Appendix 1 – Streamlined Hospital Processes

Performance Metrics and Service Improvements

1. Introduction

There are *50* acute hospitals in Ireland, varying in size, type (specialties provided) and activity volume. Collectively, these 50 hospitals treated over *1.3 million* people as either an inpatient or day case. There was an additional *3.5 million* attendances in out patient departments.

Thirty three of these hospitals have an Emergency Departments. More than *1.1 million people presented as emergencies during 2010 of which and there were 369,000 emergency admissions.*

2. Overall Hospital Performance – Inpatient, Day Case and Outpatient Activity

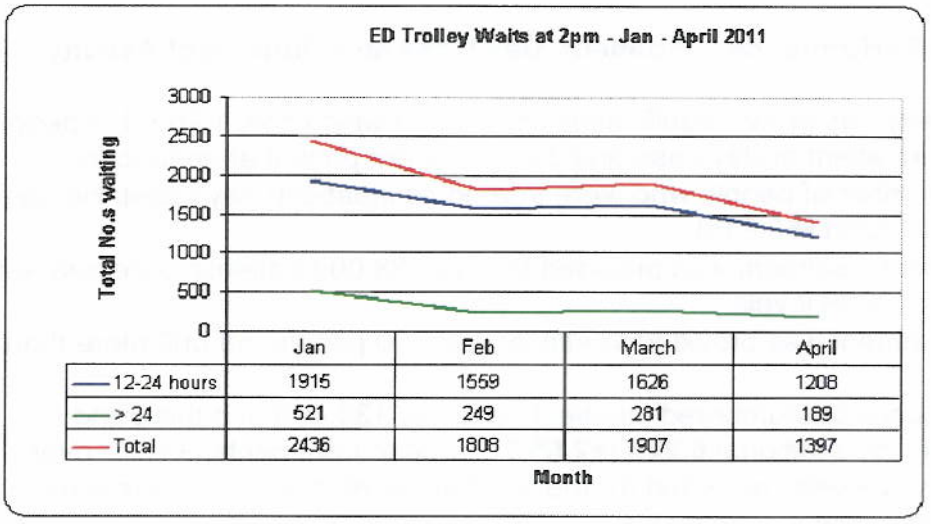
Overall hospital activity has grown significantly since 2009 which saw 1,263,314 people treated as either an inpatient or day case and 3,357,106 out patient attendances.

- In 2010 the number of people who were treated as inpatient/ day cases increased by 4% to 1,317,129 (+53,815)
- In 2010 inpatient treatment was provided to over 588,000 patients, a decrease of 1% against our 2009 levels.
- Day Case treatment was provided to almost 730,000 people, 58,000 more than 2009 (+9%).
- In 2010 day cases outnumbered inpatient cases by 139,409 and this trend continues with an additional **6,226 (+2.6%)** day case treatments (+1.3% over expected activity levels) recorded for the first four months of 2011 compared to the same period last year.
- In 2010 there were 3,557,007 outpatient attendances, an increase of almost 200,000 over 2009 (+199,901)

Key activity area	Outturn 2009	Outturn 2010	Change 2009 v 2010	April 2011 YTD	April 2010	Change April 2010 v April 2011
Inpatient Discharges	593,359	588,860	-4,499	196,013	193,960	+2,053
Day Case Activity	669,955	728,269	+58,314	247,972	241,746	+6,226
Outpatient attendances	3,357,106	3,557,007	+199,901			

3. Emergency Department Performance – Activity Levels 2009, 2010 and 2011

- Over 1.1m individual presentations were made to the 33 Emergency Departments during 2010.
- While this is a decrease of 7,755 on 2009 outturn, ED performance has proved very challenging during 2010 and for the first 4 months of 2011 with unacceptable levels of patients experiencing long waits and treatment in less than optimal settings ("trolley waits").
- Traditionally the HSE has captured and published this 'trolley' count figure at 2 pm daily. This has now become a single 8am count and will be reconciled with the figures collected daily by the Irish Nurses and Midwives Organisation. These new arrangements came into effect from 27th June 2011.
- At the end of April 2011 a total of 1,397 people were recorded as 'ED Trolley Waits' across the 33 EDs.

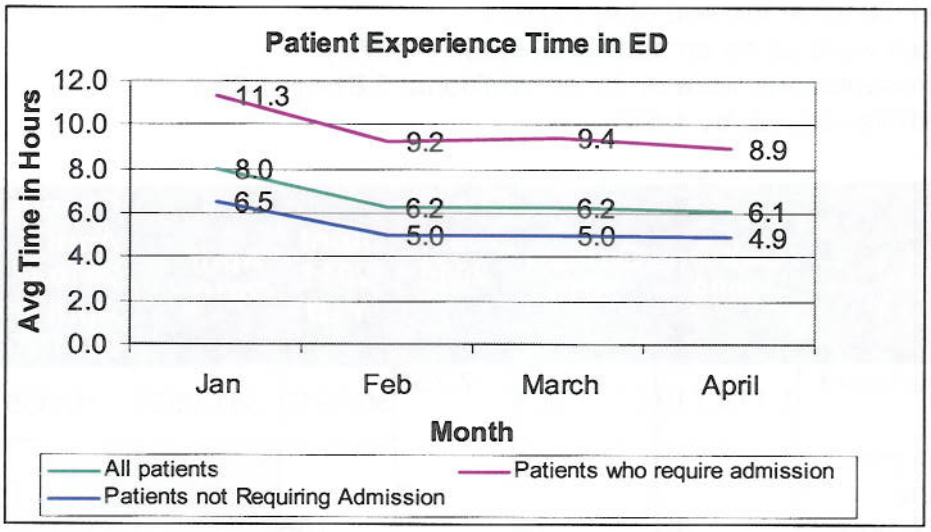


	Jan	Feb	March	April
12-24 hours	1915	1559	1626	1208
> 24	521	249	281	189
Total	2436	1808	1907	1397

