



PEAMOUNT HOSPITAL

a new direction

5 Year Strategy 2003 - 2008

independent living

rehabilitation

*high quality
health care*



PEAMOUNT HOSPITAL
a new direction
5 Year Strategy 2003 - 2008



Foreword

It gives me great pleasure, on behalf of the Board of Management, to introduce Peamount's Strategy 2003 to 2008. This document gives a detailed overview on how this final vision has come to fruition – how the strategy was developed, the decisions faced in coming to a final conclusion in the direction we have chosen to take for our hospital, and most importantly, the various action plans within each area which will help us reach our goals.

This has been a long and exciting process. In late 2002, the Board asked the Chief Executive, Robin Mullan and his management team to develop a strategy, which would provide Peamount with a clear direction. In July 2003, after an intensive process, the Board agreed the strategy put forward.

On behalf of the Board, I wish to acknowledge the hard work,

dedication and skills of the Chief Executive, staff, management team, and the Sub-Committee, and thank everyone involved in putting this strategy together.

I also want to pay tribute, particularly to Donal Collins, Chair of the Strategy Sub-Committee and to my colleagues on the Board who have driven the process to this stage. Individually and collectively they have worked tirelessly in the interest of the hospital to agree this strategy and the future of Peamount.

There is little doubt that the environment in which we work is more challenging than in the past. However, I am confident that with the support of the staff and management team in implementing this strategy over the next five years, Peamount will continue its proud record and be a major player and champion of patient care in our community.

Peamount, its staff and residents, have long been an integral part of the local community. We appreciate the favoured place we hold in the hearts of people of all levels in the near and wider neighbourhood. They have been consistently generous in their support to Peamount over the years.

We look forward to their continuing support in bringing forward our expansion plan in line with the current thinking on health care, by developing more and better services, and making those services available to a wider community.

Guidhim rath Dé ar an obair.

Ann Quinlan

*Chairperson, Board of Peamount
July 2003*



Foreword

Peamount Hospital is an organisation with a long and valued history, and a reputation for providing quality personalised care to a range of patients and clients. Since taking up the position of CEO of Peamount in November 2002, two things have struck me repeatedly.

First, is the determination of all our staff to provide an excellent, high quality service to our patients and clients. They have done this over the years, often in very difficult circumstances and with limited resources.

Second, is the desire widely evident amongst staff and our stakeholders for Peamount to decide on the direction in which we are travelling and to answer questions - some of them very difficult - that have been around for some time.

This strategy provides that clear sense of direction and will build on the excellent care that Peamount has provided for many decades. Our overall objective will be to focus on independent living. This is a new

direction for Peamount and will enable people in our care to achieve this through rehabilitation and support.

We have undergone an intensive process, since early 2003, to develop the strategy. We have tried to involve as many people as possible, staff within Peamount, our funders, hospitals and other organisations that work with Peamount or who provide similar services. All of these inputs have informed our discussions and decisions on our future direction. I would like to thank all those who participated in these meetings with us, and gave of their time and their views so freely.

I would like to take this opportunity to thank everyone involved in putting the strategy together and making this document a reality - the Board, Management team, Strategy Sub-Committee and staff. The time and effort they devoted to this strategy, over the last number of months, demonstrates their commitment to Peamount.

We have made some difficult decisions, as part of this strategy process. These decisions were not made lightly. All options were discussed and debated at length, and the advantages and short-comings clearly understood.

I believe we have made the right decisions for Peamount - decisions which will provide us with a clear and unique direction in the future. Our focus on Independent Living and Rehabilitation not only gives us this clear sense of direction, it also fits with Peamount's ethos and builds on the skills which exists within the organisation.

I hope you will all join with me in helping to build this exciting Peamount of the future.

Robin Mullan
Chief Executive
July 2003



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Executive Summary

1. Introduction

At the end of 2002, the Board of Peamount asked the Management Team to develop a five year strategy for Peamount. This Executive Summary outlines the key elements of our strategy.

The Management Team embarked on an intensive and inclusive process in developing this strategy. We involved staff, managers, the Board of Management and the Strategy Sub Committee of the Board. We met with funding agencies and other service providers to understand Peamount's working environment and obtain their views on Peamount's future direction. We also conducted desk research to establish trends in the Irish health system and research current health models and services.

2. What were the options considered for Peamount?

A wide range of ideas were considered as possible opportunities for Peamount, or focusing exclusively on one of our existing care groups. This wide range of ideas was narrowed down to six options, worthy of detailed consideration for the future of Peamount.

Having assessed the six options against a set of evaluation criteria, the Rehabilitation / Independent living option emerged as the most appropriate option for the future of Peamount.

The main reasons for this are:

- There is a significant demand for a Rehabilitation service (for example, 674 people with neurological disability are awaiting placement in appropriate accommodation in the eastern region, 120 people are in centres that cannot provide an adequate social care programme (ERHA figures) – Rehabilitation is considered a priority, at both a national and regional level
- The Rehabilitation option would represent a radical departure for Peamount and provides the opportunity for Peamount to become a “leader” in non-acute rehabilitation
- Peamount can build on its existing skills, services and reputation to develop the Rehabilitation option
- The Rehabilitation option captures the essential elements of some of the other options discussed.

3. What does Peamount want to be in the future?

Our Vision: *We will provide a range of high quality health and social care services to enable adults to live more independently*

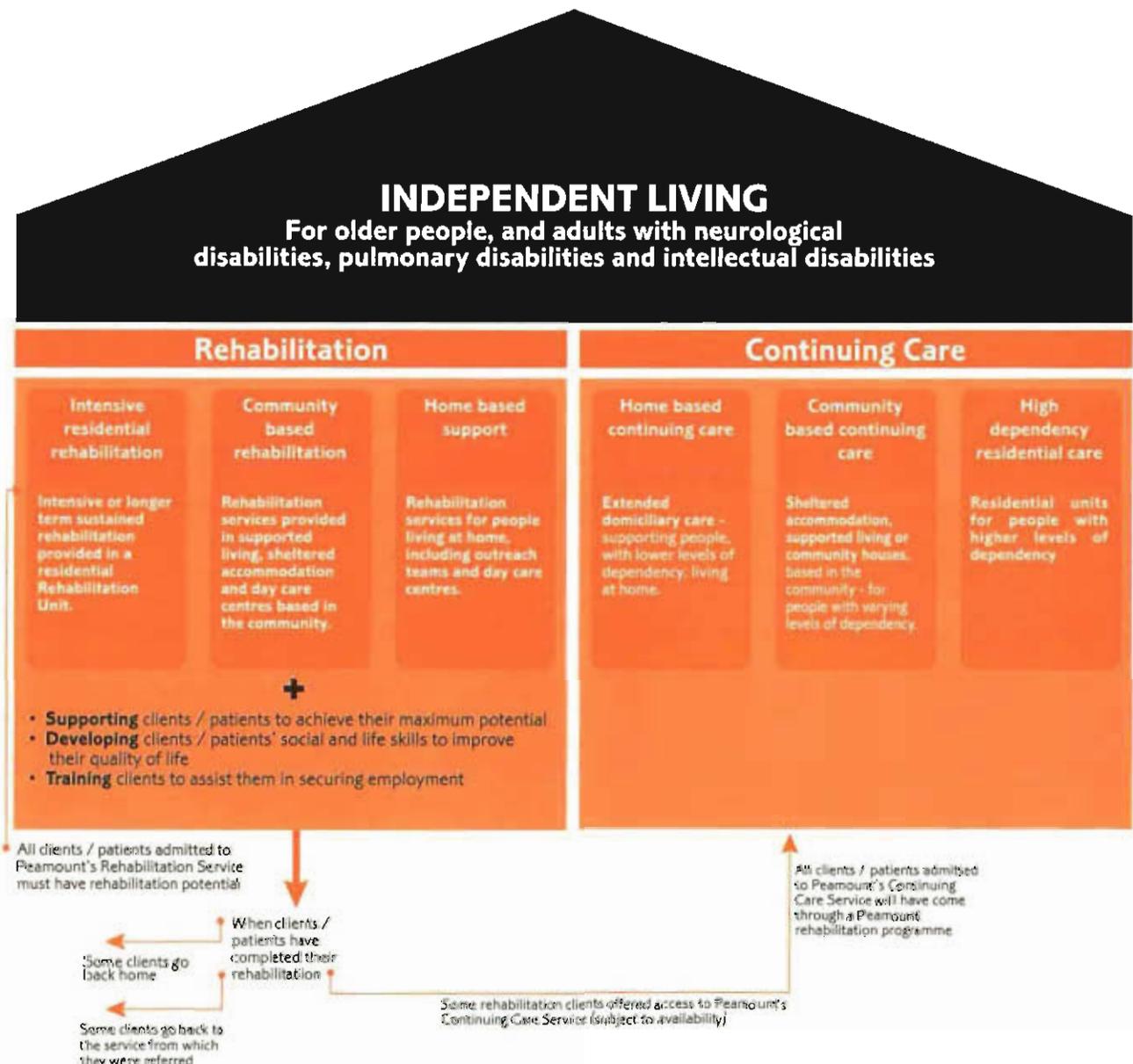
This Vision we have makes us unique:

- Our focus on *independent living* is new and different
- The objective of all of our services will be to enable people to live more independently – we will help people to do this through:
 - Rehabilitation programmes

- Supporting people in independent or semi-independent accommodation
- Giving people access to the skills / support they need to secure employment

Our services in the future

Peamount will provide a range of **Rehabilitation and Continuing Care Services**, catering for Adults with Neurological Disability; Adults with Pulmonary Disabilities; Adults with Intellectual Disability and Older People, as described in the diagram below:



Peamount's Rehabilitation Service

Peamount will provide a Rehabilitation Service, as described in the previous diagram, to Older People; Adults with Intellectual Disability; Adults with Neurological Disabilities and Adults with Pulmonary Disabilities. The service will cater for patients / clients living within the Eastern Region Health Authority.

