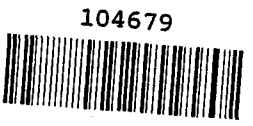
THIRD REPORT

DUBLIN HOSPITAL INITIATIVE GROUP

February, 1991



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P.23278 Gr. 30-01 3/91 1,500 Brunswick Press Ltd.

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INTRODUCTION

1.1 *Action Programme for the Health Services*

On the 6th February, 1990 the Minister for Health, Dr. Rory O'Hanlon T.D., announced an Action Programme for the Health Services for 1990 and beyond.

The Action Programme included a Dublin Hospitals Initiative — to improve the integration and efficiency of the acute Dublin hospital services.

1.2 *Dublin Hospital Initiative Group — Membership*

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

The following were appointed members of the Action Group:

1. Professor David Kennedy (Chairman)	Deputy Governor, Bank of Ireland
2. Dr. Conor Burke	Consultant in Respiratory Medicine, James Connolly Memorial Hospital
3. Professor Davis Coakley	Consultant in Geriatric Medicine, St. James's Hospital
4. Mr. Liam Dunbar	Chief Executive, St. James's Hospital
5. Dr. Joseph Ennis	Consultant Radiologist, Mater Misericordiae Hospital
6. Dr. Brid Fallon	General Practitioner
7. Professor Muiris FitzGerald	Consultant Physician, St. Vincent's Hospital
8. Mr. Austin Groome	Chairman, Meath Hospital, former Chairman, Eastern Health Board
9. Mr. David Hanly	Chairman, Comhairle na nOspideal
10. Mr. Kieran Hickey	Chief Executive Officer, Eastern Health Board

11.	Dr. Gerard Hurley	Consultant Radiologist, Meath Hospital
12.	Professor Michael MacCormac	Chairman, St. Vincent's Hospital
13.	Mr. Michael McLoone	Chief Executive, Beaumont Hospital
14.	Mr. Gearoid MacGabhann	Chief Executive, Mater Misericordiae Hospital
15.	Mr. Declan Magee	Consultant Surgeon, St. Colmcille's Hospital, Loughlinstown
16.	Ms. Eileen Mansfield	Matron, Adelaide Hospital
17.	Dr. John Mason	General Practitioner
18.	Dr. Brian O'Herlihy	Director of Community Care, Eastern Health Board
19.	Mr. Desmond Rogan	Secretary/Manager, Adelaide Hospital
20.	Mr. Niall Weldon	Chairman, Beaumont Hospital
21.	Mr. Leo Vella	Consultant in Accident and Emergency, Beaumont Hospital

The Secretariat to the Group was provided by the Department of Health.

Mr. Dermot McCarthy (Secretary)

Mr. Paul Griffin

Mr. Shay McGovern

Ms. Patsy Carr

Ms. Caroline Field

1.3 *Inaugural Meeting and Terms of Reference*

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

The Minister asked that the initial report from this initiative would be presented to Government before the Summer Dail recess.

The hospitals covered by the exercise are:

Mater Misericordiae Hospital

James Connolly Memorial Hospital

Beaumont Hospital

St. James's Hospital

Meath Hospital

Adelaide Hospital

St. Vincent's Hospital

1.4 *Reports Issued*

The Group has completed three reports to date.

1.4.1 *Interim Report (June 1990)*

The recommendations fall under three main headings:

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

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

— critique of existing organisational structure in Dublin.

Following the presentation of the Interim Report, the Group continued in existence to complete the following tasks:

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

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

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

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

1.4.2 ***Proposed Organisational Structures***

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

1.4.3 ***Geriatric Services***

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

1.4.4. ***Scope of this Report***

The issues dealt with in this Report are:

— Out-Patients Services;

— In-Patient Waiting Lists;

— Geriatric Services;

— Referral of patients from outside the Dublin area;

— Implementation of the Group's recommendations;

These are outlined in detail in Chapters 1, 2, 3, 4 and 5 respectively. A summary of our recommendations is set out on pages ix to xvi.

SUMMARY OF RECOMMENDATIONS

Out-Patients Services

The Group recommends that:

(a) ***General***

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

2. each hospital should immediately establish, where it does not already exist, an Out-Patients Services Group, representative of medical, nursing and administrative staff to assist in the co-ordination and day-to-day operation of out-patients services and to devise strategies to tackle key problems, outlined below.

(b) ***Appointments for Out-Patients Clinics***

3. standard referral forms providing for the listing of demographic and clinical details should be issued to all G.P.s and other sources of referral and that this method should be used to the greatest extent possible in requesting appointments. Inter-hospital co-operation will be required to agree on an appropriate standard format.

4. appointments should generally be issued only by out-patients services staff.

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

6. the parameters of the booking schedule for each clinic should be reviewed regularly, and amended if necessary in the light of experience, to ensure that hospital targets for performance of out-patients clinics are attained.

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

8. booking times and intervals should be reviewed regularly to ensure that they are appropriate. Average delays experienced by patients should be reviewed and measured regularly by the Out-Patients Services Group as a key indicator of

the performance of the service. Such information should be brought to the attention of individual consultants on a regular basis.

(c) ***Non-attenders***

9. a flexible approach should be adopted in the case of non-attenders and the Out-Patients Services Group should agree a policy with consultant staff for dealing with these patients. Should patients default on their appointment, they may be offered a further appointment, if appropriate. However, persistent non-attenders should be considered to have discharged themselves from the clinic and their care should be deemed to have been referred back to their G.P..

(d) ***Reducing the level of unnecessary return attendances***

10. an active part should be taken by senior medical staff in the planning and operation of out-patients clinics.

11. each consultant should prepare practical patient-plan guidelines for junior staff to assist them in dealing with each return patient, and in discharging those no longer in need of out-patient care.

(e) ***Patient Information***

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

13. the Out-Patients Services Group should arrange a systematic regular analysis of patients' experiences and opinions, in order to determine strengths and deficiencies in the service being provided to the public.

(f) ***Staffing of Out-Patients Departments***

14. staff should be specifically chosen for assignment to the out-patients department on the basis of their suitability and commitment to the delivery of high quality care. In particular, their ability to communicate effectively with patients should be a key attribute. Staff training initiatives in this area should be introduced.

15. a significant number of nursing personnel in out-patients departments should be released from certain "non-nursing" duties through the employment of non-nursing staff as receptionists/hostesses, while, at the same time, highly trained clinical nurse specialists should have a greater involvement in out-patients clinics to enhance the level and range of clinical activity in out-patients departments.

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

(g) ***Information Technology***

17. the programme of computerisation of both pathology and radiology departments and the introduction of information transmission and retrieval systems should be accelerated.

(h) ***Review of Waiting Lists***

18. consultants should be notified regularly of the average waiting time for a routine appointment in their clinics. Furthermore, in order to minimise the disruption caused by non-attenders at clinics, each consultant's list should be regularly validated where patients are waiting 6 months or more for a first appointment.

19. details of waiting times for a first appointment in all out-patients departments should be circulated to G.P.s in the Dublin region on a regular basis. Inter-hospital collaboration will be required to effect this.

(i) ***Developing the scope of Out-Patient Care***

20. each hospital should, through the proposed Out-Patients Services Group and through their consultants, set about identifying ways of making the out-patients department more effective in dealing with patients and so further alleviate the pressure on the hospital's in-patient and day case facilities. Certain procedures, with appropriate selection of patients, could be performed in out-patients departments with appropriate organisation, staffing and facilities and thus enable more demanding cases to be dealt with in both in-patient and day case facilities. Standardised discharge letters to G.P.s would enhance the link between out-patients departments and primary care services.

(j) ***Transport***

21. hospitals should review the booking system for appointments to ensure that patients travelling to the Dublin hospitals from outside the Eastern Health Board area are given suitable appointment times.

In-Patient Waiting Lists

The Group recommends that:

(a) ***Validation of Waiting Lists***

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

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

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

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

(b) ***Scheduling Activity to Reduce Waiting Times***

5. hospitals should target unacceptable waiting times by ensuring that:

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

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

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

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

(c) ***Reviewing Activity and Throughput***

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

8. a systematic review of the scope for increasing levels of day surgery for appropriate conditions should be carried out in the hospitals covered by the Group's remit.

9. greater use of day surgery should be a significant element in hospital strategy to reach acceptable levels of waiting time for patients.

(d) ***Information Technology***

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

(e) ***Referrals***

11. G.P.s should be regularly advised of average waiting times for admission.

(f) ***Resource Allocation***

12. the achievement of acceptable waiting times for elective admissions should be sought through good practice in the validation of waiting lists and the scheduling of activity. Additional resources may be necessary if the scope for improvement through good practice measures is shown to have been exhausted.

Geriatric Services

The Group recommends that:

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

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

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

   — an acute geriatric assessment unit;

   — an active geriatric day hospital;

   — an efficient transport system;

   — a multi-disciplinary support team providing intensive nursing, occupational therapy, physiotherapy, speech therapy and medical social services.

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

4. each department of geriatric medicine should have access to sufficient rehabilitation beds to enable it to function efficiently.

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

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

7. ear-marked funding should be provided to allow for the development of properly structured departments of geriatric medicine with appropriate structural links to rehabilitation and long-stay facilities.

Arrangements for Referrals from outside the Eastern Health Board area to Dublin Hospitals

The Group recommends that:

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

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

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

Implementation and follow-up of the Group's Recommendations

The Group recommends that:

1. each hospital develop an effective quality assurance programme, with the following main elements:

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

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

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

   (d) staff development and training to support specified targets.

2. follow-up action in the short term should include:

   (a) circulation of this Report to all hospitals concerned;

   (b) the organisation of a seminar on out-patients departments and waiting lists;

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

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

4. each hospital should consider having its services — either in whole or in part — put forward for external audit for compliance with official national standards for quality service.

5. the pilot project on acute hospital and community services based in the Department of Preventive Medicine at St. Vincent's Hospital be expanded to assess the scope for reducing inappropriate use of acute hospital facilities through better linkages with primary care providers.

6. existing activity in the area of rehabilitation be reviewed and focussed on the particular problems of catering for the rehabilitation of patients who do not, or who no longer, require acute hospital care.

7. health services research should be encouraged on a continuing basis in all aspects of hospital activity.

Chapter One

OUT-PATIENTS SERVICES

1.1 Introduction

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

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

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

1.2 *Throughput*

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

1.3 *Establishment of Sub-Group*

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

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

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

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

- to develop protocols for regular monitoring and validation of the out-patients waiting lists;

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

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

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

1.4 *Approach to work*

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

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

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

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

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

1.4.2 The Sub-Group also had information on the ratio of new/return patients to out-patients departments in 1989 which highlighted the high proportion of return patients to O.P.D. (almost 80% of all attendances). Details of these attendance rates are given in Table 1.

1.4.3 Hospitals were also asked to provide information on the types of problems experienced in operating out-patients departments. These were subsequently discussed with representatives of both the nursing and administrative staff from each hospital. Following the meeting with hospital representatives, a problem-oriented questionnaire was issued to these staff. This approach had been found to be successful in previous exercises carried out by the Group. The questionnaire featured a problem list related to the progress of patients through the out-patients department. Respondents were requested to rank the various potential problem areas using a semi-quantitative scoring system. Respondents were also asked to list their Top Five Priority solutions to these problems. There was a 100% response rate by the hospital representatives which permitted a clear picture to be formed of the major problems and their priority solutions. The Group is very appreciative of the widespread co-operation it received and wishes to acknowledge the high level of commitment and interest of hospital representatives in scrutinising the deficiencies in the existing system.

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

Table 1

Out-Patient Statistics — 1989

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

1.5 *Definition of role*

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

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

1.5.3 Although some hospitals have now established Out-Patients Services Groups, representative of medical, administrative and nursing staff, most have no such structure. These Groups, where they exist, are involved in co-ordinating this service and in developing standards and protocols for the operation of the department in order to develop an effective and patient-centred service.

1.5.4 In general, there is an absence of a clear definition of the role of the out-patients department and, consequently, of operational standards and procedures by which systematically to evaluate performance. This reflects the generally traditional and unfocussed approach to out-patients services within clinical practice. We are also struck by the generally limited application of information technology in this area.

1.5.5 The principal purpose of the information systems which have been developed for out-patients departments is the registration of patients. Little use is made of the data collected for performance evaluation or review. As a result, difficulties are experienced by patients at the various stages of their association with the hospital's out-patients department. These difficulties are mirrored in the problems experienced within the hospital by all categories of staff in providing what is a very pressured service to the public. The consequences are, all too often, frustration on the part of staff and dissatisfaction and complaints from patients. Staff feel they are not providing an adequate service and patients feel that they are not receiving a quality service.

1.5.6 We outline below the principal sources of difficulty at the various stages of the interface between out-patients departments and the public. These are based on the strongly-expressed opinions of the out-patients staff with whom we consulted and on our own observations. Our recommendations in the final section are designed to address both the underlying and specific factors giving rise to these difficulties.

1.6 *Difficulties in modes of Referral to Out-Patients Clinics*

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

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

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

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

(d) by or on behalf of another consultant within the same hospital;

(e) by nursing staff on the ward on the patient's discharge on the instruction of a consultant or member of his team

(i) for a return appointment to this consultant;

(ii) for an appointment with another consultant.

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

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

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

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

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

The multiplicity of sources of referral and of requests for appointments give rise to many problems.

1.6.2 Urgent cases from the Accident and Emergency department, special G.P. representations and ward referrals are generally seen at short notice at clinics, often leading to overbooking. In addition, a significant proportion of patients may attend without appointment.

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

1.7 *Problems with Waiting Times for Appointments*

1.7.1 As already stated, the Group undertook a survey of waiting times for new out-patient appointments. Long delays are generally experienced by new patients in obtaining an appointment for certain specialties, e.g. Orthopaedics, E.N.T., Ophthalmology, where new patients can be waiting up to eight months for an appointment, depending on the nature of the problem. Hospital representatives stated that they felt these longer waiting times for appointment were totally unacceptable.

1.7.2 There were wide variations in waiting times for appointments between individual consultants, sometimes in the same specialty and hospital. The Group did not have an opportunity to research the reasons for such differences. **The Group is strongly of the view that further research into this area should be undertaken.**

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

1.8 *Problems with Appointments Systems*

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

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

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

1.9 *Problems of Delays experienced by Patients in Out-Patients Departments*

(a) *Registration*

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

1.9.2 The major problems identified in regard to registration were:

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

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

(c) patients arriving early for their appointments, despite being given an appointment time. This arises mainly because of their perception that they will be dealt with on a first come/first served basis. This causes congestion in the department;

(d) delays experienced while all relevant details are recorded for new patients, whose particulars have not been notified to the hospital when an appointment was requested.

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

(b) *Post-Registration*

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

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

1.10 *Physical Condition of Out-Patients Departments*

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

1.10.2 Another legitimate expectation on the part of patients is to be provided with adequate information on their condition and treatment, which are likely to be a source of major concern to the individual. It was strongly emphasised to the Group that, because of the level of staffing available in out-patients departments and the present organisational arrangements, patients' difficulties can be unnecessarily aggravated as a result of poor communication. Clinics, as currently organised, often do not allow staff the flexibility to provide patients with such information. Another major source of complaint by patients relates to delays in receiving treatment. Again, staff do not generally have the time to explain the reasons for such delays to patients.

1.10.3 Hospital representatives also emphasised that delays in dealing with patients in out-patients departments can arise as the result of the non-availability of charts and test/x-ray results. This problem is particularly acute where the appropriate facilities are not on-site. Ease of access to these services and an efficient communication system are crucial to the effective operation of the out-patients service. The Group's recommendations in our Interim Report relating to the computerisation of information transmission and retrieval systems would directly address this problem and would greatly facilitate more effective patient management.

1.11 *Problems with Discharge from Out-Patients Departments*

(a) *Discharge policies*

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

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

(b) *Transport*

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

1.12 *Limited Role of Out-Patients Departments*

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

1.13 *Conclusions and Recommendations*

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

1.13.2 The recommendations presented in this Report represent not only the considered views of Group members, but also the expert opinion of those involved in the delivery of out-patients services, both in Dublin and in the hospitals visited by the Group in the U.K.