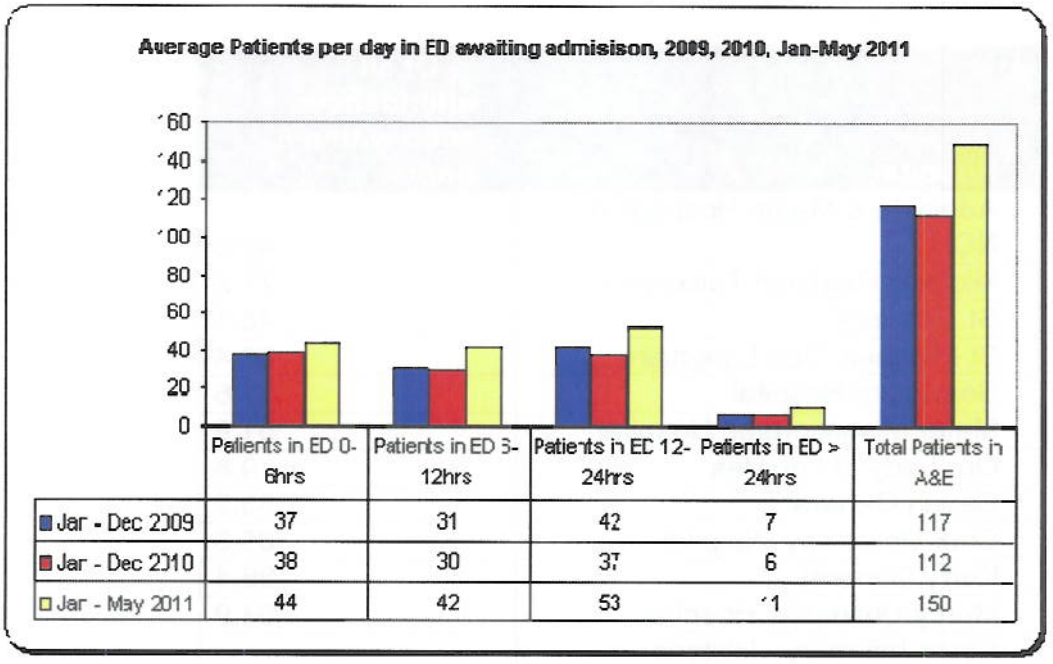
- This point in time data collection is a limited measurement of the individual experience of patients. A more informative measurement is the 'Patient Experience Time' measurement system which the HSE is implementing. This system records the time from when each patient arrives in the Emergency Department, until the time they are either admitted to a bed or discharged. At the end of April 17 hospitals were routinely returning data on Patient Experience Time. It is intended that all hospitals will be reporting using this measurement system by the end of 2011.

- Of the hospitals covered by this measurement system, the average waiting time for April 2011 from time of arrival, to leaving the Emergency Department, was 6.1 hours. This compares to an average of 8 hours in January 2011. For those not requiring admission to a hospital bed the average wait time from time of arrival decreased from 6.5 hours in January to 4.9 hours at the end of April 2011. The average experience

time for patients who required admission was higher at 8.9 hours but considerably down from a January high of 11.3 hours.



- There has been a notable increase in the average number of patients waiting in an Emergency Department for more than 12 hours per day - from 44 per day in 2010 (full year) to 63 per day (Jan-April 2011) and the average number awaiting admission over our 6 hour target – from 74 in 2010 to 106 at the end April 2011.



	Patients in ED 0-6hrs	Patients in ED 6-12hrs	Patients in ED 12-24hrs	Patients in ED > 24hrs	Total Patients in A&E
Jar - Dec 2009	37	31	42	7	117
Jar - Dec 2010	38	30	37	6	112
Jar - May 2011	44	42	53	11	150

- Since January 2011 the monthly Performance Reports consistently point to an increase in ED activity and higher acuity of patients presenting (as evidenced by Triage scores 1 and 2).
- Compared to April 2010, at the end of April 2011
  - ED attendances were up by an additional 6,866 (+1.9%)
  - Emergency presentations were up by an additional 5,614 (+1.5%)
  - Emergency admissions up by 4,535.

Key activity area	Outturn 2009	Outturn 2010	Change 2009 v 2010	April 2011 YTD	April 2010	Change April 2010 v April 2011
Emergency Department Attendances	1,119,719	1,111,964	-7,755	367,919	361,053	+6,866
Average Patients per day in ED awaiting admission (over 6 hour target)	80	74	-6	106		
Emergency Presentations	1,186,003	1,181,414	-4,589	390,100	384,486	+5,614
Emergency Admissions	366,960	369,031	+2,071	126,508	121,973	+4,535

The table below shows percentage of patients discharged from ED within 6 hours of arrival for the period January – May 2011.

Hospital	% Of all attendances seen within 6 hours
Adelaide & Meath Hospital Inc NCH	40.0
Midland Regional Tullamore	77.8
St. James's	48.1
St Michaels Dun Laoghaire	98.4
Beaumont Hospital	51.6
Mater Misericordiae Hospital	51.9
Our Lady of Lourdes	19.8
Cavan General	85.2
Cork University Hospital	65.3
Kerry General	86.4
Mercy University Hospital	64.9
South Infirmary - Victoria Hospital	87.8
South Tipperary General	83.6

St Lukes Kilkenny	91.8
Waterford Regional	67.9
Wexford General	81.0
Limerick Regional	63.2
Nenagh General	100.0
Portiuncula	88.7
St. Johns Limerick	88.1
Letterkenny General	83.8
University Hospital Galway	77.7
View of 22 Hospitals	**67.0**

4. Initiatives and Measures to Improve Emergency Department Performance

Since the C&AG's report in February 2010, the HSE has continued its work to improve the services provided by the Emergency Departments, through a range of measures and initiatives in pre-hospital, hospital and post hospital care.

