

## 8 The Way Forward

### 8.1 Emergency and Urgent Care Focus

8.1.1 The areas of improvement for individual emergency departments and networks have been set out in Section 7. Many of these areas echo the findings of the earlier piece of work carried out by Comhairle na nOspidéal in its Committee on Accident and Emergency Services. This work was carried out two years ago and therefore conclusions may be drawn that the disruption caused by significant reform of health service structures has interfered with consistent delivery of improvements to emergency care.

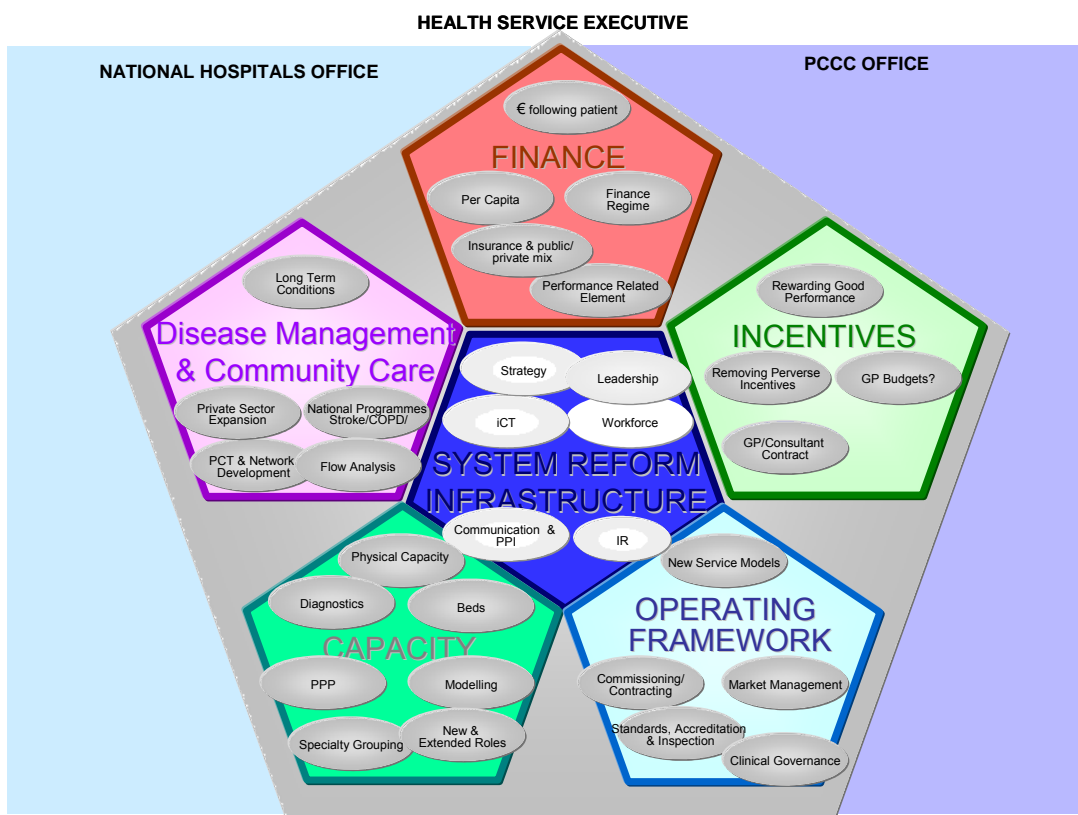
8.1.2 Given the move to health care regions and a stable management structure, it may now be prudent to develop emergency care collaborative or networks, to systematically plan and improve delivery of emergency services across the State. This will therefore provide a focus to integrate the findings and recommendations from earlier, important studies on emergency care and related areas, set out earlier.

### 8.2 A Whole System Approach

8.2.1 However this cannot happen in isolation. The A&E Mapping and Efficiency Review overwhelmingly concluded that the A&E problem is a multi-faceted one involving the whole health system and not emergency departments or professionals alone. It is clear that progress to improve the emergency waiting situation relies, in large part, on co-ordinated action across the system as a whole and particularly across PCCC and the hospital sector.

