

# **A practical guide to the Horwath and Teamwork Report**

## **“Securing clinically safe and sustainable acute hospital services”**

### **Horwath and Teamwork Report**

#### **1. Introduction**

“Quality and Fairness: A Health Strategy for You (DoHC 2001)” provides the foundation for the reforms in the Irish health service that have been taking place since 2001. This report by Horwath Consulting Ireland and Teamwork Management Services seeks to develop an integrated plan for transforming the health service in HSE South based on international best practice as reflected in this and other strategy documents that have rolled out in the intervening years culminating with the National Service Plan 2007.

To get the most from this report, the reader needs to see the reform of the Irish health service as a long term endeavour requiring sustained commitment and belief in the possibility of change, an endeavour whose origins predate the report and whose fulfilment nationally still lies over a far horizon. If the Irish health service is to meet the many challenges that confront it, and achieve best possible outcomes for as many of its citizens as possible, belief in transforming change and sustained effort by all to achieve it are called for in equal measure. What this report does is seek to apply international best practice, interpreted by government policy, to the reorganization of services in HSE South with particular reference to the region of Cork and Kerry.

The report is titled “Securing clinically safe and sustainable acute hospital services”. Its authors are Horwath Consulting Ireland Ltd and Teamwork Management Services Ltd and it is addressed to the HSE South Project Steering Group chaired by Professor G T Wrixon. Its primary objectives were to:

- 1.1. Identify the most appropriate model of acute hospital service provision for HSE South
- 1.2. Determine the optimal configuration of hospital services in Cork and Kerry to provide safe, sustainable, cost effective and high quality services
- 1.3. Determine the optimal supporting governance structure for these services
- 1.4. Draw up an action plan to move safely from today’s model of care to a model based on international best practice.

Some time into their task, the authors were asked to add two further objectives to ensure proper integration with those elements of primary and continuing care that interface with the acute hospital sector. These were:

- 1.5. Estimating the future resources that PCCC will need to provide a service that will safely avoid unnecessary acute admissions and safely promote early discharge, and
- 1.6. Identifying PCCC actions required for integrating its services in the best possible way into the action plan.

## 2. Sources of information and opinion

- 2.1. Results of a fact finding programme supplemented by written submissions.
- 2.2. Latest studies on international best practice
- 2.3. Views and comments of the Project Steering Group (chaired by Professor Wrixon)
- 2.4. Intimate knowledge of the Teamwork independent review of acute hospital services in the North East (2006)
- 2.5. Awareness of the need to integrate academic and clinical dimensions of service reconfiguration, and
- 2.6. Knowledge of the many pre-hospital services needed to deliver optimal acute hospital services.

## 3. The structure of the document

The report is set out in 8 sections, the headings for which are in large format white on a grey background. A “chapter” nomenclature is not used so it can be slightly difficult to navigate through the document until you notice that the section headings are in italics on the top right hand header of each page. In most sections, grey shaded summary boxes with black print follow immediately the larger section headings. These grey boxes set out the main points and are useful signposts for navigating through the report as a whole. On pages 2 – 6, preceding the eight sections, there is an executive summary that sets out the “Key Messages” The sequence is, therefore:

- pp 2 – 6: Key Messages
- pp 7 – 8: Definitions and abbreviations
- pp 9 – 13: Setting the Scene (see Introduction above)
- pp 14 – 21: The international trends in clinical practice
- pp 22 – 49: Benefits and risks in current services
- pp 50 – 65: The optimal configuration of acute and community services in HSE South
- pp 66 – 84: Understanding how the optimal configuration will improve services and practice
- pp 85 – 88: Dealing with the risks to successful transformation
- pp 89 – 107: Implementing the transformation plan for Cork and Kerry
- p 108: The benefits for patients from this new system

There are five appendices.