1.14. *Role of Out-Patients Services*

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

1.14.2 **The Group are of the view that each hospital should immediately undertake a systematic review of their out-patients services, focussing on patient need and the manner in which the service is provided**. The objectives of this review should be to identify specific measures, including action on the points detailed in the following paragraphs, which would have the effect of making the most effective use of the resources available in out-patients departments, minimising delays for patients in receiving appointments and being seen in out-patients clinics and facilitating the earliest appropriate discharge from the care of the hospital.

1.14.3 **We recommend the immediate establishment, where they do not already exist, of Out-Patients Services Groups, representative of medical, nursing and administrative staff, to assist in the co-ordination and day-to-day operation of out-patients services**. Such groups would be initially charged with carrying out the review proposed above and with developing and maintaining:

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

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

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

Among the specific issues to be considered by these groups would be:

— the particular strategies necessary to target long waiting times for appointments;

— the need for more clinics in certain disciplines;

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

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

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

1.15 *Appointments Systems in Out-Patients Departments*

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

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

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

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

(c) reduce the long delays in registration of patients on their first visit to out-patients departments.

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

1.15.4 **We recommend that such standard referral forms should be issued to all G.P.s and other sources of referral and that this method should be used to the greatest extent possible in requesting appointments. Inter-hospital co-operation will be required to agree on an appropriate standard**

format. We recognise that this will represent a major change in the way appointments are sought by patients and their family doctors. However, we are convinced that the benefits to patients and referring doctors will make the process of change worthwhile. The arrangement which we recommend, while resulting in a slight delay in the issue (but not the actual date) of appointments, would result in a major increase in the effectiveness of out-patients departments. Urgent cases could continue to be referred by phone or by marking the referral form appropriately. Consultants or their staff could then authorise the making of an urgent appointment within the booking schedule.

1.15.5 With regard to the process of issuing appointments, the objective is to provide an effective booking schedule agreed by the relevant consultant. The schedule, which should be automated, would reflect the number of patients to be booked for an individual clinic, the intervals between appointments, the ratio of new to return patients and the provision (if any) to be made for very urgent cases without appointment. **For the booking schedule to operate with the greatest effect, we consider that all appointments should be issued by out-patients staff**. However, where booking systems and the supporting information technology facilitate it, some appointments could be made by other hospital staff within a common booking schedule.

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

1.15.7 **Patients who arrive at out-patients departments without an appointment should, in general, not be seen since to do so is to undermine the effectiveness of the clinic system**. In cases where the issue of a future appointment would not be sufficient, the patient could be referred to the Accident and Emergency department or seen in the out-patients clinic at a time reserved for urgent cases on the booking schedule.

1.15.8 **We are convinced that the issue of specific appointment times, rather than block-booking of patients, is the appropriate method of organising out-patients services**. While accepting that patients may not always be seen on time or may not arrive at the appropriate time, the issue of specific times for attendance is the minimum to be expected of a patient-centred service which is, in a very real sense, the "shop-window" of the hospital. **Booking times and intervals should be reviewed regularly to ensure that they are appropriate. Average delays experienced by patients should be reviewed and measured regularly by the Out-Patients Services Group as a key indicator of the performance of the service**. Such information should be brought to the attention of individual consultants on a regular basis.

1.16. *Failure of Patients to attend for Scheduled Appointments*

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

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

1.17. *Commitment to Out-Patients Clinics*

1.17.1 The implications for patient care of cancelled clinics and the late start of clinics have already been documented. Problems which are likely to restrict clinic activity, such as staff leave, should be notified to out-patients staff as early as possible to enable bookings to be restricted. For similar reasons to those outlined in our Interim Report in relation to the need for dedicated "on-take" teams for A & E, **we recommend that, on the days on which consultants hold clinics, these clinics should be regarded as the first priority of consultants and their teams**. Competing commitments in A & E, theatre and in-house should be kept to the minimum.

1.17.2 We are of the view that many consultants do not have an explicit specific set of objectives for the care of their patients attending the out-patients department. In particular, the re-attendance of the large majority of patients who are return patients may indicate that more structured arrangements for planning out-patients clinics could reduce the volume of attenders and consequent delays for patients, while increasing the benefit of attendance for individual patients.

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

1.18. *Information to Patients*

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

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

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

1.19. *Staffing*

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

As a general principle, we recommend that staff should be specifically chosen for assignment to the out-patients department on the basis of their suitability and commitment to the delivery of high quality care. In particular, their ability to communicate effectively with patients should be a key attribute. Staff training initiatives in this area should be introduced.

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

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

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

1.21. *Management of Waiting Lists*

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

— consultant or staff review of all referrals;

— consultant or staff review of all referrals marked urgent;

— out-patients staff responding to G.P. requests.

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

1.21.3 **One of the key elements of good practice is for consultants to be notified regularly of the average waiting time for a routine appointment in their clinics. Furthermore, in order to minimise the disruption caused by non-attenders at clinics, each consultant's list should be regularly validated where patients are waiting more than a target period for a first appointment**. Initially, this should be done when patients are waiting for 6 months or more. It is likely that some proportion of these will no longer require treatment, having been dealt with elsewhere or otherwise being no longer interested in attending. Such cases, besides artificially increasing the average waiting time,

directly affect the speed with which other patients who require care can be seen. Validation would require the routine issue of letters to patients waiting 6 months or more and the application of an agreed procedure to deal with those who fail to reply or who state that they are no longer interested in attending.

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

1.22. *Development of the Out-Patients Service*

1.22.1 The Group has already recommended that each hospital set out clear principles of care and operational procedures for their out-patients department. The Group also recommended the establishment of a structure — an Out-Patients Services Group — to oversee the implementation and management of these procedures.

1.22.2 **Each hospital should, through the proposed Out-Patients Services Group and through their consultants, set about identifying ways of making the out-patients department more effective in dealing with patients and so further alleviate the pressure on the hospital's in-patient and day case facilities.** The Group is aware of certain hospitals where diagnostic, investigative and routine surgical procedures are carried out in the out-patients department, particularly in the areas such as oncology and diabetes clinics, which might otherwise require admission to a bed.

1.22.3 Hospital-based reviews should consider the manner in which out-patients services can complement and support primary care services. Out-patients departments should not undermine the scope of general practitioners in managing patient care and G.P. access to diagnostic services should be as streamlined as possible. In particular, **we recommend that hospitals should standardise arrangements for the issue of discharge letters to G.P.s when out-patient care has been completed.** This should cover areas of diagnosis and treatment which will enable the G.P. to provide effective continuing care for the patient.

1.22.4 A significant number of procedures, currently carried out on an in-patient basis or in day-case units, could be performed in out-patients departments with appropriate organisation, staffing and facilities. **Such procedures, with appropriate selection of patients, would enable more demanding cases to be dealt with in both in-patient and day case facilities, thus reducing delays for the patients concerned.**

1.22.5 In the course of its review of out-patients services, hospitals, through their Out-Patients Services Group, should consider surveying each of the clinicians to ascertain what further services could be offered to patients in this department, whether any additional facilities or staff will be required and the likely savings that would result from their introduction. Proper planning and targetting of patients would be crucial if hospitals were to ensure the effectiveness of this expanded service. The rotation of specialist staff, especially clinical nurse specialists, from in-patient departments to out-patients clinics would be necessary. This highlights the

need for careful planning of the out-patients workload through the adoption of the inter-related good practice proposals set out in this Report.

1.23 *Transport*

1.23.1 In our Interim Report, the Group stated that the present routine transport arrangements do not cater adequately for the needs of hospitals and that a specific level of service to hospitals be explored between the relevant authorities.

1.23.2 **We further recommend that hospitals review the booking system for appointments to ensure that patients travelling to the Dublin hospitals from outside the Eastern Health Board area are given suitable appointment times**. In addition, hospitals should endeavour to ensure that, where patients are required to wait for some time before being collected by the ambulance service, they are aware of snack bar and other facilities provided in the department for their comfort.

Chapter Two

IN-PATIENT WAITING LISTS

2.1 *Introduction*

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

2.1.2 In our Interim Report, submitted in June 1990, we made various recommendations to increase the effectiveness of the management of patients presenting at Accident and Emergency departments. We also recommended changes in the management of admission and discharge for elective patients. In our recommendations on geriatric services in Chapter 3, we propose developments in arrangements for the acute management of geriatric admissions. All of these recommendations would have the effect of reducing the level of inappropriate usage of acute hospital beds, thus facilitating admission of those patients requiring such facilities, particularly patients on waiting lists.

2.1.3 The Group decided that, because of the importance of ensuring that patients have access to necessary treatment within a reasonable time and because of the level of public concern at waiting lists, a special review should be undertaken of arrangements in the Dublin hospitals for dealing with in-patient waiting lists. A Sub-Group was established with the following terms of reference:

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

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

— to develop protocols for regular monitoring and validation of waiting lists;

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

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

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

2.2 *Our Approach to Waiting Lists*

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

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

(b) deterioration in the patient's condition, increasing the complexity of treatment or reducing the prospects of recovery;

(c) irrecoverable loss of patient's income because of incapacity or, in the case of children, delays in physical and educational development;

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

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

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

2.2.4 It would be widely accepted that an appropriate objective for hospital services is to provide access to necessary treatment in the minimum time possible. It is, therefore, not unreasonable to establish targets for waiting times as a guide to performance. For example, the objective of policy in the U.K., where waiting lists

are perceived to be a greater problem than in Ireland, is to reduce to the greatest extent possible the number of patients waiting more than twelve months for treatment and to ensure that, by October, 1992, no patient will be required to wait more than two years for admission. While such general targets are valuable as a guide to action, our concern is that acceptable waiting times should reflect the nature of the condition to be treated. For some cases, waiting times of more than a few weeks may be unacceptable. In other cases, such as some forms of cosmetic treatment, very lengthy delays may be acceptable.

2.2.5 Waiting time for access to necessary treatment is the appropriate focus of policy concern. It is important to clarify that such waiting times should be measured in respect of conditions and patients who could be treated immediately, were treatment facilities available. There are many patients who are diagnosed as requiring investigation or treatment but whose condition is such that they could not be treated immediately even if an immediate admission could be arranged. They should not be included in calculation of waiting lists or waiting times. These include patients suffering from chronic conditions who require periodic review and treatment and who are scheduled for admission at regular intervals. For other patients, their general state of health may make treatment impossible or undesirable in the short term. Such cases should not be included in the calculation of waiting lists when waiting times are the focus for concern.

2.3 *Waiting Lists in Dublin*

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

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

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

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

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

2.3.6 The responses to this questionnaire varied by specialty and by hospital. Analysis of the responses by specialty showed no significant variations by specialty in reported frequency of review or the extent of consultant involvement in review of lists. Formal scoring systems were most frequently used as a method of review by general surgeons and were most widely used in such disciplines as neurology, urology, vascular surgery and gastroenterology. Confirmation of a patient's wish to be treated was reported as a method of review by a minority of consultants in a wide range of disciplines.

2.3.7 Access to beds was widely reported to be a significant problem in dealing with waiting list cases. Only in ophthalmology did it appear not to be regarded as a significant problem. However, access to theatres was reported as a major problem in ophthalmology and also in neurosurgery. Staffing levels were regarded as a major problem in gynaecology, while difficulties in discharging patients was regarded particularly seriously in geriatric medicine, neurosurgery and gastroenterology.

2.3.8 Details of current waiting lists and average waiting times were sought from all admitting consultants. Consultants were asked to categorise their waiting list patients as urgent or non-urgent and, if possible, to distinguish between major, intermediate and minor treatments. Approximately 60% of those replying were in a position to reply, in whole or in part, to this question. Of these, 25 consultants reported that they had no waiting lists or operated primarily an ambulatory care service. The responses from those consultants identifying their waiting lists under some or all of the headings are summarised in Table 2.

2.3.9. There was considerable variation by specialty in the waiting times reported. Cases regarded as urgent involving major procedures were generally admitted in less than two weeks but delays of 20 weeks or more were reported in general surgery, orthopaedics, urology and vascular surgery. Urology and vascular surgery waiting times were very significantly greater than the average in the other categories of urgent treatment, with vascular surgery significantly skewing the average waiting time in the urgent but minor treatment category. Long waiting times for unclassified

urgent cases were reported in E.N.T., plastic surgery and gastroenterology. Long average waiting times were reported for non-urgent cases in urology, E.N.T., endocrinology and orthopaedics.

Table 2

	Major		**Intermediate**		**Minor**		**Unclassified**	
	Urgent	Non-Urgent	Urgent	Non-Urgent	Urgent	Non-Urgent	Urgent	Non-Urgent
No. of Consultants	55	55	31	34	20	22	8	16
Average no. of patients per consultant	18	28	20	28	13	27	28	118
Average waiting time	8 weeks	20 weeks	10 weeks	19 weeks	38 weeks	15 weeks	24 weeks	14 weeks

2.3.10 Our survey reveals that the vast majority of consultants recognise that systematic review of waiting lists is important. It is encouraging that so many report at least some structured arrangements to carry out such reviews. However, it is clear that a formal policy of active validation of waiting lists at regular intervals was not in operation in any of the hospitals covered by our remit. There is a clear acceptance on the part of admitting consultants that the efficient management of cases is central to the achievement of acceptable waiting times for admission of patients. It is also clear that some resource constraints are perceived by consultants to limit the extent to which waiting list problems can be addressed.

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

2.4 *The relevance of U.K. experience*

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

while those awaiting day-case treatment had risen by 11% over the same period. However, the numbers awaiting in-patient treatment for twelve months or more had fallen by 6% in that period, reflecting the particular focus on long wait patients.

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

2.4.3 As a result of this experience, the I.A.C.C. were asked by the U.K. authorities to look at the worst 100 surgical waiting lists in England using the same approach. This exercise, conducted in 1990/91, followed the same general approach as the earlier initiative. The waiting lists selected represented 40% of the long-wait patients in England. By September 1990, the number waiting twelve months or more on these 100 selected waiting lists had fallen by 33%, again in contrast to results achieved elsewhere. Part of the measured reduction was achieved by removing, through validation, patients who were not, in fact, waiting for treatment as indicated on the waiting lists.

2.4.4 While better than average improvements could reasonably be expected from any exercise focussed on worse than average waiting list problems, the scale of the improvement, relative to the national average, clearly suggests that there is much to be learned from the experiences of the I.A.C.C. team. For that reason, representatives of the Group visited the I.A.C.C. in Birmingham and also the Waiting Times Unit of the Department of Health in London. The conclusions and recommendations outlined in subsequent paragraphs draw on that experience and we wish to record our gratitude to the I.A.C.C. in particular for their assistance in sharing with us the fruits of their experience.

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

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

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

(c) review of changes in routine activity levels with a view to identifying bottlenecks within the hospital system;

(d) comparison of performance and activity levels with national trends by specialty;

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

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

This approach seems entirely applicable in an Irish context.

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

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

2.5 *Monitoring and validation of waiting lists*

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

2.5.2 Of the 162 consultants who replied to our questionnaire, only 43 said that they established patients' continued need or wish to be treated as a method of reviewing their waiting lists. The I.A.C.C. have provided examples of the effects of

validation of lists which are not regularly reviewed. The validation of the largest single surgical list in England in 1989 resulted in only 35% of the 4,000 names on the list remaining after removal of the names of patients who had died, moved away or been treated elsewhere. The need for a clear **policy** in regard to validation is further indicated by such examples as that of a general surgical waiting list whose patients were written to in two successive years but where, on both occasions, the names of all of the patients who had failed to reply were left on the waiting list. It is clear that regular validation of waiting lists is the exception rather than the rule in the areas of difficulty with waiting lists in England and the same is true of Irish hospitals.

2.5.3 Validation of waiting lists can be carried out either (a) through postal review on a particular date to confirm patients' wish to remain on the waiting list, or (b) by clinical review involving direct contact between patients and medical staff. It is clear from our survey that both methods are employed to varying degrees within the Dublin hospitals. **We recommend that validation to establish meaningful waiting list data be adopted as a firm policy in each hospital and that such policies ensure that appropriate management and clinical action is taken on foot of such reviews.**

2.5.4 **Postal reviews** can be carried out in bulk or, as part of an ongoing review process, whenever patients reach the point where they have been on the list for a specified period. **We recommend that, where this does not already happen, hospitals should immediately carry out a bulk postal review of patients who have been on a waiting list for more than an agreed period of time.** The period should relate to the nature of the condition but all patients waiting twelve months or more should be subject to review. Responsibility should be clearly assigned to one staff member to manage the review and to ensure that appropriate management reports are produced. It would be the responsibility of this person to agree the protocol for the review with the consultants concerned.

