

How good are current local hospital services?

Wide interest in improving acute healthcare in the North East

In seeking to identify best acute healthcare, we are well aware of the concerns, particularly of patients and staff, that sustained action needs to be taken both now and in the future to improve healthcare available to current and future residents of the North East.

We recognise too the inevitable trade-off between different alternatives, for example, between providing care close to home without compromising safety. Key patient requirements are for care to be patient focused, clinically effective, safe, and locally accessible. From a health system perspective, the services need to be safe, sustainable, cost effective and provide equity of access.

Identifying site specific and consultant services is sensitive and it is not the purpose of this report to intentionally single out for acknowledgment or criticism any specific location or individual involved in the delivery of healthcare. Indeed, during familiarisation visits to the five hospitals in the North East, we were impressed by the recognition and appetite among clinicians and managers to engage in changing and improving acute care.

The Health Service Executive has indicated to us that we should anticipate subsequent wide circulation of this report to the general public, patients, clinicians, staff, trade unions, local hospital groups, professional, academic and regulatory bodies, local and national politicians and governmental organisations, and private sector organisations with interests in healthcare reflecting widespread interest in improving healthcare in the North East.

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A substantial amount of public hospital acute care for North East residents is currently provided from outside the North East as illustrated in Table 1. This data relates only to public hospitals and data about use of private hospitals by North East residents was not provided to us.

Table 1: North East Resident Admissions in 2004 split by hospital area

Admission Method	Hospital				% Dublin Hospital
	North East	Dublin	Other	Total	
Day Case	31,651	15,088	455	47,194	32.0%
Elective Inpatient	4,895	5,339	129	10,363	51.5%
Emergency	28,500	4,182	731	33,413	12.5%
Maternity	9,638	2,001	399	12,038	16.6%
New Born	906	277	11	1,194	23.2%
Total	75,590	26,887	1,725	104,202	25.8%

This indicates that about a quarter of all acute care for residents of the North East is currently provided by hospitals in Dublin. More than half of the inpatient planned care is provided by hospitals in Dublin. For emergency care, a smaller but still significant amount of health care is provided from outside the North East. For Counties Cavan, Monaghan and Louth about 90% of emergency admissions are to local North East hospitals, with between 55% and 50% of planned admissions to local North East hospitals. For County Meath the respective emergency and planned admissions are about 70% and 35% reflecting greater use of Dublin hospitals.

The rest of this section is concerned with the services provided by the five public hospitals in the North East.

Hospital services in the North East

We recognise that the Health Service Executive has a key role in maintaining public trust and confidence in the health service. The Health Service Executive has specifically asked us to comment on the risks and benefits associated with the current provision of acute hospital services on the five hospital sites in the North East, without undertaking clinical governance, detailed service and site reviews, or engaging with local clinicians and staff.

Of necessity therefore, our comments in this section do not represent a comprehensive risk analysis, rather they have been derived from interpretation of the hospital discharge data and the review of previous reports dealing with specific incidents that have given rise to concern.

Our findings are both reassuring in some respects and disturbing in others:

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- Reassuring in that there are examples of good progress having been made in improving some services; and
- Disturbing in that other aspects of the acute hospital services, as presently organised and delivered, appear incapable of reliably maintaining minimum levels of patient safety, despite the best efforts of the incumbent staff.

We feel that the Health Service Executive must take immediate action to alleviate these urgent and important issues as the first step towards of a definitive longer term programme to implement best practice across the region.

The reassuring aspects

IN SUMMARY

We find that there is some movement towards implementing best practice through the amalgamation of services, the separation across sites for planned and emergency admissions for some services, and the development of joint departments.

There is evidence of movement towards best practice

The 'direction of travel' towards best practice has started in the North East, as indicated by recent changes in the service arrangements for trauma and orthopaedics across the whole of the North East and for general surgery in Drogheda and Dundalk, and Cavan and Monaghan.

In line with best practice developments already established in these specialties in other health systems, they are moving away from the traditional approach whereby every site does a bit of everything. Reconfiguration has been based upon recognised best practice methods, namely:

- The amalgamation of emergency services, with benefits to staff (less onerous on-call, better teamworking, better facilities) and to patients (more consultant input, improved patient safety and quality of care); and
- The separation of planned patients from emergencies, with benefits to staff (easier organisation, ring fencing of beds, assured theatre access) and to patients (more standardised, streamlined care, easier admission / discharge process, minimal cancellations).



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These changes have resulted in the establishment of:

- A single regional trauma centre;
All trauma patients, both adults and children, from across the North East are now triaged to the centre, based at Our Lady of Lourdes Hospital, Drogheda, where they are managed by a team of 8 orthopaedic consultants with access to a single dedicated trauma theatre.
- A separate, single, regional elective orthopaedic centre;
All adult patients in need of planned orthopaedic surgery are managed in the dedicated elective centre, based at Our Lady's Hospital, Navan.
- Two local clinical networks for general surgery;
The 6 general surgeons at Our Lady of Lourdes Hospital, Drogheda and Louth County Hospital, Dundalk have merged into a joint department to launch a local clinical network for their local catchment population. This means that all urgent general surgical patients are managed at Our Lady of Lourdes Hospital, Drogheda and all patients requiring routine planned surgery go to Louth County Hospital, Dundalk;

Similarly, the general surgeons at Cavan General Hospital and Monaghan General Hospital manage all their emergencies and routine planned surgery at Cavan, with a day surgery service at Monaghan.

There is a move towards joint consultant appointments

A number of joint consultant appointments are in place:

- In recognition of the difficulty in recruiting consultants to hospitals where the clinical activity does not justify a full time appointment;
- In response to the need to improve professional working relationships between individual hospitals and specialties; and
- To improve cross cover arrangements.

For example:

- Some of the A&E consultants based at Drogheda spend 5 sessions a week each at Louth County Hospital, Dundalk and Our Lady's Hospital, Navan A&E services;

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- The paediatricians based at Our Lady of Lourdes Hospital, Drogheda have sessional commitments supporting the paediatric unit at Cavan General Hospital; and
- The radiologists and pathologists within the two hospital groups have sessional commitments on two or more sites.

However, we have not found any evidence to suggest that the use of joint appointments across physical sites is effective as a method of establishing best practice. Even so, we do not have any practical concerns with joint appointments in principle, as long as:

- They are not used as a ‘stop gap’ solution to avoid or postpone the need for a definitive sustainable solution;
- There is an acknowledgement that the travelling element for the consultant is a reasonable and proportionate use of his/her time;
- The sessions on the second site are for planned care and add real clinical value to that service; and
- Any cross cover or on-call arrangements are really clinically appropriate and deliverable.

The disturbing aspects

IN SUMMARY

We find that the present way that some critical elements of acute care are organised and distributed across the North East predisposes that service to creating additional substantial professional risks for staff and worrying clinical risks for patients.

We consider that services, as presently set up, are carrying a range of increased risks. These risks are serious but avoidable, yet they are long standing, on-going and provide for the continued potential or actual erosion of patient safety and good clinical risk management.

We regard the high profile examples of the failures to maintain adequate care, described in the various enquiry reports into specific events, as the overt symptoms of an underlying systematic general dysfunction inherent in the present system.



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There is, as yet, no plan in place for addressing these structural issues in the current 'system' of healthcare delivery. We assume that the Health Service Executive is seeking guidance from this report to begin the process.

Our findings

The present system itself is a key source of the increased risks. Our concerns relate to:

- Unsustainable emergency general surgery service at Our Lady's Hospital, Navan
- A&E services are not sustainable
- The problem of occasional major planned operations
- The multiple, local critical care units
- Keeping acute services open with unsustainable staffing arrangements
- Repeated failure of recruitment and retention
- The increasing risks to acute medical services from the withdrawal of emergency general surgery services
- The deskilling of staff due to not enough clinical activity flowing through their service
- The absence of any formal clinical governance or peer review
- Limited accreditation for post-graduate surgical and medical training
- None of the five hospitals have yet been accredited by the Irish Health Services Accreditation Board (IHSAB)

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Simply looking at the current service configuration of the five hospitals and the relevant enquiry reports, we have identified a number of systemic 'indicators', deeply embedded in the present system, that are well recognised for their predisposition to creating circumstances that:

- Leave staff exposed to lack of supervision; and
- Leave patients exposed to an environment where there is an increased risk of something going wrong.

These general risk factors, listed below, will come as no surprise to health professionals working in the North East. They are not new, they are not subtle and they must already be well known.

They are likely to represent a potent source of frustration and excessive stress to relevant health professionals and managers alike as they try to maintain good standards of patient safety and quality of care when they know that the present system itself is a key source of the increased risks.

We are particularly concerned to draw the attention of the Health Service Executive to the following issues, which are summarised below and examined in more detail later:

- Non-viable emergency general surgery service at Navan
The emergency general surgical service is presently 'held together' by only two consultants and this staffing arrangement at Our Lady's Hospital, Navan is unsustainable.
- A&E services are not sustainable
Within the current arrangements, there is an insufficient number of A&E consultants in the North East to provide a safe and sustainable service. These consultant staff are spread too thinly across 4 hospital sites and cannot provide sufficient clinical supervision to ensure the quality of service provision.
- The problem of the occasional major planned operations
The current system accepts the traditional surgical approach, whereby any general surgeon across the region is free to undertake the occasional major planned operation, rather than referring such patients to the appropriate sub-specialty team.
- The multiple local, critical care units
The current configuration accepts that each of the five hospitals maintains its own stand-alone critical care unit, a recognised circumstance for reducing the quality of critical care to patients to problematic levels, despite the best efforts of the staff.



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There has been a general move for some years now to regionalise critical care services and concentrate scarce specialist staff and resources in order to create a critical mass that can improve and maintain the quality of critical care on a 24/7 basis. The North East is substantially behind on service developments that are now considered internationally as standard.

