Céim Chun Cinn

A Step Ahead

Strategy for Acute Hospitals

2001-2006

Western Health Board
Bord Sláinte an Iarthair

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PROACTIVE 0964

Western Health Board
Bord Sláinte an Iarthair

Table of Contents

Foreword...

In 2001, almost 40% of the health and social services allocation for this region will be spent providing acute hospital services in Galway, Castlebar, Roscommon and Ballinasloe. With an annual budget approaching £165 million, and more than 3,500 staff in place, the acute sector is by far the largest area of activity in the three counties served by the Western Health Board.

Devising a strategy which enables these hospitals to move forward together over the next five years is a significant challenge. The Acute Hospitals Steering Committee has risen admirably to the task. It recommends an appropriate increase in beds and staff, and calls for the development of alternative facilities and community supports to backup the services provided in hospitals. There is a new framework for putting the patient at the centre, and measures to boost staff morale. A whole chapter is devoted to detailing how the potential of the information age can be unleashed for the benefit of patients and providers. There are practical measures to reduce waiting lists and waiting times, and proposals for enhancing the total care and service package offered to patients. Underpinning all of this is the need to ensure that there are adequate physical, financial and managerial resources going forward.

The Board has been working hard to upgrade buildings and facilities to the standard of a modern hospital service. There is an opportunity now to make certain that each hospital develops in a way that is appropriate to its size and the needs of its catchment population. Since it is not possible to deliver exactly the same range of services at each hospital, the challenge is to ensure that all hospitals working together are able to provide a comprehensive service. Using the new service models outlined in this strategy, we will seek to determine the level of service to be provided at each hospital, identify the developments needed to deliver it, and pinpoint the pathways to more specialised treatments. We should also try to reward initiatives which deliver a more effective and efficient service locally, with existing budgets.

Céim Chun Cinn is a ground-breaking strategy. It will enable us to take advantage of national developments in bed capacity and manpower, and to build a hospital service which is geared to the needs of all patients. I would like to congratulate the Steering Committee for their time and effort in preparing this strategy, and to thank all of those who helped to shape it. A new course has been charted for our hospitals. We must focus now on implementing it.

DR. SHEELAH RYAN
Chief Executive Officer

Abbreviations and Glossary of Terms

Accountability

Responsibility to someone, or for some action

Acute Hospital

Facility where complicated medical, surgical and investigative services are delivered by highly-qualified and experienced clinical personnel, typically over a relatively short period

A&E

Accident and Emergency Unit

AHP

Allied Health Professional. Includes a wide variety of key staff in the hospital and the community e.g. Chiropodists, Dietitians, Medical Social Workers, Occupational Therapists, Orthoptists, Pharmacists, Physiotherapists, Radiographers, Speech & Language Therapists, and others.

Comhairle

Comhairle na nOspidéal, the statutory body that regulates top-level clinical appointments in the public hospital service.

CPD

Continuing Professional Development

CSO

Central Statistics Office

CT (Scan)

Computerised Tomography

DoH&C

Department of Health and Children, the government department responsible for funding and directing the overall development of health and hospital services.

ECG

Electrocardiogram

EEG

Electroencephalogram

Effective

Producing a desired result

Efficient

Working or producing effectively without wasting effort, energy or money

ENT

Ear, Nose and Throat Services

EHR

Electronic Health Record

EPR

Electronic Patient Record

Equity

Freedom from bias or favouritism. Fairness.

EU

European Union

GDP

Gross Domestic Product

GNP

Gross National Product

GP

General Practitioner

HDU

High Dependency Unit

Health Gain

One of the twin pillars of the 1994 national health strategy. Concerned with health status - in terms of increases in life expectancy, improvements in quality of life through the cure or alleviation of an illness or disability, or a general improvement in the health of the individual or population at whom a service is directed.

HIPE

Hospital In-Patient Enquiry Scheme

Intermediate Care

Range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired. (Kings Fund, 1997) Intermediate Care is sometimes referred to as step-down care.

Internet

Electronic communication network that connects computer networks and organisational computer facilities around the world. Also known as the World Wide Web.

Intranet

Electronic communication network operating like the World Wide Web, but having access restricted to a limited group of authorised users, such as the employees of a company.

ISDN

Shorthand for Integrated Services Digital Network i.e. a set of standards for digital transmission over ordinary copper wire and other media. ISDN is an effective and efficient way of carrying data, such as x-rays, from one point to another.

IT

Information Technology

MAU

Medical Assessment Unit

MCN

Managed Clinical Network

MGH

Mayo General Hospital

MPRH

Merlin Park Regional Hospital

NHS

National Health Service

NUIG

National University of Ireland, Galway

PACS

Picture Archiving Communications System

PH

Portiuncula Hospital

PPSN

Personal Public Services Number. The Government is currently implementing a plan to give everyone their own unique 'access key', called the PPSN, which they will use to avail of a wide range of public services. Examples include applying for a medical card, applying for a social welfare payment, and availing of treatment in an acute hospital.

R&D

Research and Development

RCH

Roscommon County Hospital

Social Gain

The second of the twin pillars in the 1994 national health strategy. Follows but is distinct from the idea of health gain. Concerned with the broader aspects of quality of life. Examples include the quality added to the lives of dependent elderly people and their carers as a result of the provision of support services, or the benefit to a child of living in an environment free of physical and psychological abuse.

UCHG

University College Hospital, Galway

WHB

Western Health Board

WHO

World Health Organisation

Patient / Consumer / Service User

Most people using acute services (and the majority of clinicians) are comfortable with the term patient, not least because it recognises that patients have a need which causes them personal suffering over time. Denying this suffering would not serve any useful purpose.[1]

Occasionally in this report, the term consumer is used. Consumers are people who utilise economic goods. Referring to patients as consumers infers that we value them as individuals, and are willing to listen and to respond to their needs, including their health needs.

A service user refers to anyone who is an actual user, or potential user, of a service provided by or on behalf of the Western Health Board, or someone who is affected in some way as a result of such a service.

Telemedicine

Telemedicine is the application of modern communications technology to enable medicine to be practiced over a distance. According to one prediction, "the area of telemedicine where the professional is remote from the patient or specimen … [is the area] … in which there has been, and will continue to be major activity."[2] Examples include:

- Teleradiology: Radiographic images are transmitted from a remote or rural location, for interpretation by a Radiologist.
- Telepathology: A Pathologist looks down, and in some cases controls, a microscope located even several hundred miles away.
- Teleconsulting: The Doctor and Patient (or the Doctor and Doctor) are in different places, but are joined by some kind of communications link e.g. videoconferencing. In its simplest form, this kind of telemedicine uses the telephone. More recently, full-colour, two-way video links and audio links have been used.

[1] 'Psychiatric Bulletin: The Journal of Psychiatric Practice' Volume 24, No. 12, p. 441. London: Royal College of Psychiatrists.
[2] Wootton, R., 1996: Telemedicine: A Cautious Welcome BMJ, 1996; 313: 1375 - 1377.

Executive Summary...

The Acute Hospitals Steering Committee was formed in Autumn 1998 to prepare an overarching strategy for hospital development in counties Galway, Mayo and Roscommon. The group is composed mainly of hospital consultants and service managers, is broadly representative of the acute hospital sector, and includes an input from primary care.

This report, called 'Ceim Chun Cinn' in Irish (or 'A Step Ahead' in English) has been prepared following extensive discussions among the members, taking into account the results of a detailed consultation with service users, service providers and the public. The Committee itself met eleven times, while the three Sub-Groups which were formed to examine specific issues met from time to time as required.

The Western Health Board has, for some time now, been engaged in a major hospital development programme. Buildings are being upgraded or replaced; new equipment is being purchased; newer and better hospital services are being introduced; and additional care staff are being recruited. Taken together, these developments will help to ensure that more people have better access to the best hospital services that we can provide. However, continuing investment in capacity will be needed for many years to come. This Strategy highlights the difficulties which are currently holding our hospitals back, and offers a range of solutions to enable them to go forward. It should also ensure that service providers and service users can work together in partnership to build a modern hospital service of which everyone is proud, and in which everyone has confidence. Our recommendations are contained in five chapters, each of which is centred around a number related issues:

- Ensuring that our hospitals have the capacity to deliver an appropriate level of service to their catchment population; (Chapter One)
- Putting the patient rather than the provider at the centre; (Chapter Two)
- Improving communications and developing better information technology systems, to enable staff in all care settings to deliver high-quality, seamless patient care; (Chapter Three)
- Ensuring that hospital services are more accessible to the patients who need them, while systematically enhancing the quality of care and service in line with the highest national and international standards; (Chapter Four)
- Developing new service models to link hospitals and care staff around the patient. (Chapter Five)

Each chapter follows a similar format. The key recommendations are summarised at the beginning. The main issues are then examined, and recommendations are stated comprehensively at the end. Some of the appendices also contain a considerable amount of detailed information which, had it been incorporated in the main body of the document, would have tended to disrupt the overall flow of the report. Readers should note that the services are evolving very rapidly, and that some of the information contained in the service directory at Appendix 4 may already have been overtaken by new developments. Nevertheless, the data presented will be useful when detailed regional service plans are being drawn up, taking account of the new service models outlined in this strategy.

How the Steering Committee Worked

Step 1 (Jan. - Feb. 2000)

Consultation with service providers
- 111 Hospital Consultants
- 254 General Practitioners
- 68 Line Managers and
- 216 Health Organisations and Patient Support Groups

are asked to set out their vision for the future.

Step 2 (Mar. - Apr. 2000)

Consultation with service users
- Advertisements are placed in 10 provincial newspapers and on 5 local radio stations, encouraging locally-based voluntary organisations and members of the public to get involved.

Step 3 (Apr. 2000)

Consultation ends
- Approximately 80 responses are received.
- Priority issues are identified by the members of the group during a day-long special meeting.

Step 4 (Apr. 2000)

Steering Committee forms three smaller groups:
- Values and Patient Focus Group looks at how to put the patient first. *(Chapter Two)*
- Information, Linkages and Communications Group examines the communications and information systems needs of a modern hospital service. *(Chapter Three)*
- Organisation Group looks at ways of improving accessibility, enhancing efficiency and strengthening quality in acute hospital services. *(Chapter Four)*

Step 5 (Sept. 2000 - Feb. 2001)

Project Co-ordinator prepares draft strategy on advice of Steering Committee and Sub-Groups.

Step 6 (Mar. 2001 - Apr. 2001)

Post-Draft Consultation

Direct Mailing

Almost 1,200 copies of the draft strategy dispatched to a wide range of internal and external stakeholders:
- Consultants
- Nurses
- Allied Health Professionals
- Community Services Personnel
- General Public
- General Practitioners
- Round Table Committee
- Nurses and Midwives Forum
- Partnership Committee

Public Display

Copies are put on display around the patient waiting areas at each hospital (e.g. Accident & Emergency and Outpatients Departments), in visitor areas at hospitals, and at each Public Library in the region.

GPs are requested to put on display in their clinics, a public notice informing people that a draft strategy for acute hospitals has been prepared, and inviting their comments and feedback. Similar public notices are displayed in each hospital.

The Internet

Report is posted on the Mayo General Hospital website, to ensure it is accessible to everyone with a personal computer and internet connection.[3]

Public Relations

Awareness is raised through a short campaign carried out in the print and broadcast media.[4]

✦ Feedback Invited

Service users and service providers are invited to look critically at the report and to give their views on how the draft strategy could be further improved. Feedback is received from a total of 40 individuals and groups. The Steering Committee wishes to thank those who took part in the post-draft consultation, all those who took the time to respond to the very first call for submissions in the early months of 2000, and to the individuals who read and commented on the draft report of the Values and Patient Focus Group.[5]

Step 7 (April 2001)

Revision of draft strategy.

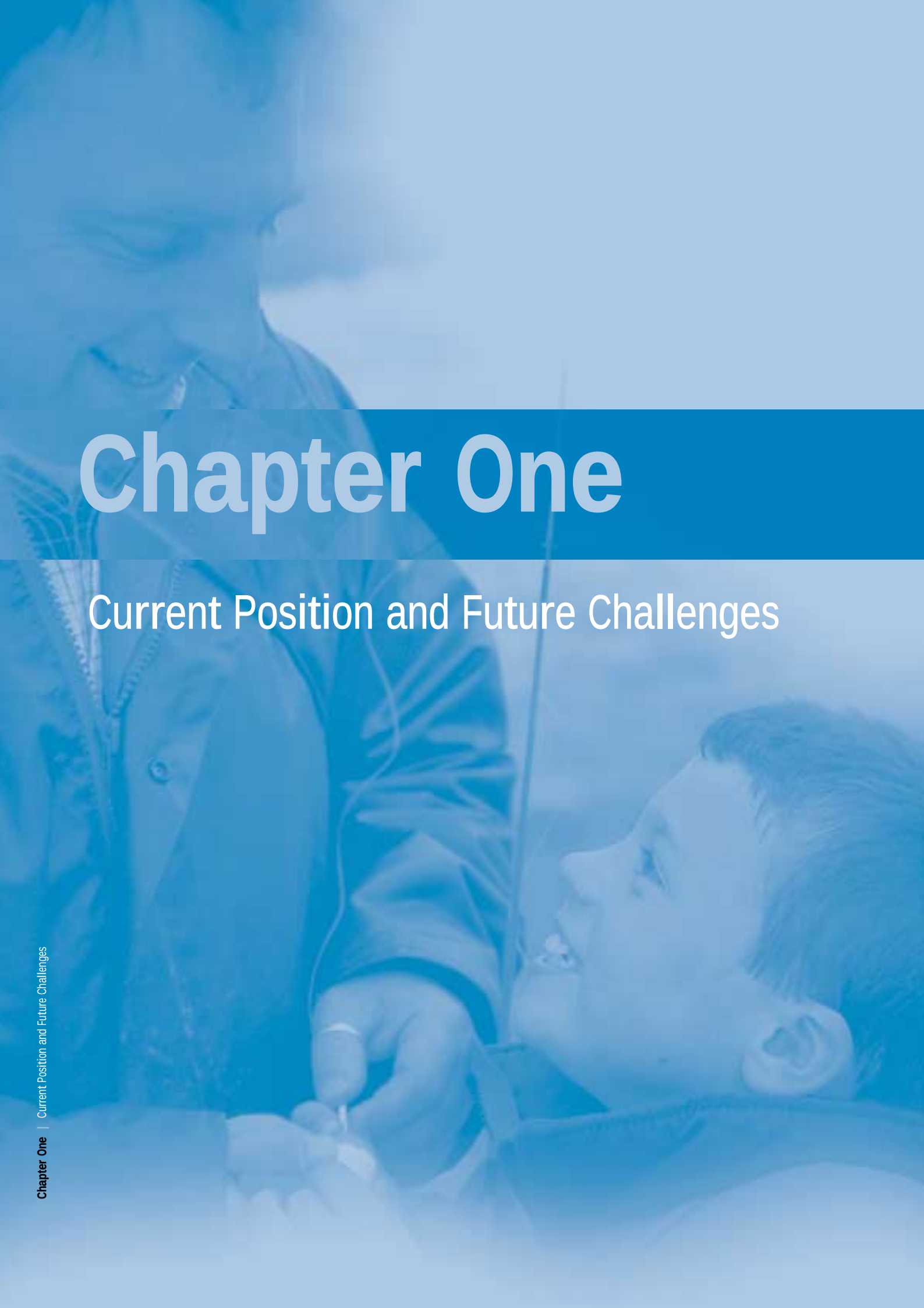
This Strategy contains 61 measures to improve acute hospitals in the West of Ireland. Fully implemented, these recommendations will bring about real and measurable improvements in the quality of hospital care we provide, as well as a much-needed improvement in the range of alternative facilities and community supports offered to the people of this region. The Board must go forward on a number of fronts at the same time in order to implement all of the improvements that are recommended here.

[3]The Steering Committee wishes to acknowledge the assistance received from Dr. Darach Corcoran, Consultant Obstetrician/Gynaecologist, Mayo General Hospital, and Mr. Ray McDonnell, who posted the draft strategy on the hospital's website.

[4]The Project Co-ordinator would like to thank Ms. Miriam Stack and Ms. Sharon Fallon, Communications Department, Western Health Board, for their help in raising public awareness of this report. Thanks are also due to Mr. Colman O'Raghallaigh, Claremorris, Co. Mayo, for his assistance in devising the title of the strategy.

[5]Reviewers were Ms. Fiona Carey, Renmore, Galway; Ms. Una Downey, Upper Canal Road, Galway; Mrs. Rosemary Flynn, Claregalway, Co. Galway; and Mr. Noel Meaher and Ms. Claire Molloy, Oranmore, Galway. We wish to acknowledge and thank all of them for their advice and assistance.

Notes



Chapter One

Current Position and Future Challenges

AT A GLANCE ...

- Provide more acute beds
- Review specialist staffing to meet overall regional needs
- Improve services for older people to ease pressure on acute hospitals
- Tackle health inequalities
- Forge better links with training bodies

There are five acute hospitals in the three counties served by the Western Health Board:

- Galway City has two major public hospitals situated about three-and-a-half miles from each other. These are the University College Hospital in Newcastle, and the Regional Hospital at Merlin Park. They are titled collectively as the Galway Regional Hospitals.
- There is a General Hospital in Castlebar which provides a wide range of acute medical, surgical, maternity, psychiatric and diagnostic services, mainly to the people of County Mayo.
- The County Hospital, Roscommon provides a range of medical, surgical and diagnostic services, in addition to an extensive hospital-based psychiatry service.
- Portiuncula Hospital, Ballinasloe has been providing medical, surgical, maternity and diagnostic services for more than 50 years. Discussions are continuing to transfer ownership of Portiuncula Hospital to the Western Health Board. Approximately one third of its patients come from other health regions, in particular the Midland Health Board. This highlights the need for close co-operation between the Western and Midland Health Boards.