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

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

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

2.5.8 It is imperative that clear procedures are followed in dealing with non-responses and indications of loss of interest in pursuing treatment. Without clear guidelines to action, the beneficial effects of validation will be lost. The person assigned responsibility for managing the review process should produce regular reports indicating the status of the review and the numbers of patients responding in various ways, together with the action taken on foot of their response. These reports should be reviewed by hospital management and consultants at regular intervals.

2.5.9 **We recommend that, on completion of this comprehensive review and validation of current waiting lists, formalised regular arrangements should be made by each hospital for the on-going review and validation of lists**. This could take the form of either (a) bulk postal review on particular dates each year or, (b) could be spread over the year as patients reach an agreed threshold of waiting time on particular lists. It should be a key responsibility of a designated hospital staff member, either management representative or consultant, to ensure that the hospital's policy on review and validation is followed by all departments.

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

2.6 *Scheduling of Activity*

2.6.1 When the dimensions of the waiting time problem are clearly established, through the validation measures proposed above, it is then necessary to consider

how admissions can be arranged to reduce waiting times. **We recommend that hospitals target waiting lists by ensuring that**:

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

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

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

The implications of these strategies are set out below.

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

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

2.6.4 In addition to scheduling practices, the organisation of clinical activity can significantly affect throughput and, therefore, the relative availability of treatment. **We recommend that hospitals should take steps to establish whether their activity levels, having regard to case mix, are broadly comparable with the productivity levels of similar services in other locations**. Clearly, staffing levels, support services and bed availability must be taken into account in making such comparisons. When this is done, any significant variations in activity levels should be a matter for review. Where such comparisons indicate scope for increasing throughput, appropriate action could significantly increase the availability of treatment, thus reducing waiting times.

2.6.5 The data required to make such comparisons are not readily available. Meeting this information requirement would, in our view, be an important task for improving the efficiency of hospital management for the future. However, a start can be made drawing on the work of the I.A.C.C. in England. Based on their detailed analysis of activity levels, they have produced suggestions for average workload for surgical firms. An illustrative outline of possible workload targets

drawn from U.K. experience is shown in Table 3. While these, or any other targets, are difficult to apply to specific locations, not least because of variations in case mix, they may be of interest in the course of discussion of strategies for action when the protocols for validation of waiting lists, outlined above, have been applied.

2.6.6 The achievement of throughput targets might be frustrated due to difficulties in access to beds or theatre sessions. Staffing problems may also present. Where these are established to be the cause of less than target throughput, initial consideration should be given to re-deployment of resources within the hospital. If particular specialties have unacceptably long waiting times for patients, the allocation of additional beds or theatre time should be considered where this would not increase waiting times in other specialties above agreed targets. Such re-deployment could be made either on a permanent basis or for a specific period to enable targetted improvements in waiting times to be achieved.

2.6.7 Activity levels and throughput can also be improved by changing the manner in which patients are treated. The particular scope for increasing the level of day surgery is outlined in the following paragraphs. It is only when the scope for re-deploying beds, theatre time and other resources within a hospital have been shown to be impossible, having regard to target waiting times, and when the scope for increasing day case activity has been maximised, that a valid case for resources can be made on the basis of waiting list problems. In short, **we do not consider that waiting times, even when validated, of themselves constitute a basis for requests for additional resources by hospitals**. The good practice model which we are putting forward extends to ensuring that all possible measures for increasing efficiency and effectiveness in dealing with elective admissions have been employed.

2.7 *Specific Strategy to Expand Day Surgery*

2.7.1 In our Interim Report last June, we identified the benefits of protected one-day and five-day beds in facilitating elective admissions. To maximise the benefit of these facilities, appropriate selection of patients and careful planning of in-patient activity is essential. When these conditions are met, very significant increases in throughput are possible. The experience of the Dublin hospitals indicate that the benefits can be experienced very rapidly.

2.7.2 The problem of waiting times for patients is particularly concentrated in the surgical specialties. It is, therefore, particularly important that the scope for increasing day activity in surgery should be realised. Day cases are defined as patients who do not stay in hospital overnight but who do need to stay for a short time after a procedure for recovery, typically for a half-day. They are formally admitted to the hospital and, as such, are distinguished from out-patients who come for minor procedures, investigations or consultations and leave as soon as these are over. Day surgery has been introduced in the various surgical disciplines in Dublin but there is scope for development.

2.7.3 Day surgery is of benefit to patients because they are treated sooner than in-patients and are less likely to have admission cancelled at the last minute. They spend less time away from home and, through development of specialised facilities, receive high-quality care. Indeed, the Royal College of Surgeons have stated that "day surgery is in no way inferior to conventional admission for those procedures

for which it is appropriate, indeed it is better" (Guidelines on Day Case Surgery, 1985). In addition to patient benefits, day surgery in appropriate cases is estimated to cost 25-30% less than in-patient treatment. As a result, more patients can be treated for any given level of resource.

2.7.4 Given these benefits, it may be surprising that the extent of day surgery is rather less than is possible. A review of day surgery in England and Wales carried out by the Audit Commission established possible targets for the proportion of surgery for common surgical procedures suitable for day surgery. These targets were based on both current best practice models within England and Wales and on higher, optimistic target figures derived from the literature. These procedures, and the associated targets, are set out in Appendix D.

2.7.5 If these possible targets are to be achieved, with consequent increases in throughput and reductions in waiting times, a number of requirements will need to be met. First among these is the careful selection of patients, having regard to their medical and social circumstances and the distance they may need to travel following discharge. The appropriate organisation of facilities and staffing will also be necessary. In particular, the identification of specific beds for day surgery is essential and, ideally, designated theatres adjacent to such beds should also be deployed for maximum cost-effectiveness. However, the benefits are still substantial even where sharing of theatres is necessary.

2.7.6 When the extent of true waiting time problems are established for the surgical specialties, **we recommend that a systematic review of the scope for increasing levels of day surgery for appropriate conditions should be carried out in the hospitals covered by our remit**. Ideally, this review should be carried out on a collaborative basis so that variations in practice can be identified and the benefits of good practice generalised. **Increasing throughput by greater use of day surgery should, therefore, be a significant element in hospital strategy to reach acceptable levels of waiting time for patients**. This will require review of the facilities available to support safe and effective day surgery based on established good practice.

2.8 *Information Technology*

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

2.9 *Conclusions*

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

2.9.2 The protocols for validation of waiting lists outlined in this Report are essential if properly targetted action is to be taken. When valid indicators of waiting times are available, a comparative approach to activity and throughput by specialty is necessary. In particular, the development of day surgery should be promoted vigorously as a contribution to reducing waiting times.

2.9.3 Much of the on-going information required to operate the good practice model in this Report can be routinely gathered, analysed and reported on the patient administration systems which are now in place or being developed in our hospitals. What is required is a clear hospital policy which will determine that such information is actively used.

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

2.9.5 Waiting lists and waiting times can be used as powerful instruments in the debate over resources. The extent to which additional resources need to be targetted at waiting list problems can be clarified only when all of the elements of the good practice model outlined above are seen to be applied. We are satisfied that significant increases in activity levels and consequent reductions in waiting times can be achieved through improved organisation of in-patient activity and re-deployment of resources.

TABLE 3

NEGOTIATED WORKLOADS FOR SURGICAL FIRMS

This table outlines the average workload suggested for surgical firms. Many people would argue there is no such thing as an average firm and, clearly a surgeon working in a district where he only has SHO support will not produce the same volume of surgery as a colleague in a neighbouring district who has support from senior registrars, registrars, housemen, associate specialists and other middle grade surgeons. The figures in this table provide a starting point for discussion. In some instances, the level of medical manpower resulted in a lower figure whereas in others a higher figure was agreed.

These workloads are now routinely met in the vast majority of districts where IACC has negotiated waiting list contracts and our studies of past performance from routine data suggest that we might be negotiating higher figures next year.

SPECIALTY	EXPECTED WORKLOAD								EXPECTED OPERATING SESSIONS*
	ADMISSIONS				OPERATIONS				
	Cold +	Emerg	DC +	Total	Cold +	Emerg	DC +	Total	
General Surgery	600	600	400	1600	550	250	400	1200	3 or 4
Urology	700	250	400	1350	650	100	400	1150	4
Trauma and orthopaedics	465	485	150	1100	400	225	150	775	2 cold 1 trauma
Ophthalmology	400	150	50	600	350	50	50	450	2
E.N.T.	650	100	250	1000	600	50	250	900	3
Gynaecology	700	350	200	1250	650	200	200	1050	2

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

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

Source: **Examining Some of England's Longest Waiting Lists,**
Inter-Authority Comparisons and Consultancy, Birmingham, July 1990.

Chapter Three

GERIATRIC SERVICES [1]

3.1 *Introduction*

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

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

3.2 *Demographic Changes*

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

(1) The contents of this Chapter were submitted to the Minister for Health on 21st December, 1990 in view of discussions then taking place on the development of services. We note the provision subsequently made in the Programme for Economic and Social Progress and in the Budget, 1991 for developing services for the elderly.

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

3.2.3 Because of the scale of this increase, the implications for services are considerable. "The Years Ahead" considered that the objectives of public policy in relation to the elderly should be:

— to maintain elderly people in dignity and independence in their own home;

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

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

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

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

3.3 *Development of services*

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

3.4 *A changing workload*

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

3.4.2 The elderly comprise over 25 per cent of admissions and over 40 per cent of bed days in acute hospitals, although they constitute only 11 per cent of the population. Almost 36% of all admissions through the Accident and Emergency

departments of the Dublin hospitals are aged over 65 years and most of these are referred by their general practitioners. Of this 36%, 19% are over 75 years of age. An Eastern Health Board survey of A & E practice which was carried out in December 1989 found that 77% of those patients referred aged over 75 years required admission.

3.4.3 The Group's Interim Report stated that part of the current difficulties in the hospitals result from a lack of sufficiently flexible strategies to adapt to their changing workload. Most of the general hospitals in Dublin are geared to deal with patients with specific acute illnesses. Such an orientation does not regard the management or care of the elderly patient, who may be admitted with multiple - pathology and whose recovery may be slow, as a core element of the hospital's work. As a result, the dominant approach to organising the acute hospital system is at variance with a major element of its workload. **The provision of appropriate care for the elderly must be planned and managed as an integral and indeed central function of the acute hospital, on a par with planning and managing the A & E workload.**

3.4.4 A low priority has been given to the development of a properly staffed and resourced geriatric service in some of the major acute hospitals in Dublin. This has resulted in large numbers of "inappropriate" patients remaining in the acute hospital when they might have been discharged earlier or been cared for more appropriately either in the community or in an extended care setting. A survey was carried out last year on behalf of the Group to identify all patients who had been over 21 days in the hospitals covered by our work. It showed that 194 patients were regarded as being inappropriately placed in an acute hospital, accounting for 7.7% of all available beds. Of these patients, 145 or 75% were over 65 years of age. 62% of the total over 65 were in Northside hospitals, despite the fact that there are almost twice as many people over 65 years of age on the Southside (including Kildare and Wicklow) than the Northside.

3.4.5 When one considers that one of the primary objectives of public policy is to restore those elderly people who become ill or dependent to independence at home, it is clear that the first priority in the future development of services for the elderly is properly resourced departments of geriatric medicine. The presence of a consultant in geriatric medicine with appropriate support services, including assessment beds and an effective role in managing a range of services for the elderly, can make a very significant difference to the efficient use of existing acute beds. In hospitals where specialist departments of geriatric medicine have been established, the geriatric department "ensures prompt admission of elderly patients to hospital, specialist diagnosis and treatment, skilled nursing and rehabilitation and, in many cases, continuing support in a day hospital on discharge. Geriatric departments tend to encourage close liaison between domiciliary, community and extended care facilities in the interest of a comprehensive response to the problems of vulnerable elderly people." (The Years Ahead)

3.4.6 The specialist Department of Geriatric Medicine encompasses:

— out-patients services;

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

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

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

3.4.8 "The Years Ahead", in dealing with the subject of the development of departments of geriatric medicine, stated:

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

3.5 *Discussions with Physicians in Geriatric Medicine*

3.5.1 Following the submission of our Interim Report, the Group established a Sub-Group (Implementation Sub-Group) to oversee the implementation of the best practice recommendations in the Interim Report. The Implementation Sub-Group also gave consideration to the priority developments in geriatric services within the acute hospital setting. The Sub-Group approached this aspect of its remit initially by requesting the physicians in geriatric medicine in Dublin to complete a problem-oriented questionnaire.

3.5.2 The questionnaire, in addition to requesting details of the existing hospital-based facilities for the elderly, also featured a problem-list relating to structured access to services outside the acute hospital setting and a semi-quantitative scoring system in relation to difficulties experienced with admission and discharge. The scoring system was also supplemented by a brief commentary. Respondents were also asked to list what they considered to be the top three priority service developments. All six physicians in geriatric medicine responded to the questionnaire and, following its receipt, met with the Implementation Sub-Group.

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

3.6 *Consultant Manpower*

3.6.1 We pointed out in our Interim Report that there are six physicians in geriatric medicine for a population of over 1 million in Dublin. This compares extremely unfavourably with the position in Northern Ireland and Wales. All respondents considered that there is a pressing need for the appointment of additional consultants on both sides of the city.

3.6.2 We have referred earlier to expected demographic changes in the Dublin area in the next two decades and to the increasing demands which this will place on the acute hospitals. The contribution which departments of geriatric medicine can make to the planning, organisation and management of acute hospital services makes a compelling case for the immediate appointment of these consultants. We consider that an effective department of geriatric medicine in a large acute hospital, with appropriate access to support services off-site, requires the appointment of at least two consultants. While there is a clear need for the appointment of additional consultants in South-East Dublin and in St. James's Hospital, **the Group recommend that physicians in geriatric medicine should be appointed as a matter of extreme urgency in both the MANCH and the Northside Hospitals (Mater and Beaumont). These appointments should be full-time physicians in geriatric medicine rather than physicians with an interest in geriatrics. The Group also recommend that, in view of the scale of the service need, these appointments should be given priority over all other consultant appointments in the Dublin hospitals.**

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

3.7 *Assessment/Day Facilities*

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

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

- **— a major commitment from at least two physicians in geriatric medicine;**
- **— an acute geriatric assessment unit;**
- **— an active geriatric day hospital;**
- **— an efficient transport system.**

3.7.3 **A multi-disciplinary support team providing intensive nursing, occupational therapy, physiotherapy, speech therapy and medical social services would also be a prerequisite**. In the case of the South-East Dublin area, such provision should be made on a co-ordinated basis by St. Vincent's, St. Michael's and St. Colmcille's Hospitals. The Group therefore supports the thrust of the joint proposals for development in this area.

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

3.8 *Extended Care*

3.8.1 One of the major problems identified by the physicians in geriatric medicine and also highlighted by the Eastern Health Board in its report "Services for the Elderly" is the clear shortfall in the provision of extended care beds in the Dublin area. The physicians felt that there was an immediate need for approximately 150 places in Dublin, distributed in accordance with current need levels by area, and for a planned increase over the years ahead in line with the demographic trend.

3.8.2 "The Years Ahead" had indicated that, nationally, there was a significant proportion of patients in extended care who were inappropriately placed. This, coupled with the fact that extended care beds may be accessed in many areas without structured assessment, indicated that some improvement in the availability of extended care beds to those who require them could be achieved. However, the gross under-provision in the Dublin area is such that there is very little contribution to be made by a more intensive management of available places.

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

3.9 *Rehabilitation*

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

— there is no immediate access to diagnostic facilities;

— patients need to be stabilised in an acute unit before transfer;

— should the rehabilitation programme fail, there is great difficulty in placing the patient in another appropriate setting.

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

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

3.10 *Psycho-geriatric Services*

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

— services for elderly patients with functional mental illness, and

— services for elderly persons with varying degrees of dementia.

