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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Public Accounts Committee Meeting

July 7th 2011

Opening Statement

by
Mr. Cathal Magee

Chief Executive Officer
Health Service Executive

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Good morning Mr. Chairman and members of the Committee.

Thank you for the invitation to attend the Committee to discuss matters arising from the 2009 C&AG's Report 70 on Emergency Departments. We look forward to working with you and the Committee and extending to you every cooperation and assistance in your work.

Today I am joined by a number of my colleagues:
Ms Laverne McGuinness, National Director Integrated Services
Dr Barry White, National Director Clinical Strategy and Programmes
Dr Philip Crowley, National Director Quality and Patient Safety
Dr Una Geary, National Lead Emergency Medicine Programme
Mr Liam Woods, National Director of Finance

In attendance and available to the Committee are Dr Cathal O Donnell, Medical Director Ambulance Services, Professor Gary Courtney, National Acute Medicine Lead, Mr Brian Gilroy, National Director Integrated Services and Mr Sean McGrath, National Director of HR.

These are very challenging times in our health care service. Demand for services continues to grow year on year and is exceeding our capacity to meet this demand. At the same time we are implementing almost €1 billion in budget reductions in 2011. For example:

- Over 588,000 Inpatient treatments were provided in 2010 an increase of 47,000(9%) over our planned activity.
- Almost 730,000 Day case treatments were provided in 2010 an increase of 60,000(9%) over 2009 outturn.
- Over 3.5m attendances in our Outpatient Departments an increase of 200,000(6%) over 2009 outturn.

During 2010 there were just over ***1.1 million*** individual presentations in the country's ***33*** Emergency Departments. Almost one third, or ***369,000*** of the people who presented, were subsequently admitted to hospital. Data for the first four months of 2011 shows that there was an increase of ***5,614*** presentations and ***4,535*** emergency admissions when compared to the same period last year.

There are considerable challenges in our Emergency Departments. We accept that patients waiting on trolleys for long periods of time is not acceptable. The C&AG report raised a number of important conclusions in relation to more streamlined hospital processes, community initiatives, the relative cost of ED attendances, acute hospital services and regional centres. As an introduction, I will comment briefly on each of the areas.

Streamlined Hospital Processes

The National Clinical Programmes have been established to drive improvements in how services are delivered. These Programmes, which are being led by Dr Barry White, have been established over the last year. The two most significant programmes in this context are the Acute Medicine Programme (focused on the management of sick medical patients attending the Emergency Department, which represent the majority of cases requiring admission) and the Emergency Medicine Programme. The programmes focus is on implementing key solutions which have been shown to drive major improvements in the care of patients with emergency presentations. This includes standardised protocols, early access to senior decision makers, rapid access to diagnostics, availability of community intervention teams and home IV services and 7 day a week discharge planning. This Programme will commence implementation in 12 hospitals by the end of 2011. The Acute Medicine Programme Document, outlining these interventions, was published within the last six months.

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,
- Increasing the numbers of patients receiving day surgery,
- Increasing day of surgery admission.
- Putting in place additional ward rounds by Consultants
- Increasing the number of senior clinical decision makers.
- Putting in place early discharge policies to ensure patients are discharged by 11am.

The programmes are working on plans to recruit 14 new Consultants posts in emergency medicine and 34 new Consultant posts in acute medicine to support the implementation in 2011 and 2012.

Appendix 1 sets out details on service performance improvements and performance metrics in Emergency Departments and identifies key interventions for the National Clinical Programmes for 2011.

Acute Services - Regional Centres and Safety of Smaller Hospitals

A critical factor is to ensure that our hospitals and all the services they provide are safe and comply with the appropriate clinical standards.

The safety of the care we deliver must be central in our planning for the role of smaller hospitals within our acute hospital networks. We are regulated by the Health Information and Quality Authority, HIQA. They have set out very clear recommendations in their reports on Ennis and Mallow hospitals, as to what is safe and what is not safe when delivering care in hospitals of this size. We are required to implement the HIQA recommendations to ensure that the standards of care delivered in smaller hospitals are as high as possible and that the type of care provided is appropriate to the clinical setting and to the needs of patients. An implementation process has been established. This process involves all the relevant national clinical leads in critical care, emergency medicine, acute surgery, acute medicine and the ambulance services. The clinical leads have set out what type of patient should go to smaller hospitals, taking into account the level of specialist cover and the volume of care provided in each hospital. The clinical advice of the national clinical leads is consistent with and reinforces the HIQA Recommendations for smaller hospitals.

