UL Hospitals
Oispidéil OL

Submission to the HSE for consideration by the Committee on the Future of Healthcare in Ireland

2016

UL Hospitals Group

August 2016

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Introduction

The UL Hospitals Group is comprised of six clinical sites functioning collectively as a single hospital system providing a range of acute inpatient and daycase services to a population of 379,327 people from Clare, North Tipperary and Limerick. The group is governed by an interim Board of Directors, an Executive Management Team led by the CEO supported by four Clinical Directorates (Medicine, Peri-Operative, Child & Maternal Health and Diagnostics) who are accountable for the operation of services across the sites.

The six sites include University Hospital Limerick, University Maternity Hospital, Croom Orthopaedic Hospital, Ennis Hospital, Nenagh Hospital, and St. John's Hospital. University Hospital Limerick is the only Model 4 hospital in the group and provides major surgery, one of the eight nationally designated cancer centres, emergency services, as well as a range of other medical, diagnostic and therapy services. As there is no Model 3 hospital in the group, all critical services are located here, and it has the second busiest Emergency Department in Ireland with annual attendances of 61,000 presentations and the only 24/7 emergency service in the group.

The Model 2 hospitals provide inpatient medical beds, a medical assessment unit, injury unit, day surgery and 5-day surgery. The Maternity and Croom Orthopaedic hospitals are specialist hospitals.

The UL Hospitals Group provides a service to the people of Limerick, Clare and North Tipperary; however various services (Emergency PCI service, Day Services, Oral Maxillofacial etc.) treat patients from neighbouring catchment areas.

One of the key success factors in the ability of UL Hospitals Group to meeting waiting lists targets is attributed to the successful utilisation and working of our Model 2 hospitals. This is mainly due to the fact that most of our day surgery is now done in the Model 2 Hospitals other than more high risk surgery, which is not cancelled when there are pressures on the Emergency Department which result in the cancellation of non urgent surgeries in our Model 4 Acute Hospital. In addition the creation of a central referrals hub has also contributed to the management of our outpatient waiting lists where referrals are now referred to speciality rather than consultant and appointments allotted to the shortest waiting lists. Another success factor has been the directorate model of working across all hospital sites within the group along with the previous reconfiguration of surgery has also provided the opportunity for a seamlessly movement of consultant to deliver services across all hospital sites within the group.

Our future plans would also be to reduce the patient waiting time to closer to international standards.

Demographic Projections

Nationally our population is projected to increase by 4% (or 188,600 persons) between 2016 and 2021. By 2021 there will be 107,600 additional persons aged 65 or over and 15,200 additional persons aged 85 and over. We know that 64.8% of people aged 65 or over have two or more chronic conditions, equating to 404,470 persons in 2016 and rising to 461,710 persons by 2021. It was

projected for 2015 that to maintain the same level of service that would equate to an additional funding requirement of €158 million[i].

Our catchment area contains a diverse demography, from the most deprived area nationally in Limerick City to the more affluent local authority area in Limerick County. We have an above average suicide rate, the highest national rate of self-harm, and the highest national rate of births to mothers under 20 years in Limerick City. Tipperary North has a higher than average rate of male Colorectal and Prostate cancer. County Clare has the highest national incidence of breast cancer. All of our catchment areas have a higher than average amount of people aged 65 and over.[ii]

Historical Background

The Emergency department (ED) and Surgical Services were reconfigured in the mid-west in 2009. This coincided with the establishment of motorways between Ennis and Nenagh, such that the travel time by ambulance between the hub and spoke was never more than 30 minutes. All emergency and major complex surgery was centralised, and this model continues now to this day. The building of the new Critical Care Block which houses Intensive Care, High Dependency and Cardiology was the next development in the centralisation of emergency services. This has led to most of the regions anaesthetic services being reconfigured with the removal of intensive care units from the smaller hospitals, such that the UL Hospital Group has only one hospital with ICU and 24 hour emergency services for its entire population, supported by three Model 2 hospitals.