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

3.10.3 One of the problems emphasised in "The Years Ahead" and again highlighted in our discussions with the physicians in geriatric medicine was the lack of adequate provision for the long-term care of elderly persons with dementia. If the needs of such patients are to be dealt with in a comprehensive fashion, it is clear that a co-ordinated multi-disciplinary approach is required.

3.10.4 The Group considers that the recommendations contained in the "The Years Ahead" for the future development of psycho-geriatric services form a concrete basis for this approach. While acknowledging the progress made by the Eastern Health Board in developing psycho-geriatric services, **the Group are concerned that development should be accelerated and, in particular, that adequate in-patient facilities are made available for use by the psycho-geriatricians.**

3.11 *Conclusion*

3.11.1 We are satisfied that the development of properly structured departments of geriatric medicine with adequate consultant staffing are vital to the efficient management of acute hospital services. While recognising that the majority of patients over 65 years may not require specialist geriatric services and that most

consultants will continue to cater for large numbers of elderly patients, the needs of the very elderly with high dependency and multiple-pathology are such that a structured approach is needed. That need is all the greater in the Dublin area, given the demographic trends which are already apparent.

3.11.2 **The Group considers that each major general hospital should have a major commitment from at least two consultants in geriatric medicine**. Within this target, the immediate need, in the Group's view, is for the appointment of additional consultants in geriatric medicine to the Mater and Beaumont and to the Meath/Adelaide and subsequently to Dublin South-East, MANCH/Naas and St. James's. Acute beds for treatment and assessment are already in use for the treatment of elderly patients so we do not consider that additional beds are required. However, additional investment is required to provide day hospital facilities with appropriate multi-disciplinary staffing and transport support. **Additional long-stay places — of the order of 150 places — should also be provided, i.e. 50 places for each of the three major catchment areas in Dublin** (Dublin North, Dublin South-East and Dublin South-West). The planning for additional consultants and support facilities, including extended care places, should also commence now, in line with the known increase in demand which the hospitals will face in coming years.

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

Chapter Four

ARRANGEMENTS FOR REFERRALS FROM OUTSIDE THE EASTERN HEALTH BOARD AREA TO DUBLIN HOSPITALS

4.1 *Introduction*

4.1.1 The number of patients referred from outside the Eastern Health Board area to the Dublin hospitals constitutes a significant element of the workload in those hospitals. In the light of this, a Sub-Group was established with the following terms of reference:

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

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

— to develop protocols for the future organisation of access by referrals from outside the Eastern Health Board area to services in the Dublin hospitals.

4.2 *Approach to Work*

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

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

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

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

— the problems experienced in discharging these and similar patients;

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

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

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

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

4.3 *Extent of Referrals to Dublin Hospitals*

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

4.3.2 The returns from the questionnaire showed that a total of 2,382 patients were discharged from the Dublin hospitals to areas outside the Eastern Health Board in the six-week period in 1990. Details are given in Table 5. The North-Eastern and South-Eastern Health Boards again had the highest number of discharges with 705 (29.6%) and 558 (23.4%) respectively.

TABLE 4

NUMBER OF ADMISSIONS/DISCHARGES BY HEALTH BOARD AREA IN 1989

Hospital	Others	Eastern	Midland	Mid-West	North-East	North-West	South-East	Southern	Western	Total	% admission outside EHB
St. James's	89	16,383	629	300	1,080	321	1,114	121	309	20,346	19.0%
Mater	472	14,767	590	368	1,901	447	612	157	271	19,585	22.2%
Beaumont	86	15,557	543	369	1,397	849	971	142	485	20,399	23.7%
Meath*	10	8,387	193	112	171	145	325	92	77	9,512	11.7%
Adelaide*	7	3,972	105	53	138	63	208	24	82	4,652	14.5%
St. Vincent's*	72	14,856	688	348	655	425	1,548	98	159	18,849	20.8%
J.C.M.H.*	23	5,975	67	23	969	128	40	19	41	7,285	17.6%
Total	759	79,897	2,815	1,573	6,311	2,378	4,818	653	1,424	100,628	19.8%

TOTAL	19,972

* approximate figures

TABLE 5

REFERRALS FROM OUTSIDE THE EASTERN HEALTH BOARD AREA

1st October 1990 — 16th November 1990

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

*approximate figure

4.3.3 The returns also identified a range of problems and delays experienced by the hospitals in attempting to discharge these patients to their respective functional areas. These included:

— delays in obtaining ambulance/other transport services;

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

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

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

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

4.3.4 Although all of the hospitals continue to experience some of these difficulties in discharging such patients, none regarded them as major problems. While delays still occur, the number of bed-days lost is minimal. While each of the hospitals stated that no major difficulties are experienced in discharging such patients, most considered that an efficiently organised and co-ordinated transport system would improve the existing situation.

4.3.5 The hospitals were also asked to indicate the standard arrangements which exist for the acceptance and discharge of such patients, either with particular hospitals or health boards. The returns show that, while most of the hospitals have ad hoc arrangements with other health boards/hospitals for the acceptance and discharge of these patients, no formal structures or protocols are in place.

4.4 *National Role of the Dublin Hospitals*

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

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

4.4.3 Given the demanding tertiary role of the Dublin hospitals, it is clearly desirable that unnecessary admission to secondary care beds should be avoided. Equally, duration of stay beyond what is clinically necessary can directly reduce the availability of specialist services which are in particular demand. In our Interim

Report, we recommended approaches to the management of admission and discharge to minimise such negative effects. Similarly, in our recommendations on geriatric services, we have proposed developments to ensure that appropriate and effective responses are made to the growing numbers of elderly patients in acute beds.

4.4.4 The appropriate management of workload by Dublin hospitals is also of great importance to patients outside the region. In so far as regional services or national specialties are provided to such patients by Dublin hospitals, patient access to these services will reflect the extent to which appropriate use is made of beds in the Dublin hospitals.

4.4.5 Given the possibility that patients referred to Dublin hospitals may require a period of care for which the specialist facilities of a tertiary referral centre are not required, concern has from time to time been expressed that delay in discharging patients to their referring hospital or region may result in inappropriate use of beds. Our survey of Dublin hospitals indicates that this is not a significant problem. It follows that the main focus for concern in ensuring that patients, whether from Dublin or elsewhere, who require the services of the Dublin hospitals have access to them, is whether these referrals are appropriate. This is considered below.

4.5 *Appropriateness of Referral to Dublin Hospitals*

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

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

4.5.3 In order to examine the extent to which these problems may arise, the Dublin hospitals were asked to provide details of referral levels by consultant and by specialty. Unfortunately, a breakdown of referrals by consultant was, in most cases, unavailable. In the time available, a detailed breakdown by specialty was not able to be supplied by all of the hospitals either. From the partial information supplied, it would appear that a substantial proportion of referrals — of the order of 40% — are in respect of specialties which are not formally designated as national or regional services for the referring regions. However, a significant proportion of these referrals would be in respect of treatments and procedures which form part of sub-specialties or particular expertise which is available within the Dublin hospitals, though not formally designated as providing supra-regional services. It is, unfortunately, impossible to measure the residual level of referral which would not be regarded as appropriate according to the objective criteria set out above. However, it is clear that such referrals constitute a relatively minor element — we estimate it to be of the order of 4% — in the activity levels of Dublin hospitals in respect of non-E.H.B. patients.

4.5.4 While most referrals may be regarded as appropriate by current criteria, the question arises as to whether such levels of referral are necessarily desirable. In particular, we are concerned at the level of dependence on the Dublin hospitals for specialist services which could, in principle, be developed more locally. For example, the level of referral to E.N.T. and gastroenterology services in Dublin is particularly high. Our measured referral activity excludes services provided in specialised hospitals in Dublin and thus understates the level of usage of Dublin hospitals. In the case of such services, where complexity levels do not require super-specialisation and where a significant proportion of procedures can be performed on a day surgery basis, there is a prima facie case for greater development of more local services. Considerations of patient convenience and comfort, particularly in the case of children, would tend to support such a case.

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

4.6 *Views of other health boards*

4.6.1 We invited the Chief Executive Officers of the health boards outside Dublin to comment on their general experience in accessing services, both in-patient and out-patient, for their patients in Dublin hospitals. Constraints of time did not permit a detailed examination of the situation on their part. However, the general view conveyed to us was that they did not perceive there to be significant difficulty in having patients referred or treated in Dublin hospitals where this was necessary. Their concern was that maximum use should be made of local services and that these should be developed to reduce the need for referral to Dublin, where this was viable and capable of being resourced. A view was expressed that alternative

funding arrangements for the referral of such patients to Dublin would result in a more balanced provision of services.

4.6.2 A number of specific procedural difficulties with referrals were mentioned, such as the need to refer patients through the Accident and Emergency department even where prior contact was made with the admitting consultant. Similarly, the possibility of having follow-up of patients carried out locally rather than by recall to Dublin out-patients departments was mentioned as an area for possible improvement.

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

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

4.7 *Conclusions and Recommendations*

4.7.1 Our survey of the Dublin hospitals has shown that no significant problems occur due to delays in discharge of patients referred from outside Dublin. The main focus of our concern, therefore, has been to examine the appropriateness of such referrals which we have outlined in section 4.5.

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

- **referrals by specialty to Dublin hospitals from outside the region should be monitored regularly**;
- **discussions should take place on a regular basis between hospitals and referring health boards on all aspects of the process of referral and discharge of patients**;
- **the development of some specialist services, which are highly dependent on referral to Dublin, in hospitals outside Dublin should be considered as a matter of urgency**.

Chapter Five

IMPLEMENTATION AND FOLLOW-UP OF THE GROUP'S RECOMMENDATIONS

5.1 *Introduction*

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

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

5.1.3 The emphasis on identifying workable solutions to common problems was facilitated by:

(a) the fact that our membership included a wide range of backgrounds with many different perspectives on the problems experienced by hospitals and their staff;

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

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

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

5.1.4 We believe that implementation of our recommendations is enhanced by the fact that they are grounded in the experience and priorities of the hospital personnel with practical experience of the difficulties which gave rise to our establishment. Furthermore, we have proposed remedies for these difficulties which are based on proven benefits experienced by those already operating the good practice models which we outline. Our conclusions are, therefore, neither academic

nor speculative; they derive from the real world of the busy acute hospital. The benefits to be expected from their implementation can be seen and verified.

5.1.5 Despite these structural elements which are conducive to implementation, we recognise that change can be difficult in any organisation. Many of the recommendations which we have made involve changing long-established and widely-observed practices. More importantly, many of them require a change in attitude and orientation. It follows that the issue of a report, no matter how compelling the case for its conclusions, is unlikely of itself to be sufficient to bring about change. We, therefore, recognise the need for a specific implementation strategy. This is not to say that hospital staff have been unwilling to change. On the contrary, we have been impressed by the openness with which our analysis and conclusions have been received and the readiness of hospitals to review and adapt their policies when provided with models of good practice.

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

5.2 *Implementation of the Interim Report*

5.2.1 The Interim Report of the Group was presented to the Minister on 22nd June, 1990. The text is attached at Appendix F for ease of reference. Recommendations were made under three main headings:

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

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

— critique of existing organisational structures in Dublin.

Following the presentation of the Interim Report, the Group continued in existence to complete a number of tasks, including overseeing the implementation of the recommendations in relation to best practice.

5.2.2. In July, 1990 the Department of Health wrote to each of the hospitals covered by the exercise and to the Eastern Health Board, enclosing a copy of the Interim Report and asking them to implement the series of recommendations which were designed to enhance the performance of the acute hospital system. Implementation was sought not later than 1st October, 1990 which was the target date given in our Report. Each hospital was asked to prepare a plan to give effect to these recommendations and to submit it to the Department.

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

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

(a) should introduce, if it did not already have, an effective admission policy involving the active co-operation of consultants, nursing staff and management;

(b) should have an effective bed management policy in operation to ensure maximum utilisation of available bed stock, including the appointment of senior nursing personnel as bed managers to operate this policy;

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

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

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

(f) should ensure that teams rostered for A & E duties are sufficiently free of other commitments to meet the increasing needs of A & E departments;

(g) should have an observation ward adjacent to the A & E department under the overall administrative control of the A & E consultant;

(h) should develop better communications with general practitioners. Every A & E department should have available the services of a medical social worker;

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

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

5.2.5 On 30th July, 1990, the Implementation Sub-Group met with representatives of the hospitals covered by the exercise in the Royal College of Physicians in Ireland. The purpose of the meeting was to outline the background to the "best practice" recommendations and to discuss ways in which the Sub-Group could be of assistance. Papers were delivered by representatives of those hospitals where certain best practice models were operating. Following the meeting, detailed summaries of the presentation were circulated to each of the hospitals to assist them in preparing their plans.

5.2.6 The Sub-Group has surveyed the hospitals and met with hospital representatives on a number of occasions since July. It is clear that a considerable amount of discussion has taken place, both within and between hospitals, to give effect to the recommendations. This has required, in some instances, their addressing complex problems, some of which are unique to the circumstances of individual hospitals.

5.2.7 The Sub-Group decided in September, 1990 to provide hospitals with a summary of the implementation plans received from each hospital, as it was felt that these might indicate possible lines of action to those hospitals which had yet to

adopt policies in respect of particular recommendations. The Sub-Group also stressed that the recommendations were based on best practice profiles which had already been introduced and were working successfully in certain hospitals. All the hospitals were urged once again to introduce best practice policies based on:

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

(b) re-deployment of existing human resources;

(c) flexible rostering arrangements; and

– (d) other appropriate strategies that do not depend on additional monetary allocations.

5.2.8 It is clear that, for the most part, hospitals took steps to put in place all possible measures in advance of the anticipated pressure of the Winter season. It is recognised that some of the recommendations will require a longer period for full implementation. However, it is also clear from the contents of the hospitals' implementation plans that the discussions and consultations have, in some instances, failed to result in clear-cut decisions or policies, for instance:

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

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

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

While accepting that some of these recommendations have resource implications, their proven benefits in other hospitals justify their introduction as a matter of urgency.
A summary table outlining progress to date in implementing these recommendations is at Annex 1.

5.3 *Implications of the Follow-Up to the Interim Report*

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

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

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

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

(c) the benefits of good practice models were clear from those already operating them, particularly from those who had participated in the general meeting for hospital staff;

(d) implementation was given a high priority by the Department of Health;

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

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

5.4 *Developing a quality service*

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

5.4.2 The primary orientation of this commitment to excellence has been to the care of individual patients. The care of patients is, of course, the fundamental criterion for assessing clinical performance. Within the various professional disciplines, there is a growing realisation that such excellence is best promoted in an atmosphere of critical appraisal of performance. For that reason, audit procedures have been introduced in most disciplines. The operation of an audit programme is increasingly regarded as a criterion for recognition of a hospital for training purposes by the relevant professional bodies. Such audit requires review of activity and outcome on a comparative basis. In this way, the highest standards of achievement within a particular discipline are taken as the target for development of clinical practice.

5.4.3 Our good practice recommendations, both in this and earlier reports, are designed to broaden the scope of the concern for quality. Our focus has been upon the efficiency and effectiveness with which hospital resources are organised. Our concern has been with the way in which hospitals approach the management of their workload and the management of the flow of patients, both out-patients and in-patients. If this management task is not addressed properly, the resulting inefficiencies can result in too few patients or the wrong mix of patients being dealt with for any given level of resource. A concern for quality patient care must, therefore, extend to a concern for all aspects of the hospital's service to patients. This includes aspects of hospital activity which are not immediately clinical in nature, such as the organisation of out-patients clinics. However, as we have shown

in Chapter One, organisational problems in this area can have clinical consequences through, for example, the impact of high levels of recall of patients to clinics and the anxiety experienced by patients if they are unable to have the time and privacy to discuss their concerns about their condition and treatment.

5.4.4 **Our central conclusion regarding implementation of the good practice recommendations on management of out-patients services and waiting lists is for hospitals to develop an effective quality assurance programme**. Such an explicit commitment to the review of the care of patients would serve to broaden and deepen the existing strong commitment to provision of the highest possible quality of care.

5.4.5 **The main elements of a quality assurance programme are**:

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

(b) **availability of measures of performance reflecting the targets**;

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

(d) **staff development and training to support specified targets**.