We will offer our Rehabilitation Service only to patients/clients with rehabilitation potential. Each patient/client will have a customised Rehabilitation Programme with specified objectives and a fixed duration / timescale for participation in the service.

A 50-bed Rehabilitation Unit will support the Rehabilitation Service. This will be a shared facility providing beds and facilities essential for rehabilitation (such as a gym, equipment for physiotherapy, etc.). In addition to this, a transition bungalow will help patients / clients move from the Rehabilitation Unit to supported living or living at home.

Having participated in Peamount's Rehabilitation Service, the objective is for patients/clients to leave Peamount's Rehabilitation Service and:

- Return home, or continue to live at home (sometimes with support from Peamount).
- Move into sheltered accommodation/supported living in the community (run by Peamount or other providers).

Some patients/clients may need to move into, or return to, long term residential care (depending on their level of dependency).

Peamount will not be involved in Acute Rehabilitation, that is rehabilitation provided in an acute hospital setting, which involves early medical rehabilitation and management of an acutely ill patient.

Peamount's Continuing Care Service

In the future, the Continuing Care Service provided by Peamount will increasingly be based in the community (in Newcastle, Clondalkin, Tallaght, etc.)

It will cater for Adults with Neurological Disability, Adults with Intellectual Disability and Older People.

It will provide:

- Extended domiciliary care to people in their own homes (who have a defined need, which is not being met by other service providers). This would be delivered in partnership with local community services.
- Sheltered accommodation, supported living or community houses (based primarily in the community, in Newcastle, Clondalkin, Tallaght, etc).
- High dependency residential care providing residential units for adults with high levels of dependency.
- Access to supported and open employment, training and day activation
 - Peamount will continue to phase out the involvement of people with intellectual disabilities in Peamount Industries.

Peamount's Continuing Care Service may only be accessed through Peamount's Rehabilitation Service. The service will be offered primarily to patients / clients living within the ERHA area.

The Chest Hospital

Pulmonary Rehabilitation will be an integral part of Peamount's Rehabilitation Service. This service will care for patients / clients with:

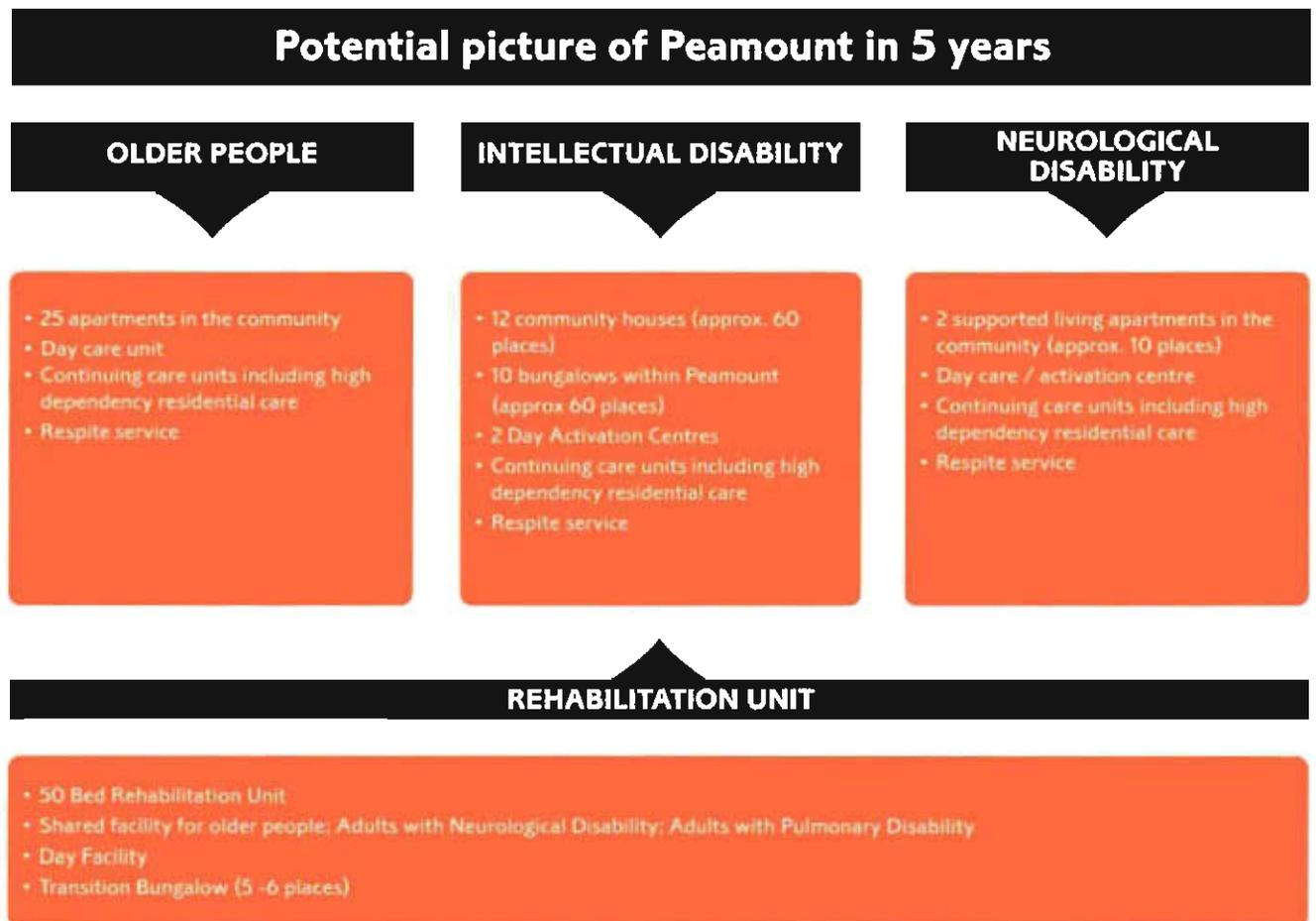
- Chronic bronchitis / Chronic Obstructive Pulmonary Disease (COPD)
- Emphysema
- Thoracic surgery (pre and post-op service)

The elements of Pulmonary Rehabilitation are detailed in Section 5.2.4.

After careful deliberation, the Board of Peamount has decided that Peamount should not pursue the Chest Hospital Option, as it does not fit with Peamount's Rehabilitation / Independent Living vision for the future. The Chest Hospital Option would have involved Peamount providing a broad TB and Non TB Respiratory service. A transition plan for the Chest Hospital will outline exactly what will happen to Peamount's TB and Non TB Respiratory service.

Summary of Peamount's services in the future

The diagram below paints a picture of what Peamount might look like in five years time, provided we develop our Rehabilitation and Continuing Care Services, as described earlier.



Implications for our existing services

Peamount is committed to providing high quality care to all of our current patients / clients, in our Intellectual Disability Service, Service for Older People and Service for Adults with Neurological Disabilities, for the remainder of their lifetime. A detailed description of the implications for each care group can be found in Section 5.3.

4. How will we get there?

We have identified **7 Strategic Goals** that will help us to achieve our vision. We will deliver on these goals within the five year timeframe of this strategy (2003-2008). These are detailed below:



Goal 1 - Rehabilitation

We will develop our Rehabilitation Service, providing Intensive residential rehabilitation; Community-based rehabilitation; Home-based support to the following care groups:

- Adults with Neurological Disability
- Adults with Pulmonary Disabilities
- Adults with Intellectual Disability
- Older People



Goal 2 - Continuing Care

We will develop a Continuing Care Service, through:

- Sheltered accommodation and supported living within the community
- Assisting those living at home to remain at home
- Providing high dependency residential care



Goal 3 - Staff

We will develop our staff

- Providing appropriate training and development
- Enhancing the existing skills mix to ensure an excellent quality of care, in a safe and fulfilling environment.



Goal 4 - Transitional arrangements

While developing our services, we will facilitate a smooth transition for:

- Our existing patients/clients - continuing to provide excellent care.
- Our staff - enabling them to fully participate in the opportunities arising from our future services, while maintaining the high quality of care currently provided.
- Our facilities – maintaining and developing our facilities to the required standards.



Goal 5 - Partnerships

We will work in partnership with other healthcare and social care providers to deliver a dynamic and evolving service, which meets the needs of the community.



Goal 6 - Organisational development

We will have appropriate structures and processes to allow effective management and operation of our services.



Goal 7 - Financial resources

We will acquire the appropriate financial resources to fund our strategy and apply them effectively to ensure value for money.

We have developed an **Action Plan** which identifies what we will do, over the next five years, in order to achieve our goals. The Action Plan is outlined in Section 6.2 of this document. We have also identified **Key Milestones** detailed on Page 33.

The following Chapter details:

- a brief history of our organisation
- the services we currently provide
- why Peamount needs a strategy

Chapter 1 - Introduction

Our history

Peamount Hospital was founded as a sanatorium in 1912 by the Women's National Health Association to draw attention to the plight of the poor in the city. Under the leadership of Lady Aberdeen, the Women's National Health Association applied for and received a grant in 1912. This money was used to purchase the land at Peamount and thus Peamount Sanatorium was established. It had 700 beds and played a key role in providing a much needed service to people with TB (Tuberculosis).

Peamount's role has changed radically over the years from its origin as a TB Sanatorium. With the decline in the incidence of TB, more accommodation became available at the hospital. In 1962, the word Sanatorium was dropped from the hospital's name and the new name of 'Peamount Hospital Incorporated' was registered. In 1963, at the request of the Department of Health, a residential unit for Mental Handicap (now the Intellectual Disability Service) was opened.

In early December 1995 we opened our first unit for Care of the Elderly, and a little over twelve months later, in January 1997, we opened a second unit.

A special unit for the Young Chronic Disabled (now called the Neurologically Disabled Service) was opened in December 1996 and this was followed by a second unit in March 2000. These units care for people with neurological disabilities, suffering from stroke, head injuries, spinal injuries and multiple sclerosis.

With all of these developments, today, the hospital provides a range of services which are quite different to those that Peamount Hospital was originally established to provide.

