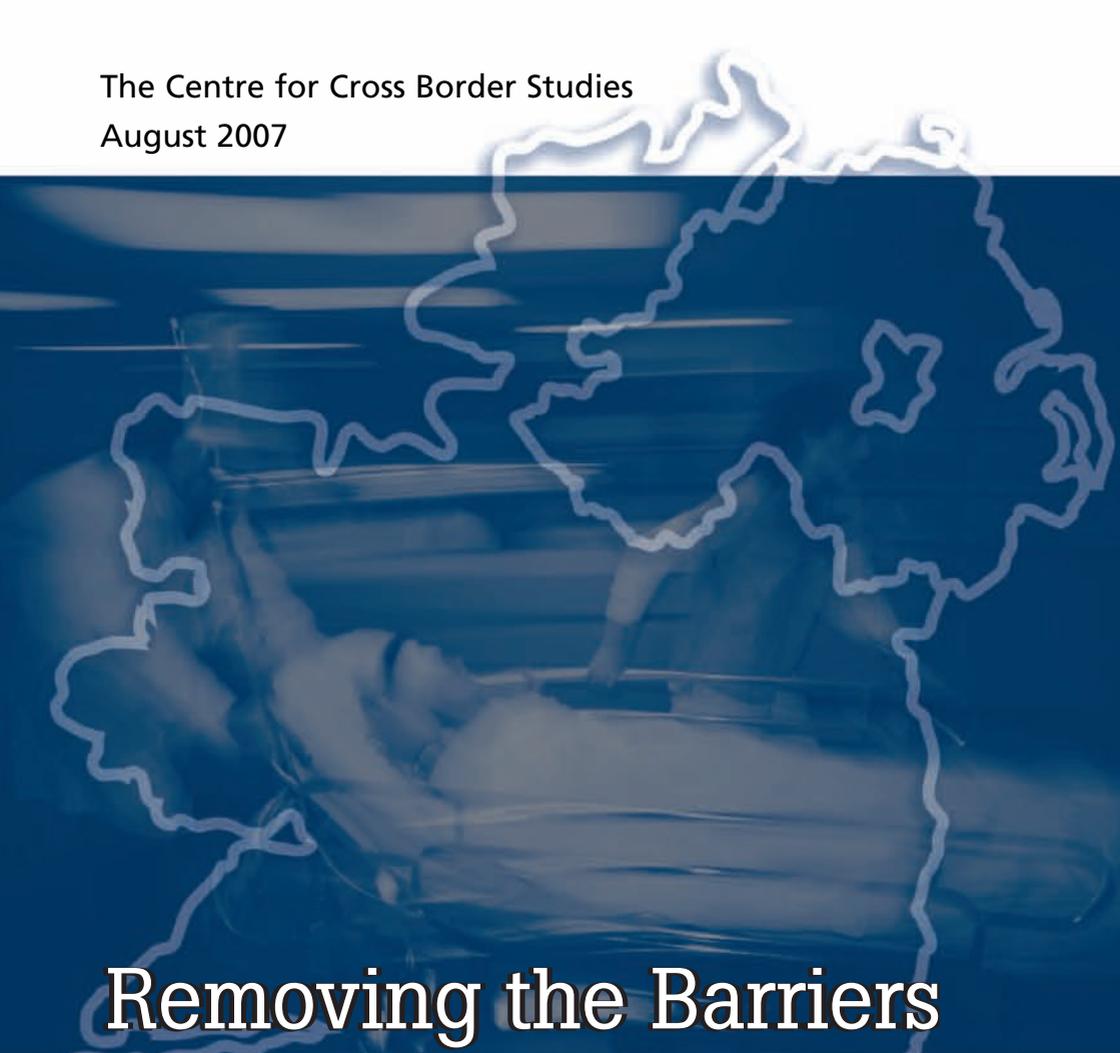


The Centre for Cross Border Studies
August 2007



Removing the Barriers

An Initial Report on the Potential for
Greater Cross-Border Co-operation in
Hospital Services in Ireland

Dr Jim Jamison

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Foreword

Dr Patricia Clarke

The state of health care provision remains at the forefront of the political debate both in Northern Ireland and in the Republic of Ireland. However the enthusiasm for cross-border co-operation in hospital services on the island, repeatedly documented by the Centre for Cross Border Studies and other organisations since 2000, has met with disappointingly little response. In an effort to stimulate the debate and provide an independent perspective, the Centre has commissioned this short report which compares the policy and planning of hospital reconfiguration north and south of the border.

