes 2% who also had a medical card.) This suggests that they had access to private medical treatment — in public and/or private hospitals — and would therefore be less likely to rely on the public system for elective treatment. Of the remaining 52% of respondents, half reported they had a medical card and half reported that they had neither private insurance nor medical card cover. Patients in both these categories are more likely to rely on the public system for elective treatment.





Source: Central Statistics Office

Coordination with General Practitioners

4.44 Reliable waiting time performance could be very useful to GPs in referring patients for treatment. In other jurisdictions, special websites have been created to make this information readily accessible.

4.45 Since June 2002, the Department has begun to publish on its website quarterly information about numbers of patients waiting. The Department publishes the reported number of patients waiting for inpatient and day case treatment, by hospital and specialty. The number of patients waiting longer than the target time is also shown. However, the form and content of this section of the website could be developed to make it more helpful to GPs in making their referral choices.

4.46 The following performance measures could enhance the currently published information

- the number of elective procedures carried out (each year or each quarter), by hospital and specialty, to allow the number waiting to be put in context
- the average waiting times for treatment in each specialty area
- the longest waiting time for an individual patient in each specialty area
- waiting time for initial outpatient consultation appointments
- presentation of data on a time series basis, so that trends in waiting time can be identified
- presentation of direct comparisons of waiting times for the same specialties at different hospitals.

Conclusions

4.47 CSO statistics indicate that, nationally, the proportion of public patients waiting longer than three months for elective treatment is almost twice the proportion for private elective patients. Benchmarking of public patient waiting against waiting times for private treatment in public hospitals would be useful in reviewing the performance of service providers in delivering the services funded by the State whether out of core funds or under targeted initiatives like the WLI.

4.48 Recent developments in data collection are beginning to generate better information about waiting times for elective treatment. The available data suggests that, at end December 2002 in the Eastern Region (where most of the elective treatment waiting time problem is located), both adults and children were, on average, waiting significantly longer that the target maximum waiting times. This implies significant improvements in waiting times are required in the short term if the Department's waiting time targets are to be met. The Department should encourage the national production of similar data to that now collected in the Eastern region.

4.49 Significant further improvements are required in the performance measurement and management systems in relation to waiting lists.

- Individual hospitals and the Department report quarterly on the overall number of patients waiting more than three months for treatment and the number waiting longer than the target maximum waiting times for selected specialties. While data collection in relation to numbers on waiting lists has been improving, these measures of numbers waiting provide little information about the length of time the average patient is waiting or how fast the waiting list is moving. These are more relevant considerations from the patients' point of view.

- Greater accuracy and consistency is required in the data collection process.
- Since time spent waiting for outpatient appointments is potentially a significant part of a patient's overall waiting time for treatment, this should also be measured and monitored.
- Existing waiting time targets set by the Department are largely aspirational. In managing waiting time under an initiative like the WLI, milestones and time deadlines should be established and regularly reviewed if they are to function as clear and achievable performance targets.

Appendices

Appendix A Summary of Recommendations of the Review Group on the Waiting List Initiative, July 1998

Overall Conclusions

The Review Group believes that a series of immediate, medium term and long-term initiatives must be taken if waiting lists and waiting times are to be reduced substantially. There are no simple short-term solutions which, on their own, will have a significant impact. In addition, a satisfactory response must reach beyond the acute hospital services alone. The report makes a number of recommendations regarding organisational initiatives that could be implemented quickly, but these must be accompanied by an integrated set of medium to long term initiatives both within and outside the acute hospital sector.

Immediate Term Recommendations: 1998

Further study of hospital capacity is needed as a matter of urgency. Some hospitals have reached full capacity with existing resources in relation to elective work. Where staffing is an issue, these hospitals should be funded for the provision of appropriate temporary staff in target specialties, subject to certain conditions. Where physical capacity is an issue, favourable consideration should be given to developing, in the medium to long term, additional capacity in hospitals which demonstrate that their existing facilities are already appropriately utilised and fully committed.