- Keeping acute services open with unsustainable staffing arrangements

Usually as a consequence of failure of recruitment and retention, attempting to keep local acute 24/7 hospital services 'alive' with:

- Only one, two or at the most three consultants to run a 24/7 service, resulting in gaps in consultant supervision and excessive on-call commitments, if not workload. There are numerous examples of this arrangement across the region, affecting all the clinical specialties, including radiology and pathology;
- Use of long term locums; and
- Sub-contracting services to a third party commercial medical staffing agency drawing in 'independent' doctors from abroad.

- Examples of repeated failure of recruitment and retention

This can be interpreted as the end result of allowing local 24/7 hospital services to continue to serve small local catchment populations. There is not enough clinical activity going through the local hospital to attract suitably qualified health professionals, even if resources were available for recruitment.

- The increasing risks to acute medical services from the withdrawal of emergency general surgery services

Improving emergency surgery services means moving towards centralisation, as this is now happening in the North East and elsewhere. This leaves acute general medicine exposed in these areas, due to the withdrawal of emergency general surgery support, with consequences for the capacity of those services to maintain patient safety.

- The deskilling of staff

The system is exposing its service staff, placed in the situation of managing low numbers of patients with acute clinical problems, due to the small size of the local population, to deskilling, loss of competencies and demotivation over time.

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- The absence of any formal clinical governance or peer review

The system currently operates in the traditional manner, on the 'assumption' that the safety and quality of patient care is satisfactory, rather than ensuring that clinical performance is audited, measured and reported against a set of recognised standards.

- Limited accreditation for post-graduate surgical & medical training

There is a strong natural relationship between education and research programmes and quality of patient care. All hospitals seek accredited teaching status as a key element of its service, reputation and ability to recruit and retain the best staff. The accreditation status for hospitals in the North East is:

- The Royal College of Surgeons of Ireland accredits only one of the five hospitals, Our Lady of Lourdes Hospital, Drogheda, as suitable for training in general surgery and is planning to withdraw accreditation for A&E training from Cavan General Hospital, effective July 2006.
- The Royal College of Physicians of Ireland accredits four hospitals for the purposes of general medicine training, but none for sub-specialty training.

- None of the five hospitals have yet been accredited by the Irish Health Services Accreditation Board (IHSAB)

- The primary purpose of the IHSAB, an independent statutory body launched in October 2002, is to 'establish, continuously review and operate an Accreditation scheme for the Irish health system within a quality framework';
- The IHSAB stated in its newsletter of April 2005 that 80% of acute public sector hospitals in Ireland were utilising the Quality and Safety framework.
- The IHSAB website indicates that in December 2005 applications for accreditation were received from the hospitals in the North East.



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What needs sorting out urgently?

These general risk factors have expressed themselves operationally in different ways, affecting, in particular, the A&E services, emergency general surgery and critical care, where we regard some elements of each as in need of urgent support, action and resolution, to improve safety and protect patients and staff. The following section describes our most immediate concerns in four areas:

- The emergency general surgery service at Our Lady's Hospital, Navan is not sustainable;
- Major planned surgery is being undertaken on an occasional basis at all sites;
- None of the A&E services are sustainable in their present form; and
- The 'critical care' units are too fragmented and too small to be fully effective or sufficiently safe.

Problem One There is an unsustainable emergency general surgery service at Our Lady's Hospital, Navan

The emergency general surgical service is presently 'held together' by only two consultants (1.6 WTE). This level of staffing and commitment to on-call is substantially less than the other local hospitals and has been accepted by the system for far too long. It is much too onerous, and is recognised to be an unsustainable, arrangement. This is independent of the level of emergency surgical activity that the two surgeons are required to perform.

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To put this issue into context across the region, Table 2 below shows that Our Lady’s Hospital Navan admits at a daily average rate of 4.2 adult general surgery emergencies and compares it to all the other hospitals in the north east and north Dublin.

Table 2 Emergency general surgery services in the north east and north Dublin: Average daily rate of adult discharges in 2004

Hospital	Adults		Total Discharges	Total Daily Rate
	Discharges	Average Daily Rate		
In the North East				
Our Lady of Lourdes, Drogheda	1,731	4.8	2,196	6.0
Our Lady's Hospital, Navan	1,527	4.2	1,552	4.3
Louth County Hospital (*)	1,158	3.2	1,171	3.2
Cavan General Hospital	2,165	5.9	2,488	6.8
Monaghan General Hospital (**)	654	1.8	655	1.8
In north Dublin				
Mater Misericordiae Hospital	1,296	3.5	1,299	3.6
Beaumont Hospital (***)	1,697	4.7	1,714	4.7
Connolly Hospital	1,901	5.2	1,915	5.3
GRAND TOTAL	12,129	33.2	12,990	35.6

(*) Since 2005, Louth County Hospital no longer takes general surgery emergencies. They are referred to Our Lady of Lourdes Hospital, Drogheda

(**) Since 2005, Monaghan General Hospital no longer takes general surgery emergencies. They are referred to Our Lady’s Hospital, Navan

(***) General surgery only, excludes vascular and hepato-biliary surgical emergency discharges

The total daily average adult emergency general surgery discharges for the north east and north Dublin hospitals comes out at only 33.2 per day, 19.8 for the north east and 13.4 for north Dublin. Cavan General Hospital has the highest rate, at 5.9 per day, a rate that looks ‘at odds’ with the other hospitals and raises the question of whether there are differences in the criteria for admission.

The way the service is currently organised, there are two small networks and a third hospital each managing a small volume of daily general surgical emergencies. We would argue that the hospitals are not managing enough general surgical emergencies for long term sustainability and that there is a need for further rationalisation of these services.

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A similar exercise indicates that the total orthopaedic trauma across the whole of the North East and north Dublin comes out at a daily average rate for adults at 14.4 per day (6.9 in the north east and 7.6 for north Dublin). This confirms the rationale for centralisation of trauma in the North East and also raises a similar question for north Dublin, where the three hospitals had daily rates of 3.0, 3.0 and 1.6 respectively.

How do the average daily emergency general surgical admission rates in the North East and north Dublin compare with UK admission rates?

Based upon our concerns about the emergency general surgery service at Our Lady's Hospital, Navan, we wished to understand the bigger picture on service viability, concentrating on the variation in admission rates themselves and how these rates related to the catchment populations.

Table 3 compares the daily activity in the North East and north Dublin hospitals and their populations in 2004 with the UK experience, using information from available sources.

Table 3 Range of daily average rates of adult emergency general surgery discharges: comparison between the Irish and UK experience, 2004

Healthcare Provider	Catchment population	Spells or Discharges	Daily Rate	Daily Rate per 100,000 Population
North East Hospitals	371,980	7,235	19.82	5.33
North Dublin Hospitals	498,906	4,894	13.41	2.69
NHS Trust 1	350,000	4,907	13.44	3.84
NHS Trust 1	500,000	3,096	8.48	1.70
Welsh Region	675,000	8,489	23.26	3.45
NHS Trust 3	240,000	2,694	7.38	3.08
NHS Trust 4	300,000	2,355	6.45	2.15
Strategic Health Authority	2,500,000	27,583	75.57	3.02

The comparison show that the hospitals in the North East have the highest rate per 100,000 at 5.9, more than double the rate in the north Dublin hospitals and substantially higher than any of the UK rates.

These findings are also highly relevant when we come to look later on at the evidence around what size of catchment population is needed for a regional hospital. At least with regard to general surgery there is a need to plan for an average of 33 patients per day, although as Table 4 suggests some 18% of admissions may not have needed admission at all.

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Seeking further explanation for these high rates, we looked at what happened to patients after admission. We found a very wide variation, from 1% to 50% across the hospitals, when we examined those patients who had no procedure, either diagnostic or surgical, recorded for their episode of care. This is demonstrated in Table 4.

Table 4 Comparison of adult emergency general surgical discharges who did not undergo a procedure during their episode of care

Hospital	Adults		% No procedure
	Total Discharges	Discharges, No procedure	
In the North East			
Our Lady of Lourdes, Drogheda	1,731	26	2%
Our Lady's Hospital, Navan	1,527	319	21%
Louth County Hospital	1,158	469	41%
Cavan General Hospital	2,165	569	26%
Monaghan General Hospital	654	330	50%
In north Dublin			
Mater Misericordiae Hospital	1,296	439	34%
Beaumont Hospital (*)	2,146	20	1%
Connolly Hospital	1,901	111	6%
TOTAL	12,578	2,283	18%

(*) Includes vascular and hepato-biliary emergencies

The high percentages of emergency patients with no recorded procedure raises the question of whether patients are being admitted unnecessarily to hospital, particularly at the hospitals at Navan, Cavan, Dundalk and Monaghan. We would anticipate that the proposed patient dependency census would help identify the current position.



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Problem Two: None of the A&E services in the North East are sustainable in their current form

In 2004, the new A&E attendances for each hospital site are shown in Table 5.

Table 5: New A&E Attendances, 2004

Hospital Site	New A&E attendances	Consultant staffing
Drogheda	35,858	2
Dundalk (*)	18,754	0.5 (from Drogheda)
Cavan	18,101	1 (long term locum)
Navan (*)	15,323	0.5 (from Drogheda)
Monaghan (**)	7,812	0
TOTAL	95,848	4

(*) These A&E services are sub-contracted to a commercial medical staffing agency

(**) Operates as a 'Treatment Room' service, receiving minor injuries and illnesses

The review of the British Association of Emergency Medicine (BAEM)⁹⁶ recommended a minimum of 3 consultants to staff a small local hospital A&E service, i.e. the size of Our Lady of Lourdes Hospital, Drogheda. However, this level of consultant staffing provides clinical cover for less than 40 hours a week and BAEM states that it is only with 6 consultants that provision for 12 hours daytime cover on weekdays and 6 hours at weekends can be provided.