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

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

5.4.8 The review of targets and the gathering of information on performance will be effective only if it is undertaken in the context of a clear and structured commitment on the part of the hospital authorities. We have proposed the creation

of mechanisms, such as the Out-Patients Services Group, to provide a focus for this commitment in certain areas. Overall, however, there is a need for hospitals to develop a corporate arrangement for ensuring that all aspects of the commitment to quality are pursued. The particular structures may vary but all should involve opportunities for active participation by the relevant interests and staff. They should also involve the allocation of specific responsibility to named individuals for ensuring that various elements of the quality assurance programme are, in fact, operated. In particular, they should ensure that patient complaints and feedback are given a high priority in the review of the performance of the hospital.

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

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

5.4.11 In the short term, however, we feel that a specific follow-up is required in regard to the particular recommendations contained in this Report. We envisage that this might take the following form:

(a) **circulation of this Report to all the hospitals concerned**;

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

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

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

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

5.5 *Areas requiring further research*

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

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

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

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

— the opportunities which exist to improve liaison with community services, including G.P.s, on admission and prior to discharge;

— the scope for improving physical arrangements for communication between hospitals and community services (liaison personnel, FAX machines, etc.);

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

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

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

5.5.4 The Group became aware of a research project which was being developed in the Department of Preventive Medicine/Cardiology in St. Vincent's Hospital. The study, whose pilot phase has been supported by the Health Research Board, was designed to look at integration of hospital and community services. The focus of the study was patients in designated G.P. practices in the catchment area of St. Vincent's Hospital who are considered by their family doctor to require hospital care or who, otherwise, received hospital care.

5.5.5 The essential question being considered by the Study Group was the natural history of patients who are considered to require admission to an acute general hospital. With that in view, the pilot phase developed methods for recording details on all patients referred to hospital and patients from the study G.P. practices actually admitted to hospital. Having reviewed this material, we are satisfied that the study design can be extended to address the question of what community resources might obviate the need for admission to an acute general hospital or reduce the length of stay in hospital.

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

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

5.5.8 On this basis, the Group "recommended that, on a pilot basis, a comprehensive rehabilitation service geared to the needs of such patients and drawing on the appropriate range of disciplines should be introduced in a special unit. The purpose of the pilot scheme would be to establish the level of intervention which patients with appropriate levels of incapacity require and the most effective means of supplying such services."

5.5.9 In approaching the question of design of a pilot project, the Group were in a position to draw on its experiences when meeting the various hospital staffing groups, including the physicians in geriatric medicine in addition to reports from Comhairle na nOspideal and the Irish Association of Rheumatology and Rehabilitation. The Group, in association with the various institutions involved, drew up an inventory of existing rehabilitation facilities in Dublin and made contact with the Royal Hospital, Donnybrook and Our Lady's Hospice, Harold's Cross.

5.5.10 Our information shows that a wide range of rehabilitation facilities exist for the treatment of various categories of patients, including geriatric, spinal injuries, head injuries, multiple sclerosis, spina bifida, rheumatic, stroke, etc. However, although some shared clinical appointments exist, it is clear that, generally, services are provided in stand-alone institutions without any formal structural links to the major acute general hospitals.

5.5.11 In the case of geriatric patients, we have already referred to the need for the development of specialist departments of geriatric medicine. In Chapter 3, the Group, while acknowledging that the problems associated with the operation of rehabilitation services in isolation from the acute general hospital would continue for the foreseeable future, also endorsed the recommendations of Comhairle na nOspideal for a greater integration of general hospital and rehabilitation facilities. It is the Group's view that the development of specialist departments of geriatric medicine in general hospitals, which would include a rehabilitation unit and day hospital facilities, would represent a significant improvement in the co-ordination and integration of rehabilitation services for the elderly.

5.5.12 In our discussions with the various clinical and para-medical staffing groups, it was represented to the Group that staffing levels and facilities for the treatment of patients in need of rehabilitation services were inadequate. While the inventory of facilities and staffing levels shown in Appendix E indicates that the numbers of staff in some disciplines are low, the Group considers that it is the organisation and direction of rehabilitation services which require priority attention. This applies both to the overall structure of services, as well as to the specific direction of services targetted at specific catchment populations.

5.5.13 The immediate priority is to identify what organisational and staffing changes would most effectively improve the prospects for early discharge of patients from acute beds. This can most effectively be done in the context of a specific acute hospital and its catchment area. One option would be to focus on the Dublin South-East area, where we have recommended an action research programme on acute hospital/community service linkages. There are a number of agencies in this area providing a range of rehabilitation services. However, we leave the selection of the location to the Department of Health and the Eastern Health Board. **Our concern is that the existing activity be reviewed and focussed on the**

particular problems which the Group's work has shown to apply in relation to rehabilitation of patients who do not require acute hospital care.

5.5.14 There are many other aspects of the work of the acute hospitals which would merit detailed analysis and research. We have recommended, for example, in Chapter 1 that variations in the waiting times for out-patients appointments within the same specialty should be the subject of detailed research. The on-going application of a health services research perspective to all aspects of the work of the acute hospitals would, in our view, contribute greatly to the efficiency and effectiveness of this, as to other branches of the health service.

Annex 1

Progress Report 28 January 1991

	J.C.M.H.	St. James's Hospital	Mater Hospital	Beaumont Hospital	St. Vincent's Hospital	Meath Hospital	Adelaide Hospital
Bed Manager	Operational.	Had previously been appointed.	Bed Manager Post advertised on 16.12.90. Interviews taking place shortly.	Had previously existed.	Temporary appointment made on 17.12.90. Awaiting approval from Department for permanent post.	Bed Manager appointed on 7.1.91.	Admissions Officer acts as bed manager.
Bed Management Committee	Operational.	Had previously existed.	Operational.	Already in existence.	Has been appointed. Operational.	Has been appointed. Operational.	Previously existed. Operational
Admissions Policy	Has been circulated to all appropriate staff.	New policy agreed. In place.	Has yet to be agreed by the Executive Committee of the Medical Council.	Currently being revised to a specialty by specialty approach. Not yet completed.	Circulated and agreed.	In place.	Now in place. Circulated to all appropriate staff.

	J.C.M.H.	St. James's Hospital	Mater Hospital	Beaumont Hospital	St. Vincent's Hospital	Meath Hospital	Adelaide Hospital
Protected 1-day and 5-day beds	27 1-day beds open. 5-day ward (10 beds) - to be brought into operation with effect from 8.2.91.	1-day beds previously existed. A 5-day ward (18 beds) opened on 5th November.	1-day ward to be opened on 1st March. 5-day ward (31 beds) has also been opened.	1-day ward (12 beds) currently in operation. A proposal to open a 5-day ward still under consideration.	Have been established and are in use.	Have been established.	16 1-day beds available. No proposal to open 5-day beds.
Observation Beds	8 observation beds available.	Had previously existed.	A revised bed schedule is at present being drawn up which includes 15 observation beds.	Had already existed.	Not possible to open observation beds due to lack of resources.	Available but not opened due to lack of resources	Not applicable.
Discharge Planning Policy	Has been circulated to all appropriate staff.	New policy agreed.	This is currently under consideration by the appropriate medical staff	New policy being developed.	In place. Has been circulated to all appropriate staff.	In place but limited success as there are no para-medical support staff.	Previously existed. Has been circulated to all appropriate staff.

Appendices

APPENDIX A

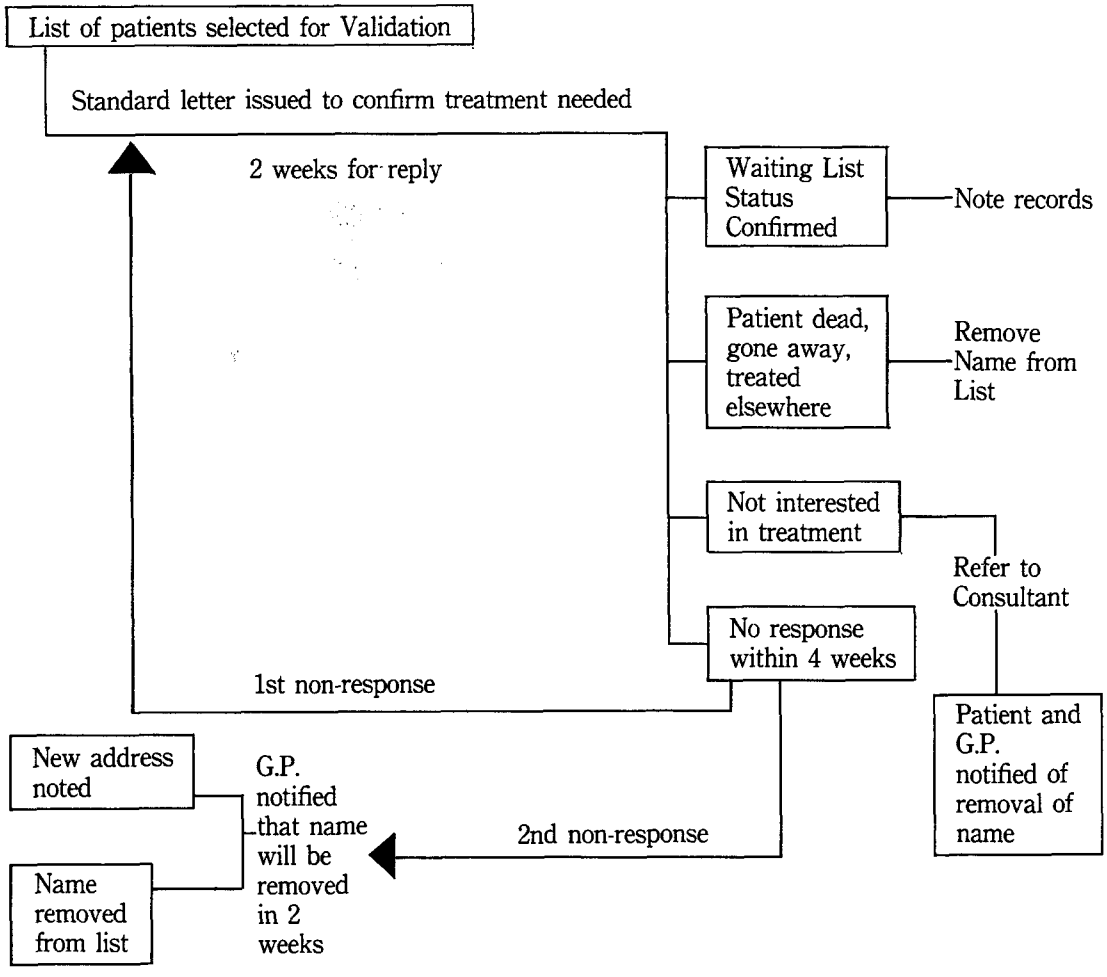
Illustrative Statement of Out-Patients Standards

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

APPENDIX B

Summary of Protocol for Validation of Waiting Lists

A. *Initial Review: Bulk Postal Review*

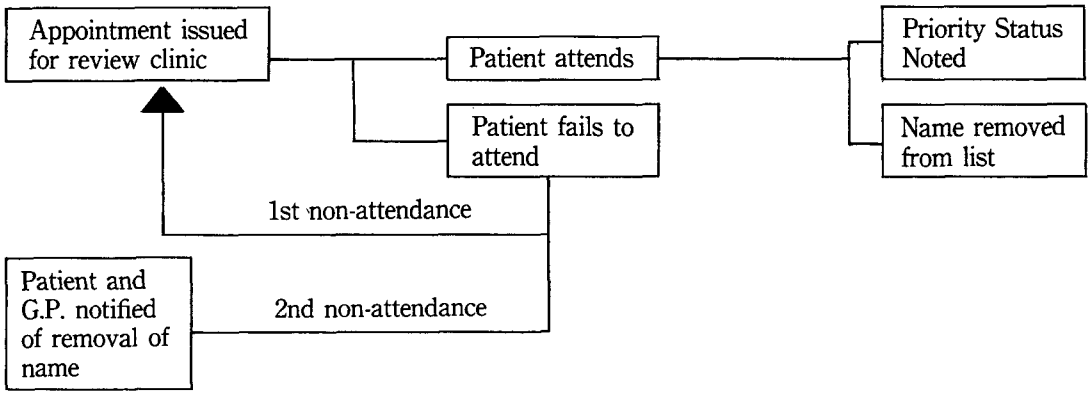


B. *On-going Review*

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

or

2. Clinical review at out-patients clinics:



APPENDIX C

Sample Letter for Postal Validation of Waiting Lists

Dear Patient

Date as postmark

WAITING LIST REVIEW

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

Please amend any of the following information if it is incorrect.[1]

Name ..... Date of Birth .....

Address ..... Consultant .....

..... Unit No. .....

Telephone No. H ..... G.P. .....

W ....

1. Do you wish to remain on the waiting list? YES/NO*
2. If no, please state reason:

[ ] no longer wish to be treated

[ ] already treated in another hospital

[ ] no longer resident at this address

[ ] other, please state reason

.....

.....

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

Thank you for your co-operation.

Yours sincerely

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

* Delete as appropriate.

APPENDIX D

Target Levels of Day Surgery for Common Procedures

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

	Possible target % treated as day cases	
	Upper quartile[1]	Optimistic[2]
1. Inguinal hernia repair	10	55
2. Excision of breast lump	41	60
3. Anal fissure dilatation or excision	66	70
4. Varicose vein stripping or ligation	17	60
5. Cystoscopy, diagnostic and operative	59	70
6. Circumcision	50	60
7. Excision of Dupuytren's contracture	18	70
8. Carpal tunnel decompression	79	95
9. Arthroscopy, diagnostic and operative	60	65
10. Excision of ganglion	84	95
11. Orchidopexy	24	50
12. Cataract extraction, with or without implant	1	20
13. Correction of squint	2	25
14. Myringotomy, with or without insertion of grommets	72	97
15. Sub mucous resection	9	15
16. Reduction of nasal fracture	66	95
17. Operation for bat ears	45	45
18. Dilatation and curettage	73	86
19. Laparoscopy, with or without sterilization	16	65

[1] Based on a sample of 54 DHA's in England 1988/89.

[2] These estimates are based on various sources, including published literature and data from other countries.

Source: **A Short Cut to Better Services**, Audit Commission, 1990.

Appendix E

Rehabilitation Units

Hospital	No. of beds (not all currently funded)	Category of patient	Consultant Staff	Physiotherapists	O/Ts	Speech Therapists
Beaumont	7 (elective)	Neurological	1 x Consultant Physician in Rheumatology/ Rehabilitation	1 Grade 3 1 Grade 2 5 senior 15 basic	1 head 1 senior 2 basic	1 senior 1 basic 1 sessional
St. James's	48	Geriatric	2 x Consultant Geriatricians	2 (WTE 1)	2	N/A
Our Lady's Hospice, Harold's Cross	70	Rheumatic	2 x Consultant Rheumatologists	5	3	N/A
James Connolly Memorial	28	Geriatric	2 x Consultant Geriatricians (shared)	2	2	1
St. Vincent's	Day-care only	Stroke, Rheumatic, Neurological, etc.	1 × Consultant Rheumatologist	3	2 W.T.E.	1
St. Colmcille's	30	Geriatric	1 x Consultant Geriatrician (shared)	1	1	N/A
N.M.R.C.	140	Spinal Injuries, M.S., Spina Bifida, Neurological, Stroke	2 x Consultant Rheumatology/ Rehabilitation	16	7	3.5 WTE
Royal Hospital, Donnybrook	30	Geriatric	1 x Consultant Geriatrician	2	2	1 (sessional)
St. Mary's, Phoenix Park	51	Geriatric	2 x Consultant Geriatricians	1	1	N/A
Baggot Street	Day-care only	Geriatric	–	1.5 WTE	1	Access to community speech therapist

APPENDIX F

INTERIM REPORT

DUBLIN HOSPITAL INITIATIVE GROUP

JUNE, 1990

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SUMMARY

1. We approached our terms of reference by identifying three main areas of concern:

— problems which are hospital-based in the management of both A & E and other admissions;

— issues external to the hospital;

— organisational and structural issues affecting the delivery of health care in Dublin.