Service Improvements - Wider Hospital Initiatives

Whilst the clinical programmes (as set out in the attached) will over time improve the services in our Emergency Departments, it is important that we ensure that the services we provide today are fit for purpose. During 2010 and 2011 there has been a renewed focus on implementing a range of service improvement measures and initiatives. These include;

- Reducing the length of time people stay in hospital *(from 6.2 days in 2010 to 6.1 days at end April 2011)*
- Increasing the numbers of patients receiving day surgery *(+58,000 2010 versus 2009 and up 6,226 (+2.6%) at end April 2011 versus April 2010)*
- Increasing day of surgery admission rates *(from 46% in 2009 to 50% at end April 2011)*.
- Percentage of day case surgeries *(from 65% at end 2009 to 71% at end April 2011)*
- Putting in place additional ward rounds by Consultants
- Increasing the number of senior clinical decision makers. It is planned that 14 new consultants in Emergency Medicine will be recruited later in 2011 which will significantly increase the number of senior clinical decision makers. The future development and recruitment of Advanced Nurse Practitioners (ANP) also forms part of the comprehensive workforce pan for Emergency Care. There are currently 40 wte ANP's working in Emergency Departments. For example the ANP team in St. James (n=8 2009) treated 5618 patients representing 13% of new attendances in 2010.
- The C&AG Report refers to the use of a Full Capacity Protocol across a range of hospitals. This protocol means that when the number of patients waiting on trolleys in an Emergency Department reaches a certain threshold, a decision is taken to move these to wards within the wider hospital, which is best practice. The use of this

process was regularised in January 2011, as part of an overall *Discharge and System Wide Escalation Framework* which takes a balanced approach to improving admission and discharge processes and reducing overcrowding. So far this year, 11 hospitals have utilised this protocol, a total of 24 times.

- Eight Medical Assessment Units/Acute Medical Assessment Units are in place and a further 15 are being developed. Medical Assessment Units/Acute Medical Assessment Units treat medical patients who constitute the largest volume of Emergency Department activity. The introduction of these units together with greater access to Consultants will lead to faster access to diagnosis and treatment.
- Minor Injuries Units (MIUs) are being established to provide for people whose injuries are not serious and who would have traditionally visited an Emergency Department resulting in long waits as Emergency Department staff treated more serious cases. Minor injury units have been developed in for example Louth and Monaghan hospitals.

Laverne McGuinness, National Director, Integrated Services Directorate Performance and Financial Management

Appendix 1 – Streamlined Hospital Processes

National Clinical Programmes

Issue	Programme Solution
Service Performance	
Variance in costs between EDs	▪ Types or levels of EDs and the scope of services provided including roles and responsibilities of staff is being defined by the EMP and is on target to complete by end September 11. ▪ Standardisation of models of care and improved data quality will allow variance in costs to be analysed, monitored and controlled.
Access to senior decision makers in ED	▪ 14 new Consultant in EM posts in 2011 will be recruited in 2011 which will significantly increase the availability of senior decision makers in ED. ▪ The EMP is developing a longer-term medical workforce strategy to enable increased levels of consultant provided care in EDs.
Access to Consultants in Other specialties was unsatisfactory in most cases	▪ The EMP defines clear protocols in all hospitals with EDs governing the timeliness of access to senior decision makers in all on-call specialties. ▪ The AMP will commence implementation in 12 sites by end 2011. One of the key performance target of this programme is access to a senior decision maker (consultants and Registrar) within 1 hour from the medical specialty team on call. 34 New Consultant appointments in Acute Medicine will be recruited in 2011 as part of AMP. ▪ Additional consultant posts are also being recruited in Neurology, Rheumatology, Dermatology and Radiology in 2011 to improve rapid access consult and OPD services for ED patients. ▪ The development of Emergency Care Networks as part of the EMP will ensure equitable access to regional specialty services.

Improve Timeliness of Access to Diagnostic Support	▪ As part of the AMP and EMP implementation timely access to diagnostics (including reporting) is mandatory with focus on same day diagnostics. ▪ Diagnostic access measures are included in AMP and EMP with the focus on same day diagnostics. ▪ Diagnostic access will be the focus of Key Quality Performance Indicators for specific Emergency presentations (e.g. time to CT scan in suspected Subarachnoid Haemorrhage, Head Injury). ▪ Diagnostic turn around times will be monitored and upper control limits applied.
Waiting times for bed accommodation following decisions to hospitalise ED patients was unsatisfactorily long	▪ The Acute Medicine Programme (AMP) has defined a range of actions required by the hospitals to ensure and support the effective bed utilisation. The Special Delivery Unit will utilise the clinical leadership and strategy of these clinical programmes to performance manage the effective implementation of these actions. ▪ The total ED Time Target of 6 hours (i.e. admitted to an inpatient bed or discharged from the hospital within 6 hours of ED attendance) will be primary measure of access to in-patient beds and will be implemented by end of 2011. This will include a sub measure of time from Disposition Decision (decision to admit) to ED Departure.
Measures to improve care in EDs	
Introduction of a comprehensive set of performance measures that are applicable to all EDs would help drive performance.	▪ A standardised national suite of process measures, access and quality KPIs have been developed by the EMP. The process measures have been agreed with the SDU and will be implemented in all EDs in 2011. ▪ Standardised data definitions have been developed to promote reliable comparisons between units and performance monitoring. A national data quality assurance system for EM process measures is being developed at present as a collaborative project between the EMP and Health Intelligence Ireland. ▪ Consultants in EM have been involved in discussions with HIQA

	regarding quality indicators and have developed a suite of agreed clinical indicators using a Delphi process. These discussions will inform the multidisciplinary development of clinical quality indicators by the EMP.
ED patient direction to Rapid Access clinics	▪ A range of rapid access clinics are being implemented through the National Clinical Programmes. These include, *inter alia*, clinics for Epilepsy, COPD, Heart Failure, Asthma, all of which are relevant to EM. In addition specific measures are being put in place to improve access to Medicine for the Elderly assessment for patients who present to EDs and AMUs.
Wider hospital Organisation	
Improving hospital capacity	▪ All Clinical Programmes are focused on improving quality and access and reducing unnecessary hospital bed use.
Bed management function	▪ A key component of the work of the National Clinical Programmes and the SDU will be to ensure optimal use of beds. ▪ Implementation of effective bed management function will be mandatory across all sites in 2011 as part of the work of the SDU.