Governance and Management

The Group Board was established to manage public hospitals within the Group in line with the Government's programme for reform of the health service, initially on a non-statutory basis pending the establishment of Hospital Trusts. The Board will be required to oversee the effective planning, management and implementation of the integration of services across the Group to achieve an optimum, cohesive, high quality and safe service provision. They will also need to establish a process to oversee the development of relationships with all key stakeholders including the academic partners of the group, primary, community and social care providers, local patient representative groups, research institutes, research funding agencies and professional bodies.

List Hospital Group Board Chair/Members

Professor Niall O'Higgins, Professor Emeritus of Surgery, UCD, Chairman
Professor Don Barry, President of University of Limerick
Mr. Maurice Carr, Chartered Accountant
Dr. Mary Gray, General Practitioner
Mr. Seamus Gubbins, Chartered Accountant
Dr. Sheelagh Ryan, Former Chair of the National Cancer Screening Service Board

In attendance:
Ms. Colette Cowan, Chief Executive Officer
Ms. Noreen Spillane, Chief Operations Officer
Mr. Hugh Brady, Chief Financial Officer
Dr. John Kennedy, Chief Clinical Director

List Hospital Group Management Team

Ms. Colette Cowan, Chief Executive Officer
Dr. John Kennedy, Chief Clinical Director (Dr Paul Burke incoming Chief Clinical Director)
Ms. Margaret Gleeson, Chief Director of Nursing & Midwifery
Ms. Noreen Spillane, Chief Operations Officer
Ms. Josephine Hynes, Director of HR
Mr. Hugh Brady, Chief Financial Officer
Ms. Shona Tormey, Clinical Director, Peri-Operative Care
Dr. Declan Lyons, Clinical Director, Medicine
Dr. Gerry Burke, Clinical Director, Maternal & Child Health
Prof Paul Finucane, Chief Academic Officer
Vacant post – Clinical Director, Diagnostics (oversight provided by CEO until CD is appointed)
Mr. Brian McKeon – Director of Informatics, Planning and Performance

Funding Model

The underlying principle of Activity Based Funding (ABF) should be to positively reinforce the organisations strategic objectives and it should also account for the demographic and specific socio-economic factors of the region.

- There have been a number of previous funding models for the healthcare system; the time has come for a sustainable one.
- One of the most fundamental changes to improve the stability and planning of the Irish healthcare system is to put healthcare funding on a multi-annual basis to facilitate proper long-term planning and optimal decision making. Ideally there should be a three-year budgetary cycle.
- Activity Based Funding is the preferred model but it needs to be more prescriptive in terms of cost allocation to ensure equity across the system and to avoid cherry-picking on "profitable" specialities. The mechanism to incorporate major developments needs more thought as do the adjustments required for the additional costs within teaching hospitals
- Currently ABF considers only inpatient and day case activity. However it is planned to extend to outpatients in 2017, but it also needs to encompass diagnostic elements such as radiology and laboratory services.
- ABF must be incorporated across the whole spectrum of health including the Community Healthcare Organisations (CHOs). This would allow a more efficient and transparent healthcare system and ensure an aligned strategic direction
- The current reimbursement in ABF is based on discharge. It does not take account of quality of healthcare. Indeed there are perverse incentives for some reimbursements. It does not take account of re-admissions nor clean discharges. Therefore there is a need to index reimbursement based on agreed staffing levels, infrastructure and patient outcomes. There must be a quality control aspect taking account of the costs associated with re-admissions
- We support the Commissioner Style model where initiatives such as the national screening programmes can be purchased from the group
- Performance Related Pay (PRP) is a natural outcome of ABF and should be adopted across all areas of the healthcare system. With patient level costing, activity can be measured and measured across the system and therefore pay should be linked to activity and quality targets
- Hospital Groups do not exist in isolation from the community and therefore the funding models of both needs to integrate through formal SLAs e.g. Home help packages. The anomalies between costs of treatments between the hospitals and the community needs to be formalised such as enzyme drugs, renal home dialysis

Integrated Care and Access to Care

Relationship between Acute Hospitals and GPs

The change in medical technology and patient expectation over the last number of decades has resulted in a greater reliance on hospital care particularly in the final stages of a patient's illness. Diagnostics have become more sophisticated and treatment of acute illness more effective. The result is that the family practitioner is no longer able to manage all the episodes of care which they would have in the past.