2. In addition to the information already available, the Group had regard to information and views which it gathered as a result of:

(a) the responses to a detailed problem-oriented questionnaire to management, senior nursing staff, consultants and junior hospital doctors in each of the hospitals covered by the exercise. This questionnaire was followed up by interviews with all of these groups and allowed a clear picture of priority problems and likely solutions to be drawn;

(b) a survey of patients who were in the acute hospitals for 21 days or more and who might be deemed to be inappropriately placed. This was carried out through the community medicine staff of the Eastern Health Board on the 10th April, 1990;

(c) a survey of 100 G.P.s in the Dublin area to establish their views about access to hospital services, capacity to support patients in the community and communications with the hospitals. The survey was carried out with the co-operation of the ICGP;

(d) meetings held with representatives of physiotherapists, occupational therapists, social workers and public health nurses to ascertain their views on problems with the present system. These groups also made written submissions.

PROPOSALS FOR MORE EFFECTIVE MANAGEMENT OF HOSPITAL WORKLOAD

3. As a result of our work to date, we are in a position to make recommendations based on the proven benefits of particular policies/practices as applied in individual hospitals and which, generally without the need for additional resources, would make for a more efficient use of the special facilities of the acute hospital. We recommend that each hospital:

1. should introduce, if it does not already have, an effective admission policy involving the active co-operation of consultants, nursing staff and management;

2. should have an effective bed management policy in operation to ensure maximum utilisation of available bed stock, including the designation of senior nursing personnel to operate this policy;

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

4. should arrange for an increase in the ratio of senior to junior medical staff in A & E departments;

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

6. should ensure that teams rostered for A & E duties are sufficiently free of other commitments to meet the increasing needs of A & E departments;

7. should have an observation ward adjacent to the A & E department under the overall administrative control of the A & E consultant;

8. should develop better communications with general practitioners. Every A & E department should have available the services of a medical social worker;

9. should ensure that expert interpretative radiology and pathology skills are available to the A & E department proportionate to its workload to facilitate prompt decision-making;

10. should ensure that discharge planning begins at the point of admission and should be a structured process involving the key disciplines as appropriate.

In addition we recommend that:

11. a programme of public education on the appropriate use of hospital services should be instituted and renewed periodically at times of particular pressure;

12. careful consideration should be given to the introduction of differential charges in respect of attendances at casualty departments so as to encourage people to attend their G.P.s in the first instance, where appropriate;

13. liaison arrangements between hospitals and community care staff should be reviewed to ensure that they operate effectively.

4. We suggest that the Minister should now invite each hospital concerned and the Eastern Health Board to prepare a report on the measures which they will take to give effect to these proposals. An implementation Sub-Group comprising members of the Group will be available as a resource to advise and assist the hospitals and will also review and evaluate action taken on foot of the recommendations. As a first step, seminars will be organised for appropriate hospital staff on implementation of the recommendations. It is considered that it should be possible to have the relevant procedures apply from the 1st of October, 1990 at the latest.

RESOURCE IMPLICATIONS

5. The Group are continuing to assess the resource implications of the measures necessary to provide an acute hospital service in Dublin which meets the various needs of the population. The need for increased resources cannot be determined until it is clear that the most effective and efficient use is being made of existing resources, not least through the good practice measures outlined above.

However, the Group believes that in future the main priority for resource allocation should be the improvement of the geriatric services both within and without the acute general hospitals.

Our survey has shown a significant proportion of elderly patients being treated in acute hospitals who do not require acute hospital services.

We recommend that:

1. each major acute general hospital should have an appropriate consultant geriatric medicine service backed up by appropriate support services;

2. priority should be given to the allocation of the resources provided for the development of services for the elderly in association with the 1990 budget, to remedying the deficiencies identified in the Eastern Health Board's policy document on the elderly;

3. a comprehensive rehabilitation service geared to the needs of patients whose rehabilitation and step-down needs are greater than the norm should be introduced in a special unit on a pilot basis;

4. an appropriately structured pilot exercise should be undertaken involving a designated area which is associated with a particular hospital(s) to determine whether additional staffing and other resources are necessary to improve the management of patients in the community.

In addition, we recommend that:

5. higher priority than at present should be given to the use of modern information technology in hospitals, in particular to areas affecting patient management (such as better data access to radiology and pathology services) and which relate to documentation of hospital activity and case-mix;

6. the provision of a specific level of transport to hospitals should be explored between the Eastern Health Board and the Dublin hospitals to deal with the deficiencies in the existing service.

The Group will continue to address the resource implications of providing the most appropriate basis for an effective and efficient service in the next stage of our work.

ORGANISATIONAL STRUCTURE

6. The Group are of the view that the present organisational structures in the Dublin area are unsatisfactory. The present structures are notable for the

fragmentation of the health service, the confusion as to the roles and responsibilities of the various agencies and the lack of an effective overview of the interaction of services at the levels of planning or delivery. The Group is examining a range of options to address the problems. The objective is to identify structures which will build on the very tangible strengths of the existing system while addressing the deficiencies.

Chapter One

INTRODUCTION AND PROCEDURE

1.1 *Action Programme for the Health Services*

On the 6th February 1990 the Minister for Health, Dr. Rory O'Hanlon T.D., announced an Action Programme for the Health Services for 1990 and beyond.

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

1.2 *Dublin Hospital Initiative Group — Membership*

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

The following were appointed members of the Action Group:

1.	Professor David Kennedy (Chairman)	Deputy Governor, Bank of Ireland
2.	Dr. Conor Burke	Consultant in Respiratory Medicine, James Connolly Memorial Hospital
3.	Professor Davis Coakley	Consultant in Geriatric Medicine, St. James's Hospital
4.	Mr. Liam Dunbar	Chief Executive, St. James's Hospital
5.	Dr. Joseph Ennis	Consultant Radiologist, Mater Misericordiae Hospital
6.	Dr. Brid Fallon	General Practitioner
7.	Professor Muiris FitzGerald	Consultant Physician, St. Vincent's Hospital
8.	Mr. Austin Groome	Chairman, Eastern Health Board
9.	Mr. David Hanly	Chairman, Comhairle na nOspideal

10.	Mr. Kieran Hickey	Chief Executive Officer, Eastern Health Board
11.	Dr. Gerard Hurley	Consultant Radiologist, Meath Hospital
12.	Professor Michael MacCormac	Chairman, St. Vincent's Hospital
13.	Mr. Michael McLoone	Chief Executive, Beaumont Hospital
14.	Mr. Gearoid MacGabhann	Chief Executive, Mater Misericordiae Hospital
15.	Mr. Declan Magee	Consultant Surgeon, St. Colmcille's Hospital, Loughlinstown
16.	Ms. Eileen Mansfield	Matron, Adelaide Hospital
17.	Dr. John Mason	General Practitioner
18.	Dr. Brian O'Herlihy	Director of Community Care, Eastern Health Board
19.	Mr. Desmond Rogan	Secretary/Manager, Adelaide Hospital
20.	Mr. Niall Weldon	Chairman, Beaumont Hospital
21.	Mr. Leo Vella	Consultant in Accident and Emergency, Beaumont Hospital

The Secretariat to the Group was provided by the Department of Health:

Mr. Tom Mooney (Secretary)

Mr. Dermot McCarthy

Mr. Paul Griffin

Mr. Shay McGovern

Ms. Patricia Carr

Ms. Caroline Field

Ms. Marina Flanagan

1.3 *Inaugural Meeting and Terms of Reference*

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

As an initial remit, the Group were asked to deal with the following tasks:

— the adoption of admission policies and out-patient arrangements in the acute hospitals to ensure that necessary services are provided to patients in an optimum manner and provided in the most convenient way;

— a review of the arrangements for referral of patients from outside the Eastern Health Board area to ensure that resources are used appropriately;

— to plan the management of beds in Dublin hospitals to provide a reasonable balance between the requirements of elective patients and the other immediate needs of emergency admissions;

— to develop more effective working relationships between general practitioners and other community based services and the hospital service so that demands which need not be placed on the hospital service are avoided;

— to introduce appropriate discharge arrangements for the care of patients who will need community support or other institutional care after hospitalisation.

The Minister also asked that the initial report from this initiative would be presented to Government before the Summer Dail recess.

The hospitals covered by the exercise are:

Mater Misericordiae Hospital

James Connolly Memorial Hospital

Beaumont Hospital

St. James's Hospital

Meath Hospital

Adelaide Hospital

St. Vincent's Hospital

1.4 *Establishment of Sub-Groups*

Because of the urgency of the current acute hospital problems, the Group decided that it would be sensible to set up sub-groups to tackle specific tasks and later at specific plenary sessions to effect a process of integration. An analysis of the Group's terms of reference suggested some natural sub-divisions and it was decided that three sub-groups should be established to deal with certain tasks as follows:

Sub-Group A — Problems which are hospital-based
Sub-Group B — Issues external to the hospital
Sub-Group C — Longer term organisational issues

1.5 *Number of meetings*

The Group has met in plenary session on five occasions, one of which was a two-day meeting. Sub-Group A had a total of eleven meetings to date; Sub-Group B a total of eight meetings; and Sub-Group C has met on seven occasions.

In addition, the Chairman held extensive interviews with senior management and consultant staff in each of the hospitals and with key people in the health boards and the Department of Health.

Contact was established with Mr. Noel Fox to discuss issues of common interest and to eliminate any possible duplication. Contact was also established between the two Secretariats.

At all stages of the exercise hospitals and other bodies readily made available considerable quantities of statistics and other data to the Group as requested. The Group is very appreciative of the widespread co-operation we received and wishes to thank all those who responded so willingly to the many burdens which we placed on them.

Approach to work

1.6 *Sub-Group A*

1.6.1 Sub-Group A examined the cause of the difficulties encountered by the acute general hospitals in coping with their A & E workload together with their responsibility for elective activity. The Sub-Group focussed on the **in-hospital** problems, cognisant of the fact that Sub-Group B would deal with "external" issues.

1.6.2 The Sub-Group targetted the "admission-to-discharge" pathway encountered by the patient and examined the problems being experienced. The Sub-Group sent a problem-oriented questionnaire to senior nursing and administrative staff and consultant and non-consultant hospital doctors in each of the Dublin hospitals covered by the Group's work. The questionnaire featured a problem list related to the admission to discharge pathway and respondents were requested to rank the "problem" using a semi-quantitative scoring system supplemented by condensed commentary. Additionally, a final section of the questionnaire asked for a list of **Top Five Priority Problems** and sought **Priority Solutions** for these. After the questionnaire had been completed, all of the above groups were met in a series of eight detailed interview sessions. A similar session was held with A & E consultants.

1.6.3 There was a 100% response rate and a very high level of commitment was evidenced by the detailed submissions. This 100% response permitted a clear picture of the major areas of consensus among the respondents in relation to priority problems and their priority solutions and also highlighted some important areas of difference in opinion. An important outcome from the main areas of consensus was the identification of two main components (1) **resource problems** — beds, physical plant, personnel, equipment, facilities and communication systems and (2) **efficiency issues** related to "best practice" in the areas of admission and discharge policies, procedures for optimum decision-making and the general area of communication, liaison and teamwork. In several areas identified as major problems the two areas of resource difficulties and efficiency problems were inter-linked.

1.7 *Sub-Group B*

1.7.1 Sub-Group B examined the extent to which issues external to the hospital impact on the delivery of an efficient and effective service within the hospitals covered by the exercise. The consideration of these issues was facilitated by the availability of the preliminary results of a survey on admissions to Dublin hospitals through A & E departments in one week in December, 1989. This indicated that 89% of admissions were, on objective criteria, appropriate admissions. While such results do not indicate conclusively that hospital admission is inevitable or appropriate to a secondary or tertiary level hospital in all such cases, it suggested that it was appropriate initially to focus on the post-admission process. Referral and admission issues were, however, considered in the course of review of the role of community-based services, especially those provided by general practitioners.

1.7.2 The Sub-Group also examined the situation in relation to continuing care and long-stay nursing accommodation in the light of the Eastern Health Board's policy document on Services for the Elderly which suggested that there is a scarcity of such accommodation. It was felt that a survey of patients in hospital who might be deemed to be 'blocking' beds could provide useful information, given that there is a need for more long-stay facilities. Accordingly, through the community medicine staff of the Eastern Health Board, the Sub-Group carried out a survey of all patients in the seven Dublin hospitals on 10th April, 1990 who were there for 21 days or over. Studies elsewhere have shown that patients with longer lengths of stay are more likely to be placed inappropriately in acute hospital care.

1.7.3 On the survey date, the 421 patients identified in the seven hospitals represented almost 17% of all available acute beds. Of these patients, 194 or 46% were regarded as being inappropriately placed in the acute hospital. Those deemed to be inappropriately placed in an acute hospital accounted for 7.7% of available beds, the equivalent of a small hospital. Of these, 119, or 61%, were in the Northside hospitals.

1.7.4 The Sub-Group was conscious of the widely-held view that many more patients could be treated in the community if community-based services were improved and that the stay in hospital of those admitted could be reduced. Accordingly, meetings were held with representatives of physiotherapists, occupational therapists, social workers and public health nurses to ascertain their views. These groups also availed of an invitation to make written submissions.

1.7.5 Each group stated that they felt that pressure on acute hospitals could be relieved if additional staff and resources were made available to them. Some of the deficiencies which they identified in the present system included:

— poor communication and liaison between professionals in the hospitals and in the community;

— a shortage of facilities such as day care, long-stay beds and respite beds for patients who require further care/support but not at the acute hospital level;

— lack of step-down facilities, including step-down facilities for the under-65 age group and the inadequacy of assessment and rehabilitation services;

— inadequate family support services in the community such as home helps, community physiotherapists and occupational therapists;

— an inadequate transport service for people to attend at the hospital or other centre for physiotherapy and occupational therapy;

— the absence of a seven-day home nursing service involving general nurses and nursing aides.

1.7.6 The Sub-Group also recognised the very important role that the general practitioner has in relation to hospital services. With the co-operation of the Irish College of General Practitioners, a questionnaire issued to a hundred G.P.s in the Dublin area, of whom fifty-one replied. The College structured the survey so that the range of practices was representative of the general Dublin scene.

1.7.7 The questionnaire sought to establish views about access to hospital services, capacity to support patients in the community and communications with the hospitals. The majority of respondents reported that emergencies were the most common reason for admitting patients to hospital, but 24% stated that they often referred patients for admission because of delays in out-patients services. 40% reported that they often had difficulty in having patients admitted to hospital and this percentage was the same for both public and private patients. However, the majority reported that they had ready access to radiology, pathology and endoscopy services in hospitals for both public and private patients. Despite the satisfaction with access to the diagnostic facilities mentioned in the questionnaire, 57% felt that they could provide more home care to patients if there were more diagnostic facilities available to them. They had, in most cases, difficulty in having access to physiotherapy and occupational therapy in the hospital sector. The majority did not favour the revival of a Central Bed Bureau nor would they be in favour of G.P.s working part-time within A & E departments.

1.7.8 One overall impression arising from these replies is that general practitioners feel that they could cater for some proportion of patients who currently rely on hospital services, including, in particular, many who come to A & E departments but are not deemed to require admission. The effectiveness of discharge arrangements would appear capable of being significantly enhanced with better and more structured co-operation and communication with the G.P.. It is not clear, however, to what extent this would reduce average duration of stay, but it could play a role in some categories of admission where discharge is delayed and it may well be an important element in the prevention of re-admission.

1.8 *Sub-Group C*

1.8.1. Sub-Group C was asked to consider and make recommendations as to the future policy for the organisational structure and management of the acute general hospitals and the co-ordination and integration of other health services in the Dublin area. The Sub-Group invited senior officials of a number of agencies to their meetings to obtain their views on how the organisation/integration of services could be improved and to identify the problems/blockages in the system at present. The Sub-Group also discussed with the G.P.s attached to the main Group their views on how the integration between primary and secondary services could be enhanced.

1.8.2. Although considerable work remains to be carried out in this area, the Group's conclusions based on the work done to date by this Sub-Group are outlined in Chapter 4.

1.9 *Broad Conclusions*

1.9.1 There are very many factors affecting the efficient delivery of hospital services in the Dublin area. One particular conclusion is that there is a significant part of the workload of the acute general hospitals in Dublin which could be carried out more appropriately in other settings. A number of proposals have been identified for the development of services which could increase the availability of beds in acute hospitals for the care of patients whose condition requires the full range of facilities in such hospitals.