Sharing good practice in improving patient flows in hospital	▪ The EMP will provide a forum for sharing good practice in EM regarding patient streaming and direction to alternative care environments. Existing best practice workshops have already been completed across all Emergency Departments over the last few months and are being shared ▪ The SDU is focused on the implementation of international best practice in patient flow and will work with the EMP and other National Clinical programmes implement same in 2011.
Divert cases currently managed in EDs to other care settings	▪ Enhanced self-care and primary care chronic disease management are currently in design phase with anticipated implementation in 2012.

Community Intervention Teams	▪ Programme on self IV and home IV antibiotics to be implemented 2011
Integrated approach to chronic disease management	▪ Currently in design phase as part of National Clinical Programmes with implementation anticipated in 2012.
Increased volume of work completed on a day case basis	▪ Increased day surgery through the Surgery Programme (targets and solutions defined with implementation to commence 2011)

Dr. Barry White, National Director, Strategy and Clinical Programmes

Appendix 2 – Regional Centres and Safety of Smaller Hospitals

HIQA Ennis and Mallow Report

1. Introduction

In 2009, the Health Information and Quality Authority (HIQA) published a report of the investigation into the quality and safety of services provided at Ennis General Hospital (as part of the Mid West Regional Hospital Group). A follow up report on Mallow was published by HIQA in April this year.

The recommendations in these reports have implications for the delivery of services across the acute hospital system. The HIQA recommendations build on previous analysis undertaken within the health service in recent years that is informing the future configuration of services with a number of key drivers for change to ensure a safe high quality service to all patients. There is a significant body of international and national evidence that indicates that acute complex healthcare particularly for emergency medicine, complex surgical services and critical care services should be provided in large high volume hospitals in order to maximise clinical outcomes and ensure safe services. Critical mass is seen as an essential determinant to service provision in line with evidence in support of better patient outcomes when patients are treated in units with appropriate numbers of specialist staff, with high volumes of activity and access to the right diagnostic and treatment facilities. Health professionals should work as part of multi-disciplinary teams, centred on delivering quality patient care on a 24/7 basis within an integrated network of hospitals.

The HIQA report recommendations also reflect the trend internationally to ensure that acute hospitals serve certain minimum catchment populations in order to provide the spectrum of acute care needed to deal with emergency and acute patients. Hospitals need to have clearly designated roles within a co-ordinated integrated clinical network of hospitals and need to function as an integral part of the wider system of primary community and continuing care. The majority of patients, those who require only a routine, straightforward level of urgent or planned care, should be safely managed locally, with treatment being delivered at home or as close to home as possible. The minority of patients who require true emergency or more complex planned care should be safely managed in designated acute regional centres, where all the relevant clinical expertise is concentrated so that consultant led, high quality care is available round the clock. Importantly, it also involves developing smaller hospitals to provide a much greater proportion of less complex care, especially in day surgery, medicine, diagnostics and outpatient services. This is in line with the general thrust of health policy, which is to provide care at the most appropriate level and as close as possible to where people live.

This evidence supports the need for significant changes in the way our current hospital and community health services are structured and delivered. The ongoing work underway within the HSE in driving the changes needed in our health system across the acute system is driven by these quality and patient safety considerations. The implementation of the recommendations of the HIQA and other key reports is set within the overall context of the roll out of the Acute Medicine Programme lead by the National Clinical Lead in Medicine. This

programme outlines the future strategic vision and a framework for the delivery of acute medical services which seeks to substantially improve patient care.

2. Immediate management of identified risk issues

The HIQA reports identified a number of significant risk issues relating to service provision in hospitals with a similar scale and profile to that of Ennis Hospital. The HSE has identified 10 such hospitals as per list below.

Dublin North East

- Our Lady's Hospital Navan
- Louth County Hospital

Dublin Mid Leinster

- Midlands Regional Hospital Group – Portlaoise
- St. Columcille's Hospital

South

- Mallow General Hospital
- Bantry Hospital

West

- Mid West Regional Hospital Group - Ennis
- Mid West Regional Hospital Group – Nenagh
- St. John's Hospital
- Roscommon County Hospital

Addressing the issues raised requires the development of both regional strategic responses and local risk mitigation plans to ensure safe and efficient services. The medium term solutions require changes to ensure that high risk patient's by-pass these hospitals where sufficient senior decision makers are not in place

The significant issues identified were:

- The need to provide urgent care centres in local hospitals and the need to develop urgent care networks across sites that operationally link smaller sites to larger ED services in regional hospitals. A public communication campaign is needed to ensure that only appropriate patients present at the urgent care centres.
- Need to ensure that low volume complex surgery is not undertaken at these hospitals
- Need to introduce appropriate by-pass protocols so that critically ill patients are brought directly to a hospital that has the range of service and expertise to meet their needs
- Need to put in place an Early Warning System so that patients whose condition deteriorates in local hospitals can be identified early on so that that they can be referred to a regional hospital in a timely manner where appropriate.
- Need to cease provision of breast services at local hospital sites

- Need to ensure that critically ill patients are cared for in a critical care unit with sufficient throughput and expertise available 24/7, including the need to have 24/7 on-site anaesthetic cover particularly for ventilated patients – this cannot be provided in a 3 to 4 bedded unit in a local hospital.
- Need to ensure that patients with medical conditions likely to deteriorate to a critical condition are brought to the Regional Centre.
- Need to cease paediatric and obstetric care at sites that do not have Paediatric and Obstetric Departments.
- Requirement to implement an integrated operational and governance structure so that local hospitals function as part of a network of hospitals.

In advance of any clinical service change the HSE has focused on developing risk mitigation plans, specifically for the identified group of small hospitals to ensure that potential risks to patients associated with the current system of care are identified and analysed, with mitigation actions recorded and monitored locally, regionally and nationally. A high level status report detailing the progress of each hospital is presented in Table 1 below.