8.2.2 This is now operationally possible with the introduction of the Health Service Executive. Figure 6 next outlines the areas which are considered to be the main focus areas for development across the different sectors, to relieve emergency pressures and improve both process and outcomes for the public and for staff. These are then described in more detail.

**Figure 6 - Focus Areas for Joint Development**



### 8.3 System Reform

8.3.1 To address patient waiting and improve emergency patient flow across the health care system in general, requires the implementation of many of the aspects of the health care reform agenda.

8.3.2 It will be important for the HSE to set a number of shared strategy objectives for the NHO, PCCC and other relevant parties, to determine how system reform will be achieved and in what order, so that patient care is more evenly balanced throughout and across the sectors. In setting out the right operational objectives, it will be important for the Executive to be clear about 'where it wants the service to be in 3 years time' - in terms of both 'hard' and 'soft' factors - and to communicate this direction of travel clearly with the health agencies and the general public. This will form the important basis for regional and local planning.

- It will also be important that the significant change management agenda associated with system reform is given appropriate attention, both in terms of hard and soft changes required.

8.3.3 Given some of the system wide challenges which were identified as impacting upon the management of emergency flow, attention has to be paid to the robust development of the PCCC sector. There has, as a priority, to be more consistent

management of patients within the community, to address the current de facto requirement to attend hospital for the majority of diagnostic tests and interventions.

- 8.3.4 It is clear that the continued development of Primary Care Teams and models is a priority for the HSE, but it is considered that an escalation in this policy is required to affect the level of practical change which is required. There are three focus areas which are considered imperative to this endeavour.

## 8.4 Disease Management

- 8.4.1 The first of these has to be with more consistent programmes for the management of long term conditions. Given the predicted rise of chronic diseases across world countries in the next decade and the emerging evidence to suggest that systematic management of long term conditions can decrease emergency attendances and in-patient admissions; this is an important area of joint focus for the NHO and the PCCC over the medium to longer term. The Heartwatch programme has been a recent successful example of such a focus. Developing consistent and national responses to supporting patients manage long term conditions and provide the correct levels of intervention in the right place, should have significant impacts upon those presenting to emergency departments and on medical admissions in general.

- 8.4.2 The structures and incentives for the management of long term diseases have however to be well integrated into the public health service delivery model, as well as the private. In the immediate term, the HSE could start a programme of disease management pilots. There are a number of ways to go about this endeavour. One way could be through a small number of national priorities, such as heart disease, asthma, diabetes, whereby joint programmes are developed through regional collaborative networks. Another way could be to learn from the US experience and develop disease management pilots procuring specific services from the private sector and to do it in a way to enable robust evaluation of value for money and health outcomes. This would involve creating a new market and would need to be done in a way that encouraged a number of disease management providers to bid.

## 8.5 Capacity

- 8.5.1 The second area has to be renewed reflection on capacity requirements across the system as a whole, rather than in-patient beds in isolation. In order to appropriately shift the emphasis of care setting and improve the patient waiting situation, there is a requirement to review capacity at all levels across the system, incorporating:
- Appropriate healthcare facilities in the community and elsewhere to deliver integrated care models. This should include primary care centres, multidisciplinary clinics, ambulatory care centres, day surgery clinics and diagnostic centres;
  - Robust projections of bed allocation within regional collaborations of excellence. Given the development of health care regions, there is probably now a requirement to revisit the National Bed Review findings, in the light of regional networks of care, including primary, community and hospital care;
  - The availability of basic and complex diagnostic equipment and machinery, within the community and the hospital sector as a whole. Where this cannot be provided in situ, serious consideration should be given to mobile diagnostic facilities;
  - Human resources to provide new facilities in the community and to support multidisciplinary and flexible working patterns across the system as a whole.

8.5.2 Based on the lack of robust capacity planning projections on a regional basis evident within the review, we would recommend that the HSE, via the NHO and PCCC offices ensure that current capacity projections are strong enough to support investment.

8.5.3 To ensure fair access and high performance across the service, the NHO could also consider increasing the level of contestability within the system, supporting more tendered provision in areas of access difficulty and incentivising hospital and Primary Care Team efficiency and responsiveness. This could be done through strengthening the role of the NPTF, for example through lowering the thresholds for eligibility for the NPTF or through strengthening the process by which eligible people are given a choice to go through the NPTF (and / or are 'removed' from the original hospital).