Using these benchmarks, as laid out in the section on international best practice, we have real concerns about the overall patient safety and the quality of A&E services as presently organised across the North East:

- Overall, there are not enough A&E consultants and they are spread too thinly across too many sites

Our Lady of Lourdes Hospital, Drogheda nominally has 3 consultants. In practice it operates with 2, due to their sessional commitments to the hospitals at Dundalk and Navan through joint appointments.

⁹⁶ The Way Ahead 2005, British Association of Emergency Medicine and the College of Emergency Medicine

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To emphasise this point further, there is a total of only 4 consultants in the North East to oversee the management of some 96,000 new attendances each year. Such a ratio would be considered woefully inadequate if they were being dealt with in a single large department. BAEM recommends at least 8 at that level of clinical activity, calculated on 1 consultant per 12,000 attendances.

We regard the overall consultant staffing arrangement as inadequate and unsustainable, for all sites. The number of consultants is too small to provide a satisfactory level of consultant supervision anywhere in the A&E system across the North East. Spreading the consultants thinly is not a situation designed to promote a satisfactory quality of service.

- The low volumes of A&E attendances at four sites.

The very low volume of A&E attendances in four out of the five sites, which is insufficient to justify appointing additional consultants in these units, and not attractive to the right calibre of A&E consultant.

- The hospital A&E services at Dundalk and Navan are not viable as A&E services

Decisions to date have been made to keep both these essentially non-viable services 'alive' by sub-contracting them out to a third party commercial provider.

Patients attending Louth County Hospital, Dundalk and Our Lady's Hospital, Navan for A&E treatment are treated by non-consultant doctors, supplied on contract by a recruitment agency. There is no consultant supervision apart from the visiting consultants from Our Lady of Lourdes Hospital, Drogheda. We are unaware of any monitoring of clinical performance and outcomes.

Our perception on this sequence of events, rightly or wrongly, is that the imperative has been to keep the services open and that scant attention has been, and is being, paid to patient safety, clinical quality and performance of the sub-contracted services. There has been no commitment to address the structural problems that led to the services failing in the first place.

As already indicated, the low volume of attendances would meet the criteria for conversion to nurse led minor injuries services.

- The Cavan General Hospital A&E service has serious problems



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In addition to the problems of A&E viability on account of the low annual attendance rate, Cavan General Hospital is also forced to rely on a single handed locum consultant for its senior input. A recent recruitment exercise has failed to make a substantive appointment and their accreditation for training will be withdrawn from July 2006. This sequence of events has resonance with the hospitals at Dundalk and Navan.

In essence, this service is seriously deficient in consultant supervision, with obvious consequences for patient safety and clinical risk management.

We are not confident that, compared to today's ordinary standards of A&E clinical practice, let alone standards of A&E best practice, the current A&E service at Cavan General Hospital is clinically viable and able to offer a reliable and safe service.

- The 'Treatment Room' service at Monaghan General Hospital

Very low numbers attended the 'Treatment Room' in 2004, less than 8,000 new attendances, managed by three non-consultant medical staff. Placing permanent non-consultant medical staff in a small, peripheral service managing a small number of patients is a long term precursor for deskilling and downgrading the quality of service. This service should be led and managed by emergency nurse practitioners.

In summary, we feel that the A&E services, as presently staffed and organised, are not in a position to offer consultant supervision on a 24/7 basis across the North East and never will be able to with the way the service is presently configured. It is not appropriate in 2006 to simply continue to bolster up failing services that lack the necessary critical mass to attract the right calibre of consultants, particularly when the low level of clinical activity would not justify the presence of a full consultant team.

Further, apart from Our Lady of Lourdes Hospital, Drogheda, the current services have difficulty meeting today's basic standards, let alone best practice standards, for a true A&E service, when compared to other health systems.

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Problem Three Major elective surgery in the region should not be undertaken on an occasional basis

As an example, a review of cancer operations performed in 2004, listed in Table 6 below, shows that many operations are being undertaken on an occasional basis on all sites. Overall, there were 199 cancer procedures undertaken across the 5 hospital sites; less than 4 procedures a week.

It is accepted that such patients run a greater risk of poorer clinical outcomes under these circumstances. It is considered much better practice to reduce the number of surgeons who undertake this category of surgery by establishing sub-speciality teams to manage them, as reflected in the reorganisation of cancer services that is well now under way in many countries ^{97 98 99 100 101}.

Table 6: Summary of cancer procedures in the North East hospitals, 2004

Cancer procedure	Hospital site				
	Drogheda	Dundalk	Navan	Cavan	Monaghan
Breast	99	#	#	#	13
Cervix	#				
Colon	24	11	10	#	
Prostate	8				
Rectum, Recto-sigmoid & Anus	13	#	#		
Uterus	6			#	

denotes less than 5 procedures

A further example is surgery performed on children. An analysis of surgery undertaken on children under 14 years in 2004, identifies that many surgeons at Cavan General Hospital and Our Lady of Lourdes Hospital, Drogheda undertook paediatric planned inpatient cases. For some surgeons, this was less than 10 paediatric cases in the year.

⁹⁷ National Service Framework for Cancer Services. DOH UK 2001

⁹⁸ The NHS Cancer Plan. A plan for investment A plan for reform DOH UK 2000

⁹⁹ New Zealand Cancer Control Strategy. Ministry of Health and Cancer Control Trust Aug 2003

¹⁰⁰ Priorities for action in cancer control, 2001 – 2003. DOH Australia

¹⁰¹ Cancer in Scotland. Action for change. HDL(2001)54 Executive Letter



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*Problem Four The critical care units are too fragmented
and too small to work effectively*

In 2004, the adult critical care services had the following characteristics, Table 7.

Table 7: Adult Critical Care Services

Hospital	Beds		Total Admissions (incl. CCU)	General Medical & Coronary Care Admissions
	ICU	CCU		
Drogheda	7	(*)	730	324
Dundalk	2	4	464	378
Cavan	4	4	745	365
Navan	10	(*)	732	474
Monaghan	3 (**)	3	426	392

(*) the CCU beds are incorporated into the ICU beds

(**) designated as High Dependency Beds

The present adult critical care 'system':

- Operates as five stand-alone critical care services across the North East, one on each hospital site;
- Has no consultant intensivists working full time on critical care;
- Has each unit receiving consultant cover from the anaesthetists, also responsible for a general anaesthetic service to each hospital;
- Are operating small units of 2, 3, or 4 critical care beds in most hospitals. As stated in the earlier section, the local element of the critical care network would not provide acute critical care services. These would be centralised into the regional hospital service led by consultant intensivists;
- Has an average daily rate of admission varying from 1.2 per day (Monaghan General Hospital) to 2.0 per day (Cavan General Hospital);
- Has a wide variation in the rates of general medicine / coronary admissions to adult critical care across the North East, with Our Lady's Hospital, Navan having the highest general medicine/coronary care admissions (474) and Drogheda the lowest (324); and
- Also operates a coronary care 'system' as five 'stand-alone' coronary care services across the North East.

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While on the face of it the local units are providing local access to critical care and coronary care, the real question is:

‘What quality of specialised care are they actually providing?’

This simple analysis is enough to give us a substantial feeling of concern about the widely dispersed nature and organisation of the present critical care and coronary care services, and the unexpected variations in admission rates across the sites, suggesting variations in clinical practice.

We see the services as too fragmented to maintain, in each locality, on a 24/7 basis, the necessary level of specialised medical, nursing and other skills for the solid, reliable provision of the appropriate quality of specialised care that patients rightly expect to be available to them in 2006. We, therefore, see the present circumstances as unsatisfactory, unsafe, unsustainable and in need of prompt attention.

For example, with regard to coronary care, a recent UK study ¹⁰² highlighted the clinical consequences of patients not being managed by a cardiologist supported by angiography facilities. The study audited the clinical outcomes of 88782 patients registered on the national myocardial infarct database in 2004-5. It concluded that ‘Patients cared for by cardiologists had less comorbidity than other patients. They were more likely to receive proved treatments and angiography, and they had a lower adjusted 90 day mortality. Large differences existed in the use of angiography between interventional and non-interventional hospitals. These findings show wide variation in the management and outcome of patients with myocardial infarct in England and Wales’. With coronary care beds centralised in a service led by a cardiologist, clinical outcomes for myocardial infarction should improve.

IN SUMMARY

We see the services as too fragmented to maintain, in each locality, on a 24/7 basis for an acute 24/7 service, the necessary level of specialised medical, nursing and other skills for the solid, reliable provision of the appropriate quality of specialised critical care and coronary care that patients rightly expect to be available to them in 2006.

¹⁰² Birkhead J et al. Impact of specialty of admitting physician and type of hospital on care and outcome for myocardial infarct in England and Wales during 2004-5: observational study. BMJ, doi: 10.1136/bmj.38849.440914.AE published 16 May 2006



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Finally, having identified detailed concerns at the service level, we need to reiterate a very basic message.

WE NEED TO GIVE THE MESSAGE THAT

The service shortcomings are largely a reflection of shortcomings in the system, the way it is organised, distributed and continues to be protected in its present form. Therefore, the present system itself is a key source of the increased risks.

In the next section, we identify the local action plan to address the immediate issues and move towards best practice healthcare.

Local action plan

This section sets out in detail an action plan with a specific set of steps.

THE ACTION PLAN IS ALL ABOUT

Dealing with today's safety issues and implementing a programme of fundamental change that moves both local and regional services in the direction of international best practice.