Table 1 - High Level Status Report

Hospital Name	Details
Louth County Hospital Monaghan General Hospital Ennis Hospital	These hospitals have completed the process of addressing clinical risk identified by the clinical leads and the reports issued by HIQA. The hospital's no longer deal with undifferentiated medical take or low volume complex surgery. A trauma bypass protocol is in place and there is no critical care. It does not have a full Emergency Department but deals with injuries of a less complex nature and has a minor injuries unit. Since these changes have taken place there have been no adverse outcomes and patient safety has improved. These hospitals are part of a regional governance structure.
Navan Hospital	This hospital has addressed a significant number of issues raised by the clinical leads and the reports issued by HIQA. The hospital does have on site anaesthetic cover and therefore can accept a broad range of medical patients. No complex surgery is undertaken on site.
Portlaoise Hospital	The volume and complexity of surgery in Portlaoise is under review with the clinical leads. Otherwise risk is being managed in accordance with clinical leads and HIQA recommendations.
St Columcilles	24/7 Anaesthetic cover is in place. A trauma bypass protocol is in place. A small ICU is in place with arrangements to transfer critical care patients to St Vincent's University Hospital from November 2011.
Mallow	This hospital has managed risk in accordance with the recent review and continues to enhance patient safety by assuring appropriate patients are dealt with in this particular hospital and more complex cases are dealt with in the Regional Hospital Plans are in place for the implementation of an early warning score, trauma bypass is in place and advanced paramedics will be in place from November 2011. An Urgent Care Centre will be in place from November 2011 and a Medical Assessment Unit will be in place

	in April 2012. Work is underway in strengthening the regional governance network.
Bantry	There are particular issues in relation to the remoteness of this hospital. There is no emergency medicine consultant input; there is a medical assessment unit and no ICU. Plans are in place for the implementation of an Early Warning Score in September and a trauma bypass is in place. There is an agreed volume and level of complex surgery. There is no ventilation overnight. The future model and range of surgery is being considered within the context of ongoing discussions with the clinical programmes.
Roscommon	A plan is in place and this was made public on the 5th of July. This addresses risk issues raised by clinical leads and reports issued by HIQA.
St John's Limerick	Arrangements are advanced in relation to transferring critical care to Limerick Regional Hospital. The complexity of surgery has been agreed with the Regional Hospital Network and is appropriate to the hospital. An Early Warning Score is being implemented and the complexity of medical take is under review.
Nenagh	Nenagh has addressed the issues raised by the HIQA report and the clinical leads. The complexity of medical takes continues be under review. Early Warning Score is in place.

3. Future roles for small hospitals

Under the Acute Medicine Programme, the characteristics of a model 2 hospital (most small hospitals) are in the areas of ambulatory care (including chronic disease management and day surgery), diagnostics and rehabilitation. Such hospitals will have:

- A daytime Medical Admissions Unit.
- GPs referring low-risk medical patients for assessment in the Medical Admissions Unit during daytime hours.
- In-patient and out-patient care for differentiated, low-risk medical patients, who are not likely to require full resuscitation.
- Patients requiring palliative, respite, rehabilitation and pre-discharge care and patients for direct GP to consultant referral (via Medical Admissions Unit)
- A medical department and medical staff as part of a wider rotation under the governance of the acute medicine service in the linked network of hospitals.
- Therapy staffing at a senior grade within each therapy discipline with additional therapy resource comprising staff and assistant grade positions.

However, a number of dependencies to finalise and implement the appropriate model status of these hospitals remain. These include:

- Final determination of which hospitals should become Model 2 hospitals in line with Acute Medicine Plan implementation approach
- Capacity of the regional hospitals to take on the additional transferred workload – noting that this must be balanced with a shift of less complex work out to the local hospitals.

- Improved ambulance/pre-hospital services and availability of ambulance transportation to facilitate timely transfer of patients.
- Some capital works to address immediate needs to support new arrangements
- Stronger Primary Care (GP) and Community health and social care service
- The challenges in maintaining recruitment to a range of clinical posts, including NCHDs, for smaller hospitals into the future due to their limited attractiveness to potential candidates
- Appropriate buy in from clinical directors to lead during implementation
- Appropriate buy in from public representatives to support implementation of changes needed to provide better quality safer care.

Dr. Philip Crowley, National Director, Quality & Patient Safety

Appendix 3 – Regional Centres and Safety of Smaller Hospitals

Ambulance Emergency Services

Use of APs versus small ED

The benefits of transfer by ambulance paramedic staff to high volume centre's even in the context of substantial increases in travel times is strong. The concept of the golden hour was initially proposed in the 1970s and only ever applied to trauma. It was based on very limited evidence four decades ago and has been superseded by significant advances in paramedic training and in-hospital trauma services. As such the golden hour does not apply. Instead the focus has been on enhanced intervention at the scene and ensuring patients attend the most appropriate facility even when there is significant additional travel time.

Trauma:

It has been clear for many years that triage by paramedics of seriously injured trauma patients to hospitals dealing with large volumes of injured patients are associated with better outcomes than those associated with initial transfer to smaller volume units. This applies even in the context of substantial additional travel times (i.e. greater than 1 hour). The Centre for Disease Control in the United States has developed Triage Criteria to assist paramedics in identifying those patients that should preferentially be transported. Studies have shown that application of this protocol by paramedic's results in a 25% improvement in mortality rates amongst injured patients.

The HSE National Ambulance Service trauma protocol is based on the CDC criteria and has been in operation since Jan 2011 in the following areas:

Cork, Laois, Meath, and South Dublin/Wicklow. It has been in operation in the Mid-West since 2008. This will apply to Roscommon from 11 of July 2011.

Myocardial Infarction (Heart Attacks):

The same principles apply to patients with heart attack. When these patients are treated in high volume centre's they do better than those in low volume centres. Paramedics have a key role in triaging patients to high volume centres, as well as administering initial medical treatment while in transit to the appropriate centre.