Peamount Hospital now consists of a mix of wards, residential units and bungalows on site, catering for older people, adults with intellectual disability, adults with neurological disability and patients in our chest hospital. An overview of the services provided is shown below.

Why do we need a strategy?

Our organisation has undergone significant change over the last 40 years and, as described earlier, we are now involved in a number of challenging and diverse areas. Peamount Hospital is highly regarded and each service plays an important role in providing much needed care to the local community and beyond. We believe the key to our future success lies in identifying where we want to go and what are the steps we need to take to get there.

A strategy sets out the future direction of an organisation and we believe that now is the right time for Peamount Hospital to decide on where we want to be in the future and what services we want to be involved in. Recognising this, towards the end of 2002, the Board of Peamount asked the Management Team to develop a five year strategy for Peamount.

In deciding on the future direction of Peamount Hospital some hard decisions have been made. We believe, however, that we have made the best decisions for Peamount Hospital – our patients / clients and our staff - and we look forward to an exciting and challenging future ahead.

This document details our strategy, which was approved by the Board of Peamount in July 2003.



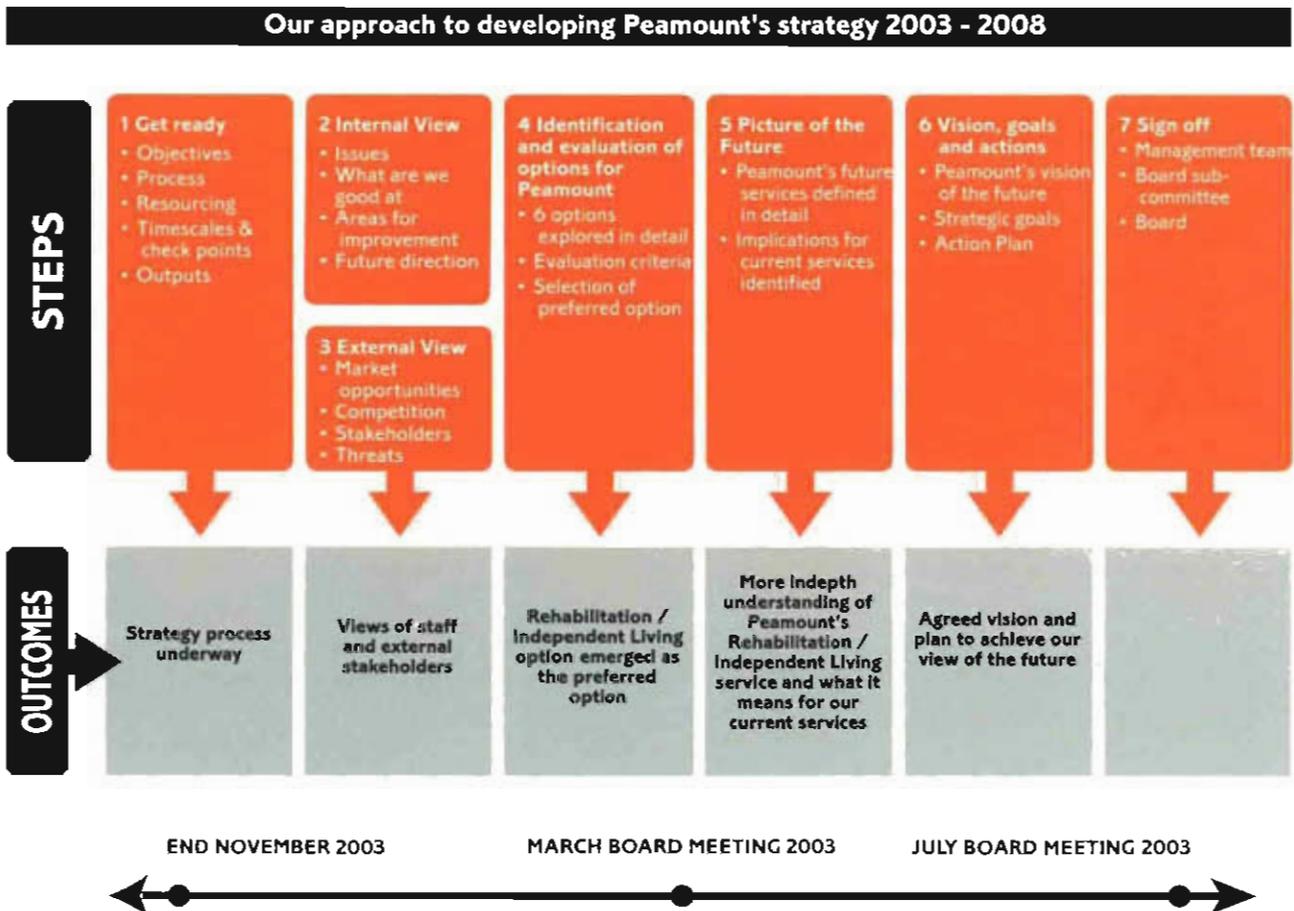
There is a total of 365 staff (Whole Time Equivalents) working across the different services in Peamount.

Chapter 2

How did we develop the strategy?

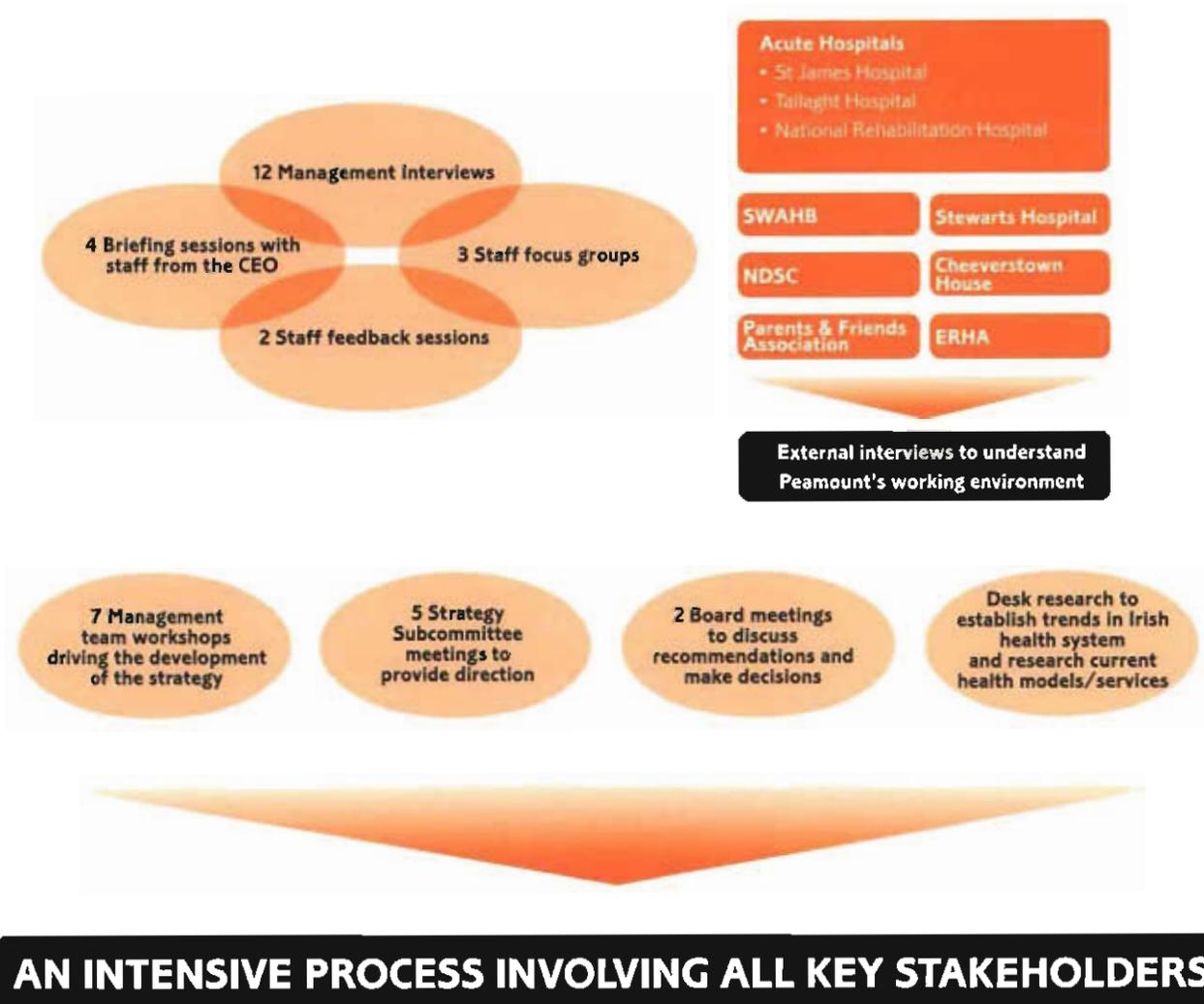
The approach used to develop the strategy has been an intensive and inclusive one, conducted over a seven month period (from December 2002 until July 2003).

It was considered extremely important that our staff, as well as external stakeholders, were involved in the process so that their views could input into the strategy. The steps involved in developing the strategy were the following:



The process involved a range of inputs from a number of sources. The process was driven primarily by the Management Team who participated in a number of workshops to develop the strategy. They were supported by the Strategy Subcommittee (a subcommittee established by the Board), who provided direction and acted as a sounding board throughout the process. The views of staff and external stakeholders were important inputs into the strategy.