Acute Hospitals are facilities where complicated medical, surgical and investigative services are delivered by highly-qualified, experienced personnel. Each of the main hospitals in this region provides a range of core services, including:

- Accident & Emergency
- General Medicine
- General Surgery
- Psychiatry
- Radiology
- Laboratory Medicine

University College Hospital, Galway is the regional centre for more specialised medical and surgical services. The Board is also developing a number of highly-specialised, supra-regional services at this hospital, including Cardiac Surgery and Radiotherapy. These services will be available to people from the Western Health Board, and to other Health Boards.

Building for the Future

The Western Health Board is investing almost £135 million to modernise its public hospital services. Though the bricks, mortar, new equipment and extra staff will help greatly to build up much needed capacity, there is still a real need to reform the way in which hospital services are organised. Providers must become more responsive to the needs of the patient, and tailor services so that the right care is delivered by the right people in the right place.

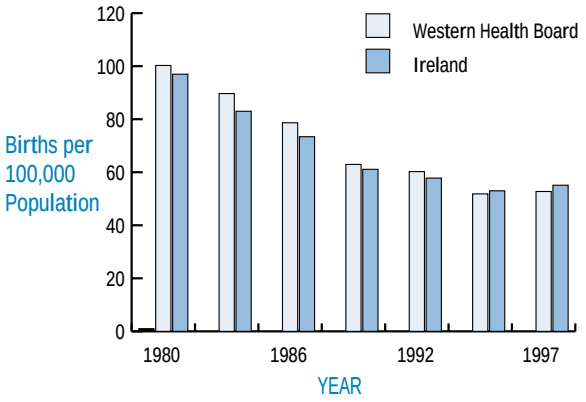
Principal Demographic Trends

The Western Health Board area is a large, predominantly rural region, with a small, thinly-spread population. Even though most people still live in the country, a noticeable trend towards town living has been recorded in recent years. The demographic structure has particular implications for the way hospital services need to be organised.

- Between 1994 and 1999, the population of all three counties in the Western Health Board increased - Galway by 5%, Mayo by 3% and Roscommon by 2%.[i]
- Average population growth in this region is lower compared to the rest of the country.
- Population density is low outside of Galway City and a few large towns.
- Galway City itself has experienced rapid population growth,[ii] whereas the increase in population in the other three local authority areas has been much smaller. Galway City is one of the fastest growing large urban areas in Ireland and Europe.
- Population growth in Castlebar has been swift, and further growth is predicted for the years ahead. Castlebar is now the second fastest growing town in the country.[iii]

- Birth rates in this region have fallen in line with the national trend - down from just over 100 per 100,000 population in 1980, to slightly less than 53 per 100,000 in 1997:

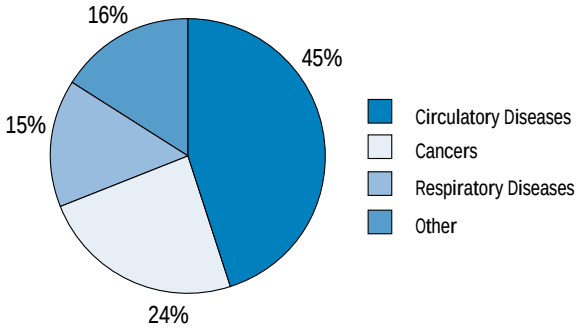
Fig 1.1 - Birth Rates 1980-1997



Source: Report of the Director of Public Health, WHB, 2000 - 2001

- Almost 80% of deaths are due to cancer, cardiovascular disease, respiratory illness and accidents. The Board must aim to reduce road, farm and water accidents substantially, as well as tackling the root causes of the major killer diseases.

Fig 1.2 - Causes of Death, WHB, 1992-1997



Source: Report of the Director of Public Health, WHB, 2000 - 2001

- The Western Health Board has a higher proportion of people aged 65 years or more (14% here compared to 11% elsewhere) and a lower proportion of people aged 20 to 55 years (44% here compared to 48% elsewhere). Projections for the next ten years indicate this trend will continue, which will lead to additional demand for hospital and social services.

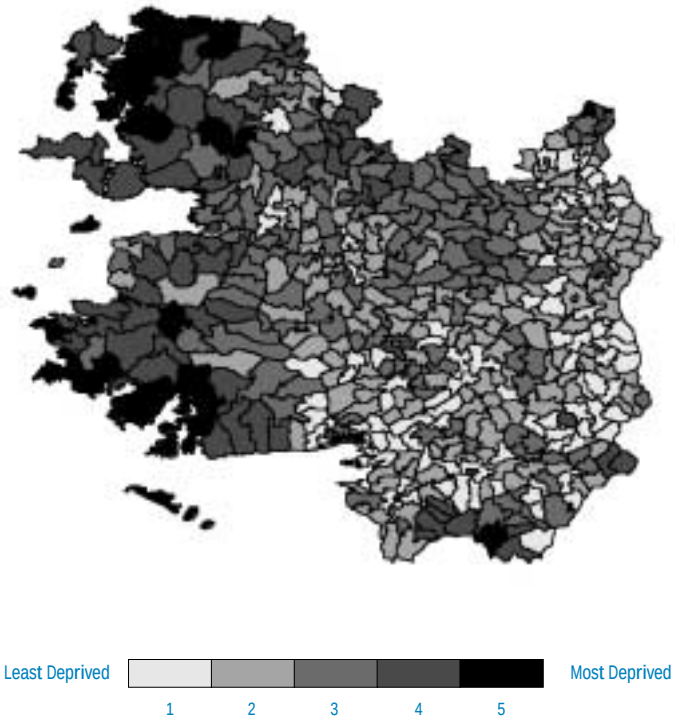
Overcoming Inequalities

Most people in the West of Ireland die from a relatively narrow range of causes. Heart disease, stroke, cancer, respiratory illness and accidents exact a heavy toll on people's health and well-being. Clearly, there are some fundamental factors underlying these figures. Some are lifestyle-related e.g. poor diet, cigarette smoking, excessive drinking, or speeding on the roads. Others include high levels of material deprivation (Figure 1.3), gaps in the health and hospital services which people actually need, or transportation problems which make it too costly or difficult to access services from remote and rural areas.

The National Health Strategy states that access to services should be determined by clinical need, rather than ability to pay or geographical location. However, we know that this is not always the case e.g. those with private medical insurance do not have to wait as long for some elective services or interventions as those without cover, while those on higher incomes have the purchasing power to 'buy' supports for lifestyle changes that are crucial to good health. People living in remote and rural areas also face particular problems in accessing hospital services. Research in North Connemara shows that some people forego healthcare because of the difficulty and costs of travel. Better transport services between the main population centres and the more isolated areas would help alleviate this hardship.

Resource allocation decisions will, however, have a far more fundamental effect. By investing carefully right now in order to develop the right kind of needs-based facilities and services, we can ensure that people in all care groups can get access to the hospital services they need, when they need them, right here in this region. Some patients will continue to opt for treatment elsewhere, of course, and for reasons that may be entirely unconnected with service gaps, or waiting lists and waiting times. Clearly, the main priority must be to continue addressing the infrastructural deficits which might otherwise cause people to travel elsewhere for services like chemotherapy, radiotherapy or cardiac surgery, to name but a few. This Committee welcomes the continuing effort to address particular service needs through detailed planning and new developments. Our new service models will complement these.

Fig. 1.3 - Material Deprivation by District Electoral Division, Western Health Board, 1996



Source: Small Area Health Research Unit, Trinity College, Dublin, 1997. Each area represents a District Electoral Division, which is the smallest demographic area for which population data is routinely collected. Deprivation is measured using five factors: the level of unemployment in the economically-active age groups (15 - 64 year olds), social class, the proportion of households without a car, the proportion of households living in private rented accommodation, and the level of overcrowding in housing (as measured by the average number of people per room in permanent private housing units.

Health funding from the current National Development Plan is already giving a real boost to the acute hospital sector. The Western Health Board is to receive just over £155 million for all care programmes, and an additional amount of £3.65 million to strengthen information and communications technology. A number of major capital development projects were already being funded in the acute sector before the Steering Committee produced this report. These include:

◆ Phase 2 of University College Hospital, Galway

- Cardiac Surgery
- Cardiac Rehabilitation
- Radiotherapy
- Critical Care
- Burns Unit
- MRI Scanner
- Orthopaedic Trauma

◆ Phase 2 of Mayo General Hospital

- Acute & Child Psychiatry
- CAT Scanner
- Orthopaedics
- Palliative Care
- Occupational Therapy
- Speech & Language Therapy
- Enhanced Geriatric Assessment

◆ County Hospital, Roscommon

* New A&E Department

◆ Portiuncula Hospital

* Upgrading Accommodation

One of the main priorities in the national plan for the 'Border, Midlands and Western Region' is to tackle the higher rates of illness and mortality, through addressing inequities which have arisen because of a higher dependency ratio, lower population density and less developed transport infrastructure. The Board should take this opportunity to work closely with interested groups in promoting a bottom-up, community-wide approach to health and well-being. People must also be encouraged to take on more individual responsibility, for example, by getting their blood pressure and cholesterol checked regularly, by giving up smoking, and by cutting down on their intake of alcohol. **Acute Hospitals have focused traditionally on treating illness. Promoting better health should be their second key objective. Hospitals must engage with the communities they serve, by encouraging people to make healthy choices and facilitating them with practical supports.**

Clearly, there is still a need for additional investment in acute services based on actual health needs. Large numbers of acute beds were lost as a result of the public spending cuts of the 1980s. Currently, there are just under 1,400 acute beds in this region. The Board is working to restore at least 176 beds in Galway and Castlebar. Approval has also been sought for an additional 224 beds in regional specialties and new medical assessment and high-dependency units. The Steering Committee endorses this plan as being an essential first step towards managing emergency pressures more effectively, and reducing waiting lists and waiting times.

It is also recognised that in addition to these beds, there is a need to increase the pool of beds available for the admission of acute medical and surgical patients, to avoid the situation of overnight patients in the A&E Department.

The Importance of Alternative Facilities

Although older people need the same access to acute hospital care as other care groups, the health problems associated with advancing age mean that they use hospital services more:

- Two thirds of acute beds are occupied by patients aged over 65.
- Half the growth in emergency admissions is accounted for by older people.
- Up 20% of total bed days in some hospitals may be lost due to delayed discharge associated with lack of access to intermediate and continuing care services.

The Western Health Board plans to spend almost £60 million over the next five years on a range of services for older people, including:

- Rehabilitation
- Day Hospitals
- Community Nursing Units
- Specialist Assessment Units
- Professions Allied to Medicine
- Home Help Services
- Long-Term Care
- Day Care

Investment on this scale is necessary and desirable to ease the pressure on acute services, as international comparisons within the OECD reveal that health systems with lower hospital bed utilisation appear to be characterised by a large range of ambulatory and intermediate care facilities.

The Public / Private Mix

The Steering Committee acknowledges and accepts that there is a clear inequity when one compares the ease of access which private patients have to elective services, with the long waiting lists and waiting times that are a feature of the public hospital system. Equally, we must acknowledge and accept the historical legacy of a two-tier hospital system, as well as the long-established right of public hospital consultants to engage also in private practice.

Everyone who is resident in Ireland is entitled to receive medical treatment in a public hospital. However, many people have opted to purchase private medical insurance, which means they can bypass the public system if they wish and be referred directly to a consultant's private practice. It is currently estimated that more than 1.75 million people in Ireland, or about 45% of the population, have private medical insurance.[v] More than 40% of the people in this region, however, are in receipt a medical card, compared to the national average of just under 31.5%. What this means is that more people here are dependent to a greater degree on having a properly-resourced public hospital service than is the case in other regions. We must make the required additional investment and introduce the necessary changes in organisation to ensure that public hospitals are able to respond fully and fairly. Specifically, we need to place a greater emphasis on providing consultant-delivered public hospital services, while strengthening the entire range of support services.

The Government White Paper on Private Health Insurance quotes research carried out by the VHI, that the most commonly cited reasons for taking out private health insurance are:

- Protection against large hospital or medical bills;
- Peace of mind about healthcare needs;
- Faster access to hospital beds / avoidance of waiting lists; and
- Option of private / semi-private accommodation in hospitals.[vi]

The 1994 Health Strategy acknowledges that the mix of public and private service providers enables each to play a complementary part, and that there is considerable inter-dependence between the public and private sectors in the provision of hospital services. The White Paper notes, however, that there are potential drawbacks to the mixed model, though it also states that these "have more to do with the management of demand for, and access to, services at the level of the hospital than with the principle of having a mixed system."[vii]

Since current government policy favours the continuation of the public / private mix, the challenge for service providers is to work closely (with central government where appropriate) to find new ways, both financial and non-financial, to balance the needs of all patients, and ensure that access for everyone is based on need, rather than ability to pay.

Funding is the most critical issue. The Board's hospitals must have a sufficient number of beds, as well as adequate clinical and support staffing, to reflect their role and importance as secondary/tertiary care facilities. Clearly, this may involve the development of a wider range of specialties at Mayo General Hospital, and at the Roscommon and Ballinasloe Hospitals. But there is also a need for greater transparency in the patient/provider relationship. Patients should receive a firm indication of how, where and from whom they are to receive their current treatment, as well as clear information on how long they may have to wait.

Enhancing Clinical Skills

Clinicians must have a wide range of skills to provide high-quality, patient-centred services for all. There should be more emphasis on continuing professional development for clinicians, including library facilities and appropriate staffing to allow protected time. The Board and the various training bodies need to work together in partnership on a the full range of training, manpower and service issues, so that those in training have all of the generalist skills they are likely to require, in order to complement their specialist skills.

With the trend towards ever-increasing specialisation, some concern has been expressed within the group that the current system tends to reinforce the separation of training and service provision. The Board's priority must be to provide a good generalist service first, and focus then on developing strong sub-specialist services.

The Minister has recently indicated that workforce planning is to be undertaken to establish the precise need for allied health professionals, specifically, chiropodists, dieticians, occupational therapists, orthoptists, physiotherapists, and speech and language therapists, as a matter of priority. Progress is being made on the supply side, with additional college places being made available on occupational therapy, physiotherapy and speech and language therapy courses. The Board is currently working with the National University of Ireland, Galway to develop these courses. It must work continually with the training bodies and the Department of Health and Children, to develop a framework which ensures that there are sufficient graduates with the necessary skills to meet the changing needs of the patient and the hospital services. Initiatives like these are essential for making better use of hospital beds, and for developing new and more innovative approaches to patient care, such as community support and hospital-at-home.

Recommendations

R1.1 The Board should seek to commission additional acute beds to improve its capacity to manage emergency pressures more effectively and offer more elective services.

R1.2 Clinical and support staffing levels should be reviewed, and funding should be tailored flexibly, so that the demands in providing a high standard of hospital care and service on a regional basis are recognised and taken fully into account. All new consultant appointments should take account of regional service needs when the posts are being structured.

R1.3 Services for older people should be appropriately enhanced.

R1.4 The Board should work with a range of interested groups, including community groups, to tackle health inequalities. It should also work closely with external agencies e.g. Garda, Fire Service and Army, in planning for major incidents.

R1.5 The Board should continue to work in partnership with the various training bodies and take account of developments at national level, so that staff continue to develop the skills needed to deliver high-quality care. Greater emphasis should be placed on continuing professional development for Consultants, NCHDs, Nurses and Allied Health Professionals.

Notes

Chapter Two

Focus on Values

OUR VISION …

By 2006, we should be able to say that:

- Every patient has rapid and convenient access to high-quality, patient-focused hospital services when they need them.
- This Health Board has the best staff recruitment and retention policies of any employer in the West of Ireland.

Ireland's health services are currently going through a period of profound and rapid change. The Western Health Board is in the middle of a massive hospital building programme. It is expanding services on all fronts and taking on large numbers of additional staff to provide more and better patient care. Increasingly, it must also work to create a more employee-friendly working environment, so that morale is improved and staff are encouraged to stay.

Our Territory

- Three counties (more for specialised supra-regional services)
- More than 5,000 square miles
- Seven inhabited offshore islands

Our People

- Population c. 352,000
- Just over 49,000 daily Irish Speakers
- Up to 4,000 Travellers
- Asylum Seekers

Our Acute Hospitals Staff

- More than 400 Medical/Dental Staff
- Almost 1,500 Nurses
- Over 300 Allied Health Professionals
- 1,000 Support Staff

The Board is not starting from a 'greenfield' situation in planning acute services for the future. We recognise the unique history, identity and role of each hospital. Our goal is to describe a set of values that will underpin and guide the services, regardless of location.

Our Main Priorities

- First and foremost, to save people's lives.
- Second, to balance the needs of emergency patients with the needs of those awaiting procedures, so that both emergency and elective work gets done.

Quality must always come first

This means having the courage to say that we value patients enough to offer them only the highest-quality services, even if this means a little less convenience.

- Services will be continually measured and evaluated.
- Improvements will be made known to service providers and service users.
- Patients will be treated first and foremost as patients, but also as consumers. The Board recognises that they are entitled to the highest standards of patient care, as well as the highest standards of consumer care.

