General Practice response to the HSE transformation process in the Mid-West Region.

General Practice [GP] considers the process of withdrawing Accident and Emergency [A/E] services from Ennis and Nenagh hospitals from 06/04/2009, and the withdrawal of all acute surgical services form 01/07/2009 to be neither safe or sensible, but to be dangerous and irresponsible. These withdrawals effectively herald the closure of all acute services at both hospitals. Rather than creating centres of excellence, the creation of teams of excellence would be a far more effective transformation process, where peripheral hospitals would provide most of the acute services for its catchment area and would use the central hospital as a referral centre for more complex care. All members of the teams could rotate between the hospitals concerned. Such corporate governance should be achievable.

The authors of the Teamwork report did not consult with GP to consider their views: nor did the Implementation project team consult with GP until the planned changes were finalised.

The Teamwork report repeatedly states that support services must be in place first, before any services are withdrawn. Yet the transformation process, as outlined by the implementation team, is being rolled out without any preparatory community support structures being put in place. The cart is clearly before the horse.

The proposed changes to the provision of acute services in the Mid-West will have profound effects on the ability of GP to provide a safe and effective service to our patients, both during the working day and during out-of-hours periods.

In all our meetings with the implementation project team it is clear that there is no understanding of the nature of the work that GP does or the effects this transformation process will have on our ability to provides a safe and efficient service to our patients.

In principle we oppose the closure of all acute services in peripheral hospitals and the centralisation of these services in central regional hospitals. In the Mid-West Ennis and Nenagh have been systematically undermined by the failure to provided essential resources to develop their services. Senior consultant staff members have not been replaced on retirement; infrastructural projects have been repeated promised but never delivered and essential equipment has not been provided to allow the hospital to deliver an acute modern service. If the transformation programme was to have any credibility then it should be redressing this process of neglect. The transformation process is fundamentally driven by saving money dressed up as saving lives.

The Teamwork report clearly states that there should be no withdrawal of services from Ennis and Nenagh until adequate infrastructural replacement

services are put in place. These include improved community services to prevent un-necessary admissions, and to facilitate the early discharge of patients from hospital. There is no provision in the transformation programme for increased funding for increased home help hours, home care packages, increased Public Health Nurse Services, or any community based support services such as physiotherapy, occupational therapy, or additional resources to support the increased work load which will inevitably fall on GP.

The capacity of Limerick Regional Hospital [LRH] to absorb the additional workload this transformation programme will deliver, has to be clinically questioned and examined. LRH is unable to cope with its present workload, with long delays for patients waiting on trolleys to be admitted to the wards. Additional resources which will be required in LRH casualty and additional beds in the wards have not been put in place, prior to the closure of services in Ennis and Nenagh. On Monday 23/03/2209 18 patients were on trolleys waiting for admission in LRH. Additional Consultant staff has not been recruited for A/E in LRH, 2 are proposed, yet the Teamwork report said 8 would be needed.

We have not seen evidence that there has been an independent risk assessment carried out on the transformation programme, which would give assurance that it was safe and sensible. This is essential before any discontinuation of services takes place.

Specifically then we wish to comment on the document entitled “Mid West Integrated Services Project” sent to the GP group from Mr. Pat Fitzgerald following our meeting on 10/03/2009, and we wish to refer to comments made at the meeting by the HSE delegates.

This document refers to the enhanced role of the local hospital and community services and the transfer of substantial amounts of care from acute hospitals into local hospitals to include minor injury clinics, local care centres, day surgery and ambulatory care services. Where are these services and why are they not in place and functioning effectively prior to any withdrawal of services from Ennis and Nenagh?
It is stated that the majority of patients will be managed locally with treatment being delivered at home or as close to home as possible. The statement needs substantial clarification. Who will deliver this additional care? Where is the funding and why is it not in place prior to the role out of the Transformation Programme?