THE ACTION PLAN IS NOT ABOUT

Closing local hospitals,

Developing more of the same, or

Maintaining the status quo

The action plan which follows sets out:

- Immediate actions for the Health Service Executive;
- A 3 month urgent action programme to improve patient safety in those services we highlighted as particularly 'disturbing' to us in an earlier section;
- A first 12 months work programme for the building up of local services, clinical networks and regional hospital development; and
- For the Health Service Executive distinct from the regional and local action plans, to establish a National Standards Co-ordination Group to address the deficiencies that this report has highlighted with regard to the shortcomings of the present system.

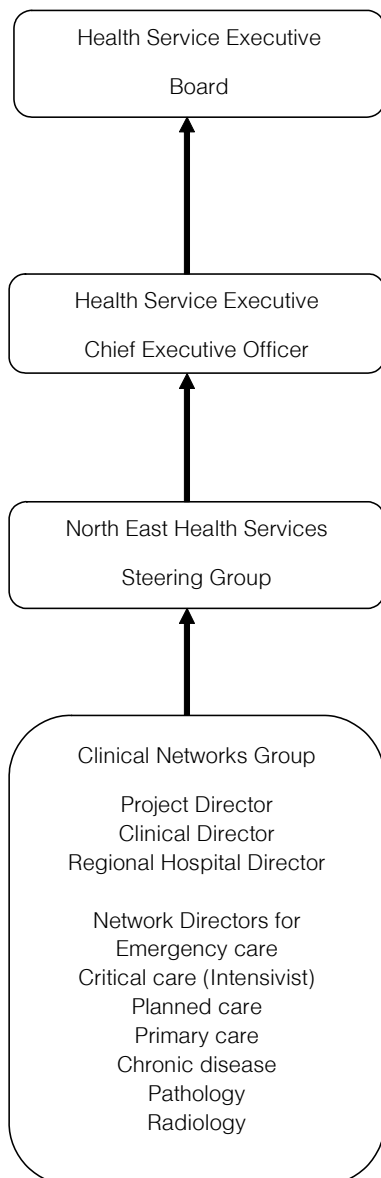
Immediate actions for the Health Service Executive

Adopt a best practice framework for acute healthcare as the basis for system change and service improvements.



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Establish a programme structure for leading and directing the work requirements. We have illustrated our suggestion for this structure as follows.



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We suggest the following actions for implementing this structure:

- Establish the membership and terms of reference for a North East Steering Group;
- Establish the membership and terms of reference for a Clinical Networks Group, including in the first instance appointing a:
 - Project Director to oversee the whole programme of change;
 - Clinical Director to get on with the urgent programme to reduce today's clinical risks, engage frontline clinicians and support clinical network development;
 - Emergency Care Director to take the lead role in developing the emergency care network;
 - Consultant Intensivist to lead on service improvement in critical care and lead role for developing the critical care network;
 - Primary Care Project Manager to accelerate the implementation of the primary care investment strategy and lead on the further integration of primary care with other local emergency and planned care services; and
 - Regional Hospital Project Manager to oversee the detailed planning and business case for the proposed new regional hospital and ensure that the services, design and estate conform to international best practice standards.

The Health Service Executive to provide funding for the project team, to support risk reduction and the development of best practice clinical pilot programmes.

In addition, the Health Service Executive to establish, with relevant national bodies, a separate national standards co-ordination group to address the following:

- The accelerated introduction of clinical standards, and clinical governance at all public and private hospitals working with the Department of Health and Children, the Medical Council, recognised training bodies and the Health Information and Quality Authority.
- The development of a comprehensive approach covering the registration and service training accreditation of all consultant and doctors, working with the Medical Council and the national training bodies.



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- The development plans for substantial workforce redesign and reskilling at a national level including a major role for the ambulance service in leading ambulatory care at home and emergency care networks.

Short term measures to improve patient safety, first 3 months

We have proposed a number of urgent measures, all designed to support local services and improve safety. Despite their urgency, they also represent the first explicit steps along the route to achieving international best practice.

We urge the immediate appointment or secondment of a clinical director with a view to leading on the urgent measures. They are:

Providing support as soon as possible to alleviate the patient safety issues highlighted in the A&E services, including:

- Increasing the emergency ambulance and Advanced Paramedics trained in emergency assessment and resuscitation, starting deployment around County Navan and County Monaghan;
- Recruitment of Emergency Nurse Practitioners for deployment;
- Increased resources and additional training for the GPs out-of-hours services to develop an alternative to A&E attendance for minor injuries and illnesses;
- Expanding GP direct access to diagnostics to avoid unnecessary referrals to A&E department;
- Establishing an urgent programme for real time telemedicine links between the North East accident and emergency services and ambulance services.

Improving patient safety in critical care, cancer surgery and general surgery by:

- Declaring that Level 3 critical care only takes place at Drogheda;

This includes the recruitment of a full time Consultant Intensivist to lead service improvements, redesign and clinical lead on the development of the critical care network.

- Declaring Our Lady's Hospital, Navan closed to general surgery emergencies, with all referrals going to Drogheda. In the absence of surgical assessment occurring at Navan, this would mean Drogheda receiving an additional daily average of 4.2 admissions;

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- Ensuring all cancer operations are referred to the sub-specialty teams at Drogheda or in north Dublin. This would mean four patients per week in the North East being referred on for cancer surgery.

Preparing for Implementation of these short term measures means first sorting out bed capacities and patient flows between Drogheda and the referral hospitals and supporting consultant arrangements. However, in planning the transfers, it needs to be remembered that the actual numbers of patients affected by these decisions are very small.

- Develop a much better understanding of the pressures upon the present emergency services by conducting a snapshot study of the patient populations and activity at all hospitals, covering all acute, critical care, coronary care and community beds and accident and emergency.

Medium term measures, Years 1 to 5, depending upon progress

With regard to clinicians driving best practice into their service delivery, we have stated that 'it is not dependent upon bricks and mortar'.

IDEALLY

Committed healthcare professionals, supported by management, should already have taken, within a few months of the start of the Health Service Executive Initiative, substantial action to move services towards best practice.

This does mean frontline health professionals being prepared to:

- Challenge the status quo;
- Work differently and move forward;
- Ignore the confines of present sites and estate; and
- Work on the imperative to improve patient safety notwithstanding any local agendas not in tune with this.

A steering group is proposed to oversee the international best practice programme together with the 'Clinical Networks Group' which will lead the development of networks across the region.



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Their impact will be wide ranging with most developments in the first few years occurring at the local level, in the local hospital, in primary care and community services, much of the effort gearing up to respond better to the increased demands from the anticipated 35% growth in the elderly population. Developments therefore include:

With regard to emergency care

Introduction: Role of the ambulance service:

The ambulance service is already implementing a new Health Service Executive strategy towards fundamental, long term change. The new 'direction of travel' is in line with developments in pre-hospital services internationally and is therefore in line with best practice developments.

The ambulance service therefore needs to be empowered to lead the way in building an operationally effective Emergency Care Network.

At the local level:

- The emergency care network, led by the ambulance services, will continue its development programme to cover the whole of the North East;
- The present unsustainable A&E services will be developed into local sustainable nurse led minor injuries and illness services;
- The present hospitals will continue to offer acute care while at the same time building upon work in progress to rationalise services to improve patient safety by expanding multidisciplinary teamworking and clinical networks;

The withdrawal of emergency general surgery at Monaghan and Navan hospitals leads to a need to review the future of acute general medical services on these sites.

- Plan to integrate the present GP out-of-hours with the network of minor injuries and illness services;
- Within the primary care arena, plan for primary care investment to develop urgent care centres, for example, by copying and extending the Virginia primary healthcare centre model;
- Plan and implement a workforce redevelopment programme to enable the present community services to expand their 24/7 access and range of skills and competencies, in order to support more patients at home and avoid admissions to acute care;

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- Plan for the establishment of a supporting infrastructure for the community services to enable the development of a home telecare service; and
- Establish a site or sites in the North East as clinical pilot programmes, in order to implement change with appropriate clinical and analytical expertise to confirm improvements in patient safety, better standards and more effective use of resources, all with a view to roll out to other regions.

At the regional level:

- Drogheda will continue to act as the regional centre for most of the specialties and most complex patient needs;
- The regional hospital development group will be finalising business planning and incorporating best practice standards, methodologies, capacities and workforce requirements into service and estate design for a new regional hospital; and
- When all the emergency ambulance /advanced paramedic / minor injuries / enhanced GP services / enhanced community services are fully bedded in at the local level, supported by a fully operational emergency care network, all A&E consultants will work on a regional basis.

With regard to planned care

At the local level:

IT SHOULD BE PARTICULARLY NOTED THAT

Best practice at the local level means being able to deliver routine planned care across all the specialties. There is an opportunity in the North East for the establishment of urology, ENT and ophthalmology as an element of local services.

Therefore, as long as there are sufficient clinical skills, expertise and numbers of patients to operate upon, existing hospitals will continue to develop an expanding planned care programme through:

- More day surgery;
- Improved minimally invasive surgical techniques;



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- Developing nurse led extended recovery service, to enable the safe recovery of patients undergoing general anaesthetic for more major operations that are otherwise routine in terms of clinical risk management; and
- Investment to develop routine urology, ENT and ophthalmology as new local services.

At the out-patient level:

- Most, if not all of the regional specialties will be represented at the local level by the establishment of comprehensive out-patient services, in order to minimise the need for travel; much of this service in the fullness of time will be by teleconsultation;
- Diagnostics will need to expand to ensure that all GPs can refer directly to the full range of diagnostics, including CT and MRI;
But only in accordance with agreed best practice clinical investigative pathways.
- Diagnostic capacity for the high tech end, CT and MRI (either fixed or mobile), and the siting thereof, will be subject to an overall needs assessment and criteria in relation to patient access and volume; and
- Pathology services will be reorganised using the clinical network model.

At the local bed level:

- We see a need for local bed capacity in the medium term, to provide a post-acute / step down / general and specialist rehabilitation service in support of the regional services, in order to maintain effective patient flows through the system and to enable patients in the recovery stage to be as close to home as possible;
- These services are likely to become nurse led, supported by the local GP and out of hours services and the community teams.