## 8.6 Infrastructure

8.6.1 A joint management and care focus of course cannot be satisfactorily achieved without the development of supporting infrastructure and in particular:

- Progression of development of both hospital and PCCC ICT infrastructure and projects to support care professionals in the delivery of their work in the most efficient and timely way;
- The development of leadership at all levels across the system to champion reform at the operational and clinical level. Too often leadership focus is devoted to 'silo' mentality, whereas patients and organisations need everyone within the system to take up the leadership mantle;
- Clear communication and transparency for patients and staff about challenges and progress, to move beyond the 'them and us' mentality;
- There are also significant industrial relation challenges and obstacles involved in the requirement to reform care delivery, both in emergency and other care areas. New solutions need to be found to these issues.
- Individual and joint systems must be underpinned by strong governance mechanisms. Some agencies are likely to need strengthened governance arrangements, particularly if some of the recommendations of this report are to be implemented. The National Hospital's Office (NHO) could set out the minimum requirements for hospital governance. For example, the NHO could require all hospitals (or a group of hospitals if that is required to obtain sufficient size) to have a board of directors (that includes a CEO, a medical director, a finance director, a director of nursing and x number of non-executive directors) all of whom had specified duties and responsibilities. The current hospital accreditation system could also be expanded to embrace elements of healthcare governance and review.

## 8.7 Finance

8.7.1 The final area to support more balanced service delivery is more clarity as to how money will flow around the system in the medium to longer term. In particular, a decision needs to be made as to how the HSE wants to use capitation based funding formulas (which can underpin equality of provision) vis-à-vis casemix adjusted hospital reimbursement (which can drive efficiency). Options could include:

- PCCC fund non-hospital services through a capitation formula and the NHO fund hospital services through a casemix reimbursement;

- HSE fund primary care organisations for all services through a capitation formula, who then fund hospitals through a casemix reimbursement;
- HSE fund 'HMO' (US Health Maintenance Organisation) style organisations for all services (primary and acute) through a capitation formula.

8.7.2 Whatever the formula, a better level of equity needs to be sought across providers, regions and sectors.

## 8.8 Incentives

8.8.1 In doing this, more transparent incentives need to be built into the forward strategy, to encourage high performance and responsive and appropriate care. It is not clear whether there is willingness to extend rewarding good performance in acute hospitals (and other sectors) with financial rewards. Without more explicit performance and efficiency measures across the system, it is difficult to see how quality can be levered up. The NHO could consider introducing a positive incentive for 2006 alongside the negative incentive of budget reductions for low performing organisations, against an agreed set of performance criteria.

8.8.2 Alongside funding measures for hospitals, review should be given to incentivisation (financial and otherwise) to changing working practices, such as GP services, diagnostic operation and nursing services.

8.8.3 In terms of raising high performance and strengthening healthcare governance measures, the NHO should set the direction of travel for accreditation. This could be that hospitals need to be accredited by a particular date in order to receive public funding. Over time the accreditation standard could become higher. In addition, individual services (e.g cancer services) could be required to achieve accreditation as well as the overall hospital in order for that service to receive funding or extra monies.

8.8.4 The NHO may also want to consider working towards a single accreditation system for public and private hospitals. The NHO could award financial bonuses for the achievement of specific quality standards. These would need to be over and above the standards required for accreditation. It would make sense to focus on a small number of priority areas, such as A&E waiting times, MRSA rates, cancer services and cardiac services. Finally, in the short term, the NHO could set out a programme for developing a similar scheme to the Clinical Negligence Scheme for Trusts (CNST) in the NHS.

## 8.9 Operating Framework

8.9.1 In order to manage consistent improvements, the HSE and the NHO will need to ensure that the operating framework set up for all organisations is consistent with the achievement of overall strategy. Therefore, commissioning/contracting will need to support quality improvement, alongside strengthened information system to support quantitative and qualitative analysis.