The diagram below gives an overview of the inputs involved



In this chapter, we have identified:

- our strengths and weaknesses
- the key trends in healthcare that are relevant to Peamount

Chapter 3

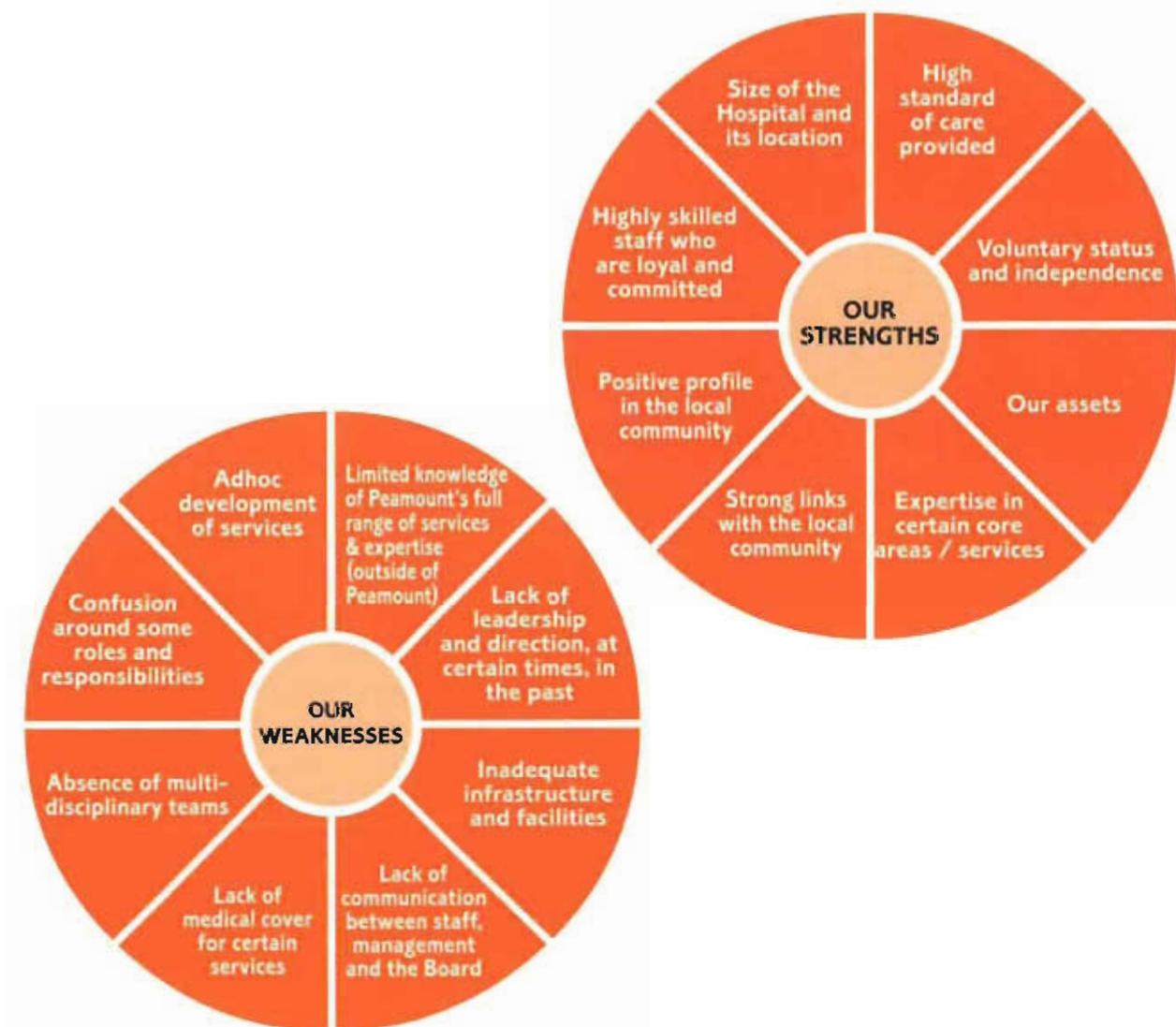
The environment we work in

A key input into the strategy development process was understanding what works well in our organisation and what needs to be improved. In addition, current trends in healthcare needed to be identified so they could be considered when developing our future direction.

3.1 Our strengths and weaknesses

One of the first steps in developing our strategy involved understanding our strengths and weaknesses as an organisation. It is important that we understand our strengths and weaknesses so that we can build on the strengths and overcome the weaknesses. Three staff sessions were held to understand what it was like to work in Peamount Hospital and to gather staff ideas on the future of Peamount. In addition to these sessions, a number of interviews were held with management to obtain their views. External parties were also interviewed to establish their views. All of these inputs proved extremely useful when developing the strategy.

The diagrams below summarise the strengths and weaknesses of Peamount Hospital which emerged from meetings with management, staff and external stakeholders.



3.2 Our external working environment

The environment in which we work will impact on how we develop over the next number of years. It is important when developing our strategy that we understand key trends in healthcare which are relevant to us. The key trends that we identified are as follows:

- **Move towards community-based care** – The objective underpinning the National Health Strategy (2002) and the Primary Care Strategy (2002) is to provide care to people in, or close to, their own homes and to keep people “out of the acute hospital system” unless they really need to be there. In the longer term, this should help to alleviate pressure on acute hospital beds.
- **Primary Care Teams and Networks** to play a leading role in delivering care to people in the community
 - Primary care teams will involve a group of primary care providers coming together to form an inter-disciplinary team (including for example GP's; nurses; public health nurses; an occupational therapist; a physiotherapist, a social worker; practice managers and administrative staff).
 - These teams will serve small population groups of approximately 3,000 – 7,000 people, depending on whether a region is rural or urban.
 - It is envisaged that a wider network of health and social care professionals will be formed to work with a number of primary care teams.
 - A long term objective for the health service is to ensure that 90-95% of all health and personal social service needs are met in the primary care setting.
- Move towards a **people-centred approach to care**. This was a key message in the National Health Strategy. It recognises the need to care for the person in a more holistic way, catering for more than just the medical needs of the person
- Greater emphasis on **external quality assurance measures** will mean a higher level of accountability.
- **Combining medical specialties on a single site/campus** in order to optimise quality, safety and efficiency.
- Increasing need for healthcare providers in the health system to demonstrate “**value for money**” to funders.
 - Difficulty in obtaining funding unless service is established as a priority area
 - New willingness to 'outsource' to private providers
- A **restructuring** within the health sector could affect Peamount's established relationships within the health system.

Chapter 4

Options for Peamount's future

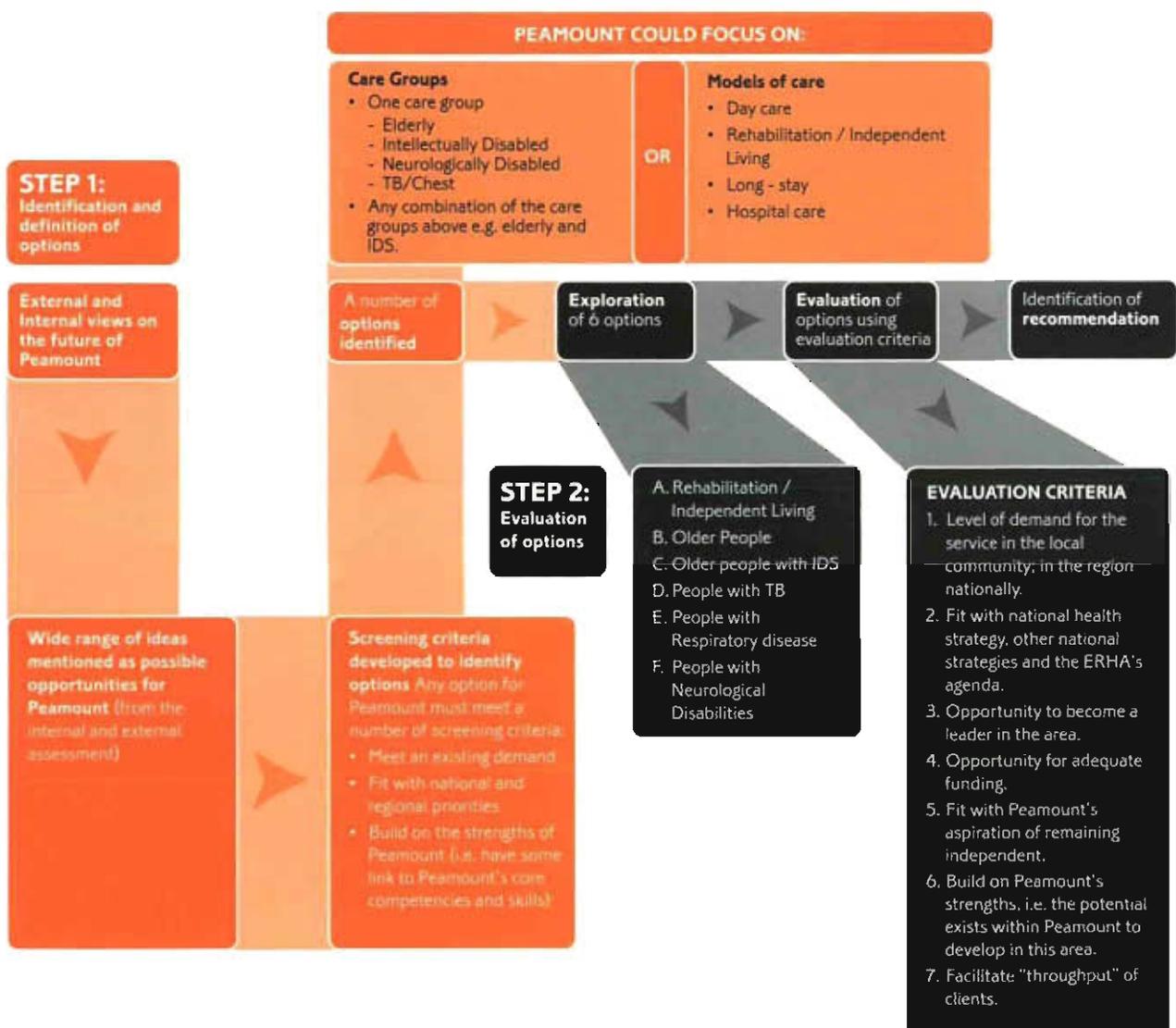
One of the key objectives of this strategy process was to provide us with the opportunity to take a fundamental look at what we do, and to ask ourselves the "hard questions" in relation to what we should be doing in the future.