At the acute bed level:

- There will be a progressive closure of acute beds in the coming years across the North East as a result of small patient volume services having to be rationalised into regional larger units and eventually into the new regional hospital.

At the regional level:

- Drogheda will continue to provide the support established in the first three months, for critical care and complex planned care.

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Longer term measures to 2015

With regard to emergency care

The new regional hospital will provide a 24/7 service for the whole range of acute specialties as described in the best practice section. To work effectively, to maintain patient safety, high quality care and international best practice standards, it will need a minimum catchment population of 300,000 and preferably closer to 500,000.

Therefore, in the run up to opening a new regional hospital, changes will be happening to achieve patient safety and quality of care.

With regard to planned care and diagnostics

By this time, all routine surgery will be taking place at the local level. With regard to actual sites, it could be in redeveloped existing hospitals or preferably in new custom designed diagnosis and treatment centres.

Having established an action plan for addressing the issues, the final section examines the prospects of a new regional hospital for the North East.



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New regional hospital

This section sets out our approach to identifying the requirement for a new public regional hospital providing complex specialist planned care and major acute care in the North East.

An acute regional hospital will provide co-located 24/7 services for accident and emergency, trauma, emergency medicine and sub-specialities; emergency surgery and sub-specialities; complex planned surgery; critical care; cancer services; maternity; acute psychiatry; paediatrics; and neonatology.

We have approached the analysis through:

- Forecasting the impact of population growth up to 2015;
- Modelling future regional public acute activity and bed requirements including improving existing service delivery performance to current best practice standards;
- Identifying the minimum catchment population for a regional hospital which maintains a sustainable medical workforce and is cost-effective and is based on international evidence;
- Comparing the North East population forecast with the minimum catchment population;
- Considering whether all North East residents will use one regional hospital;
- Understanding the potential North East and north Dublin regional hospital interdependencies;
- Proposing a new regional hospital is located in the south of the North East; and
- Setting out an action plan for developing the regional hospital.

This approach provides a high level assessment of requirements and substantial further work will be needed to complete the detail of the proposals made.

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Planning for a large increase in population

A key factor to be considered in planning for specialist acute health services in regional hospitals in the North East is the significant projected population growth rates.

Regional population forecasts, 2001 – 2031, produced by the Central Statistics Office (CSO) have been modelled through different scenarios, each applying a different set of assumptions regarding migration and fertility rates. For this review, the scenario MIFF Medium has been used, which is the scenario used most widely by the CSO in its publications and is based on recent demographic changes.

Population forecasts are accessible at a regional level, split across by age bands. The counties of Louth, Meath and Monaghan are within the Border region and County Meath is within the Mid East region, included as part of the Greater Dublin Area.

Recent and forecast population growth

Total population growth

Table 8 illustrates the forecast growth in population from 2002 to 2020 for each county based on the MIFF Medium regional growth rates.

Table 8: Population growth by County

County	2002	2006	2010	2015	2020
Cavan	56,546	59,739	62,940	67,176	70,971
Louth	101,821	107,648	113,226	120,309	126,350
Meath	134,005	149,035	163,936	182,530	199,669
Monaghan	52,593	55,558	58,441	62,225	65,595
Total	344,965	371,980	398,543	432,240	462,585

The Mid East region, whose counties include Meath, Kildare and Wicklow, is projected to be the region with the highest annual population growth in Ireland; estimated at 2.2% per annum. The population of the Border Region, which includes the North East counties of Cavan, Louth and Monaghan, is forecast to increase by 1.2% per annum; below the national average annual population growth rate of 1.4%.

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Between 2002 and 2006, the population in the North East will grow by 7.8% from 344,965 in 2002 to an estimated 371,980 in 2006, based on CSO forecasts. The predicted growth from 2006 to 2015 is 16.2% representing a large increase over a nine year time period. The 2006 forecast population of 371,980 and the 2015 forecast population of 432,240 are the key figures taken forward into considering the requirement for a regional hospital.

In addition to population size, it is particularly important to identify the changing age profile within these population projections, given the high level of healthcare resources in the acute sector devoted to both the very young and elderly.

Growth in births

The forecast increase in births from 2006 to 2015 by Region is set out in Table 9.

Table 9: Population growth in births

Region	2006	2015	% Growth
Border	6,391	6,933	8.5%
Mid-East	7,942	8,331	4.9%
Dublin	18,415	18,774	1.9%

Births are reported for the total of the Region

The CSO Border counties of Louth, Cavan and Monaghan, show the highest birth rate growth of almost 9%, whereas the Mid East Region, which includes County Meath, shows a lower increase in births of almost 5%.

Growth in the elderly

The forecast increase in the elderly (those aged 65 years and over) from 2006 to 2015 by county is shown in Table 10.

Table 10: Population growth in the elderly population (65+)

County	2006	2015	% Growth
Cavan	8,115	10,237	26.1
Louth	10,933	13,793	26.1
Meath	13,124	20,236	54.2
Monaghan	6,722	8,481	26.1
Total	38,894	52,746	35.6

Growth rates are based on the age specific growth rates identified at the regional level and applied to 2006 elderly population. There is a projected increase of more than 50% in the elderly population of County Meath. The elderly population in the counties of Cavan, Louth and Monaghan are forecast to increase by 26% over the next nine years.



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Modelling 2015 demand for acute services for the North East

Predicting future public hospital acute activity requirements

We have modelled the future public hospital acute activity based on the following assumptions:

- Using as a baseline the most recent actual public hospital data for the residents of the North East regardless of which hospital the resident was admitted to. This is based on HIPE data for 2004 and includes all acute care including specialist tertiary activity¹⁰³ ¹⁰⁴. The data does not include residents admitted to any private hospital;
- Factoring in the forecasts of 16% increase in total population and the 26% growth in the elderly up to 2015;
- Planning for hospital beds to be available 365 days a year and occupied 85% of the time, which is the generally accepted norm for efficient use of beds;
- Providing for the delivery of planned, emergency and other care to be delivered to current 'best practice standards' through reducing the hospital stay for the acute segment of care, eliminating inappropriate use of acute hospital beds and improving the effectiveness of the admission and discharge process;
- Identifying the results in terms of growth in volume of acute care required and future indicative public hospital acute inpatient bed requirements; and
- Recognising that In addition to the identified acute beds, there will be a requirement for step-down intermediate care beds in local hospital settings and for the provision of additional resources in primary, community and social care, which will form part of the separate local needs assessment identified earlier in the report.

¹⁰³ The hospital data came from the Hospital Inpatient Enquiry (HIPE) system collected by the HIPE and National Perinatal Reporting System (NPRS) Unit of the Economic and Social Research Institute. Additional data were provided by the National Hospitals Office, HSE. The analysis of the data was supported by the Population Health Directorate, HSE

¹⁰⁴ Benchmarking of other areas of clinical performance including theatre utilisation, accident and emergency attendances, outpatients and diagnostics has not been possible due to the non-availability of detailed complete and robust datasets.

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The data provides a baseline for modelling future indicative bed numbers, and we would recommend further detailed analysis in conjunction with the results of the patient dependency census before these volumes can be used more extensively for detailed planning purposes.

Current clinical best practice standards for acute care

Improvements in acute hospital clinical efficiency to current best practice standards traditionally draw on international, national and peer group comparators. We have complemented this approach with our own evidence-informed 'best practice' template for targeted collective groups of similar care called Diagnostic Resource Groups, procedures and diagnosis.

The best practice template, which covers a range of Diagnostic Resource Groups, is derived from published literature, experience from elsewhere, and other relevant sources. We have successfully used this in working with whole health communities and acute hospitals in changing clinical practice so that the move towards 'best practice' becomes the 'normal way of working'.

Key assumptions in this approach include:

- **Applying admission avoidance** assumptions that represent the percentage of admissions that typically could be avoided if appropriate alternative care provision was provided; either within a home setting or within primary and community services. Examples focus particularly on chronic disease management conditions;

For example, an assumption is made that one third of all emergency admissions for chronic obstructive pulmonary disease can be avoided. This assumes early identification of COPD/asthma in primary care together with the development of programmes for self-care and self management, automatic recall review and reassessments in primary care, and the provision of pulmonary rehabilitation for patients earlier in the stage of the disease. One particular primary care trust in the UK, which has provided its general practitioners with spirometers, has seen a reduction in admission rates for COPD of up to 50% within 2 years.

- **Increase in day case rates**, using our evidence base of increases in day case rates, the UK Audit Commission basket of day case procedures and the transfer of all planned short stay inpatient admissions of 0 and 1 length of stay;



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- **Reducing delayed transfers of care.** Patients who have an excess length of stay are often referred to as delayed transfers of care and are often waiting for social services assessments and/or places within nursing and resident homes. Some of the long lengths of stay are due to inefficiencies within the hospital system such as delays in diagnostics, therapy assessments, or receiving senior medical opinion. By ensuring that systems within hospital are streamlined and that sufficient resources are available within primary, community and social care services, then assumptions can be made regarding the potential reduction in these excess lengths of stay; and
- **Faster clinical throughput and shorter length of stay.** Assumptions have been made regarding improvements in length of stay for 2015. Firstly, it is assumed that where the length of stay by DRG is longer than the current national average for Ireland, then by 2015, all patient lengths of stay will achieve this. If the patient length of stay is currently shorter than the national average, then no reduction is assumed. Secondly, where UK national and international best practice can be identified, a further reduction is applied for particular DRGs.

For example, best practice evidence for primary hip replacements indicates an acute length of stay currently being achieved for 4 days, through robust practice guidelines and clinical pathways coupled with educational sessions for patients undergoing joint replacement surgery.

Applying these assumptions provides a projection of activity and bed requirements for 2015.