How prepared are HSE?

Since 2005 the HSE ambulance staff has grown from 1200 to 1440 today.
Within that figure we have grown advanced paramedic numbers from 14 to 220, and paramedic numbers from 1050 to 1210.

What is happening to control rooms?

Moving to single control room at Tallaght with hot standby in Ballyshannon. Building in Tallaght procured from NAMA receiver and project under way. Go live in Q1 2012. This will see the full deployment of the ambulance IT strategy including the cross agency TETRA system. Controllers will have visibility of location and status of all vehicles and crews. Crews will have ability to electronically triage, transferring date to ED staff and create clinical audit trails to enhance the development of paramedic services.

What about all other patient transport?

Patient transport policy developed. All regions rewriting transport protocols to align to policy by 1st August. This will create uniform service saving circa €10m/annum.

Invitation to tender for intermediate care services in the market. This will reduce the wasteful use of paramedic on single patient transports, utilizing EMTs in 2 patient vehicles instead.

Dr. Cathal O'Donnell, Medical Director Ambulance Services

Appendix 4 – Community Initiatives & Primary Care

Community services also play a central role in alleviating pressure on Emergency Departments through the provision of services in the community, which prevent unnecessary hospital admissions or provide hospital patients with appropriate services once they are discharged from hospital.

Primary Care Teams:

- At the end of April 2011 there were *368* Primary Care Teams in place. On examining the activity of a number of selected teams during 2010 the following demonstrates the kind of activity carried out by Primary Care Team.

  Physiotherapy:
  - Almost 70,000 referrals received and accepted
  - Approximately 69,000 patients seen for first time assessment
  - Over 230,000 face to face treatment/visits provided
  - Approximately 183,000 actual clients treated

  Occupational Therapy:
  - Over 23,652 referrals received and accepted
  - Approximately 125,500 direct patient contacts
  - Over 339,000 indirect patient contacts
  - Approximately 130,300 actual clients who received a service

  Nursing:
  - Approximately 900,000 home visits undertaken
  - Over 1,000,000 individual wound management services provided including post operative and compression.
  - Over 62,000 patients discharged from caseloads.

  General Practitioner:
  - On average, there are 14 million consultations by GPs each year (including GPs not in PCTs).
  - Over 899,000 contacts were made during 2010 with GP Out of Hour Services with almost 97,000 home visits carried out (this includes GPs not in PCTs).

Primary Care Team Initiatives

- A number of Primary Care Teams are at the stage where they are developing and implementing specific initiatives to address local health needs. Approximately 240 Primary Care Teams (67%) are providing such initiatives/programmes and these are outlined in the table below (point in time data).

- Other programmes provided by a minority of Teams include hydrotherapy, lifestyle programmes, lymphoedema services, targeted health fairs /information sessions, cancer screening/awareness services and bone health and back programmes.

Primary Care Team Initiatives

No of PCTs (Point in time, February 2011)	No. PCTs (356)	% of overall PCTs (356)	% of PCTs in operation for over 1 year (234 PCTs)
Falls prevention programmes	131	37%	56%
Diabetes care programmes including Diabetes Education	103	29%	44%
Healthy heart or stroke prevention programmes	65	18%	28%
Antenatal and parenting classes including breastfeeding support	56	16%	24%
Health promotion programmes for targeted group e.g. women and men's health	35	10%	15%
Prevention programmes such as weight management, smoking cessation programmes, anxiety management	25	7%	11%
Asthma/COPD programmes	24	7%	10%
Mental health promotion programmes	21	6%	9%
Wound/Leg Ulcer clinics	18	5%	8%

Community Intervention Teams

- There are currently *6 Community Intervention Team* (CIT) in place nationally *Dublin North, Dublin South,* Cork, *Limerick*, *Clare*, *North Tipperary*. The role of this nurse-led service is to provide a rapid response from community services to patients, so that unnecessary referrals to Emergency departments and / or hospital admissions can be avoided and to support early discharge from hospital. These Teams which will increase in number during 2011 mean that so far this year, *2,218* people have avoided the need to be admitted to hospital.
- Examples of Acute Interventions/Enhanced Services provided by a CIT include:
    - Acute Anticoagulation Care - linked to hospital avoidance/early discharge
    - Enhanced nurse monitoring following fractures, falls or surgery including dressings and acute wound care.

- Older person support & care – short term and linked to hospital avoidance/early discharge
- Other Medication Management / Administration as part of patient's acute intervention package

- GP Out of Hours services across the country cover 90% of the population. These services operate for people who need to access a GP outside their own GP opening hours. In the first four months of 2011 the *GP Out of Hours* service had 339,625 contacts which is 52,459 more than the same period last year and 21,684 ahead of expected level of activity. A national review of the out of hours' service was conducted in 2010 with a view to reducing costs and streamlining the services. A number of recommendations were made, including:
  - A reduction in the number of call centres nationally from 7 to 4
  - Standardisation of drugs prescribed through the out of hours service through the application of a national GP Out of Hours Drugs Stock List
  - All future payments to GPs should be on the basis of STC claims that would be submitted online via the call management system, to the PCRS.

  Implementations plans are currently underway in each Region.

- During 2010 almost *12 million* Home Help hours were provided. In addition Home Care Packages are provided to more than *10,000* people every month.
- There were 1,816 *new clients* in receipt of *Home Care Packages* during the four months of 2011, up 24% on target.
- 21,800 nursing beds are currently supported under the *Nursing Home Subvention Scheme (Fair Deal)*.

These measures have contributed to some improvements in the number of patients whose discharge from hospital is delayed. At the end of April this improvement over last year stood at 13% (from 673 in April 2010 to 587 in April 2011.