Agencies should be asked to review their information systems to ensure that they can maintain accurate and up-to-date WLI data and should be assisted if specific shortfalls are identified. The Department of Health and Children should develop and implement an improved IT system for recording and analysing national WLI data.

Hospitals should carry out a bulk postal review of patients on their waiting lists where they have not done so in the previous twelve months. There should be an agreed protocol for periodic further reviews on a selective basis following this validation process.

A set of short-term steps relating to the operation of hospital services should be taken. These include an improved flow of information between primary and hospital care regarding the status of patients on waiting lists; a continued move towards day case work; the appointment of bed managers and bed utilisation committees; agreement under each agency's service plan regarding the mix of public and private patients treated; and a written policy on planning the discharge of older patients and on liaising with community-based services.

Medium Term Recommendations: 1999

WLI funding should focus on a limited number of specialties and take the greatest possible account of health and social gain, the priority set according to clinical judgement and the length of time already waited by patients.

The present system of allocating WLI funding may act as a disincentive to hospitals to improve their waiting list performance. The Department of Health and Children should consider introducing positive financial incentives to hospitals to reduce their waiting times. A proportion of

total WLI funding could be retained by the Department for distribution to the hospitals which showed the greatest reduction in waiting times in target specialties. The details of any such incentive system should be developed in conjunction with the relevant hospitals.

Protocols should be developed in all major Waiting List Specialties for the validation and prioritisation of cases. This should be done either at national level through protocols devised by the relevant professional bodies, or at local level by individual hospitals.

A number of measures should be pursued to reduce the pressure from A&E services on acute beds. These include developing rapid diagnostic systems for common emergency presentations; developing effective care guidelines for managing conditions which no longer require admission; further developing treatment/observation areas to allow frequent review of certain cases; and improving access by general practitioners to urgent specialist opinion.

Long Term Recommendations 1999 - 2001

The development of Geriatric Day Hospitals on the site of acute hospitals should be prioritised in the medium to long term. The next priority should be the development of rehabilitation facilities on acute hospital sites where they do not already exist. Both of these developments would significantly increase the appropriate utilisation of scarce acute hospital services.

Each health board should evaluate the long-term residential care needs of its region. There should then be a planned programme of investment in appropriate facilities for those in need of long-term care.

For acute patients, the case for providing stand-alone day surgery units on the site of acute hospitals should be examined closely. Since many patients who are on public waiting lists could be treated on a day case basis, a dedicated day surgery unit could greatly protect them from delays that arise from other hospital pressures.

The question of providing additional hostel or other short-term accommodation for patients who do not otherwise need to stay overnight in an acute bed should be pursued as a means of reducing unnecessary hospital stays.

Appendix B Allocations of Waiting List Initiative Funding to Service Providers, 1998 – 2002