1.9.2 A number of recommendations have been developed by the Group as immediate measures which should be introduced to improve the existing situation and to evaluate and prioritise various alternative options. These recommendations can be classified as follows:

— proposals for more effective management of hospital workload (Chapter 2);

— proposals with significant resource implications (Chapter 3);

— comments on organisational arrangements and the integration of services (Chapter 4).

1.9.3 The proposals contained in Chapter 2 represent a code of best practice developed by drawing together the collective judgement of those involved in the delivery of health services in Dublin. The Group believes that implementation of these proposals would greatly improve the efficient and smooth operation of the Dublin hospital system and would ensure that maximum return is obtained from existing resources.

1.9.4 There are, in addition, a number of areas where a strong case has been made that the level of resources should be increased. In Chapter 3 we have identified the most immediately important of these. Where more data is needed to evaluate such proposals, we have suggested that a number of pilot projects be introduced to assess the merits of various proposals. The Group intends to carry out further work in this area.

1.9.5 The Group also intends to develop proposals for the overall organisational structure for the delivery of health services in Dublin. As outlined in Chapter 4, the Group believes that the present structures are not satisfactory and contain a number of fundamental deficiencies.

Chapter Two

PROPOSALS FOR MORE EFFECTIVE MANAGEMENT OF HOSPITAL WORKLOAD

2.1 *Introduction*

In this Chapter we present a range of measures which we consider would enable the workload of the acute general hospitals in Dublin to be managed with greater effectiveness and efficiency. These measures are put forward in the light of consideration of the experience of various practices within hospitals. They are based, not merely on the opinion of members of the Group, but on the proven benefits of particular policies and practices as already applied in individual hospitals. The proposals represent practices which, without the need for additional resources, make for a more efficient use of the special facilities of the hospital.

2.2 *ADMISSIONS*

2.2.1 The foundation for efficient use of hospital resources is an effective admission policy. Patients are admitted to a hospital from many sources apart from A & E and these include OPD, directly from the community and from other hospitals and institutions. It is a difficult task to meet the demands from all these sources and one that will only be dealt with efficiently if there is a clear-cut and responsive admission system. Such an admission system should involve the active co-operation of consultants, nursing staff and management.

In our discussions it emerged that some hospitals felt that it is impossible to implement a proper admission system in the face of the greatly increased level of admissions. It is our view that it is precisely this increased level of demand which makes an admission system a necessity.

2.2.2 An admission policy will require the effective co-operation of consultant and nursing staff and the full support of hospital management. We outline in the following paragraphs mechanisms which we consider would enable such a policy to be implemented. The success of these arrangements will be greatly enhanced by:

(i) prior agreement that various categories of patients can be accommodated within a designated quota of beds;

(ii) the operation of clear protocols for the acceptance and discharge of patients from/to referring hospitals;

(iii) access to an appropriate quantum of non-acute services for those patients who no longer require acute hospital treatment.

2.3 *Bed Management*

2.3.1 As a first step, it is important that each hospital has an effective bed management policy in operation. This is to ensure that beds are vacated at the earliest possible time and that full information on bed availability is available to key personnel at all times. One approach would be for each hospital to have a bed management group with representatives from the medical, nursing and management staff. The group should meet regularly so that the policy can be adapted when appropriate to meet changing demands brought about by factors such as seasonal variations in admission rates. It would seem that the system could best be operated through appropriate admission procedures which would be co-ordinated by one or more senior sister(s) who would act as bed managers with authority to operate the hospital admission policy.

2.3.2 For bed managers to function effectively, each hospital should have an admission policy which incorporates the following points:

— a division of beds to cater for elective and emergency admissions;

— protocols for admission of both elective and emergency admissions (whether from A & E, OPD, or other hospitals).

Responsibility for drawing up, implementing and reviewing this policy should be taken on by the group mentioned in 2.3.1 above. It is the Group's view that, in developing policies on bed utilisation linked to admission protocols, the allocation of beds to consultants should reflect the requirements of those consultants who undertake the responsibilities associated with participation in the rota for A & E "take". Consultants would then be responsible for using their allocated beds, with the support of the bed managers, in accordance with these protocols and for negotiating arrangements with colleagues for the sharing of beds as necessary.

2.4 *Bed Mix*

The bed complement of each hospital should be deployed so as to reflect demands made on each hospital as a result of its case mix. There should be an adequate number of protected beds for elective admissions. The efficient use of dedicated "protected" day wards and five-day wards would significantly reduce the extent to which elective admissions are displaced by A & E admissions. Such wards of their nature have an in-built incentive to the efficient use of hospital facilities. A well-run five-day ward in one of the Dublin hospitals has had the effect of eliminating a long waiting list for medical investigation and treatment. The more active use of out-patients services can also reduce the demand for elective beds and a successful example is the "one stop cystoscopy" system for the investigation of haematuria in one of the Dublin hospitals. We therefore recommend that an appropriate number of beds be designated and maintained as day wards and five-day wards in each acute general hospital.

2.5 *Management and discharge of in-patients*

A proactive discharge policy is as critical as an admission policy if the system is to work well. Such a policy should include effective protocols for optimum frequency and timing of discharge ward rounds, discharge arrangements for patients from

hospitals outside Dublin and the co-ordination of a prompt transport system to facilitate discharges. A system of early ward rounds by consultants or senior members of the non-consultant hospital medical staff would facilitate prompt discharge decisions and would, in turn, permit early plans for admission of new elective patients to any beds vacated as a result of the ward round.

2.6 *THE ACCIDENT AND EMERGENCY SERVICE*

The work of the Accident and Emergency departments of the Dublin hospitals has changed quite significantly over the past decade. Now over 45% of all the hospital admissions come through these departments and the majority of these admissions are medical. A very significant number of these patients are over 65 (37%) and most of these are referred by their general practitioners. Most of these elderly patients who are referred require admission. For instance, a recent Eastern Health Board survey of A & E practice found that 77% of those referrals aged over 75 were admitted. Part of the current difficulties in the hospitals result from a lack of sufficiently flexible strategies to adapt to this changing workload.

2.7 *The hospital interface with the A & E Department*

The vast majority of patients presenting at the Accident and Emergency department are seen, treated and discharged on the same day. This process forms by far the greater part of the workload of an A & E department. Only 20% of the patients attending A & E require admission, yet it is in this area that most delays and difficulties are experienced. When the A & E staff decide that a patient needs admission, they normally contact the appropriate medical or surgical team "on take" and it is current practice that a doctor from the "on duty" team will assess the patient in the A & E department before a final decision is made. This procedure is followed even when the need for admission is self-evident. At present there may be a delay before this repeat assessment is made and it is also usually carried out by relatively junior doctors. Based on our consultations, we are of the view that the commitment to the A & E service, despite its dominant role in the workload of the hospital, is sometimes not accorded sufficient priority in the organisation of the hospital's total activity. The interface between the "on take" teams and the Accident and Emergency department, and, in particular, determination of the point at which and the manner in which responsibility for patient management transfers, is critical if the system is to run smoothly. Following our review of existing practice, we are satisfied that this interface could be improved in most of the hospitals if the following recommendations were adopted.

2.8 *Senior decision-making*

Senior members of the "on take" team should therefore become more involved in decision-making in the A & E department. Consultants "on take" or senior members of the "on take" team should be available to discuss particular problems that arise with the A & E consultant as necessary. Clear protocols or guidelines should be drawn up in all hospitals to rationalise the assessment and admission process in the A & E department so that unnecessary duplication in assessment and decision-making does not occur and that the admission of patients is smoothly expedited.

We are satisfied from our consultations that difficulties are created for staff and patients in A & E departments by delays in obtaining prompt appropriate consultation at a senior level from medical and surgical teams "on take". This can result in delays in decision-taking about admission of patients and in the process of admitting to the wards patients who clearly need in-patient treatment.

2.9 *Dedicated "on take" teams*

The A & E "intake" has now reached such proportions that it cannot be managed satisfactorily if the teams "on take" cannot devote adequate attention to this work because of competing demands. The Group wishes to stress that the first priority of the teams "on take" must be to their A & E commitment and most of their effort and time must be dedicated to this purpose during their "on call" period. This will liberate the senior staff in the "on take" team so that they will be available to become involved directly with problems and to use their seniority in arranging ward and other resources as necessary, at the outset. For instance, teams rostered for A & E duties should not have significant out-patient, theatre, endoscopy or other elective commitments on these days. If a clash with some elective commitments cannot be avoided then a senior member of the team should be freed from elective duties so that he or she will be able to respond quickly to A & E requests/ consultations. Where the medical staff on take are not members of the same "firm", the individual schedules of the senior staff concerned should be such as to enable them to meet their A & E commitments. In order to cope with emergency surgery, an operating theatre should also be dedicated to A & E work in each of the hospitals if ready, immediate access to routine theatre sessions cannot be arranged.

2.10 *Observation wards*

A significant number of patients presenting at A & E departments require a period of observation to determine whether their condition warrants admission or, as is possible in some cases, whether they may safely be discharged. The management of such patients during the period before a decision to admit or discharge is best carried by the A & E department with the support of the "on-take" teams. An observation ward appears, from the experience of the hospitals, to be a critical factor in the smooth running of an A & E department. The ward should be adjacent to the A & E department and the successful models which we have studied have approximately 15 beds. The teams "on take" would have access and rights of admission to the beds during the 24-hour period of "on take" but this system appears to work best where the A & E consultant has overall administrative control of the ward. Admission wards which take all admissions over a 24-hour period have been tried in a number of Dublin hospitals in the past but in most instances the model has failed to work.

2.11 *A & E staffing structure*

The management of patients presenting to A & E departments is a major task for hospitals. Medical staffing levels are generally at relatively junior levels. We consider that urgent consideration should be given to increasing the number of senior staff available in the A & E department.

In addition to his clinical workload, the A & E consultant has a significant management commitment which necessarily limits his presence within the A & E department. Strategies should be examined which will increase the number of experienced staff in the A & E department. One option for achieving this would be to increase the number of registrars appointed to A & E departments or assigned to A & E duties as part of their medical or surgical rotations. Because continuity in the management of individual patients is of less importance in A & E departments than in other parts of the hospital, senior medical posts may be particularly suitable for filling on a part-time or job-sharing basis. One proposal which was made to us in relation to A & E staffing was that consideration should be given to the introduction of an intermediary grade (Associate Specialist) between senior registrar and consultant. We believe that this option should be carefully examined by the relevant authorities as a possible development for the medium to long-term needs of A & E departments.

2.12 *Interface between A & E and the Community*

The hospital A & E department is a transition zone between the community and the hospital. It is therefore essential that a good communication system is developed with general practitioners. Wherever possible, the general practitioner should be involved when decisions are being made whether to admit a patient or to discharge him/her back for on-going G.P. follow-up. In addition, we consider that every Accident and Emergency department should have the services of a medical social worker available to liaise with agencies outside the hospital when appropriate. The introduction of "Triage Nurses" in A & E departments in some Dublin hospitals has greatly facilitated communications between the A & E department and professional staff in the community when planning the most appropriate care of patients who present at the A & E department, particularly when they are self-referred. Triage nurses also perform the very important function of screening patients as they arrive so that the more serious cases can be identified and given priority. We therefore recommend the designation of appropriate nursing staff within A & E departments to perform this triage function.

2.13 *Continuous reporting of x-rays and tests*

Delays in the management of patients in Accident and Emergency departments can arise as a result of non-availability of the results of diagnostic procedures. This can give rise to the admission of patients whose condition does not warrant in-patient care. It is the opinion of the Group that the availability of expert radiology skills to the A & E department proportionate to its workload would make a significant difference to the efficiency of the A & E department. This could be most effective in reducing the number of misplaced and repeat x-rays and tests required. Decisions could be reached quickly if all the relevant information from radiology and pathology is immediately to hand. We are conscious that these proposals could give rise to additional operating costs but these must be viewed in the light of the potential efficiency gains which such a service could make possible.

2.14 *Influencing Demand on A & E Departments*

While we are satisfied that the vast majority of patients who are admitted to hospital from A & E departments require admission, the volume of attendances at casualty place a considerable strain on the resources of the hospitals, even where admission does not result. Many casualty attendances are in respect of conditions which could be managed elsewhere, particularly in general practice. Over 80% of the respondents to our survey of G.P.s felt that financial considerations are part of the reason why so many patients self-refer to A & E departments. We recommend that a programme of public education on the appropriate use of hospital services, including casualty departments, should be instituted and should be renewed periodically at times of particular pressure on the hospitals. In association with the programme of public education, we recommend that careful consideration be given to the implications of introducing differential charges in respect of attendances at casualty departments so as to provide financial incentives for patients to attend their general practitioner in the first instance, wherever this would be appropriate. Such a system of charges should involve a higher level of charge for patients attending without referral from a G.P.. Appropriate exemptions would have to apply as at present.

2.15. *DISCHARGE OF PATIENTS*

2.15.1 We are strongly of the view that, in addition to the measures suggested in 2.5 for facilitating discharge of patients, there is also scope for improving the arrangements for planning, at an early stage, the discharge of patients. This is especially so for those patients who can be identified as having potential barriers to early discharge, other than their immediate medical condition. Discharge planning of patients should begin from the point of admission. It should be a structured process with responsibility resting on the heads of the relevant disciplines to ensure that their staff are aware of all patients whose needs for rehabilitation and care are likely to be significant. In this regard, the role of the social work, physiotherapy and occupational therapy departments within hospitals is of great importance. While acknowledging that staffing levels in these departments tend to be lower than the professions in question would desire and probably lower than staffing levels in comparable hospitals abroad, we believe that the contribution of these staff would be most effective through a system of discharge planning in which they are actively involved. These support services should be involved at the earliest possible opportunity through participation in ward rounds or case conferences or other mechanisms which facilitate an inter-disciplinary approach to the planning of the patient's discharge. Because of their intimate knowledge of patient progress, we envisage ward sisters exercising a particular responsibility to ensure that the agreed arrangements operate in individual cases.

2.15.2 Liaison with community care services in the planning of discharge is of vital importance. The existing arrangement whereby public health nursing liaison staff are appointed to deal with individual hospitals is one mechanism for structuring this communication. We therefore recommend that full advantage be taken of the opportunity which exists to channel information and experience in both directions between hospital and community care staff through such arrangements. Liaison arrangements should be reviewed in each hospital to ensure that they operate effectively and are fully integrated into the arrangements for discharge planning

recommended in the previous paragraph. The liaison function should, wherever appropriate, extend to other community-based staff.

2.15.3 The importance of communication with public health nursing staff applies also to liaison with general practitioners. We referred at 2.12 above to the particular importance of such communication in the case of patients presenting at A & E departments. The G.P. plays a critical role in the continuing care of patients and should, therefore, be advised of the treatment which his patient has received and the likely requirements for effective management after discharge home. The timeliness of discharge letters has been raised with us as an area of difficulty. Our survey showed that only 4% of G.P.s were often notified when a patient was in hospital. 56% said they often had a prompt discharge letter from their local hospitals. Most G.P.s were happy with the content of the discharge summaries which they did receive. We consider that, where difficulties exist in the issue of early discharge letters or summaries, alternative arrangements should be employed to inform the G.P. of developments prior to the point of discharge, most simply by telephone. There may be merit in the use of FAX machines based in hospitals and G.P. surgeries as an aid to better communication. We consider that this proposal should be examined through an appropriate pilot project.

2.16 *IMPLEMENTATION*

2.16.1 The recommendations which we have made in this Chapter represent aspects of good practice which we consider are capable of being applied in each of the acute general hospitals in the Dublin area. Some constraints may exist in relation to physical arrangements in Accident and Emergency departments but most of the suggestions refer to organisational and procedural matters. The extent to which and the manner in which these will be capable of being applied on each site must be a matter for detailed consideration within the hospitals concerned. The process by which we have arrived at these conclusions strongly suggests that the active involvement of a range of disciplines within the hospital — consultant medical staff, nursing staff, non-consultant medical staff, para-medical staff and management — represents the most effective way of ensuring that the scope for implementing these proposals is identified and fully met. A similar approach is required in relation to the implementation of our proposals affecting community services, including general practitioners.