8.9.2 The NHO is likely to need a robust performance management system in 2006, particularly if some of the above measures are implemented. We would recommend a risk based approach to performance management, whereby the agencies at most risk of breaching targets are performance managed most closely with high levels of intervention and the agencies at least risk of breaching targets are performance managed most lightly with no interventions. Such an approach could be underpinned

by a robust risk assessment. The NHO is also likely to need a process for dealing with failing hospitals and a range of remedial measures (e.g. changing the CEO, changing the whole management team and / or merging the hospital with another one).

## 8.10 Issues and Recommendations

8.10.1 We have raised a number of issues throughout this report, this section summarises the main issues and recommendations for the system as a whole. For purposes of brevity, we have not repeated here the improvements set out in Section 7 on the management of emergency patient flow.

ISSUE: There is not a clear focus on the configuration and organisation of emergency services across the country
RECOMMENDATION: The HSE should consider developing national or regional collaborative on emergency care, to implement areas of best practice and patient flow. This should also take into account arrangements for emergency paediatric care and streaming, as well as emergency psychiatric care.
ISSUE: There does not appear to be a clear framework for the designation of patient flows and specialties (excluding allocation of national specialties) across the country
RECOMMENDATION: The HSE should consider reviewing previous recommendations to establish regional networks to manage patient flows and requirements from specialist to basic requirements.
ISSUE: There is not systematic application of best practice in emergency flow across national hospitals and care networks
RECOMMENDATION: The development of a national/regional emergency collaborative model will enable the sharing and review of best practice in emergency care management and consistency
ISSUE: There is not consistent application of national admission and discharge advice, contributing to unnecessary variability in patient management within and across hospitals.
RECOMMENDATION: National guidelines should be adopted and reviewed and built into a robust clinical governance process across each organisation and the system as a whole.
ISSUE: The current clinical governance systems and regulation of clinical quality are weak.
RECOMMENDATION: Consider the development of a clinical and/or healthcare governance framework for all healthcare organisations and establishing an independent regulator of patient care and clinical quality.
ISSUE: Too few beds or the inappropriate use of existing beds.
RECOMMENDATION: To undertake an option appraisal for each capacity gap to determine the most appropriate solution to closing the gap, across regional networks. Some gaps may be short term, others may be long term; some may be for elective services, others for non-elective work or rehabilitation. Options for closing the gaps could include (i) new capital developments with existing providers; (ii) new contracts for providers to provide elective care; (iii) consolidation or reorganisation of services; (iv) refurbishment of existing facilities.
ISSUE: The fabric of some A&E departments is very poor and some are too small.
RECOMMENDATION: Consider making capital available for interim solutions to refurbish and extend emergency departments. These monies should be focussed on the older and most overcrowded departments. Where possible the interim solutions should not hinder longer term capital developments.

ISSUE: Primary and community care services are patchy and disease management services are not consistently available in the community.
RECOMMENDATIONS: (i) Significantly increase and improve primary and community care services. We are not convinced the scale of change can be delivered through existing arrangements. As part of the development of Primary Care Teams, the HSE might want also to consider procuring primary and community care services for defined populations and allowing private, independent and existing agencies to bid for these contracts. These contracts would need to be of a sufficient size to be commercially attractive. (ii) Consider introducing disease management services. As there are few existing services, consider creating a new market by procuring disease management services from multiple providers and allow individuals to choose between them. This would give contestability between the providers and incentives to be efficient and improve quality (although we suggest such providers are included in the remit of the regulator suggested above). The market / contracts would need to be structured to ensure they were commercially attractive.
ISSUE: The current financial arrangements (block contracts and roll-over budgets) incentivise inefficiency.
RECOMMENDATION: Consider introducing a payment system for hospitals based upon the volume of service provided, adjusted for casemix. Many other developed countries have introduced such systems.
ISSUE: The current financial arrangements give rise to lobbying and even the creation of crises, or the perception of crises, in order to attract additional resources.
The above recommendation would make the payments to hospitals more transparent and rules-based.
ISSUE: The current financial arrangements are inequitable.
RECOMMENDATION: Consider introducing a 'per capita' element into the resource allocation system.
ISSUE: There is little incentive currently for GPs to screen or manage chronic or long term conditions within current contractual arrangements for public patients.
RECOMMENDATION: In addition to the recommendation above, consideration should be given within future arrangements within the GP contract to reward the management of long term conditions for the public sector, prioritised according to the potential impact for reduced acute admissions.
ISSUE: Overall numbers of key professionals, such as GPs, diagnostic professionals and consultants are lower than required.
RECOMMENDATION: Work is already on-going to support recruitment and training of medical and clinical professionals, which needs to be supported. However, in the meantime, attention needs to be focused on extended roles and workforce flexibility.
ISSUE: Capacity and workforce planning is weak.
RECOMMENDATION: Consider producing a rolling 5-year capacity and workforce projection each year.