Accessibility follows closely on quality

- The Board will state clearly and openly what services are provided, where they are provided, and how they may be accessed.
- We will do everything possible to maximise accessibility to good-quality hospital services. When we are unable to provide a service locally, we will give reasons and inform patients about the options that are open to them.
- The Board will strive to eliminate gaps in services, and unnecessary duplication.

Commitment to Patients

- **People will be treated as individuals**, with courtesy and respect, in a safe and caring setting. The Board's staff and patient charter should reflect the diversity of consumers.

- **Patients' autonomy will be respected**, even where there is a conflict with the views of family, or the views of the medical or nursing staff as to what is in their best interest.

- **The Board will work towards developing Individual Care Plans for patients, which will include details of how the various specialist supports required will be accessed.**

- **Patients have the right to impartial access** to medical treatment regardless of race, national origin, religion, disability, body size, sexual preference or source of payment.

- The Board will strive to ensure that **patients with the greatest need and acuity will have the fastest access**. People will be informed that this is our aim. We acknowledge that the level of investment in hospital services historically, and the current mixed model of hospital provision, taken together, both influence access to certain services at particular times, and that public patients can be disadvantaged as a result. We are committed to eliminating all inequalities.

- **Patients have the right to privacy concerning their medical care**. Consultation, examination, treatment and case discussion are confidential. We acknowledge that our hospitals are teaching facilities, and that clinical information may be used as a teaching aid, and to promote better patient care. We appreciate the co-operation of patients and do not take it for granted. The Board and all its staff have a special duty to protect the confidentiality of patient communications and records.

- **Patients will be informed of the make up of their multi-disciplinary care team, the part played by each member, and the name of the person who has overall responsibility for delivering and directing their care**. Patients will get a prompt and reasonable response to questions and requests. We will put more energy into responding to the needs of those with whom we have a long-term relationship e.g. those on dialysis.

- **Patients, and where appropriate their families, will be centrally involved in decisions about the care plan; and they will be listened to by service providers**. Illness, examinations and procedures present a special challenge to the bodily and personal integrity of patients.

- The Board will work to ensure that children in hospital are always cared for with other children, that their care is provided by personnel with paediatric training, and that suitable play and recreation facilities are provided. We will make a similar appropriate effort meet the particular needs of adolescents receiving care in hospital.

- **Information for patients and families will be made understandable**. Every effort will be made to ease communications problems due to illness, disability or language. Hospitals should have access to translators so that patients understand the significance of the care they are being offered, and can make their views and wishes known to and understood by service providers.

- **The Board will ensure a comprehensive process for informed consent**, especially for those with special needs, like children and people with a learning disability. Patients will have an input into ethical issues regarding their care, and may refuse to participate in research. Consent for research activities will be properly obtained and monitored.

- **The Board will take into consideration mental, emotional, social, spiritual and cultural needs of patients, and the opportunity for religious worship.**

- **People will be informed of hospital rules and regulations** that relate to patient and visitor conduct. Rules and regulations will be informed by feedback from service users.

- **The Board will provide reasonable continuity of care** and inform patients and/or their carers of continuing health care requirements following discharge from hospital.

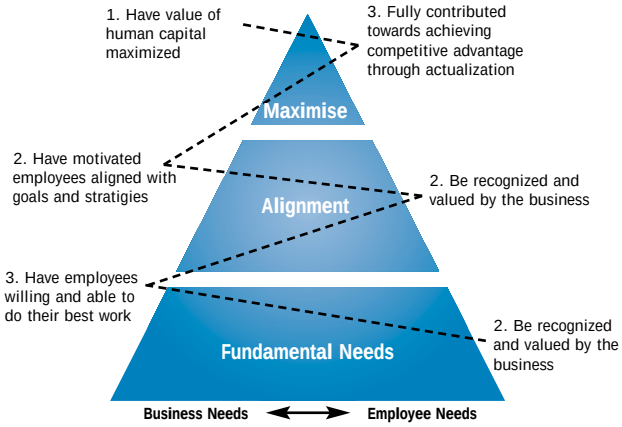
Pledge to Staff

Just as we need to value patients, so also do we need to respect all of the staff who serve them. People now change jobs more often than ever before. Many are also turning to further education, training and development in order to enhance their skills and prospects.

Many companies in the private sector now offer inducements like cash bonuses, flexible hours, health and fitness facilities, private health insurance, and workplace crèche facilities in order to recruit and retain the best people. Most if not all of these incentives are available to public service employers, and they should be seriously considered where appropriate.

- Employees at all levels will be continually nurtured, so that they choose to stay and continually update their skills to meet the changing needs of service users.
- We will encourage and facilitate all employees to take advantage of further education and training, so that they enhance their skills and we learn how to do things better.
- The Board will foster good communications and effective working relationships among staff. We will strive to ensure that the dignity of each individual is recognised, and their contribution rewarded and celebrated. More emphasis will go on management training.
- Steps will also be taken to protect staff from being injured by violent patients.
- Every effort will be made to avoid mistakes and learn from experience, and to avoid a culture of blame on those occasions when staff 'get it wrong'.
- The Board will work in partnership with its staff at all times. Employees will be empowered to make decisions locally to the greatest extent possible, and accountability will be strengthened throughout the hospital service.

Figure 2.1 shows how this partnership approach could be developed so that the Health Board and all of its employees work together in order to define and achieve common goals:



Source: Strategic Communication Management. London: Melcrum Publishing

Consumer Focus

Consumer Care will be a key feature of new service and business plans. The Board will:

- Develop a new and more relevant mission statement;
- Devise core principles for consumer care in conjunction with staff and service users;
- Provide consumer care training for all staff;
- Develop the role of Patient Advocacy;
- Advise patients about complaints procedures; and
- Set up a formal mechanism to review comments from patients, families and staff, and to suggest improvements.

Part of the induction process for all personnel will be to describe our promise to patients, our pledge to staff, our consumer focus, and the role of each individual in making things happen.

Role of Service Users in Service Planning

Recommendations

R2.1 The Board should deliver an accessible, efficient, high-quality, consumer-focused hospital service at all times. Services should be driven by values which respect the needs of patients first and foremost, and then the needs of families, staff and the wider public.

R2.2 The Board should commit itself to providing only a high-quality service, locally-based where possible, to ensure ease of access. Appropriate measures should also be taken to alleviate inconvenience e.g. one-stop pre-assessment clinics, hostel accommodation, development of technology and telemedicine, and better transport.

R2.3 Patients should be seen as quickly as possible, based on need and without discrimination.

R2.4 Hospitals should have access to translators in a range of different languages, including sign language, so that patients understand the significance of the care they are receiving, and can make their wishes known to and understood by care providers.

R2.5 Patients should be fully informed about the make-up of their care team, fully involved in decisions about their care, and given information which they can understand.

R2.6 A Quality Standard should be introduced in respect of all written information given to patients. This should address issues such as quality of presentation, readability, and understandability.

R2.7 The Board, in co-operation with service users, should devise a set of principles for good consumer care, while ensuring that staff in individual service areas have scope to include their own priorities.

R2.8 Each acute hospital should have an identified person e.g. Patient Services Manager, who is responsible for dealing with comments and complaints on behalf of service users, and for co-ordinating the hospital's response to them.

R2.9 The Board should set up a Quality Surveillance Department, staffed by appropriately trained people, to continually and systematically assess the views of patients and service users, and use this feedback to implement service improvements.

R2.10 Models of best practice for the recruitment and retention of staff should be adopted.

R2.11 Programmes should be implemented on an ongoing basis to foster strong partnership, good communications and effective working relationships between all staff.

R2.12 Service users should be actively involved in the planning of hospital services.

R2.13 All staff should adhere to the Ombudsman's Guide to Best Practice for Public Servants, to ensure that each service user is treated properly, fairly and impartially.[6]

[6]*The Guide is summarised in Appendix 5.*

Chapter Three

Better Communications and Information Systems

AT A GLANCE …

- Improve communications between personnel in the different care settings
- Use electronic communications to improve the flow of information to service users and between service providers.
- Introduce a unique patient identifier and issue a swipe card to every individual
- Develop the Electronic Patient Record and an Intranet to aid effective planning and communication
- Introduce telemedicine and teleconferencing widely

By 2006, every individual in this region should have a unique patient identifier. Basic personal information and a comprehensive hospital history going forward should be recorded against this number on 'virtual' patient files, which should be accessible through a secure intranet to appropriate staff in the different care settings. Clearly, this is an ambitious objective, and it must also be recognised that technology is only part of the solution. Personal communications between clinicians in the different care settings must be continually monitored and improved, so that service users don't fall through the gaps because of communication problems between service providers. Patients will also expect to have ready access to written and electronic information which we hold in trust for them, as well as up-to-date information on what hospital services we provide, where they are provided and how they are accessed. Again, these are significant challenges.

Careful attention will be paid to the needs of patients, clinicians, managers and the public when putting comprehensive, integrated information systems in place. Developments in national policy will be taken fully into account. Funding and technical know-how are critical issues. The Board should work closely with outside experts to ensure a successful outcome.

Our vision of what we want to achieve should be the only limiting factor in developing the systems to achieve it. There is technology in abundance. We must use it to organise and plan hospital services better, and as an aid to individual performance and teamworking.

Information and IT: The Priorities

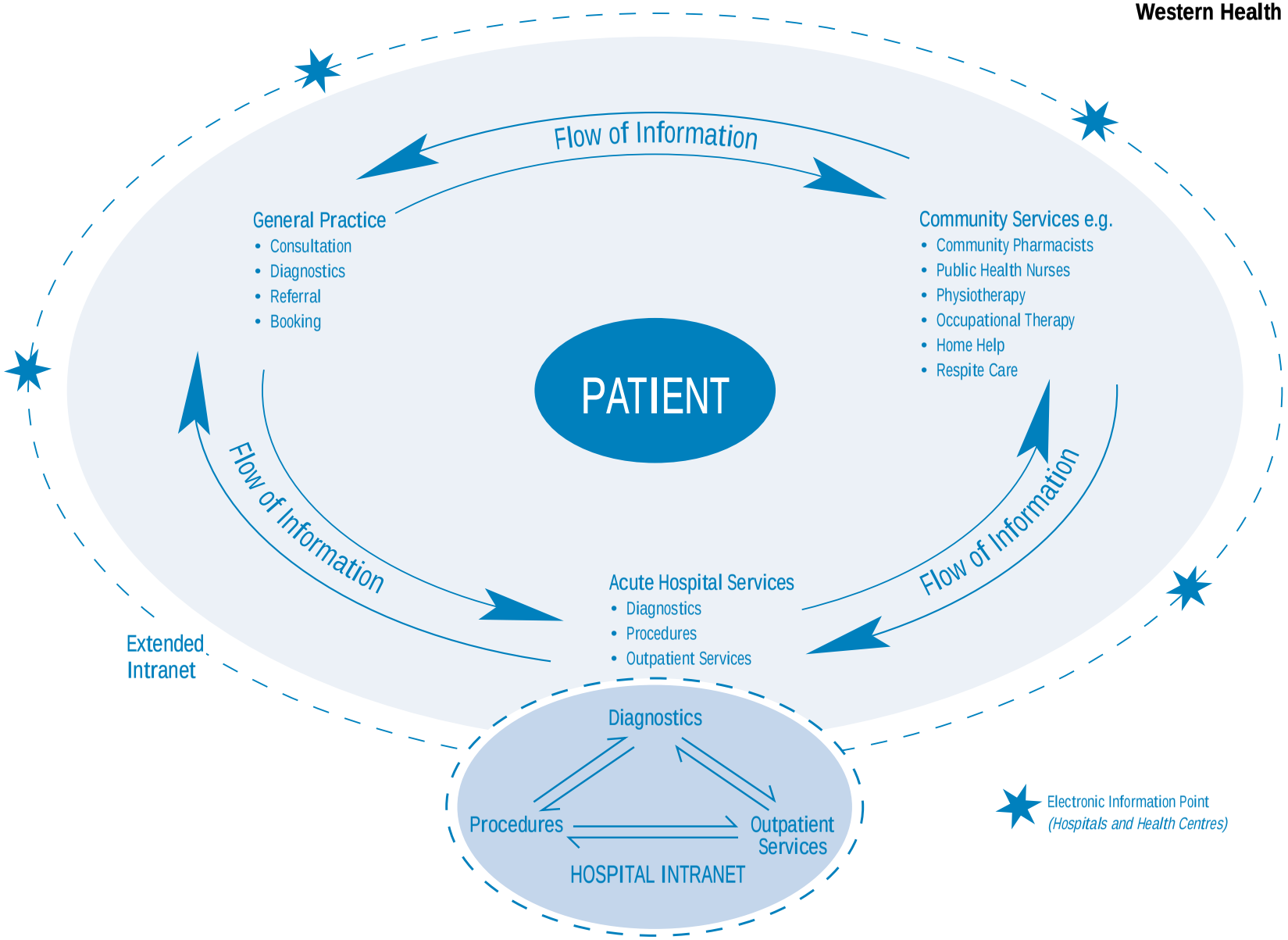
1. Systems to plan effective and efficient services, and to assess health need.
2. Automated information systems to ensure a smooth hospital journey for the patient.
3. An 'Information Sharing' Environment.
4. Electronic access to clinical evidence bases.
5. Proper training for effective and efficient management of the information and systems.

The Government have an action plan which will make it easier for people to access public services using electronic means. Every individual is being given their own unique 'access key', or Personal Public Services Number (PPSN) for this. This development is an ideal opportunity for the Western Health Board to develop high-quality, reliable information systems. It will enhance the accuracy of patient records, and make it easier to ensure that information follows the patient, rather than clinicians having to chase it. The new systems will also facilitate more effective organisation and planning. Providers will have a better idea of what services people are using, and firm details on how well their health needs are being met. Good systems will also make it easier to share relevant information between the care settings, and for clinicians to access up-do-date administrative and clinical information.

The Board should issue each person with a 'Swipe Card' containing basic personal information, including their name, address, date of birth and PPSN. Details of their treatment in hospital will be attached to this number in a secure electronic database, which will be accessed through workstations in clinical departments. Decisions about patient care will be recorded 'live' at the workstations by members of the care team. Patients will have the option of password protecting all clinical data, and the right to decide which clinician sees what data.

[7]The information, Linkages and Communications Group would like to acknowledge the assistance received from the Board's Management Services Department at the beginning of their deliberations.

Fig 3.1 - Flow of information in the Western Health Board Services



The Board should begin by introducing an Electronic Patient Record which would detail patient care in the acute setting only. Later on, this should be expanded into an Electronic Health Record detailing the whole continuum of care received over a long period of time.

An Intranet linking clinicians is a vital requirement. Most acute hospitals in this region are already connected by ISDN (a high-quality, digital telephone line) to a central data storage area. The next step is to connect hospitals with the other service providers so that efficiency and effectiveness in hospitals is improved,
and appropriate information can be shared between care settings. Using a secure intranet, it will be possible to streamline and co-ordinate acute services as never before:

- Hospital appointments will be booked on-line and in real-time.
- Patients will have more choice in setting the date that suits them.
- Clinicians will order tests and book facilities electronically. Results will be e-mailed back. GPs will be able to get test results quicker. This will help to determine how quickly their patient may need to see a consultant, whether the condition could be managed with shared care, or whether the patient needs to go to hospital at all.
- Reports will be attached to 'virtual' patient files, and the patient's progress measured continually against the requirements of the care plan.

The Intranet which we envisage will link clinicians throughout the region. People will be able to send information in text or video form. Laboratory results will be transmitted to ward staff just as quickly as they can be sent to a GP. Updates on public health issues will be notified to everyone at once. Electronic bulletin boards will enable individuals to share news and information on the latest developments. Clinicians will be able to access web pages, medical databases and research containing the latest medical data using standard internet browsers, as well as contributing to the development of an evidence base.

Together with effective organisation and good communication, the new information systems will make it easier to set up 'direct access' schemes for out-patients, endoscopy, intermediate and minor operative procedures. A similar initiative in the North Eastern Health Board area means that patients can secure a hospital appointment within 72 hours. Times can be changed to suit the patient, which cuts down on the numbers who fail to keep their appointment which, in turn, improves efficiency. Almost 90% of patients surveyed said they would prefer to use the direct access route again and by-pass the out-patients department.

Research elsewhere also confirms how important information is to the patient. Themes "relating to access to services (getting in), orientation of care to the patient's needs (fitting in), information and communication (knowing what's going on), and continuity of care have been identified in both hospital and primary care … poor experiences associated with any of the four themes lead to feelings of limbo … the need for patients to feel that they were making progress … was associated with a sense of confidence and being in control."

Patients will, however, need reassurance about the security of their personal and clinical data, and the integrity of our systems. Clinicians will also have to overcome any reservations they might have about sharing relevant data with colleagues in secondary and primary care. We see the need for an intensive programme of communications which reassures all concerned, and highlights the benefits of change for better patient care and greater teamworking.

The Board is to receive £3.65 million under the National Development Plan to strengthen its information and communications technology systems over the next few years. The Government plan to spend another £150 million on the development of high-speed communications links (principally business-to-business links) in the 'Border, Midlands and Western Region' between now and 2006. We should aim to tap some of these funds, by exploring the potential for a partnership with the telecoms companies and internet service providers, to build a communications 'backbone' between hospitals and health centres.

Telemedicine

Information and communications technology offers tremendous potential to develop telemedicine i.e. the practice of medicine at a distance with the aid of telecommunications and electronic technology. Advances in telecommunications have been made possible largely by the availability of ISDN, a digital system which is capable of transferring modest amounts of information, such as x-ray images, quickly and cost effectively. Clearly, the next step here should be to introduce a 'Picture Archiving Communications System', or PACS, at all hospitals for sending and storing x-ray images.