2.16.2 We therefore recommend that each of the acute general hospitals in Dublin should be invited by the Minister for Health to examine our recommendations in this Chapter and prepare a report on the measures which they will take to give effect to these proposals. A similar invitation should be extended to the Eastern Health Board in respect of community liaison arrangements. The report should indicate the time scale within which these proposals will be implemented and we consider that it should be possible to have the relevant procedures apply from the 1st of October, 1990 at the latest so that these measures are in place to meet the anticipated seasonal increase in demand on the hospitals.

2.16.3 To assist in the process of implementation of these proposals, we plan to establish a sub-group of our members who have been involved in the preparation of the recommendations. They will act as a resource to the hospitals and the other services in their planning for implementation of our proposals and will be a channel through which information, ideas and experience can be exchanged. This sub-group

will also review and evaluate the action taken on foot of our recommendations and their impact on the objectives which our proposals are intended to achieve.

2.16.4 As a first stage in the implementation process, this sub-group will, with the Department of Health, arrange for the organisation of a series of seminars for appropriate hospital staff on the recommendations which we have made and on the steps which may be taken by them in their planning for implementation of these new arrangements.

Chapter Three

RESOURCE IMPLICATIONS

3.1 *Introduction*

3.1.1 In the course of our review of the operation of the acute hospital sector in Dublin, we have identified a wide range of issues which have significant resource implications. Many of those who contributed to our discussions on behalf of different categories of staff within the hospitals were of the view that the level of resources, including beds, available to acute hospitals in the Dublin area was insufficient to enable them to discharge their full range of functions at both secondary and tertiary levels. Additionally, the needs of patients who were found to be inappropriately placed in an acute bed point to a need to develop additional services in the rehabilitation, convalescent and long-stay areas. Furthermore, the scope for developing community services in such a way as to reduce the level of demand on acute beds and the average duration of stay of patients in particular categories of need could also have significant resource implications.

3.1.2 We have identified a number of measures which we consider would make for a more efficient acute hospital service and which have resource implications. In addition, the increased use of hospital beds for more acute care as a result of shorter stays or the avoidance of inappropriate admissions would tend, of itself, to increase the costs of the hospitals concerned with an unchanged bed stock. It would not, however, be appropriate to conclude that the needs of hospitals can be met only through an increase in the level of funding available to the acute hospitals or to the health services in general. Such a conclusion would be warranted only if it were clear that any reasonable scope for improving the efficiency with which existing resources are used had been realised. For that reason, we have given priority to identifying areas of good practice which, on the basis of the empirical evidence which we have reviewed and the informed judgement of members of the Group, have potential to result in more efficient and/or effective care of patients. These we have outlined in the preceeding Chapter. We will be reviewing the action taken by hospitals on foot of our recommendations in the previous Chapter and our approach to resource-based issues will be developed in the light of that experience.

3.1.3 We are also aware that a major review of the value for money achieved in the health services, including the acute hospitals, is currently being conducted, under the aegis of the Efficiency Review Group, by a team headed by Mr Noel Fox. While it would not form part of our brief to evaluate the implications of the findings of that review, we acknowledge that they will be taken into account by the Minister when he comes to examine the recommendations which we will be making in due course in relation to measures which have resource implications.

3.1.4 We are of the view that some of the areas which have been identified as having the potential to contribute to a more efficient and effective overall service have not had their potential assessed in an objective and quantified fashion. In the absence of appropriate evaluation, it is not possible to determine the relative priority

to be accorded to such proposals nor the level of investment which would be warranted in their introduction. For that reason, we are recommending at this point the introduction of a number of demonstration projects on a pilot basis which we consider are essential if a full assessment of their merits is to be made.

3.1.5 Based on the work we have done to date, we have concluded that the overriding priority in resource allocation is to improve the geriatric services both within and without the acute Dublin hospitals. The large number of "inappropriate" long-stay patients in these hospitals and the high proportion of elderly patients among those, as measured in the survey carried out, leads to the conclusion that resources applied selectively in this area should greatly ease the pressure on acute hospital beds and reduce the waiting lists for elective admissions. Our work has also identified two other areas where resources could usefully be allocated on a priority basis, namely, the greater use of modern information technology and improved transport services for patients.

3.2 *DEVELOPING CONSULTANT SERVICES IN GERIATRIC MEDICINE*

3.2.1 One area where we consider that the deployment of additional resources would have a major beneficial impact is in relation to the development of an adequate geriatric service throughout the acute hospital sector.

3.2.2 At present, there are only six physicians in geriatric medicine in Dublin with a population of 1 million. This compares with 25 physicians in geriatric medicine in Northern Ireland (population of 1.5 million) and 46 in Wales (population 2.8 million). Despite the large number of elderly admissions to Dublin hospitals, some do not yet have a department of geriatric medicine. Such departments adequately staffed and resourced and with modern operational policies would play a vital role in responding to the needs of the sick elderly.

3.2.3 ***Prompt Community Response***

Departments of geriatric medicine which provide a prompt response system to requests from general practitioners obviate the need for many admissions. Referrals from general practitioners to a department of geriatric medicine in one Dublin hospital are seen at home within 24 to 48 hours by a visiting sister from the department and a follow up OPD appointment is arranged within a matter of days. Appropriate investigations and treatment can be planned and further follow up can be arranged on a day basis whenever possible. This system frees beds for emergency admissions by reducing inappropriate admissions.

3.2.4 ***Day Hospitals***

Provision of a day hospital attached to each assessment unit on the acute hospital side would prevent the admission of many elderly people to hospital and enable many others to be discharged at an earlier phase of their illness with their care continuing on a day basis. Shortage of transport facilities can be a major limiting factor to this form of treatment and care.

3.2.5 ***Interface with A & E Department***

The presence of an adequate number of assessment beds in the general hospital would enable the department of geriatric medicine to respond promptly to the needs of the older patients presenting to A & E departments thus ensuring a rapid and comprehensive assessment of the elderly when admitted to hospital. This direct involvement would reduce the delays which are inherent in any secondary referral system.

3.2.6 ***Prompt Consultation***

The appointment of more consultants would reduce the delays on consultations currently experienced. This would apply also to specialties such as neurology, rehabilitation medicine and psycho-geriatrics where there is a current shortage.

3.2.7 In our view, the presence of a physician in geriatric medicine with appropriate support services including assessment beds and an effective role in managing a broad service to elderly patients can make a very significant difference to the efficient use of existing acute beds. Increasing the number of physicians in geriatric medicine forms part of established policy on the part of both the Department of Health and Comhairle na nOspideal. We therefore recommend that steps be taken as a matter of urgency to appoint consultant staff in geriatric medicine to the Dublin hospitals which do not currently have an adequate service in this specialty and that all such consultant staff have adequate support services.

3.2.8 "The Years Ahead" — The Report of the Working Party on Health and Welfare Services for the Elderly — in dealing with this subject clearly states:

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

3.3 *ALTERNATIVES TO ACUTE IN-PATIENT TREATMENT*

3.3.1 The shortage of step-down and long-stay accommodation for patients in the Dublin area has been indicated by the results of the survey of patients conducted for the Group. The survey indicated that, of the 194 inappropriately placed patients, 143 required another level of care. 97 of these patients were awaiting a place in long-stay care but only 16 were considered suitable for discharge to the community. Of the remaining 51 patients who were inappropriately placed, the two most frequent reasons given for their remaining in hospital were their requirement for rehabilitation or for dressings of wounds often after skin grafts. It was considered that 50% of these patients could be managed in a step-down facility if such were

available and that ultimately up to 75% of them could be discharged home. In making a judgement as to the possibility of discharge to the community, the registrars in community medicine were asked to make a judgement on the basis of optimum levels of community care rather than the level of community services which may be currently available.

3.3.2 Additional resources were specifically provided for the development of services for the elderly in association with the 1990 budget. We recommend that priority be given in the allocation of such resources to remedying the deficiencies which we have identified and which are also acknowledged in the Eastern Health Board's policy document and which would enable more appropriate management of elderly patients to be put in place.

3.4 *Rehabilitation Service*

The need for intensive rehabilitation of patients, many of whom are elderly, is one of the factors which we have identified as contributing to unnecessarily long stays in acute hospital beds. The proposals which we have made for more systematic planning of discharge should help to reduce the delays which can arise as a result of this need. However, we recognise that a case exists for developing a structured service for patients whose rehabilitation and step-down needs are greater than the norm but who do not require the services of a tertiary referral hospital. We therefore, recommend that, on a pilot basis, a comprehensive rehabilitation service geared to the needs of such patients and drawing on an appropriate range of disciplines should be introduced in a special unit. The purpose of the pilot scheme would be to establish the level of intervention which patients with appropriate levels of incapacity require and the most effective means of supplying such services. We understand that a review of the provision for rehabilitation medicine in Dublin is currently taking place. We envisage that the pilot scheme which we recommend would be established and evaluated in association with any changes which may be proposed for medical rehabilitation services.

3.5 *Community Care Services*

The case has been made to the Group that additional staffing and other resources are necessary to improve the management of patients in the community. The vast majority of G.P.s who responded to our survey reported that, while they had little or no difficulty in accessing nursing and social work services in the community, they had significant levels of difficulty in accessing physiotherapy and occupational therapy services. We are not in a position to identify the contribution which specific developments in the community care services might make to alleviating pressure on the acute hospitals. The extent to which this would reduce the volume of admissions or the average duration of stay of patients is not clear. In our view every effort should first of all be made to ensure that maximum return is obtained from existing resources before requests for additional facilities can be considered. For example, we have already drawn attention to the need for better communication between community and hospital based services. We consider that the only appropriate method of assessing whether and the extent to which such a contribution might be made is to conduct an appropriately structured pilot exercise involving a designated area which is associated with a particular hospital or hospitals. We are currently

examining the desirable scope and objectives for such an exercise and will make proposals in this regard in the near future.

If additional resources are to be provided for the community nursing service to meet the objective of earlier discharge of patients, priority should be given to the employment of registered general nurses for the service. In addition, home care assistants should be provided to assist the public health nurses and the registered general nurses. The remit of the community nursing service would require to be extended to a full out-of-hours service.

3.6 *COMPUTERISATION OF INFORMATION TRANSMISSION AND RETRIEVAL SYSTEM*

3.6.1 Computerisation of information is critical to the efficient operation of the health services. However, the computerisation of information transmission has been given a relatively low priority. Without unduly taxing the resources available to the health programme in this country, a re-specification of the priorities in the computerisation programme will enable radiology and pathology to be upgraded, with a consequent emphasis on instant data access to facilitate more effective patient management. We think that this should be adopted as a priority, designed to improve the resource utilisation in the Dublin hospitals. The development of linkages to community-based personnel should also feature in the design of computer systems.

3.6.2 One of the major benefits of greater utilisation of information technology is the availability of data on hospital activity trends and patterns of demand. In addition to the use of such data in epidemiology and clinical research, this information is of vital importance to the regular review of the efficiency and effectiveness of the hospital service. This will be possible only if appropriate personnel with expertise in health services research are available to work with health care providers. An investment is required in the development of that expertise.

3.7 *TRANSPORT SERVICES*

We are satisfied that difficulties can arise in arranging transport for hospital patients which can prolong their length of stay and delay their discharge. Transport is required to enable patients to be transferred between hospitals in Dublin for necessary tests and treatment, to be brought to and from hospital for certain forms of day treatment and to be returned home or to a referring hospital outside Dublin following discharge. The pressure on health board ambulance and transport services is acknowledged, as is the need to ensure that transport fleets are used to maximum efficiency. However, present arrangements do not appear to provide adequately for the needs of hospitals. We therefore recommend that the provision of a specific level of service to hospitals be explored between the Eastern Health Board and the Dublin hospitals and that hospitals be authorised to arrange transport, at the expense of the relevant health board, if patients referred from outside Dublin are not collected within 24 hours of notification of their discharge from consultant medical care.

3.8 *OVERALL ALLOCATION OF RESOURCES*

The Group will continue to address the resource implications of providing the most appropriate basis for an effective and efficient hospital service. In the course of this, the Group shall be reviewing the existing arrangements for the allocation of resources to the individual hospitals and the extent to which this reflects the specific tasks which hospitals individually and jointly in the Dublin area are expected to perform. In particular, the Group will be reviewing the extent to which the differing and sometimes conflicting roles of individual hospitals are reflected in the budgetary process. The Group is also satisfied that the effective use of the resources provided to individual hospitals and the hospital system generally is heavily dependent on the extent to which the full contribution of clinicians is reflected in the management task. The Group is aware that the issue of resource management within hospitals and its linkage to clinical practice is currently the subject of consideration in a number of quarters within the profession and within management. The Group is also aware of proposals for pilot initiatives in this area and will be addressing these in the course of the preparation of specific recommendations on resource questions in the next stage of our work.

Chapter Four

ORGANISATIONAL ARRANGEMENTS AND THE INTEGRATION OF SERVICES

4.1 *Introduction*

4.1.1 A key objective of development of the health services in Dublin is to ensure that patients' needs are met in the settings which are most appropriate to their condition. This includes taking steps to eliminate unnecessary admissions to acute general hospitals which currently contributes to the impairment of the secondary and tertiary referral role of many hospitals.

4.1.2 The realisation of this objective requires that an appropriate range of services be available and that they be co-ordinated in a way which focusses on the specific needs of patients and identified communities. The elements of such a comprehensive range of services already exist: primary care, community hospital services, secondary care on referral from the primary sector and tertiary services accessed by referral from the secondary care level. All of these services are underpinned by a range of continuing and support services outside the acute area, in such fields as mental illness, mental handicap and institutional care of the elderly.

4.2 *Principles to Govern Organisational Arrangements*

In its review of these arrangements, the Group has identified scope for improving the balance between these various types and levels of care and the arrangements for their co-ordination. These issues are reported on in specific terms as they relate to the detailed arrangements for admission and discharge which have been examined in earlier Chapters. A comprehensive recommendation by the Group on the structural, organisational and management issues will require considerable further study. However, the Group's approach to the general organisational issues is informed by the following principles:-

- the planning of services should be based on an assessment of the overall health needs of identified communities;
- the allocation of resources to the different types and levels of care should take explicit account of their interaction and substitutability;
- the respective roles of the various institutions and services in regard to categories of need and groups of patients should be clearly understood;
- good communication links based on these mutually agreed roles must operate on a systematic basis;
- a role for clinicians to contribute to the planning and management process should be defined;

— adequate information on patterns of demand, utilisation and cost must be available to guide decision-taking;

— structured arrangements to review overall performance and the contribution of each element must apply;

— appropriate account must be taken of the demand made on services in Dublin by patients from outside the Dublin area.

4.3 *Deficiencies of Current Structures*

4.3.1 The Group are of the view that the present organisational structures in the Dublin area do not meet these criteria. The present structures are notable for the fragmentation of the health service, the confusion as to roles and responsibilities of the various agencies and the lack of an effective overview of the interaction of services at the levels of planning or delivery. The difficulties arise from the scale of the area and population to be served, the operational autonomy of most of the acute general hospitals and many of the non-acute agencies in the city, the fact that the geographical areas which apply in the organisation of community care services do not generally co-incide with the configuration of the populations served by acute hospitals and because of relative isolation of the more than 800 general practitioners in the region from the rest of the health care system.

The present structures facilitate a lack of co-ordination and provide no proper basis for resource allocation or for performance review. These are deficiencies which need to be addressed urgently.

4.3.2 The Group is examining a range of options to address these problems. The objective is to identify structures which will build on the very tangible strengths of existing organisations and services while addressing in a feasible manner the deficiencies which apply in the planning and co-ordination of activity at regional and sub-regional levels.

4.4 *Management Development*

4.4.1 Whatever the structural arrangements, it is essential that the complex tasks of managing and delivering a modern hospital service be undertaken by staff with appropriate training and expertise. The Group is satisfied that, despite the goodwill and experience which is evident among hospital staff of all disciplines, there is an urgent need for better management training for those exercising management functions in the medical, nursing and managerial streams. The Group believes that progress on these issues, even on an experimental basis, should proceed in advance of structural or organisational development. This is a topic to which the Group intends to return with detailed recommendations in the near future.

4.4.2 The Group is also conscious of the need to address the issue of the role of clinicians in the hospital system. A number of models have been developed abroad which involve the medical profession directly in critical issues of resource allocation and the Group believes that there is scope for considerable improvement in the present arrangements to harness more effectively the talent on both the medical and the management sides.