Models of care, technology working practices and incentives need to be used to reverse this trend.

The concept that the modern acute hospital should be predominantly composed of (i) emergency and critical care departments for the acutely ill patients who require those services and (ii) specialist services requiring in-patient care. Most other patients can be treated in primary care, outpatient and day care (and occasionally 5-day) settings. These needs require careful planning and implementation as was the case in the reconfiguration of services in our region.

Changes that need to be looked at include:

1) Use of technology, trained nurses and involvement of general practitioners to promote the hospital at home concept

2) Greater use of technology to provide virtual clinics in the primary practice and community settings.

3) Greater access to diagnostics and allied health professionals for GPs. Increased availability of laboratory, radiological and ultrasound facilities to GPs would be of great benefit to patients and reduce the strain on hospital services. However, high-quality and cost-effectiveness must be incorporated in such an arrangement and advice from GPs as to how this might be achieved should be sought.

4) Partial reversal of the recent trend that family practice cover outside 9am – 6pm, Monday to Friday is provided by large cooperatives who undertake the call obligations so that the call doctor may never had contact with the patient, may not be from the immediate locality, has no access to their notes and is not in a position to confer with the regular GP is required. We cannot return to the single handed practitioner 24hr, 7 day a week model. But a hybrid model whereby small groups of family physicians, were organised to provide cover in the twilight hours i.e. 6pm – 11pm and 8am -8pm, Saturdays and Sundays would be a better system. Cover outside these hours to remain on the large co-operative model.

5) Under the current system demand management for more sophisticated diagnostics and therapies is effectively through the hospital queue system. If access is increased through GPs it may only result in greater resource utilisation without any decrease in hospital beds. Therefore if GPs are going to be given resources there will need to be

an accountability system based on quality of care and outcomes including hospital avoidance.

6) Enhanced interactions between the Hospital and GPs. In the UL Hospital Group the establishment of a GP Forum with representatives nominated by the local branches of the Irish College of General Practitioners has been established. This development has considerable potential in increasing efficiency of services, improving communications and will probably reduce error and misunderstanding.

An example of an area which has been highlighted as needing improvement is agreed discharged document which focuses on the information needed by GPs to continue safely the care of their patients. This is the subject of a joint working group involving GPs and Hospital Staff.

Hospital Avoidance

Enhancing and developing care in the community through earlier intervention will require support from acute hospitals e.g. hospital in the home.

Focus is required on the elderly population due to projected growth in over 65's.

As the Mid-West CHO and the UL Hospital group share the same geographical area, joint programmes of activity are facilitated. The following are examples of collaboration between UL Hospital Group and Mid-West CHO;

- Close collaboration with the community health organisation to reduce the number of delayed discharges across the group.
- Community Discharge Co-ordinators link directly with the hospital to facilitate early and complex discharges to the community.
- Specialist Geriatric service established in St. John's hospital with therapy input – OT and SLT from the community.
- Outreach services provided from the hospital to the community, eg diabetic and paediatric end of life care.
- OPAT service well established with the Community Intervention Team (CIT) to facilitate the early discharges of patients resulting in bed days saved in the hospital.

Scheduled Care

The UL Hospital group has demonstrated strong performance and management of waiting list which is linked to the group governance model.

Group model provides day service, 5-day surgery, complex surgery in separate sites supported by the seamless movement of consultants across all sites, thus providing fair access for patients.

Unscheduled Care

The current trend is for patients to seek treatment in the ED as a result of lack of provision of alternative treatment and under-utilisation of treatment options.

Bed Capacity

There is a recognised need for additional bed capacity in this region due to infrastural defecits and the need for modern facilities for patients. A validated tool for assessing bed capacity is required.

Quality and Patient Safety

To quote Sir Cyril Chantler "Medicine used to be simple, ineffective, and relatively safe. It is now complex, effective, and potentially dangerous. The mystical authority of the doctor used to be essential for practice. Now we need to be open and work in partnership with our colleagues in health care and with our patients."