Telemedicine has been used to a limited extent in this region to date, but its potential for improving the overall quality of service to patients, and for enhancing access to hospital services from remote areas is now being increasingly realised. The Board has recently developed a teleradiology link between the District Hospital in Clifden and UCHG. X-rays taken in Clifden are transmitted over an ISDN line to Galway, where they are read by a Radiologist, who then sends back a report. In 1996, the Board installed a pilot telepsychiatry link between Inis Mór and UCHG, a first for anywhere in Ireland or Britain. Even though the number of patients treated was small, the general feeling appeared to be that the pilot should be expanded to include other specialties, such as A&E, Dermatology and ENT.

Telemedicine and teleconferencing links are needed between all hospitals in the Western Health Board, to tap national and international expertise where appropriate, and for outreaching to District Hospitals, GPs and the Islands. The Board should develop and extend these links as a matter of priority. With the advent of digital technology, for example, photographs of skin lesions taken by GPs can be e-mailed to the regional centre, where a decision can be made on which patients need to be seen urgently. Some cases could then be booked directly for surgery, which would save on outpatient visits and alleviate inconvenience for patients. The Plastics Department at UCHG is developing one such project with a Castlebar GP.

Many people in this region, particularly those living in remote and rural areas, find it very difficult or very costly to access hospital services. Some have to travel long distances to Galway. By developing a good telemedicine capability, we can bring at least some services and some specialists a little closer to the people, as well as strengthening linkages between clinicians, and facilitating greater shared care between the secondary and primary settings. Personnel who are participating in the telemedicine projects should be equivalently qualified, or have sufficient training.

Recommendations

R3.1 The Board should inform all service users and service providers about the range and location of services offered, including transport, how they may be accessed, and the options open to them when a service is unavailable locally. The Board should publish this information in a variety of regularly-updated formats e.g. in a manual and on a website.

R3.2 The Board should set up a physically accessible electronic information point at each acute hospital and health centre.

R3.3 Acute Hospitals should have telephone helplines which service users can access for information and advice about issues connected with their pre- or post-hospital care. Guidelines should be developed for telephone interaction regarding patient care.

R3.4 The Board should introduce a unique patient identifier, based on the new Personal Public Services Number, for each individual using hospital services.

R3.5 Each individual should be issued with a swipe card bearing their name, Personal Public Services Number (PPSN), and a space for their signature. Cardholders should have the option of having their photograph embossed on the card, or stored securely in the electronic information vault.

R3.6 The Board should work towards introducing a user-friendly, time-efficient Electronic Patient Record (EPR) at each hospital as a matter of priority. Staff should receive full training on the new systems, including the need to ensure that patient files are updated as quickly as possible.

R3.7 The EPR should eventually be developed into the Electronic Health Record (EHR), in order to build up a lifelong picture documenting multiple contacts with the health services over a long period of time.

R3.8 A Western Health Board intranet should be developed to connect hospitals and departments within hospitals, and to link hospitals with primary and community services.

R3.9 Telemedicine facilities should be developed in order to bring appropriate services as close as possible to the patient. Teleconferencing facilities should be widely used.

R3.10 A Picture Archiving Communications System, or PACS, should be developed in the radiology department at each hospital.

R3.11 The Board should introduce colour schemes and colour signage at each hospital to make it easier for patients to find their way around.

R3.12 Electronic Information Boards should be provided in the main circulation and waiting areas at each acute hospital, so that service users can access timely and relevant information.

Chapter Four

Improving Accessibility and Quality in Acute Services

AT A GLANCE …

- Develop and publish access, need and acuity guidelines for fairness, efficiency and transparency
- Introduce observation units, minor injury treatment areas, ambulatory care units, and facilities for medical assessment and admission in each hospital
- Upgrade support services such as laboratory and radiology to accredited standards
- Implement specific measures to reduce waiting lists and waiting times e.g. contracting between hospitals, specialist nurse clinics, pre-assessment clinics and hostel accommodation
- Provide day hospitals and rehabilitation facilities
- Introduce suitable quality improvement initiatives

Most patients will readily acknowledge that the standard of care they receive in our acute hospitals is as good, or better, than they expected. Often, it is not how well people fare once they get into hospital that is the issue, but the difficulties of accessing the investigations or treatments they need in the first place. Some patients, especially those waiting for certain elective services in public hospitals, find it frustrating that they have to wait so long for their first appointment with a consultant, only to find they may have to wait weeks, months or even longer to have a procedure. Organisational weaknesses can also prevent patients from progressing through the hospital system as quickly as their care plan might otherwise allow.

The Steering Committee is acutely aware of mounting public concern about waiting lists and waiting times. Even though health spending has doubled in recent years, and we are now offering more and better treatments to more people than ever before, it is the continuing problems with waiting lists and waiting times which impact most on the public mind. Demand for hospital services in this region has been rising year on year; and will continue to increase as additional resources, new treatments and increasing specialisation make it possible to treat a wider range of illnesses and conditions more effectively. Table 4.1 gives a brief overview of the extent to which activity has increased over the past four years alone:

Table 4.1 - Hospital Activity, WHB Region, 1997 - 2000

	1997	1998	1999	2000	Total	Increase	Percent
A&E	107,323	109,877	117,444	119,793	454,437	12,470	+12%
OPD	150,328	162,423	154,272	165,268	632,291	14,940	+10%
Day Case	13,989	16,702	23,014	28,710	82,415	14,721	+105%
Inpatients	57,121	58,240	58,377	61,533	235,271	4,412	+8%

Source: Acute Services Department, Western Health Board, 2001

Since 1997, in the Western Health Board, there has been:

- more than 450,000 attendances at Accident & Emergency Departments - up 12%
- more than 630,000 attendances at Outpatient Clinics - an increase of 10%
- close to a quarter of a million inpatient discharges - up 8%
- more than double the number of day cases

The Board's hospitals are under increasing pressure to meet rising demand for services, but all are finding it increasingly difficult to cope. Put simply, they do not have enough acute beds to meet the needs of both emergency and elective patients; or enough specialists to deliver a consultant-provided service to all, especially those who are waiting for a procedure, or to have their first outpatient assessment with a consultant. We believe that additional hospital beds, an appropriate increase in the number of consultants and support staff, and substantial and continuing investment will lead to a fairer and better hospital service for all. Steps are also necessary to ensure that support services, such as laboratory and radiology facilities, can operate to an accredited standard of quality assurance. Both areas play a critical part in enabling an accurate and timely diagnosis of disease to be made; and their importance to hospital and community medicine should be reflected fully in service and business plans. Measures are also needed to ensure that the Allied Health Professions can respond fully.

Clearly, there is also a need for new and innovative approaches to patient care, such as intermediate care,

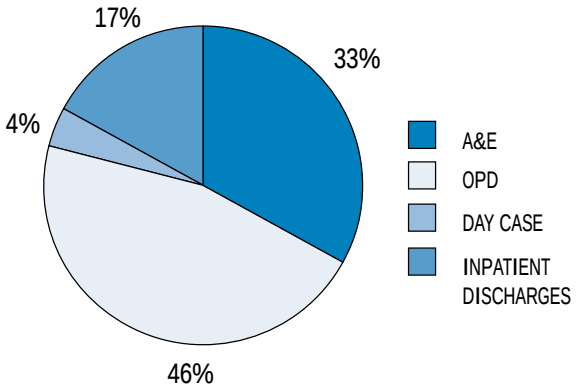
hospital-at-home and community support, so that people are admitted to hospital only when necessary, and are discharged again as soon as they are ready. Steps which improve effectiveness and efficiency in hospitals, and promote better teamworking between the different care settings are needed to complement increases in resources.

Ultimately, there must be enough capacity at every level in the acute sector to provide a full service for all those who need it. Equally, there is a need to achieve more appropriate and effective use of all health services. We need to educate patients about where health services are best delivered, and ensure that the equipment and the teams are in place to meet their needs and expectations. Adopting this kind of integrated approach will help to ease many of the pressures currently being felt in hospitals, and assist in bringing about a multi-sectoral, team-based approach to patient care. Therefore, while this strategy is concerned mainly with ensuring that resources in acute hospitals are used to very best effect, it also flags areas where co-operation and teamworking would be appropriate and beneficial for the patients. Hospitals have a critical role, but they are just one part of the health and social care system.

We are strongly of the view that all patients are entitled to treatment on the basis of clinical need and the acuity of their condition alone. People who need treatment for acute or chronic illness must have rapid and convenient access to the services they need, when they need them; while patients who need a different level of care or support should not have to occupy acute beds because of avoidable gaps in alternative or community services. All services should be organised effectively so that these objectives can be achieved.

Easing the Pressure Points

Fig 4.1 - Hospital Activity, WHB 1997-200



Source: Acute Services Department, Western Health Board, 2001

Figure 4.1 shows the overall percentage of attendances in the major areas of activity at all hospitals in the Western Health Board area between 1997 and 2000.

Accident & Emergency Departments and Outpatient Clinics together accounted for more than three quarters of all hospital attendances between 1997 and 2000.
With casualty visits since 1997 moving inexorably towards the half million mark, and more than 160,000 attendances a year now being recorded at Outpatient Clinics, there is an urgent need to look critically at the way these services are delivered, so that scarce resources are targeted to those with the greatest clinical need. One of the most important challenges facing health services providers is the need to begin rethinking the roles of all those who deliver patient care, so that an appropriate and comprehensive skill mix is available for the patient.

1. Accident & Emergency

A&E Units are at the front line in providing hospital services: "they are the pressure points of the health services. When the rest of the healthcare system overloads … [they] … take the strain." [viii] Providing an effective and efficient A&E service means that a fully-trained doctor should be in place to make key decisions and to guide the service. Without this direction, as well as access to appropriate supports to improve patient throughput, the service may not be able to respond fully to the demands placed on it.

Facilities are also needed to ensure a smooth patient flow. Appropriate facilities for assessment and emergency treatment of patients should be available within the department. An observation area should be available for those who need short-term observation. Separate from the department, should be the medical/surgical assessment area, and/or an acute admission ward.[ix] [x]Sufficient theatre facilities should be available to ensure that emergency patients can be treated in a timely fashion. A&E staff also need to have access to appropriate facilities for continuing care e.g. fracture, ophthalmic, and ENT Clinics.[xi]

The Board needs be proactive in communicating the message that primary care should be the first port of call for many patients who currently attend A&E Departments; although this may be difficult to achieve until a number of steps haven been taken. GPs do not currently have diagnostic-related equipment, like x-ray and ultrasound facilities, or direct access to diagnostic-related services in hospitals, which means that even minor trauma patients have to be referred for assessment to A&E. Clearly, there is a strong case for the immediate introduction of guidelines governing direct referral into diagnostic-related services, to ensure that patients do not have to wait unnecessarily on outpatient waiting lists. GPs should have the facility to discuss patients directly with the in-house on-call team. Therefore, improving GP access to urgent specialist opinion should also be a priority.[xii] Thirdly, all primary care clinics should have basic equipment, including scalpels, suture material and ECGs, to reduce the need for unnecessary and potentially inappropriate referrals to hospitals.[xiii]

Given that the number of attendances at A&E Departments is likely to remain at a very high level for the foreseeable future, it would also be useful to consider new ways of managing demand more effectively. Options should be explored to deal with attenders who could be dealt with more appropriately in the primary care setting. We should also look at expanding the role of nursing within the department.

Another useful idea would involve making greater use of a telephone service to provide advice to the patient, and to direct them to the appropriate place or person.[xiv] Telephone interaction between providers and patients will become increasingly important in the years ahead, as GP co-operatives develop to service the need for out-of-hours primary care. The Board's primary care unit is now developing a new telephone-based Patient Information Service. Calls will be handled by specially-trained nurses, who will provide routine clinical information to patients, and direct them to a GP when appropriate.

2. Outpatient Clinics

Like the A&E service, attendances at outpatient clinics represent a significant proportion of total attendances at hospitals in the Western Health Board. **Between 1997 and 2000, almost half of all hospital attendances in this health region consisted of people attending outpatient clinics**. Like A&E, demand for outpatient services is continuing to rise significantly and, with only a limited number of consultants, there is a pressing need for measures to manage the demand given the current supply constraints. Ultimately, there is a need to provide additional resources, but measures which maximise the skills mix available are just as important. Again, there is an important role for nurse specialists, and a clear need for shared care based on high standards in written guidelines that are reviewed regularly. Patients should also be open to persuasion to ask for a referral only when it is clinically necessary, so that all those who actually need appointments are catered for properly.

Each stakeholder has different expectations of the outpatients service.[xv] Patients want a quality service which respects and understands their needs, is easily accessible and well organised, provides a high standard of treatment within a reasonable time, and offers an individual and flexible service.[xvi] GPs give a high priority to the availability of patient notes in the out-patients department, being respected in their telephone communications with hospital doctors, avoidance of unnecessary duplication of tests, the type of hospital doctor who sees their patients, the inclusion of patient management plans in clinic letters, the timely arrival of discharge letters, and the supply of in-patients medication after discharge.[xvii] Consultants are likely to rate a referral as satisfactory if the presenting problem is reasonably significant, if the referral letter "conveys a reasonable understanding of the circumstances leading to the referral", and the outcome the GP expects is clearly outlined.[xviii]

We cannot be sure that the current outpatient services are meeting the needs and expectations of patients or providers. Unless a public patient needs to be seen urgently, they are unlikely to be seen early. Many GPs say it is frustrating to have to spend so much time on the telephone trying to secure outpatient appointments, while hospital staff are forced to grapple with the problems that occur when patients arrive early or late for an appointment, or when they don't arrive at all, or when test results or patient files are not available in time.

Unfortunately, the evidence concerning patient satisfaction with outpatient clinics is rather sketchy, although one survey carried out at the University College Hospital in Galway did find that patient satisfaction was high on preset questions, but when it came to making open responses, people were quite critical of the lengthy delays which they experienced.[xix]

Steps should also be taken to bring outpatient services physically closer to the patients who use them, and to improve the general standard of facilities in outpatient clinics. The Board should work towards developing a wider range of specialist services at Mayo General Hospital, and jointly between Roscommon County Hospital and Portiuncula Hospital, in order to improve access and outcomes, to ensure that waiting time targets are met, and to bring about a more appropriate balance in the number of attendances at each acute hospital.

Patient waiting areas and treatment areas should receive special attention. Waiting areas should be spacious enough to accommodate all those who are attending, and they should have basic creature comforts, including adequate seating, basic canteen facilities, toilet facilities, a television or stereo, and newspapers and magazines. Patients should feel assured of privacy in the treatment areas; and there should be a comfortable holding area where they can wait for further tests or examinations, or to recover following a procedure.

The Board needs better information systems and new booking methods to improve the effectiveness and efficiency of outpatient clinics. With better information, improved systems, and enhanced communication between patients and providers, it should be easier to target resources towards those who are waiting longest, and who therefore have the greatest need.

- Using partial booking, the GP logs onto the system to see what consultant is available, and makes a provisional appointment for their patient to see that specialist. The patient then gets a letter from the hospital acknowledging receipt of the referral. A second letter is issued at a later date, asking the patient to telephone the hospital, either to confirm their appointment, or to arrange an alternative, more convenient time.

- With total booking, the GP books outpatient appointments and day case surgery direct, while the Consultant books day case and ordinary admission direct. Schemes like this have a number of important advantages. Patients choose the date that is most convenient for them, which cuts down on the number of cancellations and the number who do not attend. Communication between hospitals and patients is improved and maximum waiting times are cut by up to 40% in the case of partial booking.[xx]

Patients can also be encouraged to take on more personal responsibility, not just in terms of attending for their appointments, but also for managing their condition afterwards. Doubts are being expressed in some quarters about the clinical value of routine follow-up in outpatient clinics, and there is some evidence which suggests that patients who are well informed are good at detecting and reporting complications and clinical deterioration to their GP.[xxi] One of the most useful steps which could be taken is to educate and inform patients about their illness or condition, to alert them to particular signs which should cause them to contact their GP, who can then decide whether further hospital follow-up is advisable. We have some useful qualitative evidence of how patients might react to such a change:

- Those who are being discharged value hearing this in clear terms, as well as information about their condition and care, recognition of their views and time to ask questions.

- Patients are usually realistic about the care their GP can provide, and consultants can make use of this knowledge when deciding when to discharge.

- Finally, giving patients written information about their condition and how to look after themselves once they leave the hospital setting would help patients and reduce communication difficulties between hospitals and GPs.[xxii]

3. Waiting Lists and Waiting Times

Despite continuing and substantial investment in our acute hospitals, many patients still experience real difficulties in gaining access to elective services in particular. The 1994 national health strategy - 'Shaping a Healthier Future' - states that all patients should have access to care on the basis of need. The Board has participated in waiting list initiatives, has expanded hospital services, and has achieved a degree of regional self-sufficiency, in its efforts to build a more equitable service for all. Yet, the number of people taking out private medical insurance continues to grow.