- pp 109 – 111: 1. Terms of Reference and Steering Group (membership)
- pp 112 – 113: 2. Site visits and interviews
- pp 114 – 133: 3. International best practice
- pp 134 – 155: 4. Current acute services in HSE South
- pp 156 – 157: 5. PCCC transformation programme

## 4. Section content

### 4.1 Key messages

- 4.1.1. a fully integrated world class health service for Cork city
- 4.1.2. a fundamental reconfiguration of the acute care system and processes for the Cork and Kerry population of 620,000 through redeployment of existing resources
- 4.1.3. an integrated clinical network managing patient flows through agreed care pathways reflective of international best practice

- 4.1.4. a service that will care for the vast majority of patients “at home or as near to home as possible” within the next five to six years.
- 4.1.5. a single “regional centre of excellence” responsible for all acute care.
- 4.1.6. a two phase implementation plan: phase 1 - transformation of services in Cork city, Bantry and Mallow; phase 2 - transformation of acute services in Kerry
- 4.1.7. recommendations for improving the efficiency of current services
- 4.1.8. outline recommendations for the South East with a strong recommendation for further study.
- 4.1.9. anticipated benefits of real improvement for patients and greater job satisfaction for staff.

#### **4.2 The international trends in clinical practice**

International best practice is presented as a functioning network of local and regional “centres of excellence” with an integrated approach to academic medicine, education, teaching, training and research across both the local and regional centres. Regional centres provide tertiary acute care for the relatively small number of cases requiring complex medical/surgical intervention; local centres provide much of the clinical activity that was previously hospital based including ambulatory care, day surgery, chronic disease management, diagnostics, rehabilitation and step up/step down care. Consultants are organized in specialty teams based in the regional centres providing visiting consultant services to the local centres. There are useful explanatory charts on pages 16 – 19, and particularly two charts on page 16 that compare the situation in Ireland 2007 with the optimal configuration from international best practice.

#### **4.3 Benefits and risks in current services**

This section provides a series of Figures demonstrating how current services fail to meet the international standards for critical mass of population and consultant numbers by specialty. The analysis is based on the principle that there is a critical mass relationship that matches the size of workforce to the size of catchment population to deliver the best clinical outcomes in acute care delivered 24/7. The optimum ratio is deemed to be a team of 8 consultants to a population of 350,000 to 500,000. Lower numbers of consultants cannot provide international best practice outcomes, nor cover for a 24/7 service and lower populations cannot provide the patient caseload to sustain international best practice skill levels in the consultant team. The only specialty that currently meets this standard in Cork and Kerry is Obstetrics.

#### **4.4 The optimal configuration of acute and community services in HSE South**

The optimal configuration for HSE South (total population of 1.09million) is seen in terms of two regional centres of excellence, one in Cork and one in Waterford, and “up to 10” local centres of excellence, five associated with each regional centre. The references to the South East are not intended to be more than passing references; the outline for a more detailed study is set out at the end of this section (p.65). The optimal model for Cork and Kerry is proposed on p.54 as:

- 4.4.1. Enhanced general practice, primary care and community services;
- 4.4.2. Five “local centres of excellence” in North Lee, South Lee, North Cork, West Cork and Kerry with populations ranging from 180,000 (South Lee) to 53,000 (West Cork);
- 4.4.3. One “regional centre of excellence” in CUH;
- 4.4.4. Improved emergency services including an Advanced Paramedic Ambulance Service and an Advanced Helicopter Air-ambulance Service;
- 4.4.5. An active clinical/academic alliance or partnership;
- 4.4.6. Community midwifery and home birth service based in Kerry, and
- 4.4.7. A new governance structure for the region.

Each of these elements is elaborated and the challenges of the change agenda are addressed on pp 58 and 59. The concept of the 'Academic Medical / Health Sciences Centre' is put forward on pp 62 and 63 as the model most likely to deliver and sustain the transformation of the health service in Cork and Kerry.