With this in mind, we went through an extensive process to:

- Identify the full range of ideas which should be considered in terms of Peamount's future
- Narrow down the wide range of ideas to a number of more concrete options
- Explore and evaluate the different options, against a number of agreed evaluation criteria
- Select the preferred option

The steps involved in the identification and evaluation of the options are summarised below:

OVERVIEW OF PROCESS FOR IDENTIFYING AND EVALUATING OPTIONS



Options examined

Towards the end of step 1 (identification and definition of options), six options emerged, worthy of detailed consideration for the future of Peamount:

- A. Rehabilitation / Independent living
- B. Focus exclusively on Older people
- C. Focus exclusively on People with Intellectual Disability
- D&E Focus exclusively on people with TB and with Respiratory Disease
- F. Focus exclusively on people with Neurological Disabilities

Any of the options B to F could be combined in a number of ways

Each of these options was assessed against a set of evaluation criteria

Preferred option for the future direction of Peamount

Having assessed the options against the evaluation criteria, the Rehabilitation / Independent living option emerged as the most appropriate option for the future of Peamount.

The main reasons for this are:

- There is a significant demand for a Rehabilitation service.
- Rehabilitation is considered a priority, at both a national and regional level.
- The Rehabilitation option would represent a radical departure for Peamount and provides the opportunity for Peamount to become a "*leader*" in non-acute rehabilitation.
- Peamount can build on its existing skills, services and reputation to develop the Rehabilitation option (more easily than it can for some other options).
- The Rehabilitation option captures the essential elements of the Older People, Intellectually Disabled and Neurologically Disabled care group options.

Chapter 5

What does Peamount Hospital want to be in the future

5.1 Our vision

Our vision statement defines in broad terms, the kind of organisation we want to be in the future. It is described in the diagram below:



This Vision we have for the future makes us unique:

- Our focus on independent living is new and different
- The objective of all of our services will be to enable people to live more independently – we will help people to do this through:
 - Rehabilitation programmes
 - Supporting people in independent or semi-independent accommodation
 - Giving people access to the skills / support they need to secure employment

We know there is a large and growing demand for these kinds of health and social care services. Through our many years of care for older people, people with intellectual disability, people with neurological disability and our chest hospital patients, we are familiar with many of the care groups who will avail of these services.

Delivering on this vision will involve developing new services and changing some of our existing services. It will provide many exciting challenges for us as an organisation, for our staff and, most importantly, for our patients and clients (existing and new).

5.2 Our services in the future

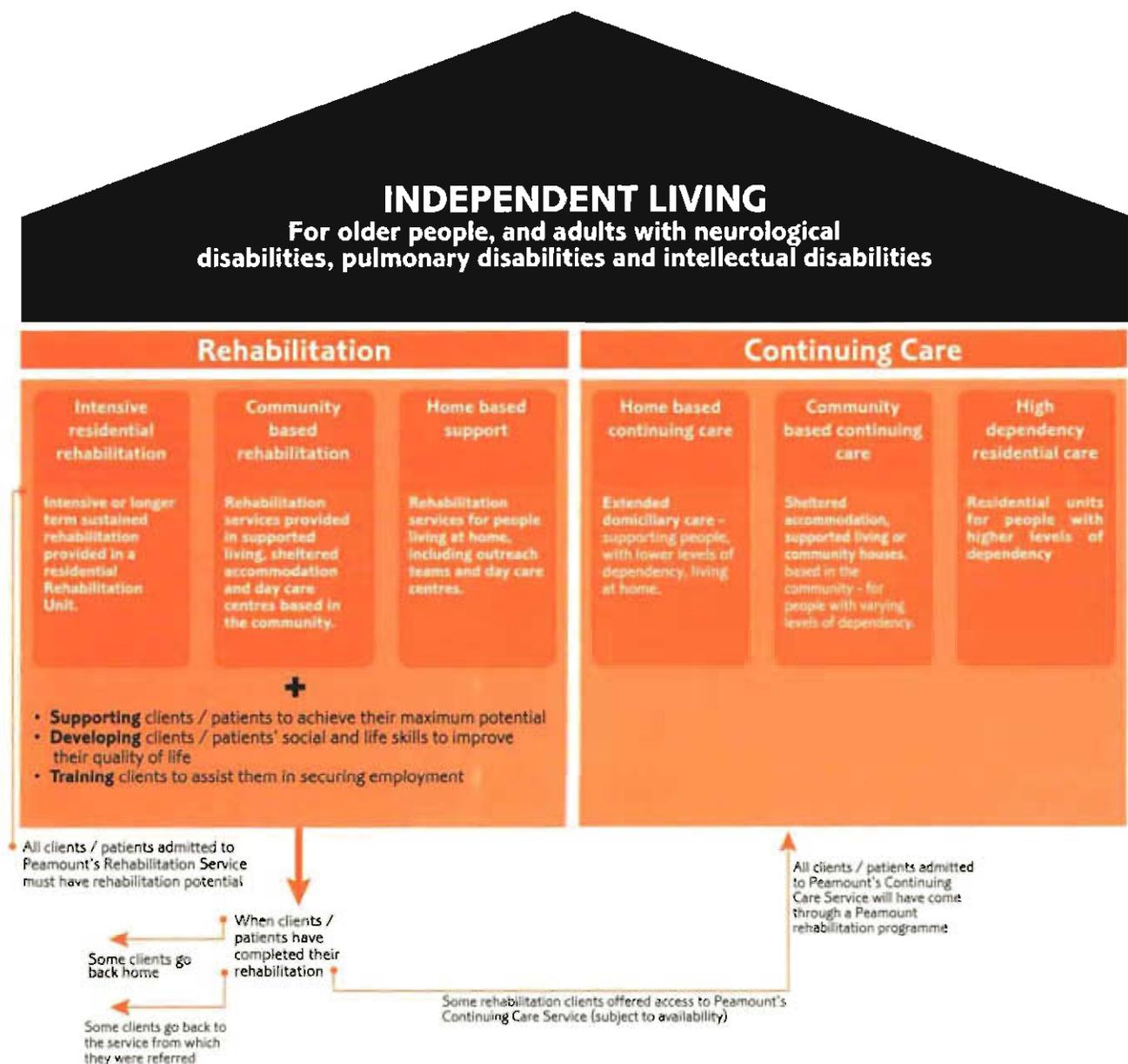
This section paints a picture of what Peamount Hospital should look like in the future. By the future, we mean the long-term future of Peamount (i.e. in 10 or 15 years time). Some elements of this picture of the future may take several years to develop; other elements may be put in place more quickly.

The implications for our existing services are outlined in section 5.3.

5.2.1 Overview of Peamount's future services

Peamount will provide a range of **Rehabilitation and Continuing Care Services**, catering for:

- Adults with Neurological Disability
- Adults with Pulmonary Disabilities
- Adults with Intellectual Disability
- Older People



5.2.2 Peamount's future Rehabilitation Service

The service

Peamount will provide a Rehabilitation Service in:

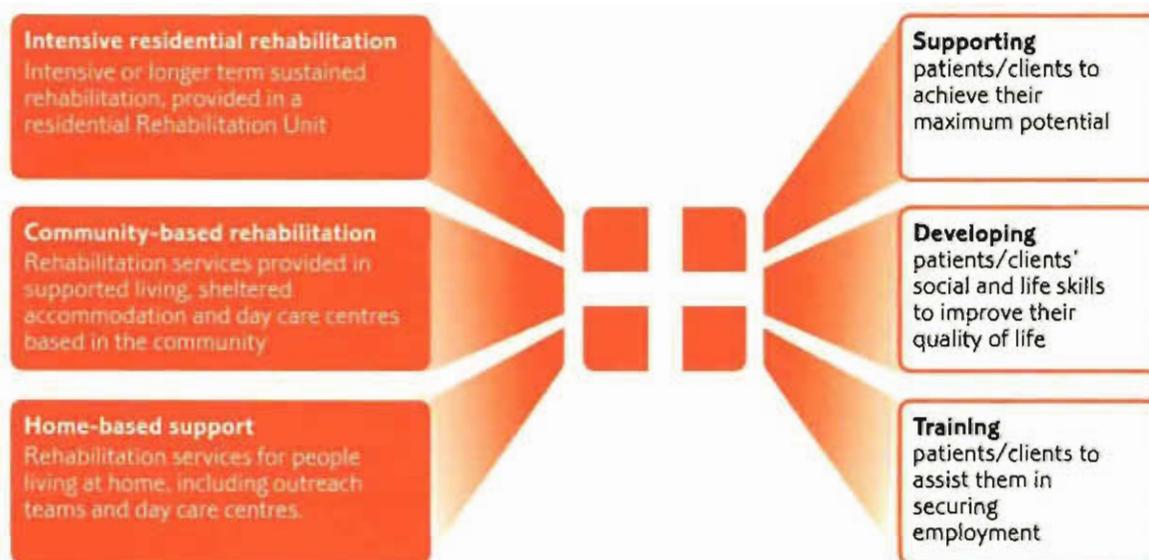
- **Intensive residential rehabilitation** – Intensive or longer term sustained rehabilitation provided in a residential Rehabilitation Unit.
- **Community based rehabilitation** - Rehabilitation services provided in supported living, sheltered accommodation and day care centres, primarily based in the community.
- **Home based support** - Rehabilitation services for people living at home, including outreach teams and day care centres

In addition, Peamount will:

- **Support** patients/clients to achieve their maximum potential
- **Develop** patients/clients' social and life skills to improve their quality of life (for example, through social training / development)
- **Train** patients/clients to assist them in securing employment (e.g. through providing vocational training – this training may be provided by other agencies, such as Fás)

Rehabilitation in Peamount will involve

The Classic Elements of Rehabilitation



Peamount will not be involved in Acute Rehabilitation – rehabilitation provided in an acute hospital setting, which involves early medical rehabilitation and management of an acutely ill patient (e.g. as is currently provided in the National Rehabilitation Hospital or large acute hospitals). It would not be appropriate for Peamount to be involved in this aspect of Rehabilitation.