In hospitals, working and participating in weekly multidisciplinary (for example, among medical specialists) and multi-professional (for example among medical, nursing and allied professions) teams is now recognised as being of critical importance. This arrangement (i) minimises error and (ii) improves accuracy both in diagnosis and treatment. In cancer care, this system also (i) prolongs survival and (ii) improves quality of life.

Following on from the above it is essential that objective measurements of the safety as well as the effectiveness of all aspects of the medical systems are put in place. To promote an open and transparent process it will be essential for a public culture which while rightly expecting the best and safest care possible accept that in complex situations errors will occur.

Staff need to be encouraged to be open and transparent however open disclosure culture in other countries took a number of years and was supported by certain legislative safeguards for participants.

Safe systems require that the organisation structure and resource allocation matches the expected standards and level of productivity required.

Modern quality and patient safety standards should ideally be on a no individual blame basis but rather looking for system errors and system solutions. However, whereas acceptance of human error is important, there is a conflicting principle of accountability. Deliberate violations of reasonable safety practices are issues where accountability has to be expected. In addition serious or consistent underperformance when it occurs needs to be addressed.

In the terms of quality matrix, standardised validated relevant measures are required. Measurement and proper public reporting of properly standardised anonymous data as regards mortality and other outcome statistics is important. However care must be taken to see that there is proper interpretation of same and that counterproductive behaviour does not ensue. Process measurements may need to be substituted where outcome measures are not available but they can be misleading.

As for all departments proper funding and resourcing of quality and patient safety measures in combination with efficient procedures is essential.

Legislative change to protect quality processes within hospitals will need to be implemented. In other jurisdictions peer review, audit and morbidity and mortality meetings are given privilege from disclosure to promote open and transparent discussion within those forms. This needs to be strongly considered in Ireland.

The role and development of ICT is central to this reimbursement strategy. It is also essential for patient safety as multiple systems for patients' records result in inefficient duplication and potentially dangerous omissions and other errors. ICT in the statutory hospital system has been under invested for years.

The educational value of a hospital as an area of public information about health and illness should be emphasised. An area devoted to health maintenance, fitness, prevention of illness and the meaning and value of screening programmes should be essential in every hospital in the state. Such educational enterprises can contribute to public health and can lead to the hospital being perceived as a valuable resource for the community and not just as a place "where you go when you are sick".

eHealth Ireland

The national EHR Programme, and the Individual Health Identifier as a key enabler, represents a significant transformation in the use of technology and data to underpin effective and efficient care. The UL Hospitals Group believe these eHealth Ireland programmes will result in improved population wellbeing, health service efficiencies and economic opportunity through the use of technology-enabled solutions.

The role and development of ICT is central to a reimbursement strategy. ICT in the statutory hospital system has been under invested for years

Health & Wellbeing

In line with the Healthy Ireland Strategy, a need for resources to further develop Health & Wellbeing initiatives for staff and the public which will have positive impact for staff morale, service delivery, mental health and hospital avoidance.

Resource Allocation and Workforce Planning

Ensuring there is enough clinical staff with the right skills to meet the demand for high-quality, safe healthcare is essential to the operation of the health service. The current arrangements for managing the supply of clinical staff is fragmented and does not represent good value for money, often forcing reliance on agency staff at significant costs.

With a worldwide shortage of clinical staff there is now a greater need for proactive workforce planning. There should be a greater focus on introducing new grades to support both existing clinical staff, including an expanded role for Health Care Attendants, along with the introduction of the role of Physician Assistants and Theatre Assistant.

Retaining our clinical staff for a period post their qualification should be considered in the context of providing them with financial support during their academic studies in order to secure a qualified workforce for a defined period.

Greater planning and discussion with the specialty training and academic bodies is required to ensure the numbers admitted to those programmes reflect future health needs. This requires greater collaboration and alignment of needs with training delivery.