The document refers to engaging with key clinical staff to support the planning and decision making. Obviously GP was not seen as a key stakeholder, as it was not consulted until all the decisions were made and HSE created deadlines were imminent.

Mr. Burke repeatedly has stated that centralisation of A/E and acute surgery does not mean the centralisation of acute medicine, yet the Mid West Integrated Services Project document clearly states that medicine will be

reconfigured in the longer term. This effectively discontinues all acute in-patient acute care, of any description, outside LRH. There are many references to the centralisation of acute medicine in the Teamwork report, which specifically states that all acute medicine will discontinue in Ennis and Nenagh.

A/E services in Ennis and Nenagh are to be discontinued from 06/04/2009. What provision has been made to fill this gap? In short nothing after 8.00pm seven days per week. There will be a doctor led Local Emergency Clinic from 8.00am to 8.00pm seven days per week, yet the Teamwork report states that the will eventually be a nurse led clinic at some future date.
Where will patients go who require A/E services? The answer is clearly Limerick A/E or Shannondoc out of hour Co-op. We have repeatedly informed the project team that Shannondoc does not have the capacity to absorb this extra workload, neither in terms of additional numbers seeking it services nor is it equipped to cater for the type of work which is the norm for A/E departments. An out of hours [OOH] service for urgent GP problems cannot suddenly take on the additional burden of the provision of A/E services. Shannondoc provides a domiciliary service: the doctor could be away from the treatment centre for several hours during his or her period of duty. How can the service cope with up to 20 additional patients seeking urgent care and assessment when the centre is unmanned? The obvious solution is that the doctor led Local Emergency Clinic should be provided 24 hours a day 7 days per week, where appropriate facilities are available to observe and assess patients, treat and discharge, treat and admit or treat and refer in the seamless manner envisaged in the Teamwork report. This will not require a full A/E staff compliment.

The document refers to the development of significant and effective local and community services at Ennis and Nenagh. Where are these services and why are they not in place. The document has many specifics on what is being removed from Ennis and Nenagh but has little or no specifics on which additional services are being provided, when they will be provided and who will provide them. At our last meeting it was stated that a CT scanner would be in place by June 2009 in Ennis and Nenagh, but only on a part-time basis. It was unclear how CT scanner would be staffed. It was unclear if the Department of radiology based in Limerick would provide consultant manpower to oversee the service. This scanner will be arriving as acute surgery departs, if it arrives and functions at all.

The document states that a strong Primary Care and Community Health and social care service would be part of the overall objectives of the transformation process. Discussions have commenced with various stakeholders in relation to the management of chronic disease. We are not aware of any such discussions and have not been party to them.

The document goes on to outline key initiatives to facilitate the plan.

Resources which are In Place:

1. An emergency operating theatre in Dooradoyle.

2. Expansion of the Ambulance Services and the deployment of Advances Paramedics.

We have not been convinced that the surgical service in Limerick has the bed capacity or the operating facilities to cope with the extra workload that centralization of surgical services with create. There is not a reference to even a single extra surgical bed being provided in LRH, in anticipation of the extra workload which is predictable and inevitable, when services are discontinued in Ennis and Nenagh.
At our last meeting we were told that the solution to the bed capacity issue would be dealt with by "an aggressive discharge policy and a quick throughput". This is a concept which requires close analysis.
An aggressive discharge policy to where? Back to community services that can't access home help services, home care packages, physiotherapy, occupational therapy; to an over worked public health nurse service, to nursing homes who have limited or no acute care expertise, facilities or staff; to GP which is already stretched to capacity.

The change to "one patient ambulances" and the doubling of travel times that the transformation programme demands, has and will seriously stretch the capacity of the ambulance service to provide a timely service. We are not convinced that the ambulance service has sufficient staff or resources in place to cope with the increased pressure that will be placed on it.

Resources which are not in place but are Underway:

1. A new Critical Care Block in Dooradoyle.
2. Endoscopy suites in Ennis and Nenagh.
3. A new theatre Block in Nenagh.
4. Expansion of radiological services in Ennis, Nenagh and St. John's.
5. Upgrading of facilities in Ennis.