We recognise that some of the increase is due to the buoyant economic times in which we live, but is also true that much of the growth is due to the fact that private medical insurance gives those who have it separate, faster access to care in public hospitals. By definition, this means that public patients can experience lesser, slower access to the care they need. Current government policy favours continuation of the public/private mix, but states that access to care is to be on the basis of need. Given that there are no common (public and private) waiting lists, these two aims are difficult to reconcile.[xxiii] Tables 4.2 and 4.3 contain the most recent data concerning waiting lists and waiting times:

Table 4.2 - Waiting List Numbers, Western Health Board, 31st December 2000:

	List at 31.12.1999	Additions 2000	Activity 2000	List at 31.12.00	% Net Change
ENT	639	243	370	512	- 20%
Ophthalmology	708	278	771	215	- 70%
Plastic Surgery	606	310	323	593	- 2%
Urology	300	201	266	235	- 22%
Vascular Surgery	156	140	126	170	+ 9%
Orthopaedics	344	544	456	432	+ 26%
Total	**2,753**	**+ 1,716**	**- 2,312**	**2,157**	**- 22%**

Source: Acute Services Department, Western Health Board, 2001

Table 4.3 - Average Waiting Times (Weeks), Western Health Board, 31st December 2000:

	Adults		Children	
	Longest	Shortest	Longest	Shortest
ENT	208	12	55	36
Ophthalmology	84	33	58	-
Plastic Surgery	112	29	76	32
Urology	158	44	23	-
Vascular Surgery	116	104	-	-
Orthopaedics	60	20	-	-

Source: Acute Services Department, Western Health Board, 2001

The Board is continuing to make good progress towards reducing the number of people on waiting lists. More than £5 million of additional funding is being used to provide procedures for almost 3,000 people who are currently on waiting lists.[xxiv] Some of these funds have also been used to provide locum cover for consultants, to extend nursing and paramedical hours, and to introduce pre-assessment clinics and a five-day ward for ENT and Ophthalmology.

Under current national targets, the maximum waiting times for adults and children are 12 months and 6 months respectively. Unfortunately, too many patients in this region still have to wait too long for their assessment and procedure. Table 4.3 shows the numbers of adults and children who were waiting up to a year and more than a year for treatment at end 2000:

Table 4.4 - Public Hospital Inpatient Waiting List, Galway Regional Hospitals, 31st December 2000:

	Numbers on Waiting List			
	Adults		Children	
	3 - 12 Months	> 12 Months	3 - 12 Months	> 12 Months
ENT	124	286	12	90
Ophthalmology	85	106	8	16
Plastic Surgery	130	353	9	101
Urology	60	172	3	-
Vascular Surgery	30	140	-	-
Orthopaedics	249	175	4	4
Total	678	1,232	36	211

Source: Acute Services Department, Western Health Board, 2001

Table 4.2 shows that there is a wide variation between the longest and shortest waiting times in the case of both adults and children. We believe that patients should be informed how long they may have to wait for treatment.[xxv] Perhaps it is also time to consider giving everyone the option of being referred to a particular service rather than to a specific consultant, especially where this would help to reduce waiting times and improve throughput, while still preserving the patient's right to be referred to the specialist of their choice. Other measures could include:

- Cross contracting waiting list work between public hospitals e.g. where a second public hospital in the region has some spare capacity to perform waiting list procedures.
- Utilising the seasonal bed closure period to treat additional waiting list patients.
- Extending the opening hours of day wards and operating theatres.
- Using hostel accommodation to increase the day case throughput.[8]

[8]Hostel accommodation should also be available for relatives of patients who are very seriously ill, or terminally ill, for parents whose children may be very seriously ill or recovering following surgery, and for certain ante-natal patients who are close to term, but live at a distance from the hospital e.g. Islanders.

- Contracting out some of the waiting list procedures to other service providers.

However, there is still a need to develop appropriate facilities for particular care groups who are being admitted to acute hospitals because the kinds of facilities they need, particularly community supports, are not sufficiently well developed. In 1998, an expert review group on the waiting list initiative made a number of specific recommendations in this regard:

- Provide day hospitals for older people and develop suitable rehabilitation facilities on acute hospital sites as a matter of priority;

- Organise hostel accommodation for patients who would otherwise need to stay overnight in an acute bed;

- Examine the case for stand-alone day surgery units at acute hospitals, to protect patients on waiting lists from delays that arise as a result of other hospital pressures; and

- Implement a planned programme of investment to meet long-term care needs.[xxvi]

The Board should also introduce guidelines and a suitable facility for older patients who are admitted as emergencies having travelled a distance, and who may be on the waiting lists to see several consultants. These patients would receive co-ordinated hospital care over a period of perhaps five days in a dedicated ward. This would improve the effectiveness of the service and facilitate more efficient management of the waiting lists.

Teamworking

Better teamworking within and between the care settings would also help to improve accessibility, effectiveness and efficiency, and facilitate a smoother journey for the patient. The Royal College of Surgeons in Ireland has recently emphasised the need for teamworking and co-operation within and between hospitals, "so as to create a culture within which consultants are encouraged to operate together more frequently, especially when complex or unusual procedures are being undertaken."[xxvii] The Steering Committee would also like to see action being taken in all of the following areas:

- Hospitals should develop the role of specialist nurses across a range of clinical services in association with consultant clinics, and make better use of the skills in professions allied to medicine, to build a multi-disciplinary approach to patient care. Nurse Specialists in particular can help to identify patients who need urgent investigation and treatment.

- Clear guidelines on access to investigations, treatment and shared care should be developed between secondary and primary care. GPs and Allied Health Professionals should be trained on examining particular categories of patients in the community to ensure that referral guidelines are applied correctly. Initiatives like this will help to ease the pressure on acute services, and assist in reducing waiting lists, waiting times and inappropriate bed usage. Patient confidence should also be strengthened.

- Community Pharmacists should be facilitated when they need to access hospital clinicians and information in order to assure the necessary continuity of care for patients. The development of an Electronic Patient Record will assist greatly in this regard.

Shared Care

Shared care is one of the most effective ways of ensuring that patients get high-quality and effective care in the most appropriate setting. It means "joint participation by hospital consultants and general practitioners in the planned care of patients with a chronic condition, informed by enhanced information exchange over and above routine discharge and referral notices." [xxviii] Chronic conditions like asthma, diabetes and leg ulcers are well suited to this approach. In the Western Health Board region, care of melanoma patients is shared between UCHG and GPs. Ambulatory Care Units in hospitals can play an important part in terms of ensuring that patients with chronic conditions who are receiving shared care have access to a range of hospital-based services and specialists when required.

Given the physical and demographic make-up of this region, the rising demand for acute services, and the distances which some people have to travel, everything possible must be done to enhance the efficiency of hospitals and ensure that patients are hospitalised only when necessary. Clearly, this would have a positive effect on patient welfare, ensure that hospitals concentrate

[8] *Hostel accommodation should also be available for relatives of patients who are very seriously ill, or terminally ill, for parents whose children may be very seriously ill or recovering following surgery, and for certain ante-natal patients who are close to term, but live at a distance from the hospital e.g. Islanders.*

expertise and equipment on those with the greatest need, and enhance the role of primary care by re-orientating care appropriately from the secondary setting. Developing hospital-based support services so that they can respond adequately to an increasing number of requests from primary care is essential to achieving this objective.

Building a more accessible and responsive hospital service also requires a proactive approach which effectively combines improved organisation, better communication and robust information systems in the different care settings. By adopting this three-pronged approach, and the specific recommendations made in this chapter, we can strike an appropriate balance between the needs of emergency and elective patients, and ensure that resources are targeted correctly. Patients requiring an elective assessment or procedure should, where possible, have the option of seeing the first available consultant, or visiting a particular sub-specialist, and should have more choice over when to have their procedure. GPs who may be uncertain as to whether to send a patient for admission should also be able to confer with their hospital colleagues, which would help to ensure appropriate patient referrals.

Enhancing Quality

Building a patient-centred hospital service that is driven by quality at every stage is one of the greatest challenges facing the acute sector. Providers cannot be satisfied to simply accept that the majority of patients are happy with the standard of care and service they receive. We often look to the future to see what medicine and hospitals will be like in ten or twenty years, but we should never lose sight of the need to ensure that the best quality services are provided in the present, using all available resources to best effect. The Board must also aim to get the basics right, because they are just as important to the patient as the standard of clinical care provided. Accordingly, we recommend that a special effort should be made to:

- Keep hospitals as clean as possible, and ensure that they are as bright and as welcoming as possible for patients, visitors and staff;
- Improve the quality, variety and nutritional value of hospital food, while offering more healthy option meals; and
- Provide basic creature comforts, such as bedside televisions and telephones, for all patients.

Ensuring that all patient areas, hospital equipment, outpatient clinics, casualty units and visitor toilets are clean is also necessary to prevent outbreaks of infection, like MRSA, which slows down the patient's recovery and may cause severe disruption to services if surgical procedures have to be cancelled, or wards have to be closed. Patients are entitled to expect that every reasonable effort is made to ensure that their hospital stay is not complicated by the development of a hospital-acquired infection. The Steering Committee can see important advantages in the idea of setting up a new Regional Task Force for Infection Control, which would take the leading role in fighting infection at all hospitals.

Increasing specialisation is making it possible for clinicians to understand and treat more illnesses and conditions more effectively than ever. Yet, rising patient expectations and the increasing volume of medical litigation means that the practice of medicine is becoming increasingly defensive. Rather than viewing this purely as a threat, we should grasp the opportunity to improve the quality of clinical care provided, and refocus our efforts on ensuring that patients are fully involved in decisions about their care. By continually taking action to protect and enhance the safety of patients, and by developing a framework which recognises that clinicians are as human as the patients they treat, we can meet our commitment to deliver a high-quality hospital service at all times, and provide the support that clinicians need when making often difficult decisions to the best of their ability.

The Minister for Health and Children has recently said that "quality is not an option, but a feature of the service which consumers have come to demand and expect." Examples of the schemes currently underway in hospitals generally include governance and management development, risk management, clinicians in management, clinical audit, patient advocacy, accreditation and performance indicators. Given that UCHG is one of eight pilot sites for the national hospital accreditation programme, we should use the lessons learned there to improve the quality of care and service provided at every level at our other acute hospitals.

Quality can also be improved by getting clinicians involved in management. Clinical Directorates are one method of achieving this. Essentially, these are business units in a hospital. Each is headed by a Clinical Director, who is concerned, not just with the quality of care provided in the departments under their direction, but with a range of organisational issues, such as managing waiting lists and waiting times, developing a strong

business and consumer focus in their unit, managing people and money effectively, and assisting colleagues who may be encountering professional difficulties.

The most recent Buckley Report notes that, in general, "progress [towards involving clinicians in management] has been too dependent on local enthusiasm and initiatives in individual hospitals". It recommends incentives for consultants to undertake management roles, whether in the form of a reduced clinical commitment, or an appropriate additional allowance, or both.[xxx] We are making good progress in this region towards getting clinicians more involved in the strategic management of hospitals:

- Portiuncula Hospital has a well-developed clinical directorate structure which enables clinicians and managers to make decisions on resource use and allocation by agreement.
- Mayo General Hospital is implementing a clinicians in management structure in 2001.
- The Clinicians in Management initiative at UCHG is being further developed at present. It is anticipated that a new and more responsive structure will be in place by end 2001.

Recommendations

R4.1 Patients should be treated on the basis of medical need. Maximum waiting times should be determined for adults and children in respect of all services. The Board should be prepared to work with other service providers to ensure that waiting times are met.

R4.2 Guidelines should be developed to enhance the patient's access to specialist hospital services, preserving where possible their right to be referred to a particular sub-specialist. Options to expand the role of nursing should be considered.

R4.3 Access, need and acuity guidelines should be agreed between secondary and primary care to ensure that patient access to hospital services is based on need and acuity.

R4.4 The Board should be proactive in gathering detailed information on a broader concept of access, including access to medical investigations, access to shared care, and access to acute treatment. It should also be proactive in addressing these access difficulties.

R4.5 Inpatient and Outpatient waiting lists should be computerised and validated regularly. Uniform guidelines and standards on the management and validation of outpatient waiting lists should be developed and applied at all acute hospitals.

R4.6 Each A&E Department should have an observation unit for appropriate patients e.g. for patients with minor head injuries.

R4.7 Consideration should be given to expanding the role of nursing in the A&E Department at each hospital.

R4.8 Suitable facilities for assessment and admission of emergency patients should be developed at each hospital.

R4.9 Ambulatory Care Units should be developed at each hospital for appropriate conditions.

R4.10 A 5-Day Ward should be introduced for appropriate patients and to facilitate efficient management of the waiting lists.

R4.11 Diagnostic services should be appropriately enhanced. Measures should be taken to ensure that laboratory and radiology services can operate to an accredited standard of quality assurance, to facilitate efficient delivery of a high standard of acute care services.

R4.12 Support services should be developed in line with good workforce planning guidelines.

R4.13 Pre-assessment clinics should be introduced across a wide range of surgical specialties to facilitate better efficiency of surgery.

R4.14 Hostel accommodation should be organised with each hospital.

R4.15 Standardised policies and procedures for patient admission, discharge and transfer in all hospitals should be introduced, with the patient and referring doctor being fully informed at every stage.

R4.16 Day Hospitals should be provided in the acute setting for older people, with appropriate linkages to other hospitals and community supports.

R4.17 Comprehensive support services should be developed in the community. Appropriately trained staff should be deployed to strengthen links between the hospital and the community, and to facilitate more effective admission and discharge planning, particularly where this occurs outside normal hours or at weekends.

R4.18 Specialist rehabilitation facilities should be developed to meet the particular needs of older people and young chronically-ill who may currently be availing of services that are inappropriate to their needs.

R4.19 Acute Stroke Units should be developed to meet the needs of patients presenting with stroke.

R4.20 The Board should foster a culture of shared care between hospital and community clinicians, and develop clear policies on where responsibility for patient care rests.

R4.21 Regular meetings should be held between personnel in secondary and primary care to agree on the appropriate settings for treatment and care.

R4.22 Guidelines should be agreed between primary and secondary care regarding appropriate access to investigative facilities in hospitals.

R4.23 Standard referral letters should be introduced at each hospital.

R4.24 The specific skills of General Practitioners should be available to the acute sector.

R4.25 The Major Academic Teaching Hospitals accreditation project, which is currently being piloted at UCHG, should be extended to other acute hospitals in the region after it has been evaluated.

R4.26 Integrated care planning should be adopted as the standard for the delivery of effective patient care.

R4.27 Quality improvement initiatives, such as risk management and clinical audit, should be developed. The Board should also give due attention to maintenance and health and safety requirements.

Chapter Five

Hospitals Configuration and Service Modeling 2001 - 2006

AT A GLANCE ...

- Expand University College Hospital, Galway as the major treatment, teaching and referral hospital for the region, and continue its development as a supra-regional centre for the most complex services
- Develop appropriate medical and surgical services at Merlin Park Hospital, and move progressively towards ending emergency medical admissions there
- Strengthen Mayo General Hospital so that it provides a full service for its expanding population
- Continue providing medicine, surgery, obstetrics, gynaecology, paediatrics, psychiatry, investigative and diagnostic services at the County Hospital, Roscommon and Portiuncula Hospital, Ballinasloe, while developing suitable joint working arrangements
- Introduce new models of service delivery to link services and hospitals around the patient
- Review individual acute services to take account of the new service delivery models

The Government's policy is that there should be close links between acute hospitals. The 1994 national health strategy, 'Shaping a Healthier Future', states that "the role of each acute hospital will be defined as part of a co-ordinated network of services delivering high quality care in the appropriate setting, in an equitable and cost-effective manner ... the development of acute hospital services ... will thus be directed towards ... providing within each health board area a self-sufficiency in community and regional specialties."[xxxi]

Support for the hospitals networking idea is restated in the follow-up health strategy statement: "the further development of hospital networks at Health Board level [will] serve the objective of regional self-sufficiency on mainstream acute services."[xxxii] The Report of the Medical Manpower Forum, in particular its emphasis on the concepts of the patient having their first point of contact with a fully-trained doctor, and services following patient needs, will be critical in achieving this objective.

Before we can define precisely what the relationship between hospitals should be, it is necessary to state exactly where acute services should be provided over the next five years.

Hospitals Configuration, 2001 - 2006

Galway City Hospitals

The Western Health Board's policy for the development of the University College and Merlin Park Hospitals was outlined in 1991. Back then, it was proposed that general medicine, nephrology, orthopaedics, rheumatology, rehabilitation and geriatric assessment services should be moved from Merlin Park Hospital to UCHG.[xxxiii] The Board is currently developing a trauma orthopaedic unit in Phase 2 of UCHG, but there are no plans in hand to move other services away from Merlin Park. Some modification of this general policy is necessary and desirable, given that the pressures of emergency admissions can, and often do, force the cancellation of elective work. Therefore, it is proposed that:

- UCHG should continue to develop as the major treatment, teaching and referral hospital for the western region, and as a supra-regional centre for the most complex services, including cardiac surgery and cancer care.[9] A Maxillo-Facial Surgery service should also be developed here.
- Unplanned emergency services in Galway City should be provided at UCHG only, and the current practice of accepting emergency medical admissions at Merlin Park should be discontinued.
- Recognising that this transition will take time to accomplish, it is recommended that appropriate medical and surgical services, and suitable critical care facilities to assure high-quality patient care, should be developed at Merlin Park. Appropriate intermediate care and rehabilitation facilities should also be developed at this hospital. The option of developing Merlin Park as a centre for elective work for selected patients should be explored. Final details should be worked out in consultation and partnership with the staff.

[9]For cancer, a regional service is one which facilitates the provision of treatment for all common cancers with speed, efficiency and quality to patients in the locality. These services can be provided in Castlebar, Ballinasloe and Roscommon, as well as in Galway. As a supra-regional centre, the University College Hospital in Galway can provide ancillary support services for cancer diagnosis to other hospitals, including specialised laboratory and x-ray examinations. The supra-regional centre will also treat the more complex and less common cancers that cannot be managed by a regional service.