#### **4.5 Understanding how the optimal configuration will improve services and practice**

This section provides supporting arguments for the model of care presented in the previous section. Optimisation of patient flows, reduction of inappropriate admissions and shorter lengths of stay will require a transfer of resources to strengthen Primary Care Teams and Home Care Packages, provide extra therapy support for rehabilitation, hospice care, mental health care and improved diagnostics. This transfer of resources is quantified on p74. The second half of this section demonstrates how clinical networks will provide improved care through better co-ordination. The networks with their organizational infrastructure are:

4.5.1. Emergency care network (adult and children)

4.5.2. Critical care network

4.5.3. Planned care network

4.5.4. Cancer care network

The section concludes with five imagined 'scenarios' describing the experience of patients before and after the transformation. These scenarios provide useful comparative examples of how the envisaged system would contrast with the existing system.

#### **4.6 Dealing with the risks to successful transformation**

This is a risk management section that identifies the preconditions necessary before each element of the new system is introduced. Risks include premature withdrawal of current services; lack of good project management; failure to deliver related strategies and failure to deliver supporting infrastructures. Successful management of these risks is a prerequisite to success. Specific sections deal with:

4.6.1. Robust project management;

4.6.2. Pre-hospital services necessary for the reconfiguration of acute care;

4.6.3. Essential infrastructure for acute and community care, including formal teamworking;

4.6.4. A network programme for education, teaching, training and research;

4.6.5. Effective management of patient information.

#### **4.7 Implementing the transformation plan for Cork and Kerry**

4.7.a A detailed implementation plan is presented that proposes five elements.

4.7a.1. Continue to make existing services safer for patients;

4.7a.2. Establish a steering group, a joint planning forum, new governance arrangements and code of practice, a clinical academic alliance and a project management team.

4.7a.3. At an early stage, conduct a risk assessment to ensure all the bullets identified in "Dealing with the risks to successful transformation" are in place in good time;

4.7a.4. Secure substantial improvements in current operational performance;

4.7a.5. Develop a workforce education plan to support new service configuration.

4.7.b High level appraisal and site feasibility tables are presented for each of the potential sites for local centres of excellence. Resources for PCCC, regional and local centres and revenue cost elements are identified though not quantified. A preparation plan for the first six months is presented based on the experience of the North East Transformation programme, as follows:

4.7b.1. Establish small steering group chaired by an HSE executive director;

- 4.7b.2. Conduct a risk assessment and take actions to ensure all strategies necessary to develop pre-hospital services and new service infrastructures are in place in good time.
- 4.7b.3. Establish a joint planning forum with all stakeholders in order to develop and implement:
  - a. Formal partnership working;
  - b. New governance system and process
  - c. A clinical academic alliance committed to excellence.
- 4.7b.4. Establish a transformation programme structure with access to all expertise covering:
  - a. programme management,
  - b. project planning and management,
  - c. clinical service/network development,
  - d. workforce development,
  - e. clinical support specialties,
  - f. infrastructure development,
  - g. procurement,
  - h. estates management,
  - i. finance,
  - j. HR,
  - k. media and communications.
- 4.7b.5. All existing acute hospitals need to be charged with taking steps to improve operational efficiency with a view to releasing some 29% - 40% of existing bed capacity as an important preparatory step to capacity planning required for the transformation programme.

Examples of key actions are given in a series of tables at the end of this section (pp 99 to 107).

#### **4.8 The benefits for patients from this new system**

This section summarises the benefits to the patient such as, for example:

- 4.8.1. Safe, sustainable high quality local and regional services operating to international standards with systems in place to monitor, report and verify compliance with these standards.
- 4.8.2. More and better care accessible at home.
- 4.8.3. Fewer unnecessary visits to the 'regional centre of excellence'.
- 4.8.4. Receiving care from a better organized and supported workforce with improved facilities, better training and education and a keener awareness of research and the evidence base.
- 4.8.5. Better communications;
- 4.8.6. Higher quality specialist care on a 'round the clock' basis.

#### **4.9 Appendices 1 – 5 as listed in 3 above**