Patient/Client profile

Peamount will offer its Rehabilitation Service only to **patients/clients with rehabilitation potential**. This applies to all patients/clients admitted to Peamount's Rehabilitation Service, be they older people, people with an intellectual disability, neurological disabilities or people requiring pulmonary rehabilitation.

An assessment of each patient/client will be completed by Peamount prior to their admission to the Rehabilitation Service, to ensure that the service is suitable for them.

Each patient/client will have a **customised Rehabilitation Programme**, with specified objectives and a **fixed duration / timescale** for participation in the service.

The patients/clients that Peamount will cater for include:

- Older people
- Adults with Intellectual Disability
- Adults with Neurological Disabilities
- Adults with Pulmonary Disabilities

Referrals

The service will cater primarily for patients/clients living within the **Eastern Region Health Authority (ERHA) area**

Patients/Clients will typically be referred from:

- Acute hospitals
- GP's
- Community services
- Disability managers
- Nursing homes or long stay home (referring older people)

Having participated in Peamount's Rehabilitation Service, the objective is for patients/clients to leave Peamount's Rehabilitation Service and:

- Return home, or continue to live at home (sometimes with support from Peamount)
- Move into sheltered accommodation/supported living in the community (run by Peamount or other providers)

Some patients/clients may need to move into, or return to, long term residential care (depending on their level of dependency).

A Rehabilitation Unit

We will provide a **Rehabilitation Unit** to support the Rehabilitation Service. This unit will be a shared facility. It will provide beds for Older People, Adults with Neurological Disability and Adults with Pulmonary Disabilities and include facilities which are essential for rehabilitation (such as, a gym, space and equipment for physiotherapy, occupational therapy, etc.).

In addition to the Rehabilitation Unit, a transition bungalow (with 5-6 places) will help patients / clients move from the Rehabilitation Unit to supported living or living at home.

Rationale for Peamount providing a Rehabilitation Service

There are a number of important reasons why Peamount should develop a Rehabilitation Service in the future. They can be summarised as follows:

- There is a strong demand for additional rehabilitation places in the local community, the eastern region and nationally. For example:
 - ERHA sources suggest that in a typical week in one major Dublin hospital:
 - o Approximately 10% of available bed days in major hospitals are lost due to delayed discharge
 - o Of 72 older people awaiting discharge, 22 needed rehabilitation
 - o 10 young chronic sick awaiting discharge required rehabilitation
 - In 2003, in the ERHA region, there are 674 persons with neurological disability awaiting placement in appropriate accommodation in the eastern region; there are 120 persons with neurological disability in centres that cannot provide an adequate social care programme (ERHA figures).
 - In 2003, in the ERHA region, 3,828 people with intellectual disability are awaiting changed or enhanced services (85 are awaiting appropriate day care places).

Providing additional rehabilitation places should help to “free up” acute beds. UK research shows that areas with higher nursing and rehabilitation care provision have lower acute bed usage (primarily due to reductions in length of stay rather than reduced admissions).

- Rehabilitation is a high priority, at local, regional and national level.
- The development of a Rehabilitation Service in Peamount provides Peamount with the opportunity to become a *leader* in non-acute rehabilitation.
- The Rehabilitation Service envisaged for Peamount will build on Peamount’s strengths. Although significant investment will be required, in terms of resources and facilities, the basis of many of the skills required are already in place, and staff are familiar with the different care groups.
- A Rehabilitation Service provides a degree of “throughput” of patients/clients. Given that one of the objectives of rehabilitation is to support people in moving out of residential care and back into a home-based environment, this will involve patients / clients moving between different services, and provide a stimulating environment for staff.
- The range of patients/clients, of different ages across a number of care groups, will provide a varied and interesting environment for patients/clients and staff.

In summary

All patients/clients admitted to Peamount’s Rehabilitation Service must have:

- Potential for rehabilitation
- A customised rehabilitation programme
- A discharge plan from the service

5.2.3 Peamount's future Continuing Care Service

The service

Peamount's Continuing Care Service will cater for:

- Adults with Neurological Disability
- Adults with Intellectual Disability
- Older People

In the future, the Continuing Care Service provided by Peamount will **increasingly be based in the community (in Newcastle, Clondalkin, Tallaght, etc.)**

It will involve the following elements:

- **Extended domiciliary care** - Supporting people, with lower levels of dependency, living at home, who have a defined need, which is not being met by other service providers.
 - The service will be provided to people in their own homes.
 - Peamount will have outreach teams, consisting of physiotherapists, occupational therapists, nursing staff, etc. to provide this home based care.
 - This service will be developed and delivered in partnership with local Community Services.
- **Sheltered accommodation, supported living or community houses (based primarily in the community, in Newcastle, Clondalkin, Tallaght, etc.)** – the people being supported in this accommodation could have mixed levels of dependency. Some of the accommodation could be used for respite care.
- **High dependency residential care** – Providing residential units for adults with higher levels of dependency.
- **Access to supported and open employment, training and day activation.**
 - Peamount will continue to phase out the involvement of people with intellectual disabilities in Peamount Industries.

We will need to carefully manage admission to, and plan the discharge from, our Rehabilitation and Continuing Care Services to ensure a smooth transition for patients/clients.

Continuing care accommodation to be provided by Peamount

The continuing care accommodation provided by Peamount will vary by care group.

For older people, Peamount will provide:

- Sheltered accommodation for older people who can live independently
- Support to Older People living at home
- Respite and day care service
- High dependency care in residential units

For adults with an intellectual disability, Peamount will provide:

- Supported living for intellectually disabled clients who can live independently
- Community houses for people with lower levels of dependency
- Support to Intellectually Disabled clients living at home
- Respite and day care service
- High dependency care in residential units

People with Intellectual Disability living in Peamount's supported living units will have different needs / levels of dependency.

For adults with neurological disability, Peamount will provide:

- Supported living apartments for people with neurological disability, who can live independently
- Respite and day care service
- High dependency care in residential units

Referrals

Peamount's Continuing Care Service (extended domiciliary care, sheltered accommodation, supported living and community houses) may only be accessed **through Peamount's Rehabilitation Service**.

Only patients/clients who participate in Peamount's Rehabilitation Service can be admitted to Peamount's Continuing Care Service.

- This will limit the number of patients/clients trying to access Peamount's Continuing Care Service
- It will provide an exit for some patients/clients in Peamount's Rehabilitation Service, who need continuing care following their rehabilitation

However, in developing our Continuing Care Service, we will need to ensure that the Rehabilitation Service does not become used primarily as a means of accessing Peamount's Continuing Care Service.

The Continuing Care Service will be offered primarily to patients/clients living within the **ERHA area**.

Rationale for Peamount providing a Continuing Care Service

It is important that Peamount provide some continuing care, in addition to its rehabilitation service, as:

- This will enable Peamount to provide a continuum of care, from rehabilitation to continuing care, for certain patients/clients. It will provide certain patients/clients who need continuing care (on completion of their rehabilitation programme) with this care.
- Peamount has developed leading expertise in continuing care for certain care groups.
- Such a service should help to release some patients from acute hospitals to a more appropriate service.

5.2.4 Peamount's future TB / Respiratory Service

Pulmonary Rehabilitation will be an integral part of Peamount's Rehabilitation Service. This will involve caring for patients / clients with:

- Chronic bronchitis / chronic obstructive pulmonary disease (COPD)
- Emphysema
- Thoracic surgery (pre and post-op service)

The service will be provided through a combination of inpatient assessment and treatment, followed by outpatient visits. It will include for example:

- An assessment unit for LTOT (Long term domiciliary oxygen therapy), NIV (Non invasive ventilation / ventilatory support) and Sleep Apnoea
- A number of inpatients beds
- An outpatient department
- Outreach services into the community
- A leading role on smoking cessation programmes

After careful deliberation, the Board of Peamount has decided that Peamount should not pursue **the Chest Hospital Option**, as it does not fit with Peamount's Rehabilitation / Independent Living vision for the future.

The Chest Hospital Option would have involved Peamount providing a broad TB and Non TB Respiratory service as part of a joint respiratory service between St James Hospital and Peamount.

A transition plan for the Chest Hospital will be developed, outlining exactly what will happen to Peamount's TB and Non TB Respiratory service.

Chest Hospital Option

A TB Respiratory service, including:

- An inpatient service (approx. 15 inpatient TB beds) – for people with extensive social and medical needs and / or with Multi-drug resistant (MDR) TB and drug toxicity complications
- Specialist Unit for MDR TB
- An outpatient department for continuing care / rehabilitation
- Implementation of DOTS (Directly Observed Therapy Short-course)
- Outreach services into the community for DOTS (primarily nurse delivered)
- Training unit for healthcare professionals
- A research department
- An international training, development and research role in TB, particularly in underdeveloped countries

A Non TB Respiratory service

Providing care for :

- Respiratory infection (chronic lung disease)
- Lung cancer management, including palliative care

Including:

- Approx. 15 inpatient beds, acting as supplementary acute beds for St. James's respiratory acute service, (seasonally adjusted)
- Establishment of a Tobacco Control Research Institute, with the Office of Tobacco Control

A transition plan for the Chest Hospital will be developed, outlining exactly what will happen to Peamount's TB and Non TB Respiratory service.

5.3 Implications for our existing services

It is vitally important that, as we seek to develop our future services (as described in section 5.2), we maintain and, where possible, enhance the quality of care for our existing patients/clients.

Many of our existing services and facilities will be of key importance to our future services. Others will need to be changed or upgraded to enable us to provide the services we want in the future. The implications vary for each care group.