With many health services strategies already produced such as the Maternity Strategy or pending such as the Trauma Strategy or Cancer Strategy there is a requirement to commence dialogue with universities and education bodies to review and assess places available for students.

Other countries have developed expertise in overseas recruitment, Ireland could learn from their approach. This requires a whole systems approach including various government departments and agencies working together to streamline the process for potential candidates to address issues such as visa, work permits and professional body registration.

Staff retention is key factor in workforce planning; continuous professional development is a necessity rather than an optional extra.

Other external influences that need to be considered would be the representative bodies as they have a significant influence in change management within the service.

Organisational Reform

A fundamental question that will need to be addressed in the hospital service is the optimal number and configuration required to develop an efficient and effective service.

The number of specialties that need to be on call to in an acute hospital holding itself out to provide safe and effective care to all acutely presenting patients has increased exponentially. Therefore the consolidation of units first proposed in the Fitzgerald report needs to continue. The concept of the Model 2 and the Model 4/5 hospital has the potential to be a robust model into the future. The role of Model 3 hospitals, due to the difficulty at least in some instances in providing the range of services for acutely presenting patients, will remain a challenge.

The role of single specialty hospitals is one which needs careful consideration. Unless on the grounds of an acute general hospital, there will be a degree of latent risk due to the lack of other acute supportive specialist services. Specialist units sufficiently large to allow the economies of scale needed to maintain the associate specialty support are required on site.

In the UL Hospital Group the present configuration of hospitals has worked well. However there is a degree of challenge in the number of units in the Group, particularly in the number of medical units of which there are four. Amalgamation of one model 2 hospitals' medical unit to increase the bed stock in the model 4 Hospital would be a more efficient configuration and would make development of speciality rosters which will be required less challenging. In addition it could be argued that one elective surgical hospital rather than two would be a more efficient model for the Group's needs.

Stakeholder Consultation

Key to stakeholder consultation is the public and patients as any future changes will have to take account of their opinions of what the future of health should look like and how it should be funded. Other stakeholders include our staff, training bodies, academic partners, staff representative bodies, regulatory bodies, the HSE and the Department of Health.

Key to stakeholder involvement is in understanding the role, remit and influence of our stakeholders.

Vision

- To establish Hospital Groups as an independent entity, there is a requirement for the management of its own resources including its own bank account. This would be part of legislative changes to operate as a statutory agency
- Capital budgets need to revert to the hospital groups to reflect preferences and priorities of the group. The ability of the group to raise finance for some of these capital projects would enhance and further the strategic planning of the Hospital Groups
- Funding resource required to build up the Community Health Organisation areas to assist in hospital avoidance strategies and provide front line care at source rather than in the acute setting. Currently hospital group have some reactive planning and winter funding provided annually. This could be diverted to develop the CHO services once hospital avoidance pathways are developed. In effect the funding stream would be best served in the community rather in an expensive, high tech, high speciality hospital setting.
- Formal close relationships between (i) CHOs and GPs (ii) CHOs (including Social Care and Mental Health) and hospitals and (iii) GPs and hospitals should be established with identifiable and agreed programmes and protocols. Interaction among these groups, each with their own range of expertise, dedication and commitment, will remain incoherent unless formal dialogue occurs and structures and protocols are put in place. Incorporation of transport services should be an intrinsic part of such formal integration.
- Formal, rather than ad hoc, associations should also be established between the Model 4 hospitals and the highly-specialised services, for example, cardiac surgery and neurosurgical services, so that easy, streamlined and timely access of patients requiring these services can be arranged and implemented without delay or administrative difficulty.
- It would be pertinent to look at the future of the health service with the commissioner provider model where service could be defined by the corporate commissioner once established. This would provide clarity on what services hospital groups should and could provide in a region based on demographics and population health.
  This could be aligned to the correct activity based funding model, which would define activity and funding streams for the future. (The ABF model is currently in shadow format and embedded since January 2016).
- A validated tool for accessing bed capacity in acute hospitals is a requirement and with clear validated data, it would define what services each region can provide and develop. This would also inform capital planning and development for the future rather than the current ad hoc special interest submissions for capital funding in a constrained infrastructural environment.
- Access to care requires a clear focus on two areas namely scheduled care, and unscheduled care. The issue regarding long waiting lists is most often associated with specific specialism's that are difficult to recruit for or provide for in a region.
- To allow access to care it is pertinent to carefully consider the current consultant contracts that are in place to address the shortfalls in the contracts and equally to set up a system of incentivised performance management and performance requirements not only on clinical competencies but on a personal performance management system. However, this will

require caution to ensure that there is not unintended adverse impact on either services or the organisation.