Laverne McGuinness, National Director, Integrated Services Directorate Performance and Financial Management

Appendix 5 – Non Consultant Hospital Doctors

1. Current Position

The NCHD workforce currently stands at 4,660, reducing by 5% over the past number of years. The projected vacancies represent a vacancy rate of 5.5% of the 4,660. As of 4th July 2011, data collated from individual HSE hospitals indicates that approximately 172 posts are vacant at this time. This follows appointment of 303 NCHDs recruited via HSE centralised recruitment to date. While these vacant posts include both training and service posts, the large majority of vacancies are in purely service settings in small to medium size hospitals.

It is anticipated that currency vacancy levels will reduce significantly as further doctors are appointed via the HSE centralised recruitment process, as a number of those doctors interviewed and offered posts in India and Pakistan take up those offers and are registered and become available for work by 11th July and as a number of doctors provided by locum agencies are interviewed and appointed.

While significant staffing problems will remain at both SHO and Registrar level in Emergency Medicine, it is anticipated that increasing the number of staff available to General Surgery and General Medicine will assist in the delivery and support of Emergency Department services. In this context, the HSE is focusing on addressing particular Emergency Department staffing issues in Our Lady of Lourdes Hospital Drogheda, the Mid-Western Regional Hospital, Limerick, the Midlands Regional Hospital at Mullingar, Tullamore and Portlaoise and Naas General Hospital.

Hospital management are working with Clinical Directors in a planned way to devise contingency arrangements which can be implemented if and as required in these and other hospitals experiencing vacancies to ensure that any resulting impact on services is minimised and to ensure patient safety is maintained.

2. Filling of training posts

As of 11th July 80% (3,750) of the 4,660 NCHD posts will be part of structured training schemes run by the postgraduate training bodies and funded by the HSE. 19% (910) will be service posts where doctors are required to participate in professional development programmes run by the postgraduate training bodies and funded by the HSE. This contrasts with the situation in 2007, when 53% (2,248) were in structured training, 31% in 'standalone training' (not participating in a training scheme but able to attend courses and sit exams) and 16% (736) in no training at all. The postgraduate training bodies have indicated that, with the exception of Anaesthesia and Psychiatry, that they have largely filled, in excess of 97%, posts on their training schemes.

3. Centralised NCHD recruitment to non-training posts: 1,791 applicants to date

The HSE has been working with the Public Appointments Service to implement a centralised recruitment process for the posts in HSE Hospitals and Agencies which are not part of structured training programmes. These constitute approximately 15% of posts nationally.

- The centralised recruitment process introduced two simple changes to the system in place up to December 2009:
- Firstly, NCHDs apply centrally (once) to the hospital and specialty of their choice. They are interviewed in line with their preference and offers made. This replaces the process operating in 2010 and previous years whereby NCHDs made multiple applications, were interviewed in multiple locations and were presented with multiple competing offers by different hospitals.
- Secondly, NCHDs are interviewed by boards comprised of consultants from a number of hospitals, rather than by consultants from a single hospital. This means that rather than competing with other hospitals, (and potentially stripping certain hospitals of NCHD staff regardless of service consequences), hospitals work together to staff NCHD posts that have been identified as being high priority.
- Applicable to non-training posts in HSE hospitals only, about 15% of NCHD posts.
- Training posts (81% of posts) centrally recruited by training bodies for many years, HSE-funded agencies such as voluntary hospitals not included in centralised recruitment for July 2011.
- Application online - opened on 28th February.
- 1,791 individual applicants to date ; 948 applicants in Round 1, 298 applicants in Round 2, 229 applications in Round 3, 101 applications in Round 4 and 215 in Round 5
- Applicants being asked to prioritise sites so NCHD is interviewed in line with choice.
- Regional Interview Boards, with facility for sub-specialty boards.

a) 208 appointments from Round 1: In summary the data from Round 1 indicates that of 948 applications to HSE centralised recruitment, 315 candidates (33%) were successful. Arising from significant work over the past fortnight, all 315 have been offered posts. Of the 315 offered, 208 accepted, an acceptance rate of 66. There are various reasons for this, including that the candidate could also have received offers from a training scheme, a HSE-funded agency or the NHS in Northern Ireland or Great Britain. This means that the rate of acceptances to applications will be in the region of 22% overall, or 208 appointees from 948 applications.

b) Round 2 - 294 additional applications were received as part of Round 2 of which 46 were successful and 37 offered. 27 acceptances have been received to date. This represents an acceptance rate of 9%.

c) Round 3 - 229 applications were received. While complete data regarding appointments from this round is not yet available, many of these appointments are reflected in the reduction of the number of vacancies to 172.

d) Round 4 closed on Wednesday 22nd June and received 101 applications. Round 5 opened on 23rd June, closed on 30th June and received 215 applications. It is anticipated that the number of appointments from these rounds will be low but will further reduce existing vacancy levels.

4. Distribution of doctors not offered and locum / agency doctors

In addition to the ongoing placement of NCHDs via centralised recruitment HSE HR working with ISD has distributed four cohorts of NCHDs nationally in the last two weeks as follows:

National distribution of NCHD not offered / panelled and Agency / Locum doctors							
Source		DNE	DML	South	West		Total
					West / North West	Mid-West	
NCHDs successful at interview but panelled or not offered posts	Round 1, centralised recruitment	23	11	5	13		52
	Round 2, Centralised recruitment	6	10	10	3	4	33
	Total	**29**	**21**	**15**	**20**		**85**
Locum / Agency Doctors for interview	CPL / Locumotion Agency / A- Team	30	31	38	36	16	151

Those doctors identified as available by locum agencies will be interviewed using the same standards and processes in conjunction with Round 3 candidates albeit they can be appointed outside the centralised recruitment process. A key concern regarding doctors recruited via locum agencies who are trained in EU countries other than Ireland or the UK is English language competency.

5. India / Pakistan recruitment

Interviews were held simultaneously in India and Pakistan between 2nd and 14th May. 34 Consultants and 6 HSE staff participated in the process. 314 candidates were interviewed in Pakistan and 276 individual follow-up meetings held; 233 candidates interviewed in India and 179 follow-up meetings held. Follow-up meetings entailed assessment and confirmation of relevant documentation and a preliminary offer of employment.