- A needs assessment for neuroscience services in this region should be carried out immediately.

Mayo General Hospital

Mayo General Hospital should continue to provide a range of medical, surgical, obstetric, gynaecology, paediatric, psychiatric, investigative and diagnostic services for its expanding catchment population. Models of best practice for patient care which have been developed between Mayo General Hospital and its three District Hospitals should be fostered and developed throughout the region.

Roscommon & Ballinasloe Hospitals

The County Hospital, Roscommon & Portiuncula Hospital, Ballinasloe should continue to provide medicine, surgery, obstetrics, gynaecology, paediatrics, psychiatry, and investigative and diagnostic services, while developing suitable joint working arrangements to meet the needs of their catchment population.

Outreach Services

Effective outreach services, e.g. specialist day and outpatient services, should be organised to ensure that appropriate specialist medical and surgical services are provided from the tertiary centre at UCHG to the secondary hospitals. Models of best practice should be considered for other specialties to improve access and efficiency.

The Case for New Service Models

Many would contend that the only sensible way to organise acute hospital services is to concentrate resources at a few large centres and hire a large number of specialist staff with a wide mix of skills and experience. Most people would probably accept that it makes perfect sense to centralise the most complex and costly services - like heart surgery, radiotherapy and neuro science - in a small number of regional or national centres. Leaving aside these notable exceptions, it seems likely that there is a whole range of acute services which do not depend on centralisation for their effective and efficient provision.

The Western Health Board is still a mainly rural region. Some places are a long way from the nearest hospital. Many people are dependant on poor public transport. Access to the mainland is especially difficult from the islands. People here are older than elsewhere which, in turn, means that demand for elective services like orthopaedics, ophthalmology, plastic surgery, rheumatology, urology and vascular surgery is high. Finally, and perhaps most importantly, at least four out of every five deaths are due to cancer, cardiovascular disease and respiratory illness. We need to address these issues by making appropriate, high-quality services as accessible as possible, using new models of service delivery which ensure that patients who need acute treatment get access to the services they need, when they need them, and as close as possible to home.

Every effort should be made to bring high-quality hospital services as close as possible to the patient, in a way that makes best use of existing facilities, and creates a real and genuine partnership between clinical teams in the different hospitals. Part of the solution is to bring appropriate services closer. Better transport will also help.

Improving Transport for Elective Patients

- One option is a partnership with An Post, which would ensure that elective patients who are most in need of public transport, but who may be most cut off from current routes, can travel in comfort to hospital in a ‘TRANS-POST’ vehicle.

- Another alternative would be to work with public or private sector transport firms to develop a more flexible and responsive bus service. Bus Eireann is currently operating this kind of pilot project in the Midlands. The scheme is very similar to the "Wiltshire Wigglybus", a demand-led, flexible public transport scheme which has been introduced specifically to overcome access problems for people living in isolated parts of one county in England.

- Yet another option would be to make suitable joint arrangements to avail of the minibuses owned by voluntary organisations throughout the region. Each alternative requires a little more flexibility in the way hospital services are organised. We are confident, however, that the measures proposed in earlier chapters will help to effect the necessary improvements.

Still, there is a requirement to bring some services closer. While there are well-founded reasons for concentrating services in larger hospitals, we must also take the social, demographic and geographic features of this region into account when planning ahead. The Western Health Board area is bigger than Northern Ireland; and the population is spread over a wide area. Concentration of hospital services is not an option that would work readily here. Unless there is compelling evidence to suggest that centralisation produces a significantly better outcome for the patient (and there are services where clinical outcomes are better), service providers should be reluctant to concentrate hospital services more than is necessary.

1. Hub & Spoke Model

Current staffing levels make it difficult, but not impossible, to organise regular specialist sessions in peripheral hospitals. While improved transport will help to make access easier, particularly for elective patients, there is still a need to look closely at bringing appropriate specialised services, or parts of services, closer without compromising on quality. Examples include pre-assessment clinics, recurring theatre sessions, and regular out-patient clinics.

Each of these is a variation on the hub and spoke model of service delivery i.e. a specialist team from one hospital helping directly or indirectly in the provision of services at or for another hospital. This is a very useful way of organising very complex specialties, like neuroscience, or for making arrangements for the transfer of patients to a central unit when no local specialist is available. It is also useful for organising many other services e.g. transport of neonates.

The Hub & Spoke model can be worked in a variety of different ways:

- Clinicians from the Hub Hospital may provide services directly at the other hospitals.
- Alternatively, they may get together with the relevant clinical teams to draw up guidelines, or protocols where appropriate, which are applied to the care of all patients in a particular category, regardless of the hospital to which they are admitted.
- Arrangements like this can help to ensure that a uniformly high standard of care is always delivered, especially in small hospitals providing a limited range of consultant services. This is especially important when, for example, a stroke patient or the victim of a road traffic accident has to be stabilised prior to transfer.
- Achieving the necessary levels of partnership and co-operation between hospitals means that "regional units must go further than simply making facilities available to surgeons working in the periphery: they must accept [them] as full members of their consultant staff with admitting rights and committee membership."[xxxiv]

The Steering Committee does not believe there is an absolute requirement to locate all specialist services at the current regional centre. It is undoubtedly the case that clinicians in peripheral hospitals have particular expertise or experience in specific clinical areas. Where this is the case, it is important to take full advantage of the range of clinical skills which are available throughout the region, in the interests of enhancing the overall standard of patient care. In other words, ***the hub should be moveable***. For some services, it would be in Galway. For others, it might be best developed in Castlebar or in Roscommon/Ballinasloe.

2. Managed Clinical Networks

Some interpretations of the hub and spoke model tend to imply that the 'hub' must always be a large regional centre, and that the peripheral hospital 'spokes' should always be subordinate to it. When designing hub and spoke arrangements in this area, however, the emphasis should be on organising services around the needs of the patient, and with the needs of the region in mind. Other issues which also need to be taken into account include:

- Acknowledging that high levels of clinical skill and experience are available in both large and small hospitals;
- Accepting that real and genuine partnership between hospitals is the best way of ensuring that the broadest range of clinical skills are made available where and when they are needed by the patient; and finally
- Persuading consultants in each hospital to work closely together, so that the total clinical skill base in the region is strengthened and the need for at least some patient referrals to hospitals in other regions is reduced.

Managed Clinical Networking is an idea which takes account of these issues. It differs from hub and spoke arrangements, but only in the sense that it features a sharing of patients, expertise and resources between hospitals, rather than a constant and continual flow of patients and resources from the periphery to the centre.

Managed Clinical Networks are defined as linked groups of health professionals and organisations from primary, secondary and tertiary care, working together in a co-ordinated manner, unconstrained by existing organisational or professional boundaries, whose mission is to ensure the equitable provision of high quality, clinically effective services.[xxxv]

With clinical networking, the emphasis is on "connection and partnership rather than isolation and self-sufficiency, on distribution of resources rather than centralisation, and on maximising the benefits for all patients rather than the fortunate few … It is not about creating additional structures or committees, but … working differently and getting things done"[xxxvi] The "emphasis … shifts from buildings and organisations towards services and patients. Thus it is a move from competition to co-operation, not just between primary, secondary and tertiary providers, but also between different health professions."[xxxvii]

MCNs can be as flexible as necessary to meet an identified and agreed need, but they can only work properly if all clinicians are involved in preparing a detailed description of services, as well as integrated guidelines, and protocols where appropriate, for patient care. Proper management arrangements also need to be put in place at the beginning, including:

- the appointment of a lead person to take overall responsibility for the network;
- a defined structure showing the points where services are provided and how they are linked;
- a clear statement of expected improvements and a quality assurance programme;
- a multi-disciplinary, multi-professional focus;
- arrangements to circulate staff in ways which improve patient access, while maintaining professional skills; and
- representation for patient organisations.[xxxviii]

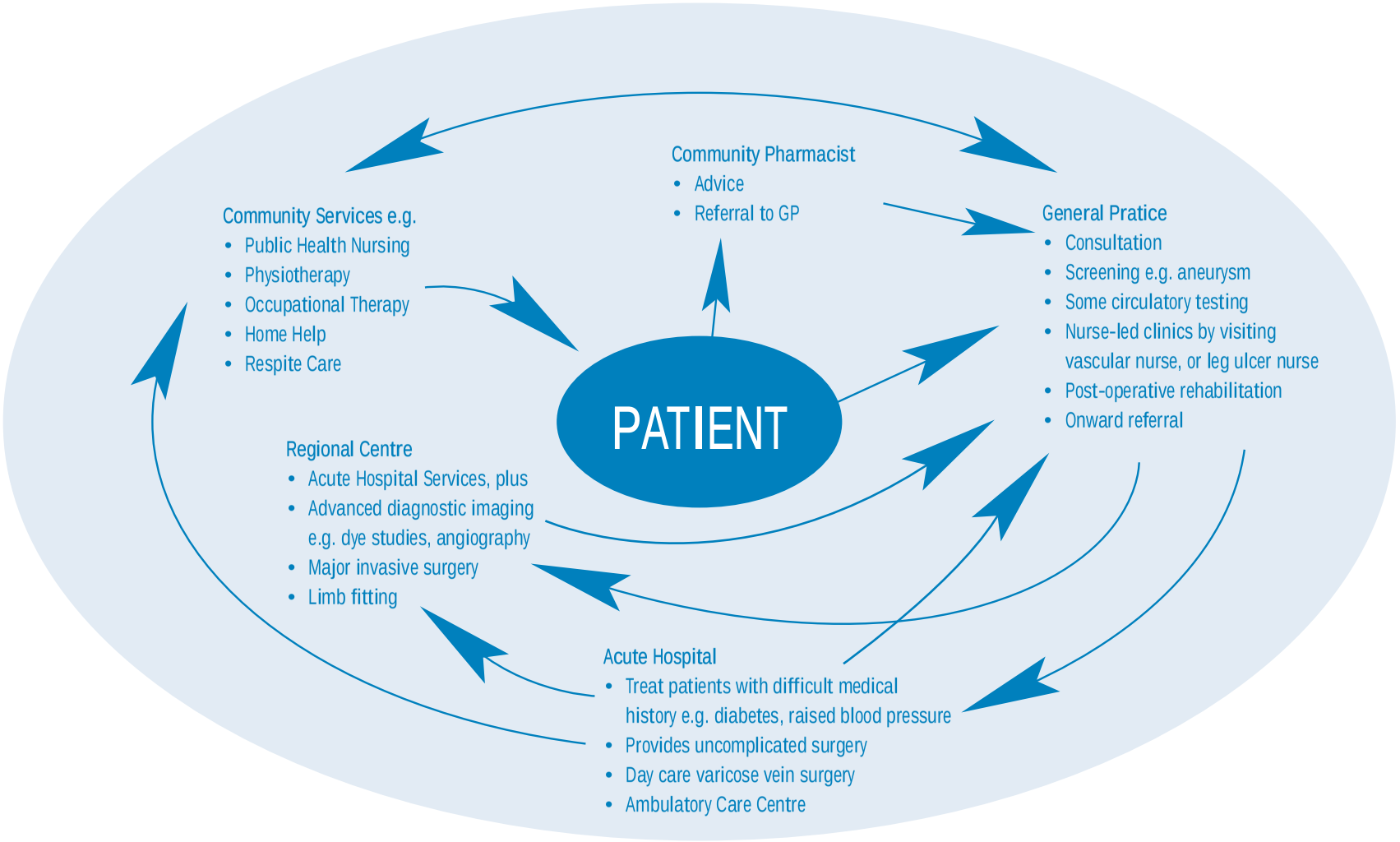
Advantages of Managed Clinical Networks

- Agreed standards of care
- Care in the appropriate setting
- Clear referral guidelines assist doctors when more specialised help is needed
- Helps overcome shortage of specialist staff
- Linkages between care settings improved
- Measurable benefits

In Scotland, a managed clinical network is being put in place to develop clinical services and to identify research, education, training, and information technology needs in the area of cardiology. Common protocols for referring patients and assigning priorities are being prepared, and databases have been developed, or are being set up, to provide good quality information. Local diagnostic and treatment networks (involving acute hospitals, primary care, intermediate care, ambulance services and health promotion services) are to be developed, and made responsible for most cardiac services from initial diagnosis and investigation through to chronic disease management. All of the elements are to be linked together through regular meetings, patient care protocols and information technology.[xl]

Managed Clinical Networks could - and should - be used to bring about better clinical teamworking within this health region, and to forge more effective linkages with hospitals in other regions, especially those offering highly specialised tertiary services like neuroscience and paediatric oncology. We see real potential for formal arrangements with centres like Beaumont Hospital and Our Lady's Hospital for Sick Children in Dublin, so that the clinical teams here are more fully informed about the follow-up needs of patients whom they themselves have referred to these hospitals.

Figure 5.1 - Integrated Regional Vascular Service – Example of a Managed Clinical Network



Recommendations

R5.1 The Board should develop appropriate hub and spoke arrangements, and managed clinical networks, across a range of specialties.

R5.2 A detailed and expeditious review of individual acute services should be carried out to assess need and the appropriate locations for development, having regard to these new service models.

R5.3 Regular meetings should be held between the clinical and managerial teams from each hospital, and involving primary care and community services personnel, to progress the elements in this strategy.

R5.4 Protocols, facilities and appropriately-trained staff should be available for inter-hospital transfers. Staff should be fully trained in using the most up-to-date equipment in every sector.

R5.5 The Board should work closely with appropriate statutory and voluntary organisations with a view to developing better transport arrangements, in order to enhance accessibility to acute hospitals for people living in remote and rural areas.

Appendix 1

Acute Hospitals Steering Committee

Terms of Reference

- To advise on vision and policy for a comprehensive and integrated Acute Hospital Service in the Western Health Board region, taking account of demography, population needs and achieving the highest quality affordable service.

- To identify the current provision of service, its strengths and weaknesses, and to recommend options for strategic alliances and development, having regard to the unique role and values of constituent Hospitals and Government policy.

- To recommend priorities and costed action plans for phased implementation within specific time frames.

- To take account of the role of the Acute Hospital as a key but integral part of a broader health system, and to ensure that a seamless or appropriate care response to patient needs can be achieved.

- It is envisaged that the Steering Group would consult extensively with the wider group of specialties and sub-specialists, and / or establish working sub-groups to ensure the inclusion of all specialty interests.

Appendix 2

Acute Hospitals Steering Committee

Membership

- Dr. Mary Hynes, Regional Manager, Acute Services & Primary Care, Western Health Board (Chairperson of the Steering Committee).
- Mr. Noel Brett, General Manager, Mayo General Hospital, Castlebar.
- Mr. Tony Canavan, Regional Co-ordinator, Acute Services & Primary Care, Western Health Board.
- Dr. Sean Conroy, Regional Manager, Corporate and Public Affairs, Western Health Board.
- Ms. Mary Courtney, Director of Nursing & Midwifery Planning Development, Western Health Board.
- Dr. Fidelma Creaven, Consultant Psychiatrist, St. Mary's Hospital, Castlebar.
- Dr. Kevin Dunne, Consultant Paediatrician, University College Hospital, Galway.[10]
- Dr. Ken Egan, General Practitioner, Ballindine, Co. Mayo.
- Mr. Kealan Flynn, Project Co-ordinator, Acute Hospital Services, Western Health Board.
- Dr. Gabriel Fox, Consultant Paediatrician, Mayo General Hospital, Castlebar.
- Ms. Majella Harte, A/General Manager, County Hospital, Roscommon.
- Ms. Bridget Howley, General Manager, University College Hospital, Galway.
- Dr. Fionnuala Lavin, Consultant Physician, Mayo General Hospital, Castlebar.
- Mr. William Moran, former Regional Manager for Acute Services & Primary Care, Western Health Board.[11]
- Mr. Anthony Martin, Consultant in Accident & Emergency, University College Hospital, Galway.
- Mr. Denis Minton, Finance Manager, Portiuncula Hospital, Ballinasloe.
- Dr. Margaret Murray, Consultant Haematologist, University College Hospital, Galway.
- Mr. Brendan Naughton, former Regional Co-ordinator for Acute Services & Primary Care, Western Health Board.[12]
- Dr. Michael O'Dowd, Consultant Obstetrician / Gynaecologist & Medical Director, Portiuncula Hospital, Ballinasloe.
- Dr. Tom O'Malley, Consultant in Medicine for the Elderly, Roscommon County Hospital and Portiuncula Hospital.

[10]Dr. Dunne retired from the group. He was replaced by Dr. Gabriel Fox, Consultant Paediatrician, Mayo General Hospital.

[11]Mr. Moran retired from the Western Health Board in February 2001. The Steering Committee wishes to acknowledge his immense contribution to the work of the Board, and his support for this review group.

[12]Mr. Naughton is currently on leave of absence and was replaced on the group by Mr. Canavan. The Steering Committee wishes to acknowledge and thank him for his contribution and participation.