Service Provider / Region	1998 €'000	1999 €'000	2000 €'000	2001 €'000	2002 €'000	Total (1998-2001) €'000
Voluntary Hospitals in Eastern Region						
St James's Hospital	1,764	2,133	4,919	4,713	5,915	19,444
Mater Misericordiae Hospital	1,200	4,979	3,697	1,053	3,647	14,576
Beaumont Hospital	938	1,765	2,842	3,249	3,970	12,764
Our Ladys Hospital, Crumlin	1,178	983	2,425	4,177	1,316	10,079
St Vincent's Hospital, Elm Park	1,152	1,422	2,203	1,930	2,512	9,219
Tallaght Hospital	394	949	2,165	2,165	0	5,673
Royal Victoria Eye & Ear Hospital	348	510	805	939	1,536	4,138
St Mary's Hospital, Cappagh	0	0	660	1,270	2,024	3,954
Temple Street Children's Hospital	127	190	301	99	0	717
Rotunda	114	140	220	0	0	474
Coombe	43	57	90	0	0	190
St Michael's Hospital, Dunlaoire	0	65	102	0	0	167
External Service Providers						
Mater Private	584	0	161	2,337	404	3,486
Blackrock	584	0	0	415	108	1,107
East Coast Area Health Board	0	0	0	0	28	28
Eastern Region	**8,426**	**13,193**	**20,590**	**22,347**	**21,460**	**86,016**
Midland Health Board	736	1,765	2,720	2,222	2,200	9,643
Midland Region	**736**	**1,765**	**2,720**	**2,222**	**2,200**	**9,643**
Mid-Western Health Board	780	1,351	2,720	2,603	2,565	10,019
St John's Hospital, Limerick	95	138	218	317	336	1,104
Mid Western Region	**875**	**1,489**	**2,938**	**2,920**	**2,901**	**11,123**
North Eastern Health Board	660	1,060	2,528	2,286	2,050	8,584
North Eastern Region	**660**	**1,060**	**2,528**	**2,286**	**2,050**	**8,584**
North Western Health Board	762	1,448	3,385	1,143	2,070	8,808
External providers	25	283	0	1,038	0	1,346
North Western Region	**787**	**1,731**	**3,385**	**2,181**	**2,070**	**10,154**
South Eastern Health Board	885	1,715	3,785	3,238	3,530	13,153
South Eastern Region	**885**	**1,715**	**3,785**	**3,238**	**3,530**	**13,153**
Southern Health Board	1,244	1,174	3,333	3,492	3,860	13,103
Mercy Hospital, Cork	84	470	574	1,206	1,420	3,754
South Infirmary/Victoria Hospital	191	178	150	676	1,055	2,250
Southern Region	**1,519**	**1,822**	**4,057**	**5,374**	**6,335**	**19,107**
Western Health Board	1,336	2,582	3,832	3,238	3,260	14,248
Portiuncula Hospital, Ballinasloe	0	38	60	0	0	98
Western Region	**1,336**	**2,620**	**3,892**	**3,238**	**3,260**	**14,346**
Totals	**15,224**	**25,395**	**43,895**	**43,806**	**43,806**	**172,126**

Source: Analysis by the Office of the Comptroller & Auditor General

Appendix C Target Group as a Percentage of Total Waiting, by Hospital, end December 2002

Hospital	Total Waiting	Target Group	Target Group as a % of Total Waiting
Temple Street Children's Hospital	756	552	73%
Tallaght Hospital	1,440	885	61%
Our Lady's Hospital, Crumlin	1,034	523	51%
Our Lady's General Hospital, Navan	604	293	49%
South Infirmary/Victoria Hospital	175	73	42%
University College Hospital, Galway	950	371	39%
Merlin Park Regional Hospital, Galway	472	177	38%
Cavan General Hospital	609	208	34%
Beaumont Hospital	4,240	1,423	34%
James Connolly Memorial Hospital	706	225	32%
Mater Misericordiae Hospital	3,878	1,217	31%
St Vincent's Hospital, Elm Park	3,287	953	29%
Royal Victoria Eye and Ear Hospital	976	271	28%
St Luke's Hospital, Kilkenny	180	46	26%
Orthopaedic Hospital, Kilcreene	144	33	23%
Cork University Hospital	1,053	231	22%
St Mary's Hospital, Cappagh	699	148	21%
Sligo Regional Hospital	817	161	20%
Our Lady of Lourdes (NEHB)	281	53	19%
Midland Regional Hospital, Tullamore	548	100	18%
Letterkenny General Hospital	2,563	453	18%
Mercy Hospital, Cork	259	41	16%
Waterford Regional Hospital, Ardkeen	931	82	9%
Regional Hospital, Dooradoyle, Limerick	1,150	83	7%
St Mary's Hospital, Gurranebraher	110	5	5%
St James's Hospital	529	4	1%
St John's Hospital, Limerick	251	0	0%
Other Hospitals	517	72	14%
Totals	**29,159**	**8,683**	**30%**

Source: Analysis by the Office of the Comptroller and Auditor General
Note: Hospitals included are those with a waiting list of 100 people or more.