During the recruitment process, candidates were informed that should they be offered a post, that the HSE would provide the following:

- An allowance of €700 towards the cost of their flight to Ireland to take up their contract of employment with the Health Service Executive;
- An allowance of €100 per week towards the cost of accommodation for the first 8 weeks of their contract of employment with the Health Service Executive;
- Refund of their Irish Medical Council Registration cost;
- Refund of their Irish Visa cost.

A series of meetings have taken place between the HSE and the Medical Council since late 2010 and there is ongoing dialogue to resolve the precise requirements for registration on the General Division of the Medical Register in conjunction with the Department of Health & Children and other parties.

As of 4th July, taking account of the 202 candidates from India and Pakistan who have received visa application reference numbers from the Immigration and Naturalisation Service, the following is the projected effect of the appointment of these doctors:

Effect of Pakistan / India Recruitment on NCHD vacancies as of 4th July 2011

Note: These doctors will be registered on the new 'Supervised Division' and will be not be able to practice in certain locations - e.g. hospitals identified as not appropriate for acute or emergency care by HIQA

Specialty	Vacancies "-" represents difference from funded complement			Pakistan / India candidates who have applied for visas at 4th July			Surplus / Vacancies. Remaining vacancies are represented by a minus "-".		
	SHO	Registrar	Total	SHO	Registrar	Total	SHO	Registrar	Total
Anaesthesia	0	-11	**-11**	3	18	**21**	3	7	**10**
Emergency Medicine	-12	-35	**-47**	37	10	**47**	25	-25	**0**
General Medicine	-8	-14	**-22**	19	7	**26**	11	-7	**4**
General Surgery	-28	-1	**-29**	20	16	**36**	-8	15	**7**
Otolaryngology	0	0	**0**	0	4	**4**	0	4	**4**
Orthopaedic Surgery	-14	0	**-14**	12	4	**16**	-2	4	**2**
Obstetrics & Gynaecology	-5	-4	**-9**	5	6	**11**	0	2	**2**
Paediatrics	-4	-12	**-16**	16	11	**27**	12	-1	**11**
Pathology	-1	0	**-1**	0	0	**0**	-1	0	**-1**
Psychiatry	-9	-2	**-11**	11	3	**14**	2	1	**3**
Radiation Oncology	0	-2	**-2**	0	0	**0**	0	-2	**-2**
Subspecialties of the above	-2	-8	**-10**	0	0	**0**	-2	-8	**-10**
Total	-83	-89	**-172**	123	79	**202**	40	-10	**30**

Next steps include further communication with candidates regarding registration requirements, include registration of successful candidates with the Medical Council; distribution of registered candidates to NCHD posts in hospitals experiencing staffing difficulties and; induction of successful candidates (subject to registration) in an Induction Programme agreed between the Forum of Postgraduate Training Bodies and the HSE.

6. Progress since 2009

Over the last two years the HSE has initiated a series of actions to address NCHD staffing issues, including:

- **Professional Development Posts:** On 3rd December the HSE advertised all vacant non-training NCHD posts as 'Professional Development Posts' under 2 year contracts to one of the four HSE Areas, with a minimum of 6 months in a regional centre, participation in a Professional Development Scheme under the relevant postgraduate training body and

access to a range of financial incentives. Posts were and are being advertised through a dedicated website, www.irishhospitaldoctors.com, and via the Irish and international press, including the UK, EU states, the US, Canada, Australia, New Zealand, India and Pakistan.

- **International recruitment:** the HSE provided Consultants to and facilitated two recruitment campaigns in Budapest (A Team) and Bucharest (Locumotion) in recent months. This has resulted in a significant number of potential candidates for vacant NCHD posts. During 2010, the HSE worked with the Departments of Health & Children, Justice & Law Reform and Enterprise Trade & Innovation to make it easier to for non-EU doctors to work in the Irish public health system from June 2010 onwards.
- **Increase in training posts:** Each year the HSE invests more than €25m in medical education and training and as part of this the HSE has worked to increase the number of doctors in training. In 2007, a survey conducted by the Royal College of Physicians of Ireland found that while nearly all NCHDs had 'training numbers' less than 40% of NCHDs were in structured training. As of January 2011, following significant work by the HSE in partnership with the medical training bodies and the Medical Council, 78% of NCHDs are in structured training. In July 2011, that will rise to 80%.
- **Changing the arrangements and costs associated with hiring locum doctors:** A new locum framework agreement will commence shortly with two providers covering the 4 HSE Areas resulting in reduced costs.
- **Visa and Employment Permits:** Earlier this year the HSE worked with the Departments of Health & Children, Justice & Law Reform and Enterprise Trade & Innovation to make it easier to for non-EU doctors to work in the Irish public health system from June 2010 onwards.
- **NCHDs registered on Trainee Specialist Division working in other hospital sites** - the HSE has written to HSE and HSE-funded agencies clarifying that NCHDs registered on the Trainee Specialist Division may be offered the opportunity or required by their employer to *provide services appropriate to their training specialty, grade and training programme in other clinical sites".* This would allow, for example, the employer to offer a trainee in emergency medicine employed in St. James's Hospital the opportunity to perform additional work in Beaumont.

7. Longer term measures

In addition, a range of longer term measures are helping to address NCHD vacancies. These include:

- **Increases in Consultant posts -** the HSE has increased the number of Consultant posts by 26% since 2005, from 1,947 in 2005 to 2,446 in 2011. As part of the doubling of numbers of NCHDs in structured training, the number of Specialist and Senior Registrar posts has increased by 66%, from 691 in July 2005 to 1,039 in July 2010.
- **Changes in doctors' work practices** - In 2008, Consultants moved from a contracted 33 hour week delivered 9am – 5pm, to a 37 hour week, delivered 8am – 8pm with provision for structured weekend working. Similarly, in 2010 NCHDs moved from a core 39 hour week delivered 9am – 5pm Monday to Friday to an extended working day, delivered on a five over seven basis.

Sean McGrath, National Director, Human Resources