Appendix 3

Table 1: Acute Beds Census - January 2001[13]

	UCHG	MPRH	MGH	RCH	PH	TOTAL
General Medicine *(incl.)*	145	105[14]	65	57	60	432
Cardiology						
Coronary Care			4	4	5	13
Dermatology						
Haematology						
Nephrology						
Neurology						
Respiratory Medicine						
General Surgery *(incl.)*	77		67	30	54	228
ENT	18					18
Ophthalmology	18					18
Oral Surgery						
Orthopaedics		105				105
Plastic Surgery	20					20
Urology	26					26
Obstetrics & Gynaecology						
Obstetrics	49		30		30	109
Gynaecology	31		12		9	52
Paediatrics						
Paediatrics	34		28		26	88
Premature Baby Unit	14		10		6	30
High Dependency Unit	4					4
Intensive Care	7		4			11
Medical Assessment			14			14
Geriatric Assessment		28	32			60
Day Beds	30		8	5	12	55
Psychiatry	43		35[15]	30		108
Palliative Care				1		1
Totals	**516**[16]	**238**[17]	**309**	**127**	**202**	**1,392**

[13]Western Health Board (2000): Review of Acute Hospitals Bed Capacity Figures revised at 1st January 2001. This Review was carried out following a commitment given in the Programme for Prosperity and Fairness.

[14]Nephrology, Rheumatology and Respiratory Medicine are provided at Merlin Park.

[15]Inpatient psychiatric services are to be provided as part of the Phase II Development at Mayo General.

[16]An additional 55 beds are available at UCHG as a result of upgrading work at two wards. These beds are allocated as follows: 28 for medicine and 27 for surgery. This development should alleviate seasonal pressure on beds and facilitate admissions from the Accident & Emergency Department.

[17]This figure does not include an additional 103 beds for long-stay geriatric patients.

Table 2: Additional Bed Needs (Under Continuous Review)[18]

Specialty	In-Patient Beds	Day Beds	Rehab Beds	Other	Total
Haematology and Medical Oncology	24	15	-	-	**39**
Gastroenterology	13	-	-	-	**13**
Neurology	7	-	-	-	**7**
Dermatology	2	-	-	-	**2**
Vascular Surgery	21	-	7	-	**28**
Cardiology	10	6	-	-	**16**
Maxillo-Facial Unit	4	-	-	-	**4**
Radiotherapy Unit	14	-	-	-	**14**
Genito-Urinary & Infectious Diseases	10	-	-	-	**10**
Urology	10	5	-	-	**15**
Rheumatology	12	-	-	-	**12**
Plastic Surgery	5	3	-	-	**8**
Breast Surgery	15	5	-	-	**20**
HDU @ MGH	-	-	-	11	**11**
MAU @ UCHG, RCH[19]	-	-	-	25	**25**
Totals	**147**	**34**	**7**	**36**	**224**

[18] Western Health Board (2000): Bed Capacity Review, op. cit.
[19] A Medical Assessment Unit should also be developed at Portiuncula Hospital.

Appendix 4

Hospital Services in the Western Health Board

Specialty/Service	Description	Service Provided	UCHG	MPRH	MGH	RCH	PH
Accident & Emergency	Treating suddenly developing medical, surgical and psychiatric disorder	24-Hour Service Observation Trolleys	Sp.[20] Yes		Sp.	Gen.	Gen.
Anaesthesiology	Peri-operative care of patients undergoing surgery; and intensive care therapy	24-Hour In-Patient Service Intensive Therapy Pain Management Hyperbaric Chamber	Sp. Yes Yes[21] Yes	Sp. Yes Yes	Sp. Yes Yes[22]	Sp. Yes	Sp. Yes Yes
Cardiology	Treating disorders of the heart	24-Hour In-Patient Service Out-Patient Clinic Cardiac Rehabilitation Emergency Resuscitation Out-Patient ECG 'Pacing' Service Angiography	Sp. Yes Yes Yes Yes Yes Yes	Yes	Gen. Yes App. Yes Yes CCU	Gen. Yes App. Yes Yes Off-Site	Sp. Yes App. Yes Yes Yes Off-Site
Clinical Biochemistry[23]	Chemical examination of body fluids and tissues. Investigates and advises on diagnosis and prognosis, exclusion of disease, and the management and treatment of disease	24-Hour Service Referrals from Consultants and GPs Consultant Service to GPs	Sp. Yes Yes	Sp.	Gen. Yes Yes	Gen. Yes	Sp. Yes Yes
Dermatology	Treating skin disorders	24-Hour In-Patient Service Out-Patient Clinic[24]	Sp. Yes		Yes	Yes	Yes
Ear, Nose & Throat	Treating ear, nose and throat disorders	24-Hour In-Patient Service Out-Patient Clinics	Sp. Yes		Yes[25]	Yes	Yes
Endocrinology	Treating ductless gland disorders e.g. thyroid	24-Hour In-Patient Service Endocrinology Clinic Diabetes Clinic Ante-Natal Diabetes Service Diabetes Nurse Specialists	Sp. Yes Yes Yes Yes		Gen. Yes Yes Yes Yes	Gen. Yes Yes	Gen. Yes Yes Yes

[20]Sp. indicates that the service is provided by a consultant who specialises in that area e.g. Consultant Dermatologist. Gen. indicates that a generalist service is provided by a consultant who also has a special interest in a particular area e.g. Consultant Physician with an interest in Cardiology.

[21]UCHG provides a consultant-led chronic pain service.

[22]Mayo General Hospital does not currently have a pain management service, but does provide a 24-Hour epidural service for obstetrics.

[23]The Department of Clinical Biochemistry at UCHG provides a diagnostic and consultative service for hospital inpatients and outpatient clinics, community care centres and General Practitioners in the Western Health Board. It also acts as a referral centre for specialised biochemistry, for hospitals and General Practitioners in the North-Western and Mid-Western Health Boards. The Department offers a core service in biochemistry, specialised biochemistry including endocrinology, and tumour markers/oncology.

[24]Regular out-patient dermatology clinics are also held in Ballina, Ballinasloe, Castlebar and Roscommon.

[25]Mayo General also provides a one-hour theatre session for ENT day cases each week.

Specialty/Service	Description	Service Provided	UCHG	MPRH	MGH	RCH	PH
Gastroenterology	Treating digestive disorders	24-Hour In-Patient Service Out-Patient Clinic	Sp. Yes		Gen. Yes	Gen. Yes	Sp. Yes
General Medicine	Treating disease using non-surgical means	24-Hour In-Patient Service Out-Patient Clinic	Gen. Yes	Gen. Yes	Gen. Yes	Gen. Yes	Gen. Yes
General Surgery	Treating disease by surgical means	24-Hour In-Patient Service Out-Patient Clinic Surgical Breast Care Clinic Stoma Care Nurses Breast Care Nurses	Sp. Yes Yes[26] Yes Yes		Sp. Yes Yes Yes Yes	Sp. Yes App.	Sp. Yes Yes
Gynaecology	Treating and preventing disorders of the female genital tract	24-Hour In-Patient Service Out-Patient Clinic Ultrasound Scan Service	Sp. Yes Yes		Sp. Yes Yes	Yes Yes	Sp. Yes Yes
Haematology	Management of blood and blood-related disorders	24-Hour In-Patient Service Out-Patient Clinic Day Treatment Centre Nurse Specialists Referrals from Consultants and General Practitioners Consultant Service to GPs	Sp. Yes Yes Yes Yes Yes	Sp.	Gen.	Gen. Yes	Gen. Yes
Histopathology[27]	Branch of pathology to do with the tissue changes characteristic of disease	24-Hour Service Referrals from Consultants and GPs Consultant Service to GPs	Sp. Yes Yes	Sp.	Sp. Yes Yes		Sp. Yes Yes
Immunology[28]	Consultative service relevant to the diagnosis and management of disorders of the immune system	24-Hour Service Referrals from Consultants and GPs Consultant Service to GPs	Sp. Yes Yes	Sp.	Gen. Yes Yes		Gen. Yes Yes

[26]UCHG also provides a minimally invasive breast biopsy service: this procedure can be performed on an out-patient basis in the hospital x-ray department, and is an improvement on the open breast biopsy procedure.
[27]The Laboratory at UCHG receives, sorts, processes and reports on specimens, including urgent specimens frozen sections from within the Galway Regional Hospitals, and from General Practitioners. Post-mortem services are also provided for both hospitals, for the coroners in the area, and for the Castlebar and Roscommon Hospitals. The laboratories train pathologists and laboratory technologists. Gynaecological and non-gynaecological cytology screening is also provided for the Western and other Health Boards.
[28]The Department of Immunology at UCHG provides a diagnostic immunology service for the Western Health Board area, and for other Health Boards as well. It plays a key part in the context of the development of regional and supra-regional cancer services.

Specialty/Service	Description	Service Provided	UCHG	MPRH	MGH	RCH	PH
Medical Microbiology	Prevention, diagnosis and management of infection	24-Hour Service Referrals from Consultants and GPs Consultant Service to GPs	Sp. Yes Yes	Sp.	Gen. Yes Yes	Some	Gen. Yes Yes
Medical Oncology	Medical treatment of cancers	24-Hour In-Patient Service Out-Patient Clinic Medical Oncology Treatment Centre Nurse Specialists Combined St. Lukes Radiotherapy Clinic[29] Referrals from Consultants and General Practitioners Referrals to Hospice Care Team	Sp. Yes 5-Day Yes Yes Yes Yes		Yes 5-Day (Satellite) Yes Yes Yes	Yes[30]	Yes 5-Day (Satellite) Yes Yes Yes
Hepatology	Treating liver disorders	Hepatitis C Care Specialist[31] Out-Patient Clinic	Sp. Yes				Some[32]
Medicine for the Elderly	Treating age-related disorders	24-Hour In-Patient Service Geriatric Assessment Unit Out-Patient Clinic Acute Rehabilitation Respite & Continuing Care	Sp. Yes Yes Yes	Sp. Yes Yes Yes	Sp. Yes Yes	Sp. Yes Sacred Heart Home Sacred Heart Home	Sp. Yes Yes
Neonatology	Treating disorders in the new-born infant	24-Hour In-Patient Service Referrals from WHB Hospitals	Sp. Yes		Sp. Yes		Sp.
Nephrology	Treating disorders of the kidneys	24-Hour In-Patient Service Out-Patient Clinic Renal Dialysis		Sp. Yes Yes	Yes Yes		

[29]The Haematology Department also avails of the Combined St. Lukes Radiotherapy Clinic and makes referrals to the hospice care team.
[30]The County Surgeon refers patients to St. Lukes Hospital, Dublin for specialist assessment and treatment by a Consultant Oncologist, who then refers them back to the second Consultant Surgeon at Roscommon for follow-up care.
[31]The Health (Amendment) Act, 1996 provides that a comprehensive range of services should be made available, without charge, to people who have contracted Hepatitis C through the use of a blood product or as the result of a blood transfusion.
[32]Provided in-house by a member of the consultant staff.

Specialty/Service	Description	Service Provided	UCHG	MPRH	MGH	RCH	PH
Neurology	Treating disorders of the nervous system	24-Hour In-Patient Service Out-Patient Clinic Neurophysiological Diagnostic Service (EEG)	Sp. Yes Yes		Gen.		Gen.
Obstetrics	Care of women during pregnancy, labour and up to 6 weeks after delivery	24-Hour In-Patient Service Out-Patient Clinic Midwife Clinic Ultrasound Scan Services Referrals from GPs Parentcraft Education Home Birth Pilot Project Fertility Clinic	Sp. Yes Yes Yes Yes Yes Yes Yes		Sp. Yes Yes Yes Yes		Sp. Yes Yes Yes Yes
Ophthalmology	Treating disorders of the eye	24-Hour In-Patient Service Out-Patient Clinic Pre-Assessment Clinic Orthoptist Service Laser Service Prosthetic Fitting/Visual Aids	Sp. Yes Yes Yes Yes Yes		Note[33]	Yes[34]	Yes
Oral and Maxillofacial Surgery	Treating disorders of the mouth and face by surgical means	24-Hour In-Patient Service Out-Patient Clinic	Sp. Yes				Yes[35]
Orthodontics	Correcting irregularities of the teeth	Regional Consultant-Led Service Screening (6th Class, Primary School)		Yes Yes	Community Yes	Community Yes	Yes Yes
Orthopaedics	Treating disorders of the bone and soft tissue	24-Hour In-Patient Service Out-Patient / Review Clinic Out-Patient Fracture Clinic Scoliosis Clinic		Sp. Yes Yes Yes	Approved Yes Yes	Yes	Yes

[33] *Trauma service and onward referral only.*
[34] *Outpatient Clinics by Community Ophthalmology Services. Day Case procedures also provided.*
[35] *Affiliate member of the consultant team carries out in-patient dental surgery and holds out-patient dental clinics at Portiuncula Hospital.*

Specialty/Service	Description	Service Provided	UCHG	MPRH	MGH	RCH	PH
Paediatrics	Care, diagnosis and treatment of sick children	24-Hour In-Patient Service	Sp.		Sp.		Sp.
		Services for disabled and chronically ill children	Yes		Yes	Yes[36]	Yes
		Consultative service for GPs	Yes		Yes	Yes	Yes
		Child Protection, Health Promotion & Immunisation	Yes		Yes	Yes	Yes
		Investigation/Treatment Ward	5-Day		7-Day		Yes
		Out-Patient Clinics e.g.	Yes		Yes	Yes	Yes
		• General Medicine					
		• Respiratory Medicine					
		• Cystic Fibrosis					
		• Diabetes					
		Out-Patient Clinics e.g.	Yes			Yes	
		• Ophthalmology				Yes	
		• Orthopaedics				Yes	
		• Urology				Yes	
		• Neurology/Rehabilitation	Yes				
Plastic Surgery	Surgically repairing or reconstructing tissue to correct deformity	24-Hour In-Patient Service	Sp.				
		Laser Service	Yes				
		Out-Patient Clinics	Yes				
		Cleft Lip/Palate Clinics	Yes				
		Hand Clinics & Telemedicine	Yes				
Palliative Care	Physical, emotional, social and spiritual care of patients with terminal or end-stage disease	24-Hour Service	Sp.			Yes	
		Hospice Care Teams[37]	GHF		MRHF	MRHF	
Acute Psychiatry	Assessment, diagnosis and treatment of mental disorders	24-Hour In-Patient Service	Sp.				Sp. Approved
		Out-Patient Clinics	Yes		Yes	Yes	
		Day Hospital	Yes			Yes	
		Community Nursing Service	Yes		Yes	Yes	Yes
Radiology	Use of radiant energy (e.g. as x-rays) or radioactive material in the diagnosis and treatment of disease	Diagnostic Radiology Service	Sp.[39]	Sp.	Sp.	Sp.	Sp.
		Emergency Service	Yes	Yes	Yes	Yes	Yes
		CT Scan Service	Yes		Yes		Yes
		MRI Scan Service	Yes				
		Referrals from Consultants and General Practitioners	Yes	Yes	Yes	Yes	Yes
		Teleradiology[38]	Yes				

[36]Roscommon County Hospital provides dental services to disabled children in conjunction with Community Dental Services.

[37]GHF means Galway Hospice Foundation and MRHF means Mayo-Roscommon Hospice Foundation.

[38]The Board has recently introduced a teleradiology service at the District Hospital in Clifden. Patients can be referred to the hospital by their General Practitioner and have their x-rays taken there. The images are then sent over a telephone line to the University College Hospital in Galway, where they can be examined and a report prepared.

[39]The Radiology Department at UCHG has further expanded the range of diagnostic services offered, with the opening of the first of two new interventional/vascular rooms.

Specialty/Service	Description	Service Provided	UCHG	MPRH	MGH	RCH	PH
Respiratory Medicine	Treating breathing disorders	24-Hour In-Patient Service Out-Patient Clinic Nurse Specialists Pulmonary Function Lab. Pulmonary Testing Respiratory Diagnostic Tests (incl. Sleep Studies)	Sp. Yes Yes	Sp. Yes Yes Yes Yes	Gen. Yes Yes	Gen. Yes	Gen. Yes Yes Yes
Rheumatology	Treating connective tissue disorders, e.g. rheumatoid arthritis	24-Hour On-Call Service Out-Patient Clinics Out-Patient/Juvenile Patient		Sp. Yes Yes			
Thoracic Surgery	Treating disorders of the thorax and chest by surgical means	24-Hour In-Patient Service 24-Hour Out-Patient Service	Sp. Yes				Gen.
Urology	Treating disorders of the urinary tract	24-Hour In-Patient Service Out-Patient Clinics Nurse Specialists Lithotripsy Urodynamic Service Gynae. Urodynamic Service Intravesical Chemotherapy	Sp. Yes Yes Yes Yes Yes Yes		Gen. Yes Yes Yes Yes	Yes[40]	Some[41] Yes
Vascular Surgery	Treating disorders of the blood vessels	24-Hour In-Patient Service Out-Patient Clinic Varicose Veins Limb Fitting Clinic Laser Service Vascular Laboratory	Sp. Yes Yes Yes Yes	 Yes	Gen. Yes	Yes	Yes[42]

[40]Cystoscopies - day cases every quarter.

[41]Patients requiring surgical treatment for diseases such as cancer are referred to UCHG, though some of the work-up tests may be performed at Portiuncula.

[42]The Consultant Surgeons and Consultant Physicians also provide a service to patients who present with peripheral vascular disease.

Appendix 5

Summary of the Ombudsman's Guide to Best Practice for Public Servants

The Ombudsman's Guide to Standards of Best Practice for Public Servants, published with his Annual Report for 1996, provides a checklist that helps to ensure that people are dealt with properly, fairly and impartially. The following outlines some of the key points.