This section identifies the high-level implications of Peamount's vision and future services for our existing patients, clients and services:

- Service for Older People
- Intellectual Disability Service
- Service for the Neurologically Disabled
- TB / Respiratory Service (i.e. the Chest Hospital)

5.3.1 Implications for our Service for Older People

Patients / clients

- There are currently 46 continuing care beds for older people & 4 respite beds. This service will continue.
- Day Care Centre catering for 100 patients/clients per week will continue.
- There may be a small number of the current patients/clients in our residential units who would be suitable for rehabilitation or sheltered accommodation / community housing. Peamount will assess the needs of the current patients/clients to determine if they are appropriate for:
 - Rehabilitation
 - Sheltered accommodation / community housing

Infrastructure

- The existing wards will need to be upgraded for continuing care of the current patients/clients.
- The day care centre will be used as part of the Rehabilitation / Continuing Care service for older people in the future.
- As part of the development of the Continuing Care Service for Older People, 20 – 25 new purpose-built apartments (in one area / complex) will be developed

Staff

- Multi-disciplinary teams will be developed, including a consultant geriatrician
- There is significant potential for staff development and retraining

5.3.2 Implications for our Intellectual Disability Service

Patients / clients

- There are currently 167 places for adults with intellectual disabilities
- Over the next five years, approximately 25 intellectually disabled clients will move from the bungalows to community houses / supported accommodation in Newcastle, Clondalkin, Tallaght, etc. (Peamount will also bring in approximately 25 new adults with intellectual disability to the community houses).
- Approximately 60 clients will be accommodated in the bungalows (with higher staffing levels, than currently) – these would include some of the existing bungalow clients, plus some clients from St. Anne's and St. Brendan's moving to the bungalows
- Approximately 25 clients will stay in St. Anne's or St. Brendan's in the short-term until they can be accommodated in the bungalows or Fernwood / Hollybank.
- Approximately 25 clients (with higher levels of dependency) will stay in Fernwood and Hollybank.
- Peamount will continue to phase out the involvement of people with intellectual disabilities in Peamount Industries.

Infrastructure

- Peamount will phase out the use of St. Anne's and St. Brendan's gradually. Neither St. Anne's nor St. Brendan's will be suitable for the Rehabilitation / Continuing Care Service for people with intellectual disability, in the longer term.
- The bungalows will be refurbished to accommodate 6 people each (they each currently accommodate 9 - 10 people).
- The day activation centre will be used as part of the Rehabilitation / Continuing Care Service in the future. A 2nd day activation centre will be developed in the community.
- Over the next 5 years, approximately 12-15 community houses will be established (approximately 60 places).
- Services to provide access to supported employment and vocational training will be developed.

Staff

- Some of our existing staff will move into domiciliary care, community houses / sheltered accommodation, based, for example, in Clondalkin, Newcastle and Tallaght.
- Additional staff will be required to staff the community houses and the 2nd day activation centre.
- There is significant potential for staff development and retraining.
- Multi-disciplinary teams will be developed. In addition, staff to co-ordinate supported and open employment will be required.

5.3.3 Implications for our Service for the Neurologically Disabled

Patients / clients

- There are currently 46 beds for the neurologically disabled in Peamount.
- It is estimated that approximately 25% of the current patients/clients could go through a Rehabilitation programme and move on to continuing care in supported living apartments in the community.
- The other neurologically disabled patients/clients will need to be cared for in a continuing care residential setting. Many of these patients/clients are in their 40s; Peamount will be caring for them for another 20 years.
 - They will be cared for in a high quality residential unit, on the Peamount site (St. Brid's, upgraded), for people with higher levels of neurological disability.
 - As the current patients/clients leave St. Brid's, they will be replaced by other neurologically disabled patients/clients, who have come through the Rehabilitation Service.

Infrastructure

- St. Brid's will be upgraded so it is suitable for use as the residential continuing care unit, in the future.
- St. Mary's will be closed as soon as more appropriate accommodation is developed by Peamount.
- Supported living apartments will be developed in the community (10 places within 5 years: growing to 15 places within 10 years).
- A new day care / activation centre (catering for 10 – 15 people per day) will be established.
- Services to provide access to supported employment, vocational training and rehabilitation training will be developed.

Staff

- Some staff will move to the supported living apartments based in the community.
- There is significant potential for staff development and retraining.
- Multi-disciplinary teams will be developed. In addition, staff to co-ordinate supported and open employment will be required, including input from a neurologist or rehabilitation physician and paramedical staff.

5.3.4 Implications for our TB / Respiratory Service, i.e. the Chest Hospital

A transition plan for the Chest Hospital will be developed outlining exactly what will happen to Peamount's TB and Non TB Respiratory Services. The transition plan will determine how our staff will transition to other services, medical cover arrangements and the timeframe for ceasing TB and Non TB Respiratory Services in Peamount.

Many of the Chest Hospital staff will play a leading role in the development of Pulmonary Rehabilitation, which will be an integral part of Peamount's Rehabilitation Service, building on their expertise developed in the Chest Hospital. Other Chest Hospital staff may decide to avail of some of the exciting opportunities arising from the development of our Rehabilitation and Continuing Care services.

We will assess the facilities currently used by the Chest Hospital to determine how they can best be put to use in developing our Rehabilitation and Continuing Care services.

Having described what we want Peamount to be in the future, we need to establish how we will get there. The following chapter details Peamount's strategic goals for the next 5 years. The goals are supported by an action plan which outlines specific tasks, responsibilities and timeframes to ensure we achieve our goals.

We have also detailed the key milestones for implementation of the strategy and some issues relating to the successful implementation of the strategy and managing the transition.

Chapter 6

How will we get there

Our vision statement and the description of our future services clearly outlines how we see our services developing. We also understand what this vision of the future means for our existing services. The question then becomes 'how will we get there?'

Over the next five years, we will take substantive steps towards our vision of the future. We have identified 7 strategic goals that will help us to achieve our vision. We will deliver on these goals within the five year timeframe of this strategy (2003 – 2008).

For each strategic goal, we have an agreed set of actions. These actions identify what we will do over the next five years, the service / area that is responsible for each action and when it will be completed.

Peamount's Vision for the future, goals and actions



OUR VISION

We will provide a range of high quality health and social care services to enable adults to live more independently

6.1. Our strategic goals

We have identified 7 strategic goals that will help us to achieve our vision. We will deliver on these goals within the five year timeframe of this strategy (2003 – 2008).

Our strategic goals

Rehabilitation



1. We will develop our Rehabilitation Service, providing:

- Intensive residential rehabilitation
- Community-based rehabilitation
- Home-based support

to the following care groups:

- Adults with Neurological Disability
- Adults with Pulmonary Disabilities
- Adults with Intellectual Disability
- Older People

Continuing Care



2. We will develop a Continuing Care Service, through:

- Sheltered accommodation and supported living within the community
- Assisting those living at home to remain at home
- Providing high dependency residential care

Staff



3. We will develop our staff

- Providing appropriate training and development
- Enhancing the existing skills mix to ensure an excellent quality of care, in a safe and fulfilling environment

Transitional arrangements



4. While developing our services, we will facilitate a smooth transition for:

- Our existing patients/clients - continuing to provide excellent care
- Our staff - enabling them to fully participate in the opportunities arising from our future services, while maintaining the high quality of care currently provided
- Our facilities – maintaining and developing our facilities to the required standards

Partnerships



5. We will work in partnership with other healthcare and social care providers to deliver a dynamic and evolving service, which meets the needs of the community.

Organisational development



6. We will have appropriate structures and processes to allow effective management and operation of our services.

Financial resources



7. We will acquire the appropriate financial resources to fund our strategy and apply them effectively to ensure value for money.

6.2. Our action plan

We have developed a high level action plan, which identifies what we will do, over the next five years, in order to achieve our goals.

For each goal, we have identified

- a number of high-level actions
- the service / function / area which is responsible for delivering on each action
- when each action will be completed.

This Action Plan is a “living” document that will change and be updated as we make progress in terms of implementing our strategy. The plan is more detailed in terms of the actions to be taken in the short-term. Many of the actions identified below, for the short term, will lead on to other actions.

| | | |
|--|--|---|
| <p>Goal 1. Rehabilitation</p> <p>We will develop our Rehabilitation Service, providing</p> <ul style="list-style-type: none"> • Intensive residential rehabilitation • Community-based rehabilitation • Home-based support | <p>to the following care groups:</p> <ul style="list-style-type: none"> • Adults with Neurological Disability • Adults with Pulmonary Disabilities • Adults with Intellectual Disability • Older People |  |
|--|--|---|

| Goal | ACTION | Responsibility (by service / function area) | End date |
|------|--|---|----------------|
| 1.1 | Assess facilities within Peamount which could be used as a Rehabilitation Unit | Maintenance | September 2003 |
| 1.2 | Define the precise staffing numbers and skill mix required for the Rehabilitation Unit – including medical, nursing, paramedic and support staff | Nursing Mgmt, Finance | September 2003 |
| 1.3 | Develop a proposal (capital and revenue) for the Rehabilitation Unit, and submit it to the ERHA | Mgmt Team, Maintenance, Finance | September 2003 |
| 1.4 | Define the specifics of the Rehabilitation Service which will be provided to older people and people with intellectual disability or neurological disability, living at home | Nursing Mgmt Paramedical staff | December 2003 |
| 1.5 | Assess facilities within Peamount which could be used as a Transition bungalow | Maintenance, Nursing Mgmt | September 2003 |

Goal 2. Continuing Care

We will develop a Continuing Care Service through:

- Sheltered accommodation and supported living within the community
- Assisting those living at home to remain at home
- Providing high dependency residential care



| Goal | ACTION | Responsibility (by service / function area) | End date |
|------|--|---|---------------|
| 2.1 | Agree which of the current facilities used for Continuing Care need to be upgraded and how | Nursing Mgmt, Maintenance | December 2003 |
| 2.2 | Define the specifics of the Continuing Care Service which will be provided to older people and people with intellectual disability or neurological disability, living at home | Nursing Mgmt | December 2003 |
| 2.3 | Develop proposals on the upgrading of facilities, for submission to the ERHA, as appropriate | Nursing Mgmt, Maintenance, Finance | March 2004 |
| 2.4 | Decide on locations, and explore options, for community based continuing care accommodation, in the surrounding towns / areas, including: <ul style="list-style-type: none"> • Single bed apartments for older people • Community houses for adults with intellectual disability • A 2nd Day Activation Centre for adults with intellectual disability • Supported living apartments for adults with neurological disabilities | Nursing Mgmt, Maintenance, Finance | June 2004 |