How will these "underway" projects be funded? The document says the majority of the funding will need to come as a result of new ways of working and organising services.
That is a nice way of stating that the majority of the funding has not been provided and must come as savings elsewhere. We listened very carefully to Mr. Burke at our last meeting when he referred to how these "underway" key facilities would be funded. He did not identify the capital cost of these necessary developments, or where the money would come from. He was "optimist and had reassurances that thing will go to plan and he hoped that things will be in place". In Clare we have had 10 years of such reassurances, and in the end of the day none of the promised developments have been delivered on.

The document referred to the lack of corporate Governance of the Emergency Care Physicians who work in casualty in Ennis and Nenagh and the fact that they work autonomously from the consultants in the hospital. Well that was how the HSE employed them. That is the type of contract they were given. It is strange that the HSE is complaining about this situation when they were the body that created and sustained this working arrangement and lack of governance. It is a situation that was set up to fail. Similarly, the HSE's failure to reappoint key consultant staff and its failure to deliver promised essential services and equipment, even when it was pointed out to them that failure to do so was unsafe, set up both Ennis and Nenagh to fail as acute hospitals.

The HSE, having starved these hospitals of staff and resources, now use their present downgraded state as the reason to close them down. Is it any wonder that GP looks at this transformation programme with a jaundiced eye?

The document refers to the expansion of day surgery in general surgery, urology, ENT, and Orthopaedics: and the expansion of general and specialist out-patient clinics in Ennis and Nenagh. If this happened it would be most welcome. If we saw these services in action prior to the withdrawal of acute surgery, it would give some confidence that promised services would devolve to Ennis and Nenagh. These aspirations of expanded services in Ennis and Nenagh come as the last 3 items in a long list of required actions, and thus one can only assume they are of low priority.

The document now refers to how acute medical services should be delivered. What could not be organised for acute surgery is being organised for acute medicine. There will be agreed team structures and rotas between the medical departments of the 4 hospitals which will facilitate the seamless transfer of patients between the local and regional hospital, through agreed protocols and close team cooperation.
Centralisation is essential to deliver a safe acute surgical services but medicine can be safely delivered at 4 separate sites. How can that be if the HSE is to be consistent? Surely it can develop a plan to provide a similar team structure for acute surgery on multiple sites. Could there be another agenda? And of course there is. The long term plan is to centralise all medical services in Limerick when the Critical Care block is commissioned, otherwise as the document states, patient would be exposed to unnecessarily increased clinical risks if allowed to be cared for in small hospital ICU's and CCU's. Acute medicine is peripheral hospitals is safe and acceptable at the moment, but only in the short term, at least until 2010. Then it will suddenly become unsafe when the Critical Care Block is built. A unit which has not had planning permission sought for yet and whose funding is uncertain.

We are provided with a time table for service changes. In mid 2010 the process will be complete, when the regional departments of Critical Care and Cardiology are established. Just 15 months from now. This timeline is very difficult to believe and impossible to achieve.

The role out of the transformation process in the North East has been a failure as far as GP is concerned and many hospital bases specialists agree with this assessment.
Our Lady of Lourdes hospital has experienced unprecedented over crowding due to transfer of work from downgraded peripheral hospitals in the region, without the hospital being given sufficient resources to cope with the predictable increased work load.

We have letters and documentation from GP's and consultants working in the North East which outline the difficulties that the 3 years of "transformation" have brought.

We have documentation from LRH which shows how dysfunctional its corporate governance and management structures are, when dealing with overcrowding in the A/E department and how this is managed by clinical and non clinical staff. To try to portray LRH as a centre of excellence as it is presently constituted, flies in the face of our patients experiences as they attempt to get assess to services and admission for in-patient care. Their experiences can only get worse under the proposed new arrangements.