Grúpa Ospidéal Bhaile Átha Cliath Lár Tíre FSS
Dublin Midlands Hospital Group HSE
Páirtnéir Acadúil Coláiste na Tríonóide Baile Átha Cliath
Academic Partner Trinity College Dublin

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Our Values
Care Compassion Trust Learning

Dublin Midlands Hospital Group,
Bridgewater House,
Bridgewater Business Centre,
Conyngham Road,
Islandbridge,
Dublin 08T 9NH.

Tel: (076) 695 7280

Dublin Midlands Hospital Group

Dr Susan O'Reilly:

Good morning Chair and members of the Committee.

Thank you for inviting the Dublin Midlands Hospital Group to meet you.

I am Dr Susan O'Reilly, the CEO of the Group and I am joined by my Group Clinical Director, Mr Martin Feeley.

Our Group began in January 2015. Our hospitals comprise: 3 voluntaries in Dublin, St James's Hospital, the Adelaide & Meath Hospital, Tallaght, and the Coombe Womens and Infants University Hospital and 3 statutory general hospitals, Naas General Hospital, Midland Regional Hospital Portlaoise and Midland Regional Hospital Tullamore and the specialised St Luke's Radiation Oncology Network (across 3 sites).

We lead services to 800,000 people, there are 9,746 staff and a gross 2016 expenditure of €1 billion. We appreciate that in 2016, the final budget allocation, was, for the first time, a realistic one. 70% of our expenditure occurs in the voluntary hospitals, with whom we have service level agreements, thus our governance and management structure is different from Groups which principally manage statutory hospitals. Our academic partner is Trinity College Dublin and both education and research take place in our hospitals.

In 2015, there were 95,142 admissions, 190,595 Emergency attendances and 10,011 births.

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How does our Group Add Value?

- Working closely with hospitals and clinical leaders to develop clinical networks and optimal patient pathways eg the Coombe/Portlaoise maternity and neonatology network.
- Collaborating closely with Community Health Areas 7 and 8 to optimise admission avoidance through community intervention and OPAT teams and reduce delayed discharges via their home care and nursing home resources.
- Community integrated care with General Practitioners, hospital consultants and CHOs will be a new focus. This is contingent on a new GP contract. More GPs and community resources will be needed to develop joint programmes in chronic disease management and care of the elderly.
- All our general hospitals, for local and historical reasons, provide 24/7 ED, both acute and elective surgery, medicine and critical care. In low patient volume specialities, staff recruitment fails and professional skills cannot be maintained, thus services depend on temporary agency and locum staff. This was evident in the 2015 HIQA report on Portlaoise which mandated we developed an Action Plan to address safety concerns and risks in both general and maternity services.

Our Group has developed a draft Action Plan to consolidate specific complex services in high volume hospitals and to invest in the smaller hospital developing 7 day local injuries unit, 24/7 Medical Assessment Unit accommodating direct GP referrals. Smaller hospitals will expand capacity for high volume, low acuity day care surgery, endoscopies and outpatient medical and surgical clinics.

The leaders of the National Clinical Programmes advised on optimal design. Local stakeholders and other relevant Hospital Groups were engaged. Committee members should understand that some current ED services may be replaced by a Medical Assessment Unit and a Local Injuries Unit in accordance with the policies in “Securing the Future of Smaller Hospitals: a Framework for Development”. It will need the combined engagement of 6 of our hospitals to align optimal service delivery.

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Capacity Development

- National and international shortages of consultants, NCHDs, ICU, theatre and ward nurses will need time to resolve.
- Replacement of old, small, unfit facilities preclude rapid change, especially when capital is limited.
- Front line staff have performed heroically during the recession and moratorium but radical change can only succeed with thoughtful planning for both community and hospital staff, technology and facilities.

Quality improvement and patient safety

The Group provides networked leadership and learning to focus on improving patient experience and safety as well as better care processes and pathways.

What Will Work?

- Groups need legislative authority in a model similar to the “accountable autonomy” of voluntaries, if our potential for creativity and productivity is to be achieved.
- Clinical leadership – at all levels.
- Clinical Networks.
- Consultant delivered services.
- Evidence based guidance from National Clinical Programmes and the National Cancer Control Programme.
- Smaller Hospitals Framework (Models I-IV).

In Conclusion

21st Century medicine takes longer to achieve than a single government term. Change must be planned, agreed, resourced (staff, equipment and facilities) and implemented!
Your committee, the Minister and the Department of Health have the opportunity to develop an all-party approach to address Ireland’s endemic problems in service capacity and alignment of care to match growing complexity and demand.

I endorse the advice of my predecessor in the National Cancer Control Programme, Dr Tom Keane, that collective political support is key. I also caution that individuals’ resistance to change can be a barrier to progress for our patients.