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Summary of projected 2015 acute activity

The increase in demand for public hospital inpatient planned and emergency care for the North East from 2004 to 2015 based on the cumulative impact of applying this set of planning assumptions shown in Table 11.

Table 11: Impact of change in activity and occupied bed days North East residents

Planning Assumption	Admissions			Occupied Bed Days	Modelled Beds
	Day case	Elective Inpatient	Emergency		
Baseline 2004	47,129	14,935	41,921	318,204	1,026
Population change	59,407	18,709	51,769	413,063	1,331
Admission avoidance	58,833	18,410	49,168	395,429	1,275
Day case rates	63,417	13,826	49,168	388,661	1,253
Excess bed days	63,417	13,826	49,168	351,277	1,132
Ireland average	63,417	13,826	49,168	318,539	1,027
Best practice	63,417	13,826	49,168	281,165	906

The activity baseline excludes those admissions to hospices, rehabilitation and continuing care facilities

This indicates an increase in day cases, a reduction in planned inpatient admissions and an increase in emergency inpatient admissions.

Public acute hospital bed requirements in 2015

A summary of the current and future modelled public hospital inpatient bed requirements are set out in Table 12. The 1,026 beds in 2004 reflect the number of beds required based on the numbers of days patients spent in beds (occupied bed days) and assuming a bed is occupied 85% of the time.

Table 12: North East Resident Based Modelled Current and Future Bed Requirements in Public Hospitals

Admission Type	Year		Change	
	2004	2015	Absolute	%
Elective Inpatients	276	233	-43	-15.6%
Non-Elective	750	673	-77	-10.1%
Total	1,026	906	-120	-11.6%



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This indicates a requirement for patients in the North East to have access to 906 public hospital acute inpatient beds in 2015. The future requirement for acute hospital beds is less than the current modelled beds used by North East patients.

The modelling of future bed numbers will require further refinement through working up a more detailed clinical specification for a regional hospital. For example, we recognised the need to exclude from the baseline certain diagnostic procedures. This will further reduce the future bed requirement. Similarly, the forecast bed numbers currently include tertiary services which may be provided in a tertiary hospital rather than a regional hospital.

Future proofing requirements

There are future proofing factors to keep under review in modelling the future requirement for public hospital acute inpatient bed requirements, including:

- The extent to which existing and planned growth in day cases and planned inpatients may be undertaken in private hospitals, reducing the requirements for public acute beds;
- Changing needs assessment of public health requirements, which through the development of programmes to target specific improvements in health care, can result in changes in acute interventions;
- Continuing improvements in clinical best practice, which carry on the longer term reduction in acute hospital length of stay and hence bed requirements. We have used current best practice as supported by current evidence. Evidenced based best practice in 2015 is likely to indicate lower acute length of stays than currently; and
- Clinical innovation and new technologies which change the way in which care is delivered. These are harder to forecast and can both increase and decrease usage of specialist hospitals. Over the past decade clinical technology has supported an overall shift of care away from specialist to less intensive hospital settings¹⁰⁵.

¹⁰⁵ New York Healthcare Commission, Commission on Health Care Facilities in the 21st Century, February 2006

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The importance of each of these factors is recognised and may lead to further downward pressures on acute bed requirements by 2015. We recommend that these be kept under review and considered as more detailed changes in clinical practice are being planned and implemented.

Identifying the minimum catchment population for a public regional hospital

The next stage is to identify the minimum catchment population for a regional hospital based on international evidence which maintains a sustainable medical workforce and is cost-effective. Catchment populations provide a proxy for ensuring a sufficient critical mass of patient volumes to provide safe and viable services staffed by specialist and sub-specialist consultants and medical staff working in sustainable rotas.

The Royal College of Surgeons in Ireland has identified that the minimum number of general surgeons required within a unit is 12 allowing for sub-specialty interests and suitable rota cover. Assuming a ratio of 1 general surgeon per 25,000 of the population, this derives a catchment population of 300,000 for a regional hospital¹⁰⁶. A review of medical staffing workforce undertaken by a national task force in Ireland modelled consultant numbers on a catchment population of between 350,000 and 500,000¹⁰⁷.

Published literature in the United Kingdom does suggest that catchment populations for specialist acute centres should, in the future, be larger than the catchments currently being served by hospitals providing a range of inpatient acute services.

Recommendations made by the Royal College of Surgeons in England is that the preferred catchment population size for an acute general hospital providing the full range of facilities, specialist staff and expertise for both planned and emergency medical and surgical care would be 450,000-500,000¹⁰⁸.

¹⁰⁶ The Future of Surgical Specialties in Ireland, Royal College of Surgeons in Ireland, April 2004

¹⁰⁷ Report of the National Task Force on Medical Staffing, June 2003

¹⁰⁸ Delivering High-quality Surgical Services for the Future, A Consultation Document from the Royal College of Surgeons of England Reconfiguration Working Party, The Royal College of Surgeons of England, March 2006



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NHS Scotland, in its report on the future of health care provision¹⁰⁹, stated that a minimum of 10 consultants per specialty would be needed in order that high-intensity specialties such as acute medicine, general surgery or orthopaedics could be sustained on a 24/7 basis and secure compliance with the European Working Time Directive.

The framework for health services developed by the Welsh Assembly Government¹¹⁰, identified the need to consolidate major planned and emergency services, allowing for the development of sub-specialisation, higher clinical standards and improved training opportunities. This anticipates the need for consolidation within fewer centres, which are strategically located to serve catchment populations, some of which are substantially rural. The framework identifies 10 centres which would provide acute and/or specialised and critical care services, some of which may also provide tertiary and highly specialised services. Given the projected population of Wales in 2013 of just over 3 million residents¹¹¹, this would suggest that the catchments to be served by these specialist centres are around 300,000.

The population catchment must also be balanced with the availability of projected future medical staffing workforce. The more regional hospital units required in the future, the greater the requirement for medical staff.

While there is no generally accepted international model which identifies one catchment population for a regional hospital, there is a range of catchment population sizes from 300,000 to 500,000.

Comparing the North East population with the minimum catchment population

Both the North East 2006 forecast population of 371,980 and the 2015 forecast population of 432,240 is within the range of catchment population size of 300,000 to 500,000, indicating sufficient population for the development of one regional hospital in the North East. The 62,260 growth in population is significant to this.

¹⁰⁹ Building a Health Service Fit for the Future, NHS Scotland, May 2005

¹¹⁰ Designed for Life: Creating world class Health and Social Care for Wales in the 21st Century, Welsh Assembly Government, May 2005

¹¹¹ 2003 Based National and Sub-National Population Projections for Wales, National Assembly for Wales, October 2005

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This assumes that all the population of the North East would use a single hospital sited locally in the North East, rather than for example in north Dublin and requires that a substantial amount of current North East planned inpatient work will transfer from Dublin hospitals to a new North East regional hospital. Similarly much of the day case work currently undertaken in Dublin hospitals will transfer to a new regional hospital and other standalone day case facilities in the North East, some of which will be on current local hospital sites.

However, patients in the North East may choose to use hospitals outside the North East even if a new hospital was available in the North East, hence reducing the likely catchment population.

This is related to a number of factors such as the availability of services from such hospitals in adjacent areas like north Dublin and the location of existing and future public regional hospital in the North East.

Factors influencing patients choice of regional hospitals

Factors influencing current and future North East patient choice of regional hospitals may include:

- Patient perception and knowledge about which specialist consultants and public and private hospitals will provide the best healthcare for their particular condition;
- Current patient patterns of care with a third of day case activity and over a half of planned inpatient activity for North East patients taking place outside the North East, mainly in Dublin hospitals. A limited amount of this activity will be for tertiary care which is likely to continue to be provided in tertiary hospitals;
- The current absence of a single acute centre of excellence in the North East of sufficient size and staffing to provide a focus for developing new services;
- Family convenience with traditional patterns of family access to hospitals. This may particularly apply to people who move into the North East from Dublin and who may still chose to use Dublin hospitals;
- Patients accessing healthcare close to work as well as close to home, which may apply to the substantial number of residents commuting to Dublin;



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- Natural geography and the extent to which part of the North East is effectively part of north Dublin, with County Meath which has 42% of the forecast population of the North East also forming part of the Greater Dublin Area. For example, nearly a quarter of County Meath residents currently access north Dublin hospitals, including Beaumont, Connolly and the Mater Misericordiae University Hospital for emergency care, presumably as their natural local hospital;
- The impact of the developing road network radiating out from Dublin has on general public perceptions of access to hospital services, potentially reducing transport times and opening up further access to hospitals in north Dublin. This could also work in the other direction with residents for north Dublin potentially accessing any new hospital in the North East;

The healthcare relationships identified between the North East and north Dublin suggest that a decision about whether and where a new regional hospital should be located in the North East cannot be taken in isolation from the current and future regional hospital demands and requirements of north Dublin.

We were originally asked to take account of the availability of services in adjacent areas and following discussion and agreement with the Health Service Executive Project Management Group, we have undertaken additional analysis of population forecasts and future acute hospital best practice activity analysis for the residents of north Dublin. We also undertook familiarisation visits to Connolly and Beaumont hospitals. A proposed visit to the Mater hospital did not take place. We next examine the combined North East and north Dublin position.

Combined North East and north Dublin requirements for regional hospitals

We have not conducted the same in-depth analysis of all the north Dublin healthcare system and hospital requirements, but have focused on the potential for joint development of solutions for public regional hospital acute services covering the North East and north Dublin.

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Population growth for north Dublin

By 2015, the population of North Dublin is forecast to grow by 14.3% to 588,044 as set out in Table 13.

Table 13: Population Growth in north Dublin

Area	2002	2006	2010	2015	2020
North Dublin	486,934	514,453	547,465	588,044	619,048

The projected 2015 population of 588,044 falls between the sizing for 1 and 2 regional hospitals. The combined North East and north Dublin positions are considered after looking at the projected 2015 north Dublin acute activity.