The HSE recognise that changes to the role of smaller hospitals must be accompanied by the commensurate development of our ambulance emergency services. Over the past few years, the HSE has invested significantly in the training of ambulance paramedic staff and the number of Advanced Paramedics has increased from 14 in 2005 to 220 to-date.

Appendix 2 sets out an assessment of the implications of the HIQA Ennis and Mallow reports for the delivery of services in our smaller hospitals.

Appendix 3 sets out a briefing note on the ambulance emergency service.

Community Initiatives and Primary Care

Community services and primary care also play an important role in relieving the pressure on Emergency Departments by providing services in the community which prevent unnecessary hospital admissions or provide hospital patients with appropriate services once they are discharged from hospital.

At the end of April 2011 there was 368 Primary Care teams in place. Approximately one third of these teams are well developed and offering a range of services including falls prevention, diabetes and

asthma programmes. The remaining teams are at earlier stages in the development cycle. Our Service Plan target is to have 527 teams in place by the end of 2011.

The GP out of hours service plays a very important role in pre hospital emergency care. In 2010 there was over 899,000 contacts made with the GP Out of Hours Services. The HSE carried out a National Review of the GP Out of Hours Service in 2010 with a view to driving down cost and achieving greater efficiencies. The recommendations arising from the review are being implemented in each of the four regions.

Appendix 4 sets out additional information on these initiatives and performance data .

Cost of Emergency Department Attendances

The report of the Comptroller and Auditor General found that there were significant variances in the cost per attendance at Emergency Departments nationally. The C&AG also noted some issues in deriving the costs used and made recommendations such as;

- The need to distinguish EDs that have diagnostics from those that do not;
- The need to filter out costs associated with additional services such as chest pain and endoscopy;
- Review cost treatment of streaming units;
- Review the accuracy of cost capture and design an overhead allocation model.

These conclusions are being addressed in our approach to costing service in the acute setting and the clinical programmes. ED costs represent on average 7% of total hospital cost. HSE has adopted the approach of costing all inpatient, daycase and ED attendances and has implemented full costing on a Diagnosis Related Groups basis (DRG) with the support of the ESRI. This is a standard method of defining inpatient and daycase work used internationally. This costing approach takes into account the full cost of treatment including ED attendance. The output of this costing process is used to influence the funding of the 39 hospitals involved. This costing approach includes the development of a standard cost allocating model for all overhead costs as referred to by the C&AG.

There has been no common classification of ED activity. The work undertaken in EDs varies from minor injury to major trauma. In some instances ambulance bypass protocols are in place to ensure that patients go to the most appropriate facility. The ED programme is looking at the classification of activity in these settings to allow for appropriate comparative analysis and benchmarking.

HSE has undertaken a patient level costing exercise in both 2010 and 2011 as a precursor to moving to funding at a patient level. In 2011 the HSE will introduce a pilot project in orthopaedics which involves payment per treatment from July 2011.

Non Consultant Hospital Doctors (NCHDs)

The Committee will be aware that that our hospitals are currently facing challenges in recruiting sufficient Non Consultant Hospital Doctors across a range of hospital specialties; this is despite a major overseas recruitment drive. There are 4,660 NCHD posts in the Irish health system and 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. The postgraduate training bodies have indicated that they have largely filled – in excess of 97% - posts on their training schemes. The remaining 19% (910) are service posts and the key issue is the extent to which this complement of posts is filled. As of 5th July 172 posts remain unfilled and while the full impact of any vacancies will not be known until the next rotation commences next week, we are aware that there will be shortages in a number of Emergency Departments, particularly in smaller hospitals. Hospital management are working with Clinical Directors in a planned way to devise contingency arrangements which can be implemented if and as required, to ensure that any resulting impact on services is minimised and to ensure patient safety is maintained.

Appendix 5 sets out a full report on the current NCHD situation.

Special Delivery Unit

Finally you will be aware that the Programme for Government committed to the establishment of a Special Delivery Unit in the Department of Health. This unit under the leadership of Dr Martin Connor will initially focus on the areas of reducing trolley waits in Emergency Departments and on cutting inpatient, day case and outpatient waiting lists in the health services. Dr. Connor has also been appointed to the Board of the HSE and a dedicated Committee of the Board has been established to support the Special Delivery Unit in its work.

This concludes my introduction and together with my colleagues we will take any questions you may have.

Thank you