STATEMENT FROM THE MINISTER FOR HEALTH & CHILDREN
MICHEÁL MARTIN TD
BUDGET DAY
DECEMBER 3RD 2004

Following the publication of Budget 2004, Micheál Martin TD, Minister for Health and Children welcomed the additional allocation of €25 million for disability services. This brings the additional funding for disabilities services to €35 million for 2004 "The additional funding announced today, underlines the Government's commitment to the provision of services to people with disabilities and their families".

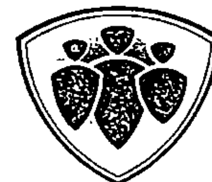
The Minister also welcomed the announcement that a programme of decentralisation will be put in place. "The new Health Service's Executive (incorporating the National Hospital's Office, the Primary, Community and Continuing Care Pillars and the Shared Services Centre) and the Health Information and Quality Authority will be located outside Dublin. I believe this decentralisation programme will have significant benefits for staff.

Commenting on the announcement of a €33.6 billion 5 year capital development programme. Over this period funding for capital projects in health will total €2.7 billion. "This funding will give greater certainty and allow for better project planning and substantially improve the country's health infrastructure".

Welcoming the additional 25c to the price of a packet of 20 cigarettes, the Minister said "In line with our public health policy, this increase is an important measure. I believe that an increase such as this will have an impact on the pattern of smoking, and particularly may discourage young people from taking up smoking".

"This Budget provides substantial additional funds for those most in need. The improvements in social welfare payments come to an additional €630 million in a full year, €100 million more than last year. The social welfare increases announced today are well ahead of the rates of inflation. As Minister for Health I would particularly welcome the increase in the old age pension".

"This Budget reflects the Government's sound management of the economy, good fiscal policies will create the conditions necessary for our economy to be strongly positioned to benefit from future economic recovery, maintain and create employment and increase wealth".



MID-WESTERN
HEALTH BOARD

CENTRAL OFFICES.
31/33 CATHERINE STREET.
LIMERICK. IRELAND.
TEL 00353 (0) 61 316655
FAX 00353 (0) 61 483350
WEBSITE : http://www.mwhb.ie

/tf 11/12/03

For Meeting of the Board to be held on Friday, 12th December, 2003

Question submitted by Mr. Liam McNamara

"That the Mid-Western Health Board would publish the report and recommendations on the review of later life psychiatric services in Limerick. In the context of the 10 year strategy for older persons now being developed I will ask that our most vulnerable elderly – i.e. those with a functional or organic mental illness be given priority."

Reply:-

The Board will publish the report in early 2004. The delay was due to clarifications and discussions with national bodies in relation to some of the recommendations and their implications.

It is envisaged that these discussions will continue with the Mental Health Commission in 2004.

Yours Sincerely,

pp James Conway
James Conway,
Assistant Chief Executive Officer

Chief Executive Officer Briefing Note

For Meeting of the Board to be held on Friday, 12th December 2003

Orthodontics
A Specialist in Orthodontics in the UK has been selected to undertake the review of Orthodontic Services agreed at the October Board meeting.

The review is likely to commence in January 2004 and should be completed by midyear.

Private Hospital
The tendering process has commenced. A PIN Notice (Prior Information Notice) was placed in the OJEU, the EU's official journal for publication of tender notices on 17th November 2003 signalling that the Board intended to dispose of circa. 4 acres for the purpose of building a private hospital. To date, 12 written queries have been received.

The next stage in the process is the completion of "Expressions of Interest". The document in this regard is likely to be finalised before the year-end.

The final stage of the process is to commence the formal bid by inviting tenders. No timeframes to this process have been finalised as yet.