Dealing properly with people means dealing with them:

- Promptly without undue delay
- Correctly, in accordance with the law or other rules governing their entitlements
- Sensitively, by having regard to their age, capacity to understand often complex rules, to any disability they may have and to their feelings, privacy and convenience
- Helpfully, by simplifying procedures, forms and information on entitlements and services, maintaining proper records
- Responsibly, by not adopting an adversarial approach

Dealing fairly with people means:

- Treating people in similar circumstances in like manner
- Accepting that rules and regulation, while important in ensuring fairness, should not be applied so rigidly as to create inequity
- Being prepared to review rules and procedures and change them if necessary
- Giving adequate notice before changing rules in a way which adversely affects a person's entitlements
- Having an internal review system so that adverse decisions can be looked at again and reviewed by someone not involved in the first decision
- Informing people how they can appeal, co-operating fully in any such appeal and being open to proposals for redress

Dealing impartially with people means:

- Making decisions based on what is relevant in the rules and law and ignoring what is irrelevant
- Avoiding bias because of a person's colour, sex, marital status, ethnic origin, culture, language, religion, sexual orientation, attitude, reputation or because of who they are or who they know
- Ensuring, where a service is based on a scheme of priorities, that the scheme is open and transparent
- Being careful that one's prejudices are not factors in a decision

Appendix 6

Submissions to the Acute Hospitals Steering Committee

Individual Responses

- Mr. Andrew Barber, Chief Pharmacist, University College Hospital, Galway.
- Dr. John Barton, Consultant Physician, Portiuncula Hospital, Ballinasloe, Co. Galway.
- Ms. Mary Belov, Dietitian, Merlin Park Regional Hospital, Galway.
- Dr. Michael Brassil, Consultant Obstetrician/Gynaecologist, Portiuncula Hospital, Ballinasloe, Co. Galway.
- Dr. Gerard Brennan, General Practitioner, Newcastle, Galway.
- Dr. Marion Broderick, General Practitioner, Inis Mór, Aran Islands, Co. Galway.
- Dr. Michael Brogan, General Practitioner, Ballyhaunis, Co. Mayo.
- Ms. Pauline Burke, Senior Occupational Therapist, University College Hospital, Galway.
- Ms. Anne Byrne, 81 Westbrook, Knocknacarra, Galway.
- Ms. Edel Callanan, Physiotherapy Manager, Merlin Park Regional Hospital, Galway.
- Dr. Anthony Carroll, Consultant Psychiatrist, University College Hospital, Galway.
- Mr. John Carter, A/Senior Medical Laboratory Technician, County Hospital, Roscommon.
- Ms. Bridget Casey, Dangan Heights, Galway.
- Dr. Michael Cassidy, Consultant Pathologist, Portiuncula Hospital, Ballinasloe, Co. Galway.
- Ms. Niamh Cavanagh, Principal Biochemist, Portiuncula Hospital, Ballinasloe, Co. Galway.
- Mr. Oliver Clinton, Consultant Surgeon, County Hospital, Roscommon.
- Dr. Deirdre Collins, General Practitioner, Westport, Co. Mayo.
- Ms. Geraldine Colohan, Chief Pharmacist, Portiuncula Hospital, Ballinasloe, Co. Galway.
- Ms. Martina Connellan, Senior Dietitian, County Hospital, Roscommon.
- Dr. Darach Corcoran, Consultant Obstetrician/Gynaecologist, Mayo General Hospital, Castlebar, Co. Mayo.
- Professor Martin Cormican, Consultant Microbiologist, University College Hospital, Galway.
- Dr. Robert Coughlan, Consultant Rheumatologist, Merlin Park Regional Hospital, Galway.
- Dr. Joseph Curran, General Practitioner, Clonbur, Co. Galway.
- Ms. Esther Mary Darcy, Physiotherapy Manager, University College Hospital, Galway.
- Ms. Mairead Dobey, Senior Dietitian, Merlin Park Regional Hospital, Galway.
- Ms. Emer Donohue, Senior Occupational Therapist, County Hospital, Roscommon.
- Ms. Johanna Downes, Clinical Nurse Manager, University College Hospital, Galway.
- Dr. Brendan Duffy, Consultant Physician & Nephrologist, Merlin Park Regional Hospital, Galway.
- Mr. Paddy Duffy, Ambulance Officer, Western Health Board, Castlebar, Co. Mayo.
- Mr. Paul Eustace, Consultant Surgeon, Mayo General Hospital, Castlebar, Co. Mayo.
- Dr. Eamonn Faller, General Practitioner, The Crescent, Galway.
- Mr. Gerry Flynn, Community Pharmacist, Claremorris, Co. Mayo.
- Mr. Peter Gormley, Consultant ENT Surgeon, University College Hospital, Galway.
- Dr. Sean Gormley, General Practitioner, Ballina, Co. Mayo.
- Mr. Joe Goulding, Chief Technologist, Blood Bank, University College Hospital, Galway.
- Dr. Helen Grimes O'Cearbhaill, Consultant Biochemist, University College Hospital, Galway.

- Dr. Joseph Groarke, Consultant Physician, Portiuncula Hospital, Ballinasloe, Co. Galway.
- Mr. Derrick Hambleton, Kingston, Galway.
- Dr. Martina Hanratty, General Practitioner, Roscommon.
- Ms. Carmel Higgins, Accreditation Manager, University College Hospital, Galway.
- Dr. Maccon Keane, Consultant Oncologist, University College Hospital, Galway.
- Ms. Mary Keane, Senior Occupational Therapist, Merlin Park Regional Hospital, Galway.
- Ms. Geraldine Keenan, Senior Speech & Language Therapist, University College Hospital, Galway.
- Dr. Donal Kelly, General Practitioner, Abbeyknockmoy, Co. Galway.
- Dr. Michael Kennedy, Consultant Radiologist, Merlin Park Regional Hospital, Galway.
- Mr. Frank Kinsella, Consultant Ophthalmologist, University College Hospital, Galway.
- Ms. Norah Kyne, A/Physiotherapy Manager, University College Hospital, Galway.
- Dr. Matt Linehan, General Practitioner, Mountbellew, Co. Galway.
- Professor Gerry Loftus, Consultant Paediatrician, University College Hospital, Galway.
- Ms. Rena Lyons, Principal Speech & Language Therapist, Western Health Board, Shantalla, Galway.
- Dr. Una Logan-Mullowney, Consultant Radiologist, Mayo General Hospital.
- Dr. Roderick Maguire, Locum Consultant Radiologist, County Hospital, Roscommon.
- Mr. Oliver McAnena, Consultant Surgeon & Regional Director of Cancer Services, University College Hospital, Galway.
- Mr. Jack McCann, Consultant Plastic Surgeon and Chairman of the Surgical Committee, University College Hospital, Galway.
- Dr. Colette McDonagh-White, Occupational Health Physician, University College Hospital, Galway.
- Dr. Nora McGarry, General Practitioner, Milltown, Co. Galway.
- Ms. Dorothy McKane, Community Pharmacist, Ballina, Co. Mayo - on behalf of the Irish Pharmaceutical Union.
- Dr. Laura Mannion, Consultant Psychiatrist, University College Hospital, Galway.
- Mr. Joe Molloy, Director of Capital Projects, Western Health Board, Merlin Park Regional Hospital, Galway.
- Ms. M. Molloy, Clinical Nurse Manager, A&E Department, University College Hospital, Galway.
- Mr. Martin Molloy, Senior Executive Officer, Information Services Department, University College Hospital, Galway.
- Dr. Michael Morkan, General Practitioner, Elphin, Co. Roscommon.
- Dr. James Mulhall, Consultant Anaesthetist, Mayo General Hospital, Castlebar, Co. Mayo.
- Dr. John Murphy, Consultant Physician, Mayo General Hospital, Castlebar, Co. Mayo.
- Ms. Geraldine Murray, A/Divisional Nurse Manager, University College Hospital, Galway.
- Dr. Michael Mylotte, Consultant Obstetrician/Gynaecologist, University College Hospital, Galway.
- Ms. Bonnie Neary, Superintendent Radiographer, Merlin Park Regional Hospital, Galway (who also co-ordinated the response of her colleagues on the team).
- Mr. John Nolan, Consultant Ophthalmologist, University College Hospital, Galway (Retired).
- Ms. Pat O'Brien, Chief Pharmacist, Merlin Park Regional Hospital, Galway.
- Dr. Aidan O'Colmain, General Practitioner, Salthill, Galway.
- Mr. Don O'Connor, Chief Technologist, Portiuncula Hospital, Ballinasloe, Co. Galway.
- Dr. William O'Connor, General Practitioner, Hollymount, Co. Mayo.
- Dr. John O'Donnell, Consultant Physician, University College Hospital, Galway.
- Dr. David O'Flaherty, Consultant Anaesthetist, Portiuncula Hospital, Ballinasloe, Co. Galway.
- Dr. David O'Gorman, Consultant Dermatologist, University College Hospital, Galway.

- Dr. David O'Keeffe, Consultant Radiologist, University College Hospital, Galway.
- Dr. Shaun O'Keeffe, Consultant Physician, Merlin Park Regional Hospital, Galway.
- Dr. Michael O'Neill, Consultant Paediatrician, Mayo General Hospital, Castlebar, Co. Mayo.
- Dr. Maura O'Shea, Specialist in Public Health Medicine, Western Health Board, Merlin Park Regional Hospital, Galway.
- Mr. Michael O'Sullivan, Consultant Orthopaedic Surgeon, Merlin Park Regional Hospital, Galway.
- Mr. C.V. Prasad, Consultant Orthopaedic Surgeon, Merlin Park Regional Hospital, Galway.
- Ms. Priya Prendergast, General Manager, Community Services, Western Health Board, Newcastle Road, Galway.
- Mr. Denis Quill, Consultant General & Vascular Surgeon, University College Hospital, Galway.
- Mr. Michael Relihan, Consultant Surgeon, County Hospital, Roscommon.
- Mr. Padraic Regan, Consultant Plastic Surgeon, University College Hospital, Galway.
- Ms. Regina Rogan, Chief Technologist, Department of Pathology, Mayo General Hospital, Castlebar, Co. Mayo.
- Dr. Sheelah Ryan, Chief Executive Officer, Western Health Board, Merlin Park Regional Hospital, Galway.
- Dr. Gerard Solan, Consultant Pathologist, Mayo General Hospital, Castlebar, Co. Mayo.
- Ms. Helen Shortt, Senior Dietitian, University College Hospital, Galway.
- Ms. Mary Syron, Senior Public Health Nurse for the Travelling Community, Western Health Board, Merlin Park Regional Hospital, Galway.
- Dr. Michael Thornton, Consultant Anaesthetist, Mayo General Hospital, Castlebar, Co. Mayo.
- Mr. Michael Towey, Physicist, Portiuncula Hospital, Ballinasloe, Co. Galway.
- An Dr. Seaghán Ua Conchubhair, Dochtúir Teaghlaigh, Uarán Mor, Gaillimh.
- Dr. Wil van der Putten, Department of Medical Physics and Bioengineering, University College Hospital, Galway.
- Dr. Matt Walshe, Principal Dental Surgeon, County Hospital, Roscommon.
- Ms. Grace Wickham, Senior Occupational Therapist, Merlin Park Regional Hospital, Galway.

Group Responses

- Age Action Ireland/Age Action West, Lower Abbeygate Street, Galway.
- Ankylosing Spondylitis Association of Ireland, Whitehall, Dublin 9.
- Anne Sullivan Foundation for Deaf/Blind, Drumcondra, Dublin 9.
- Arthritis Foundation of Ireland (Mayo Branch), Swinford, Co. Mayo.
- Association of Clinical Biochemists in Ireland, St. Vincent's Hospital, Dublin 4.
- Association of Internal Medicine, c/o St. Joseph's General Hospital, Nenagh, Co. Tipperary.
- Association of Lactation Consultants in Ireland, Mullingar, Co. Westmeath.
- Association of Optometrists, Ireland, Harold's Cross, Dublin 6W.
- Bodywhys, Blackrock, Co. Dublin.
- Brothers of Charity Services, Lanesboro Street, Roscommon.
- Central Remedial Clinic, Clontarf, Dublin 3.
- Children in Hospital Ireland, North Brunswick Street, Dublin 7.
- Combat Poverty Agency, Islandbridge, Dublin 8.
- Diabetes Federation of Ireland (Roscommon Branch), Lough Road, Roscommon.
- Disability Federation of Ireland, Sandyford Office Park, Blackthorn Avenue, Dublin 18.
- Down Syndrome Ireland (Mayo Branch), Ballinrobe, Co. Mayo.
- Galway County Association, Quay Street, Galway.

- Health and Safety Authority, Hogan Place, Dublin 2.
- Irish Fostercare Association, Ballinteer, Dublin 16.
- Irish Hyperlipidaemia Association, c/o Cardiology Department, The Adelaide and Meath Hospital, Tallaght, Dublin 24.
- Irish Kidney Association, Pembroke Road, Dublin 4.
- Irish Pharmaceutical Healthcare Association, Pembroke Road, Dublin 4.
- Irish Raynaud's and Scleroderma Society, Foxrock, Dublin 18.
- Irish Society for Colitis and Crohn's Disease, North Brunswick Street, Dublin 7.
- Irish Society of Gastroenterology, c/o Daisy Hill Hospital, Newry, Co. Down.
- Irish Society for Rheumatology, c/o Rheumatology Department, St. Vincent's Hospital, Dublin 4.
- Migraine Association of Ireland, Carmichael House, North Brunswick Street, Dublin 7.
- National Association for the Mentally Handicapped of Ireland, Fitzwilliam Place, Dublin 2.
- National Council on Ageing and Older People, Clanwilliam Square, Dublin 2.
- National Federation of Voluntary Bodies, Oranmore, Co. Galway.
- National Rehabilitation Board, Clyde Road, Ballsbridge, Dublin 4.
- Parkinson's Association of Ireland, North Brunswick Street, Dublin 7.
- Patient Focus, Templeogue, Dublin 16.
- Polio Fellowship of Ireland, Stillorgan, Co. Dublin.
- Postgraduate Medical and Dental Board, Fenian Street, Dublin 2.
- Post Polio Support Group, North Brunswick Street, Dublin 7.
- Rape Crisis Centre, Lower Leeson Street, Dublin 2.
- Reach Ireland, Garristown, Co. Dublin.
- Schizophrenia Ireland, Blessington Street, Dublin 7.
- Social Work Department, University College Hospital, Galway.
- Society of St. Vincent de Paul (Elphin Branch), Castlerea, Co. Roscommon.
- St. John Ambulance Brigade of Ireland, Upper Leeson Street, Dublin 4.
- The Academy of Medical Laboratory Science, Old Kilmainham, Dublin 8.
- The Anne Sullivan Foundation for Deaf/Blind, Drumcondra, Dublin 9.
- The Galway County Association Services, Quay Street, Galway.
- The Irish Society of Chartered Physiotherapists, c/o Physiotherapy Managers Group, Western Health Board.
- The Royal College of Psychiatrists (Irish Division), St. Stephen's Green, Dublin 2.
- The Volunteer Stroke Scheme, Crumlin, Dublin 12.
- Western Care Association, Castlebar, Co. Mayo.

Appendix 7

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ii Galway Chamber of Commerce is projecting a population of 100,000 in the city proper in 10 to 20 years time, with another 150,000 in a conurbation including places like Barna, Claregalway and Oranmore (Irish Times, 20th December 2000, Supplement entitled 'IT in Galway'. Another estimate, announced in a study on transportation undertaken for Galway Corporation and Galway County Council, suggests that the population of Galway City and its environs will grow by at least 31,000 up to the year 2016.

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x In the UK, emergency admission units have been set up mainly for acute medical admissions; they provide intensive early assessment and treatment, with patients staying for up to three days. Source: BMJ 1996; 313: 646.

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xvii Bowling, A., Jacobsen, B., Southgate, L., and Formby, J. (1991): *General Practitioners' Views on Quality Specifications for Out-Patient Referrals and Care Contracts* BMJ 1991; 303: 292 - 294.

xviii Hartog, M. and Hime, M. (1992): *What Does the Consultant Want?* in Hopkins, A. and Wallace, P. (eds)

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is shorthand for 'did not attend'.

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xxv Galway Regional Hospitals received £2.165 million to provide 1,250 waiting list procedures in the year 2000. In June 2000, an additional £853,000 was approved which enabled an extra 600 patients to get their procedures. In 2001, a sum of £2.25 million has been received to provide 1,194 procedures.

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xxxi Department of Health (1994): *Shaping a Healthier Future* pp. 62 - 63. Dublin: Stationery Office.

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xxxiii Geriatric Assessment Services may be developed on a joint basis between UCHG and Merlin Park in the years ahead, although a firm decision on this has not yet been taken. A 30-bed assessment and rehabilitation unit for Merlin Park is currently in planning. Similar units are being planned for Mayo General Hospital and for the Sacred Heart Hospital, Roscommon.

xxxiv Marston, A.: *Concessions on All Sides are Needed* Letter to BMJ 1998; 316: 305.

xxxv Baker, CD, and Lorimer, AR, 2000: *Cardiology: The Development of a Managed Clinical Network* BMJ 2000; 321: 1152.

xxxvi Scottish Office, 1998: *Acute Services Review Report* pp. 23 - 24. London: The Stationery Office Ltd.

xxxvii Baker and Lorimer: op. cit.

xxxviii NHS Management Executive (1999): *Introduction of Managed Clinical Networks in Scotland* MEL (1999) 10.

xxxix Scottish Office, 1998: op. cit. p. 28. Adapted with the assistance of Dr. Declan McKeown, Acting Director of Public Health, Western Health Board.

xl Baker and Lorimer: op. cit. The Scots are also working on two major pilot projects to advance the managed clinical networks idea: one for vascular services (a disease network) and one for neurology with particular reference to stroke (a specialty network).

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