Summary of projected 2015 acute activity for north Dublin

The increase in demand for public hospital inpatient planned and emergency care for north Dublin from 2004 to 2015 based on the cumulative impact of applying this set of planning assumptions is shown in Table 14.

Table 14: Impact of change in activity and occupied bed North Dublin residents

Planning Assumption	Admissions			Occupied Bed Days	Modelled Beds
	Day case	Elective Inpatient	Emergency		
Baseline 2004	57,982	19,727	34,925	416,185	1,341
Population change	72,599	23,697	42,632	533,154	1,718
Admission avoidance	71,806	23,413	40,657	518,988	1,673
Day case rates	77,278	17,941	40,657	510,313	1,645
Excess bed days	77,278	17,941	40,657	396,936	1,279
Ireland average	77,278	17,941	40,657	363,228	1,171
Best practice	77,278	17,941	40,657	324,526	1,046

This shows that even with the significant growth in population, if the improvements in clinical utilisation can be achieved by 2015, then the acute hospital beds required to deliver the activity generated by the north Dublin residents in 2015 would be 295 beds less than the bed requirement in 2004.



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Combined populations sufficient for 2 or 3 regional hospitals

While the population in the North East is forecast to increase by 16.2% between 2006 and 2015, the population of north Dublin is also forecast to increase by 14.3% over the same period. By 2015, the combined population of the North East and north Dublin exceeds 1 million residents, as set out in Table 15.

Table 15: Population Growth in north Dublin and the North East

Area	2002	2006	2010	2015	2020
North East	344,965	371,980	398,543	432,241	462,585
North Dublin	486,934	514,453	547,465	588,044	619,048
Total	831,899	886,433	946,008	1,020,285	1,081,633

The combined 2015 forecast population of 1,020,285 is sufficient for 2 or a maximum of 3 regional hospitals based on the international catchment norm of between 300,000 and 500,000.

Some of the current north Dublin hospitals also provide tertiary and other services to other parts of Dublin and the country, which may provide further catchment to suggest that 3 rather than 2 regional hospitals should be considered for the combined North East and north Dublin area.

A new regional hospital located in the North East

Working from the basis of a requirement by 2015 for a total of 3 regional hospitals serving the combined North East and north Dublin, one new regional hospital in the North East is proposed, provided key locational factors are used to determine the precise site including:

- A minimum catchment population of 300,000 is robustly identified for the new hospital. There is only sufficient catchment for one regional hospital to be located in the North East;
- The location needs to be sufficiently to the south of the North East region to attract patients who would otherwise use north Dublin regional hospitals, while also ensuring that most of the residents in the north of the North East will also use this same regional hospital; and
- The interdependency of the location in the south of the North East with the locations and catchments of current hospitals and future regional hospitals in north Dublin is clearly established.

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A detailed site location study will be required including mapping of population growth and catchments, a review of current and future transport plans and in particular road networks, together with considering the longer term strategy for the development of regional hospitals in north Dublin.

Our action plan for a regional hospital

More detailed work is required to determine the exact location of a new public regional hospital in the south of the North East and to understand how this affects the future viability of north Dublin hospitals. Therefore, our action plan for developing this includes:

- Develop the clinical specification, based on clinical network plans, for the new public regional hospital in the south of the North East identifying in more detail the clinical content, workforce and size as well as the clinical relationships to other existing and planned hospitals in north Dublin;
- Develop the outline business case for the new public regional hospital for the North East including commissioning a detailed site location study; and
- Review the future provision of best practice acute care in north Dublin and the impact on the current and future north Dublin hospitals of establishing a new public regional hospital in the south of the North East.

FINALLY BY 2015

Patients will be experiencing safe best practice emergency and planned care in local hospitals and local centres and, where necessary, accessing specialist acute services in a new public regional hospital located in the south of the North East



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Appendix 1 - Terms of reference

The purpose of the consultancy is to examine acute hospital services in the north east in line with the following terms of reference for the consultancy:

- i. To determine with reference to international best practice the optimal configuration hospital services and consultant staffing for the geographic area and population of the north east in order to provide safe, sustainable, cost-effective and high quality services. It should take account of the existing transport infrastructure and the availability of services in adjacent areas.
- ii. To evaluate the benefits and risks associated with current provision of acute hospital services on five sites serving a population of approximately 350,000.
- iii. To review the current capacity, usage and deployment of consultants, beds, theatres, day case, out-patient, accident and emergency facilities, diagnostic and other facilities in the hospitals in the region and compare them to international norms.
- iv. To consider the current and potential contribution of primary care services, including out of hours GP services, ambulance and advanced paramedical services etc. to reducing risk to patients.
- v. To take account of current and projected demographic trends affecting the north east.
- vi. To make recommendations to the CEO, HSE, on the above considerations, including short term and long term recommendations on the future configuration of acute hospital services and consultant staffing which will minimise risk to patients and provide high quality and safe services to patients with reference to international best practice.



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Appendix 2 - Interview and site visit schedule

During the review, we undertook a number of fact finding interviews and site visits. Detailed below are those individuals and organisations that were engaged.

Site visits:

- Our Lady of Lourdes Hospital, Drogheda;
- Louth County Hospital, Dundalk;
- Our Lady's Hospital, Navan;
- Cavan General Hospital;
- Monaghan General Hospital;
- Beaumont Hospital; and
- Connolly Hospital, Blanchardstown.

Interviews:

- Professor J. McKenna, President, Royal College of Physicians in Ireland
- Dr. B. Silke, Dean of Higher Medical Training, Royal College of Physicians in Ireland
- Dr. J. Crowe, Assistant Treasurer, Royal College of Physicians in Ireland
- Professor A. Tanner, Director of Surgical Affairs Royal College of Surgeons in Ireland
- Mr. F. McClintock, Assistant National Director, Ambulance Services, Health Service Executive
- Dr. G. King, Director, Pre-Hospital Emergency Care Council
- Mr. J. Somers, Assistant Director IT Services, Health Service Executive
- Mr. T. O'Brien, Assistant National Director, Dublin / North East, PCCC, Health Service Executive



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- Dr. John Hillary, President, Medical Council
- Professor M. X. Fitzgerald, Director of Education & Training, Medical Council
- Professor G. Bury, Former President, Medical Council
- Mr. J. Lamont, Registrar, Medical Council
- Dr. M. Boland, GP, Irish College of General Practitioners
- Dr. M. O'Riordan, GP, Irish College of General Practitioners

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Appendix 3 - Document review

Below are listed the reports supplied by the Health Service Executive for the review:

Documentation relating to the North East		
Doc No.	Document	Date
1	North East Hospitals – The Next Five Years	1998
2	North East Hospitals – The Next Five Years – A Framework for Continuing Development	1998
3	Report of the Review Group on Maternity Services in North Eastern Health Board (Condon Report)	2000
4	Report of the Review Group on the Pathology and Laboratory Services Within the North Eastern Health Board	Jun-00
5	Risk Assessment of Cavan/Monaghan Acute Hospitals Report - Healthcare Risk Resources International	Jul-01
6	Risk Assessment of Louth/Meath Acute Hospitals - Healthcare Risk Resources International	Jul-01
7	Strategy for Capital Developments for the Acute Hospital Services 2001-2011 - North Eastern Health Board	Oct-01
8	Report of the Maternity Services Review Group to the North Eastern Health Board (Kinder Report)	Sep-01
9	Capita 'Clinicians in Management' Review of Management Structures at the NEHB Acute Hospitals Groups – Executive Summary	Feb-02
10	College of Anaesthetists Report re Training Recognition for Monaghan General Hospital	2002
11	Correspondence from RCSI regarding training recognition for Monaghan General Hospital	2002
12	NEHB Extract from Appendix 6 Deloitte & Touche VFM Report	
13	Report on Medical Council Visit to Monaghan General Hospital	2002
14	Summaries of Key Strategies / Reviews / Evaluations / Report – North Eastern Health Board	Jul-02
15	Bonner Report on development of development of Monaghan Hospital - Appendix	2003
16	Comhairle na nOspideal – Report of the Committee Reviewing Maternity and Related Services in the North Eastern Health Board Area	Jul-03
17	Monaghan General Hospital Proposals for Further and Future Development (Bonner Report)	Jul-03
18	North Eastern Health Board Spatial Analysis – Ambulance Service: Compilation as related to Road Traffic Accidents and Population	Dec-03
19	Proposal for a joint department of surgery OLOL and LCH 2003	2003



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Documentation relating to the North East		
Doc No.	Document	Date
20	Proposal submitted by Consultant Surgeons in Our Lady Of Lourdes (OLOL) regarding a single department of General Surgery for OLOL and Louth County Hospital (LCH)	Apr-03
21	Capita Risk Assessment Report – Obstetrics and Gynaecology Services at OLOL – Final Draft	Jun-04
22	Directive from CEO, NEHB re Joint Departments C/M Group	2004
23	Directive from CEO, NEHB re Joint Departments Cavan/Monaghan Group	Apr-04
24	History of North East 1971 – 2004	2004
25	Report of Accreditation Peer Review Special Visit to the Maternity Unit at OLOL	Sep-04
26	Our Lady of Lourdes Hospital, Drogheda – Feasibility Study	Oct-05
27	Our Lady of Lourdes, Drogheda: Framework for Action – Final Report – Tribal Secta	Nov-05
28	Response to doc no.104 from Network Manager to Surgeons at Cavan Monaghan Hospital	2005
29	Sector Healthcare – A Report on the Appraisal and Risk Assessment of the Pathology Laboratory Information Management Systems of the Cavan/Monaghan Hospital Group of the North Eastern Region, Health Service Executive	Aug-05
30	Supporting Analysis Document for A&E Mapping - Our Lady of Lourdes, Drogheda – Tribal Secta	Aug-05
31	Report on the General Surgical Services at Our Lady's Hospital, Navan	Mar-06
32	Review of Hospital Services in the North East – Louth County Hospital, Dundalk	Apr-06
33	Review of Hospital Services in the North East: theatre – Cavan General Hospital	Apr-06
34	Staff Census – Cavan / Monaghan	Apr-06
35	Staff Census – Louth/Meath Group	Apr-06
36	The Lourdes Hospital Inquiry – An Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda – Report of Judge Maureen Harding Clark S.C.	Jan-06
37	Update of Theatre - Our Lady of Lourdes Hospital, Drogheda	Apr-06
38	Update on North Easter Area iPMS Replacement Project	May-06
39	Bed Numbers at Cavan General Hospital	
40	Bed Numbers at Monaghan General Hospital	
41	Internal NEHB Risk Management Report re. Bronagh Livingstone	
42	NCHD and Consultant Information for Cavan & Monaghan	
43	Patients resident in NEHB admitted to NAHB acute hospitals	
44	Profile of each of the 3 hospitals within Louth/Meath Group	
45	Social & Geographic NEHB	