- Specialisation in medicine is both desirable and inevitable. Modern medicine has been transformed by specialisation and sub-specialisation in the universal drive towards excellence by improving quality of care. Most doctors in Ireland who aspire to become consultants spend some part of their training overseas as they develop in their chosen specialty. Almost all specialties, in all areas of Medicine, Surgery, Radiology and Pathology require technical skills and crafts in addition to clinical knowledge and learning. Thus trained consultants of today can practice satisfactorily only in a hospital which provides the diagnostic and therapeutic facilities and backup needed for them to carry out their work. To make consultant posts attractive therefore requires better integration of specialist services. This needs to be balanced with the requirement to ensure core service provisions are met.
- Recruitment and retention of newly-qualified doctors to training programmes in Ireland is an issue of importance in considering the future of healthcare. Training programmes in Ireland for consultants should be made more flexible and less rigid and more attentive to the individual personal and professional needs of trainees. Duty rotas should be arranged well in advance, training programmes should be streamlined and each trainee should be assigned a long-term supervisor or mentor.
- The involvement of the private and third sector should be agreed through robust discussion, collaborations and SLAs. These areas have key resources and expertise that could enhance partnership with the Health Service as a whole.
- Resources, the Irish approach to retaining well educated staff provided by our academic partners needs more focus and assurance at undergraduate and post graduate level. A change in Government policy to encourage timely retention and enhancement of roles is required as we continue to export our best out of the country.
- Values in action and behavioural management, a clear focus on health and wellbeing is government policy however there is a need for further work to be completed on staff awareness, values and pride in their Heath Service. Currently a values in action programme is underway in the UL Hospitals Group and CHO area that would to increase pride and compassionate care for our patients amongst our staff.
- Discussion with our regulators in how they would work with hospitals and Community Health Organisations to address core challenges and key infrastructural challenges in a proactive planned manner.
- Integrated care will be of crucial importance and we have addressed this is page 6 above.
- A task for should be set up to agree the criteria and framework for Model 3 Hospitals. The smaller hospital's Framework for Model 2 Hospitals is an example that could be utilised.

Challenges

- Resources – having both the financial and human resources to support a future healthcare model
- Training – having the additional budget to support additional training posts to meet the future staffing requirement.
- Political willingness and support for change in the interest of delivering safe patient care
- External influence – representative bodies will need to be engaged in a proactive manner to ensure cooperate and avoid any unnecessary delays to implementing the changes required
- ICT – not having the required technologies to support initiative such as telemedicine, virtual hospital
- Public Support for any changes being introduced. This will need to be supported by clear on-going and regular communications.
- Infrastructure – Capital investment will need to be a factor to support the changes in order to gain public support.
- Hospital Group and Community Health Organisation not being co-terminus to ensure smooth transition of patients through the health care system.
- Resources – having both the financial and skilled human resources to support a future healthcare model
- Training – having the additional budget to put in place additional training posts to meet the future staffing demands.
- Political willingness and support for change in the interest of delivering safe patient care
- External influence – representative bodies that will not cooperate or delay cooperation with change.
- ICT – not having the required technologies to support initiative such as telemedicine, virtual hospital
- Public Support for any changes being introduced. This will need to be supported by clear ongoing and regular communications.

Prof. Niall O'Higgins	Ms. Colette Cowan
Chairman of the Board	Chief Executive Officer
UL Hospital Group	UL Hospital Group

[i] Health Information Paper 2015/2016: Trends and Priorities to Assist Service Planning 2016
[ii] Mid-West Health Profiles 2014 – HSE Public Health Working Group