ISSUE: Workforce flexibility.
RECOMMENDATION: As part of examining the workforce flexibilities (and forward projections to meet the EWTD), consideration should be given to sharing best practice on pragmatic ways to extend working roles and times, to support the hospital in busy periods. (Including for example, hospital at night, sub-consultant roles, emergency practitioners, paramedics, joint working and delivery between health sectors)
ISSUE: In places diagnostics are a bottleneck.
RECOMMENDATION: Consider undertaking a capacity planning and option appraisal process for diagnostics, similar to that outlined above for beds and staff. The options to close the diagnostic capacity gaps should include the use of mobile diagnostics and health ports.
ISSUE: Machine capacity in diagnostics.
RECOMMENDATION: To consider procuring additional capacity within the private sector. (Mobile units could take the tests and they could be read elsewhere).
ISSUE: GP and Consultant relationship has become distant in some areas and does not support a shared care agenda.
RECOMMENDATION: Emergency collaborative will enable a more integrated approach to the management of emergency care patients. The regional network will also
ISSUE: There is not consistent availability and application of the Acute Medical Unit model across hospitals nationally
RECOMMENDATION: The HSE should look to support the development of AMUs across the country, according to the criteria and operation set out at national level. It will however be important to link the operation and review of these facilities to national governance and performance management arrangements, so they do not become 'blocked'.
ISSUE: Hospital Emergency and Elective Workloads are out of kilter, perpetuating the likelihood of increased medical admissions in the medium and longer term
<p>RECOMMENDATION: The HSE should ensure that organisations are not unduly penalised for attending to their elective workloads in balance with emergency demands. As a priority regional and hospital networks should ensure that:</p> <ul style="list-style-type: none"> <li>○ best practice is applied in terms of development of day surgery as the surgery of choice;</li> <li>○ separate streams for emergency and elective work;</li> <li>○ dedicated surgical periods, throughout the week and year, to avoid conflicts with emergency peaks;</li> <li>○ same day admission practice for surgery;</li> <li>○ efficient timing and co-ordination of theatre time;</li> <li>○ more predictive practice in elective workloads and not cancelling planned surgery;</li> <li>○ more flexible arrangements for surgery across a seven day week</li> </ul>

<p><b>ISSUE:</b> The lack of available and high quality facilities in the community and the home are causing significant operational delays in hospitals</p>
<p><b>RECOMMENDATION:</b> The management of delayed discharges is receiving attention at national level, which is to be supported. As part of this work, the following is considered important:</p> <ul style="list-style-type: none"> <li>○ Collaborations for the proactive rehabilitation of older people should be explored through regional networks, bringing together consultant, GP, public health nurse, occupational therapist and physiotherapists with others. These collaboratives could be based around rehabilitation centres in localities, which would look to support the appropriate and positive rehabilitation of older people to support early and safe discharge home;</li> <li>○ More sustained input to the training of nursing home and residential staff, so that older people are not admitted to hospital unnecessarily;</li> <li>○ Single assessment and application processes for the State subvention system, to avoid protracted delays and duplication;</li> <li>○ Where collaboration is not pursued, the possibility of charging between the acute and the community sector should be explored, where delay is identified to be a consequence of inefficiency or delay in one sector.</li> </ul>
<p><b>ISSUE:</b> There is not a standard minimum data set to support the monitoring of emergency or in-patient care performance and improvement</p>
<p><b>RECOMMENDATION:</b> Clear data definitions and minimum data sets should be established for all future performance monitoring. Given the significant data issues both for collection and analysis which were thrown up as part of this project, it is recommended that a clear baseline is established for the management of in-patients, to support future benchmarking, but most importantly, capacity discussions and planning.</p>