Goal 3. Staff

We will develop our staff

- Providing appropriate training and development
 - Enhancing the existing skills mix
- to ensure an excellent quality of care, in a safe and fulfilling environment.



| Goal | ACTION | Responsibility (by service / function area) | End date |
|------|---|--|------------------------------|
| 3.1 | <p>Develop a HR strategy, covering for example</p> <ul style="list-style-type: none"> • Recruitment and retention • Training and education • Performance management • Recognition and reward • Staff relations • Communication | HR, Management Team | March 2004 |
| 3.2 | <p>Specify the staffing numbers and skill mix required to support all of Peamount's services over the next five years, including:</p> <ul style="list-style-type: none"> • Medical staffing • Nurses • Care staff • Paramedic staff – Physiotherapists, Occupational Therapists, Social Workers, Speech & Language Therapists, Psychologists, etc. • Support services, including for example, catering, maintenance, housekeeping and administration | CEO, Medical Staff, Nursing Mgmt, Finance | June 2004 |
| 3.3 | Secure approval from the funding agencies for the staffing levels (agree priorities, phasing of posts, etc.) | CEO, Finance | June 2004 |
| 3.4 | Enter discussions with the relevant hospitals and agencies to agree medical staffing and cover for the different services (e.g. in relation to consultant sessions, junior doctors, GP's, etc.) | CEO, Medical Staff | December 2003 and ongoing |

Goal 4. Transitional arrangements

While developing our services, we will facilitate a smooth transition for:

- Our existing patients/residents - continuing to provide excellent care
- Our staff - enabling them to fully participate in opportunities arising from our future services, while maintaining the high quality of care currently provided
- Our facilities – maintaining and developing our facilities to the required standards



| Goal | ACTION | Responsibility (by service / function area) | End date |
|------|--|---|----------------|
| 4.1 | Develop and agree a transition plan for the Chest Hospital | Medical staff, CEO | September 2003 |
| 4.2 | Complete assessments of all existing patients / clients to determine who would be suitable for a rehabilitation programme, sheltered accommodation, supported living or community houses | Each Service | June 2004 |
| 4.3 | Develop a training and development programme to support staff in developing and maintaining the required skills | HR | September 2004 |
| 4.4 | Develop a maintenance plan to ensure existing buildings are maintained to the appropriate standard during the transition period | Maintenance | March 2004 |

Goal 5. Partnerships

We will work in partnership with other healthcare and social care providers to deliver a dynamic and evolving service, which meets the needs of the community



| Goal | ACTION | Responsibility (by service / function area) | End date |
|------|--|---|---------------------------|
| 5.1 | Meet with other providers to present Peamount's strategy and discuss opportunities to develop services collaboratively | CEO, Management Team | December 2003 and ongoing |
| 5.2 | Meet with local / voluntary groups to discuss opportunities to collaborate on community and home based care | CEO, Management Team | December 2003 and ongoing |
| 5.3 | Identify and actively participate in relevant representative and professional associations | CEO, Management Team | December 2003 and ongoing |

Goal 6. Organisational development

We will have appropriate structures and processes to allow effective management and operation of our services.



| Goal | ACTION | Responsibility (by service / function area) | End date |
|------|---|---|------------------------------|
| 6.1 | Review existing corporate governance arrangements: <ul style="list-style-type: none"> Board role and membership Role and membership of Board Sub-Committees | Board Chair and Vice-Chairs | December 2003 |
| 6.2 | Review Management structure <ul style="list-style-type: none"> Management Team role and membership, reporting arrangements and decision making authority Management structure of the services | Board Chair, Vice-Chairs & Management Team Management Team | September 2003 March 2004 |
| 6.3 | Develop a PR plan in light of new developments | CEO, Management Team | March 2004 |
| 6.4 | Review and update promotional material produced (annual reports, use of name 'Peamount Hospital', etc.) | CEO, Management Team | March 2004 |
| 6.5 | Review corporate structure and legal entity | CEO, Management Team | June 2004 |

Goal 7. Financial resources

We will acquire the appropriate financial resources to fund our strategy and apply them effectively to ensure value for money.



| Goal | ACTION | Responsibility (by service / function area) | End date |
|------|---|---|---------------------------|
| 7.1 | Develop detailed costings for the different services | Finance, CEO | December 2003 |
| 7.2 | Present Peamount's strategy to funding agencies, and begin discussions on funding | CEO, Management Team | December 2003 and ongoing |
| 7.3 | Identify and assess options for funding the development of the different services. | Finance, Management Team | June 2004 |
| 7.4 | Agree approach to generation of additional income /fund raising, in addition to annual allocation | CEO, Management Team | June 2005 |
| 7.5 | Decide on approach to devolving budgets to services | Finance, Management Team | December 2004 |
| 7.6 | Develop and distribute management information (activity and financial) | Finance, Management Team | June 2005 |

6.3 Key Milestones

We have identified the key milestones, for the first two years of the strategy. They are outlined in the table below.

Further investment will be required to implement the strategy.

In order to deliver on this ambitious timeframe, additional skills and resources will be needed to support the implementation of the strategy. This will involve utilising the significant expertise of our management and staff, as well as some specialist expertise, brought in from outside to assist on certain activities.

| KEY MILESTONES | | | |
|--------------------------------------|---|--|--|
| GOAL | BY DECEMBER 2003 (within 6 months) | BY JUNE 2004 (within 1 year) | BY JUNE 2005 (within 2 years) |
| 1. Rehabilitation | <ul style="list-style-type: none"> Decision on the facilities that will be used for the Rehabilitation Unit, and the staffing required Proposal for Rehabilitation Unit submitted to the ERHA | | |
| 2. Continuing Care | <ul style="list-style-type: none"> Decision on continuing care facilities to be upgraded | <ul style="list-style-type: none"> Decision on the location and number of community based continuing care accommodation units Proposals on upgrading of existing facilities developed and submitted to ERHA | |
| 3. Staff | | <ul style="list-style-type: none"> HR Strategy developed and agreed Details on staffing numbers and skills mix required for each service developed | |
| 4. Transitional arrangements | <ul style="list-style-type: none"> Transition plan for Chest Hospital agreed | <ul style="list-style-type: none"> Maintenance plan developed (to ensure existing buildings are maintained to the appropriate standard) Assessments conducted of all existing patients / clients to determine their suitability for rehabilitation, sheltered accommodation or supported living in the community | |
| 5. Partnerships | <ul style="list-style-type: none"> Meetings conducted with funding agencies and other providers to explain Peamount's strategy and explore opportunities for working together | | |
| 6. Organisational development | <ul style="list-style-type: none"> Review of Board, and Board sub-committees', role and membership complete Review of Management Team role and membership complete | <ul style="list-style-type: none"> Review of management structure of each service complete PR Plan complete and promotional material updated Review of corporate structure and legal entity complete | |
| 7. Financial resources | <ul style="list-style-type: none"> Detailed costings for each service developed | <ul style="list-style-type: none"> Options for funding the development of the different services identified | <ul style="list-style-type: none"> Approach to devolving budgets to services agreed Approach to generating additional income / fund raising agreed |

6.4 Managing the transition

Implementing our strategy will involve a significant amount of change for our services, our staff and our facilities. This change provides us with an opportunity to deliver an even higher quality of care to our patients/clients, and to develop our own skills and careers. We will need to actively manage the risks associated with our strategy. We must ensure that the transition between today and the future is as smooth as possible.

Staff

Successful implementation of Peamount's vision and our Rehabilitation and Continuing Care Services will require the ongoing commitment and support of our staff. A number of new roles and skill sets will be required to deliver our strategy. The future described will involve new ways of working and opportunities for many staff. We will also need to recruit new staff. We are committed to training and developing our existing staff so that they may continue to play a key part in Peamount's future.

Facilities

A number of new facilities will be required to ensure effective delivery of the service. Where appropriate, existing facilities will be up-graded. In some cases, the role of certain facilities may change substantially.

Funding

Substantial capital investment will be needed to develop the facilities required for the range of services planned. The annual cost of running our service will increase over the course of the strategic plan (mainly due to increased staff numbers). The Management Team and Board will work closely with the ERHA and other agencies to secure the funding required.

Given the uncertain economic environment in which we will be working, it may not be possible to secure all of the funding necessary from public sources. We may, therefore, need to look at supplementary sources of funding to complement the public funding. The Board of Management and the Management Team will be responsible for ensuring that adequate funding is in place prior to the implementation of each major phase.

Leading and managing the change

The management team will be responsible for leading and managing the implementation of our strategy. Each member of staff also has a key role to play in implementing the strategy.

The Action Plan will be used to drive the implementation of our strategy. We will review the Action Plan regularly to identify progress made and areas which need more attention. This Action Plan will evolve over time and may need to change to reflect the different circumstances which may arise in our working environment. Regular reviews of our Action Plan will ensure it is still relevant and focused on our future direction.

We will ensure that we have the relevant expertise in place to support the implementation of the strategy. We will make use of the significant expertise of our management and staff, as well as some specialist expertise, brought in from outside, to assist on certain activities.

Successful organisations, delivering on visionary and exciting strategies, share a number of common characteristics. As an organisation, we will work hard to ensure we develop and maintain these characteristics:

- **Ownership and leadership** – Ownership and leadership from the Board and the management team is vital, and is needed on an ongoing basis.
- **Clear roles and responsibilities** – Change happens where individuals have clear responsibilities, are given a very precise mandate, and where resources are made available. People find it easier to deliver when they understand exactly what is expected of them, and also when they have a particular interest in the issue they are asked to address.
- **Clearly defined tasks and milestones** – It is easier for us as an organisation to deliver when issues are broken down into specific tasks, with names and dates beside them.
- **Clear and ongoing communication** – Changes and initiatives will be communicated to staff, and external stakeholders on an ongoing basis, right throughout the process.

a new direction...



PEAMOUNT HOSPITAL

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