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Documentation relating to the North East		
Doc No.	Document	Date
46	Business Case for PACS in the North East	
47	NEHB Hospitals implementation report - iPMS	

Documentation relating to the wider Irish health system, including the North East		
Doc No.	Document	Date
48	A New Direction for Acute Hospital Services	1993
49	Comhairle na nOspideal – Report of the Committee on Haematology Services	Dec-99
50	A Chronology of Events regarding Dr. Michael Neary	2000
51	Comhairle na nOspideal – Report of the Committee on Immunology Services	24 th November 2000
52	Comhairle na nOspideal Department of Health & Children – Report of the Joint Committee on Vascular Surgery Services	Apr-00
53	The Condon Report	2000
54	CSO – Regional Population projections 2001-2031	Jun-01
55	DOHC Bed Capacity Technical Report	2001
56	DOHC Primary Care Health Strategy Report	2001
57	DOHC Quality and Fairness Health Strategy	2001
58	AHPF Strategic Plan for the Development of Acute Hospital Services in Cork City Part 1- 3	Oct-02
59	Comhairle na nOspideal – Report of the Committee on Accident and Emergency Services	Feb-02
60	Comhairle na nOspideal requirements for appointments of Consultant Orthopaedic Surgeons	2002
62	Correspondence from RCSI regarding training recognition for MGH	2002
63	Development of Day Surgery and Day Medicine in the Northern Area – Eastern Regional Health Authority – Secta	8 th May 2002
64	DOHC Acute Hospital Bed Capacity Review	2002
65	Eastern Regional Health Authority Draft Report on Development of Day Surgery and Day Medicine in the Northern Area	May-02
66	Independent Review concerning the birth of baby Bronagh Livingstone	2002
67	Report of Maternity Services Review Group: Kinder Report	2002
68	Report of the Independent Review Panel to the Minister for Health and Children Concerning the Birth of Baby Bronagh Livingstone	Dec-02
69	Report of the RCSI Specialist Advisory Committee on Trauma & Orthopaedic Surgeons	May-02



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Documentation relating to the wider Irish health system, including the North East		
Doc No.	Document	Date
70	Report on Medical Council Visit to MGH	2002
71	Report on Consultant Clinical Scientists in Academic Medicine / Clinical Research	Oct-02
72	Census 2002 – Volume 1 Population classified by area	Jul-03
73	Census 2002 – Volume 2 Ages and Marital Status	Jul-03
74	Comhairle na nOspideal – Report of the Committee on Dermatology Services	Nov-03
75	Comhairle na nOspideal – Report of the Committee to Review Neurology and Neurophysiology Services	Apr-03
76	PHECC – A&E Regionalisation: Implications for Pre-Hospital Emergency Care	May-03
77	RCSI – The Future of Surgical Specialities in Ireland	Nov-03
78	RCSI Clinical Guidelines – Initial Management of the Severely Injured Patients	Nov-03
79	Report for National Cancer Forum – Surgical procedures for selected cancers in Ireland 1997-2002	Mar-03
80	Report of the National Task Force on Medical Staffing – Pre-Hospital Emergency Council (PHECC)	Jun-03
81	Review of General Services Trauma Orthopaedic and A&E Emergency Services : Seagrave Report	2003
82	Review of General Services Trauma Orthopaedic and A&E emergency Services: Seagrave Report	2003
83	Review of General Services, Trauma Orthopaedic and Accident and Emergency Services (Seagrave Report)	Apr-03
84	St. Paul Consultancy: Facilitation Report	2003
85	The Development of Radiation Oncology Services in Ireland – Secta	Oct-03
86	Comhairle na nOspideal – Acute Medical Units	Oct-04
87	Comhairle na nOspideal – Consultant Staffing in the Mental Health Services	Dec-04
88	Guidance document from Professor WA Tanner, RCSI re joint Department of Surgery	2004
89	PIMS Project Report – Primary and Continuing Care ICT in the SHB – Primary Care Strategy	Jun-04
90	Review / Report into the circumstances pertaining to the death of Frances Sheridan	2004
91	Review Report into the circumstances pertaining into the death of Frances Sheridan	2004
92	Steering Group Report on Directive Implementation	2004
93	Update from Steering Group on Progress	Dec-04

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Documentation relating to the wider Irish health system, including the North East		
Doc No.	Document	Date
94	Report of the Joint Working Group to Review Consultant Cardiology Requirements	Apr-04
95	Beaumont Hospital Strategy 2006-2010	Dec-05
96	Comhairle na nOspideal – Consultant Chemical Pathology / Top Grade Biochemist Services	Dec-05
97	Comhairle na nOspideal – Oral & Maxillofacial Surgery Services	Jun-05
98	Comhairle na nOspideal – Otolaryngology Services	May-05
99	Comhairle na nOspideal – Plastic Surgery Services	Jun-05
100	Comhairle na nOspideal – Rheumatology Services	Dec-05
101	Comhairle na nOspideal – Urology Services	Nov-05
102	Comhairle na nOspideal 9 th Report	February 2001 – December 2005
103	Connolly Hospital Blanchardstown Strategic Plan	2005
104	Correspondence from Consultant Surgeons C/M to HSE NE Acting Network Manager	2005
105	NEDOC Report (Out of hours GP Service)	2005
106	Notification to Primary Care Services re Bed Status at CGH	2005
107	PCCC ICT Strategy and Action Plan	May-05
108	PCCC ICT Strategy and Action Plan – Summary	May-05
109	Statement of Requirement and Business Process Maps for a National Child Care Information System	Dec-05
110	Tánaiste's Press Release re. Radiation Oncology Network	Jul-05
111	The Hanly Report – Note on Implementation 15/11/05	Nov-05
112	YHEC – Hospital Activity Analysis – Nine Pilot Sites – Summary Report	Aug-05
113	Consultant Staffing Statistics	
114	Annual Report 2005 and Programme for 2006 – National Roads Authority	20 th April 2006 (Received at HSE)
115	Mater Misericordiae University Hospital – Corporate Plan 2005-2007	3 rd May 2006 (Received at HSE)
116	Census 2002 – Population by area – Map 1	
117	Census 2002 – Population by area – Map 2	
118	List of ARDRG	
119	HSEEA Weekly Census 06.09.05	
120	National Spatial Strategy for Ireland 2002-2020	
121	Population by County and Health Board 1996-2002	
122	Profile of each of the 3 hospitals within L/M Group	



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Documentation relating to the wider Irish health system, including the North East		
Doc No.	Document	Date
123	The Merit Project – PHECC	
124	Info regarding Higher Medical Training Posts at the RCPI	
125	National Draft Telemedicine Strategy	
126	Business Case for PACS in the SHB	
127	PCCC ICT Strategy – Summary Report	
128	Interim report on the deployment of pilot Isoft in the Community care setting SHB	
129	Acute Beds available by hospital 2000-2005 (DoHC figures)	

Statistical data organised via Dr. Declan Bedford		
Doc No.	Document	Date
130	HIPE Data North East residents and hospital based 2002 - 2005	
131	HIPE Data North Dublin resident and hospital based 2002 - 2004	
132	OPD data - The number and type of OPD clinics including timetable by Specialty, doctor and by hospital	
133	OPD data - The number of patients (new and reviews) seen in OPD annually by Specialty, doctor and by hospital for 2005 and 2003 and 2004 if available.	
134	A&E data - The number of new/review attendances for each A/E for the years, 2003, 2004, and 2005.	
135	A&E data - The number and type of theatres (general, orthopaedic, day surgery, etc) in each hospital.	
136	Theatre Data - The number of theatre sessions by consultant and by specialty for each theatre.	
137	Theatre Data - The scheduled time for each session.	
138	Theatre Data - Theatre timetables March-2006	
139	Theatre Data - Theatres - The number of early starts, late finishes and reports on utilisation of time.	
140	Theatre Data - Workloads for 2003, 2004, 2005	
141	Diagnostic Data - A list of available diagnostic tests in each hospital including facilities, equipment in both laboratory and radiology	
142	Diagnostic Data - The workload in laboratory and radiology for 2005 and 2004 and 2003	
143	Overall - The number of beds in each hospital, by specialty, both inpatient and day case	
144	Tests – Pathology Dept	
145	Ambulance services - Breakdown of staff	

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Statistical data organised via Dr. Declan Bedford		
Doc No.	Document	Date
146	Ambulance services - Location of ambulance headquarters and bases	
147	GP Data - North East doc on call	
148	GP Data - No. of practices on the 4 counties and the no. of GPs	
149	Population data - 5-year age groups for each of the counties for years 2002, 2003, 2004	
150	Population data - Population projections	



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