Both jurisdictions are seen to be developing strategies favouring the concentration of specialist services on a smaller number of sites, with local hospitals being used increasingly as diagnostic, outpatient, day surgery and minor injury centers. However there are important differences in the two strategies which leave them incompatible. The North places a greater premium on travel time from a consultant-run A&E or obstetric unit, while the over-riding factor in the South is the size of the catchment population. For example, if the population standard in the South were to be applied across the border there would be only four or five acute hospitals (rather than nine or ten as planned) in the whole of Northern Ireland, and large segments of the population would be more than an hour's distance from the nearest hospital. On the other hand, applying the Northern accessibility criterion in the South would mean that there would have to be more than the one acute hospital which is currently planned for the former North East region.

The authors point to clear scope for joint hospital planning and rationalisation in the border region, stating:

“It is most unlikely that resources available for health care on the island are being used to maximum benefit for the population concerned, particularly in the border region... and the interests of institutions are being placed ahead of the health and safety of the population”.



Indeed major hospital rationalisation exercises appear to have proceeded independently of each other, as if each jurisdiction were ‘an island unto itself’ rather than conjoined along an increasingly permeable border. A clear example of this is the policy in the Republic, based on the Teamwork Report, which has effectively ignored the existence of Northern Ireland despite there having been a longstanding pattern of patient flows from North Louth into Newry for maternity services and renal dialysis.

Looking forward, the Centre believes that service planners and commissioners North and South need to work more closely together to develop a common strategic framework which would provide optimal care for all people on the island, particularly those living in the border region. This initial short report aims to inform a second project which plans to develop a spatial model of access to hospital care on an all-island basis.

As always, the Centre welcomes all views and opinions to inform and enhance this debate.

Dr Patricia Clarke
Research Manager
Centre for Cross Border Studies

39 Abbey St, Armagh BT61 7EB
Telephone: 028 3751 1550
[048 from Republic of Ireland]
Email: patricia.clarke@qub.ac.uk

Influences on acute hospital configuration

Introduction and background

This is the report of a short desk-based study exploring, in broad terms, the potential for cross-border co-operation in hospital services on the island of Ireland. However considerable investment, not least by EU agencies, has yielded disappointingly little progress. Previous work by these authors and others^{1,2,3} has found marked enthusiasm about the potential for such co-operation in hospital and other health services. A recent report funded by the EU Framework research initiative⁴ concluded that there remained a need for more detailed, exploratory work to investigate the true potential for improving hospital services in the vicinity of the border.

There have been marked changes in the pattern of acute hospital services in most industrialised countries over the last 15 to 20 years, including almost all European jurisdictions⁵. The drivers have been largely technological: as laboratories and operating theatres have grown more specialised, and imaging technology more expensive, it has become expedient to concentrate resources in larger hospitals at a smaller number of sites.

Changes in the configuration of hospitals have usually involved overall reductions in bed numbers: in the 1990s most countries in Western Europe saw reductions of between 10% and 20% while particularly large changes occurred in Finland and Sweden (47% and 45% respectively). (A more detailed analysis of international trends in hospital activity from the mid-1980s to the mid-1990s can be found in Hensher, Edwards and Stokes⁶).

This, along with concomitant reductions in accessibility, has meant that proposals for rationalising hospital services are often contentious. Bed reductions are often associated with increases in activity: for example although the number of hospital beds in England has fallen in the last 20 years by 31%, there has been a 57% increase in inpatients and a 341% increase in day cases⁷. In a recent briefing paper on hospital configuration, Edwards et. al. (2004)⁸ adduce a number of pressures for change (**Box 1**).

Box 1.

Pressures for change (from Edwards, Wyatt and McKee, 2004)

Changes in health care. There has been a long-term shift towards much greater specialisation, which limits the number of conditions that an individual specialist is able to diagnose and treat. Larger caseloads are needed for a hospital staff to keep up to date and to ensure that specialist skills do not atrophy with under-use. In turn, greater caseloads require much larger populations than hospitals have previously served.

Increasing specialisation. One of the consequences of new training regimes and increased specialisation is that a specialty team often has to be available 24 hours a day. This requires much larger teams of trained specialists than in the past, when teams relied on trainees or interns and general practitioners.

Changes in employment practice. In the European Union, the European Working Time Directive and associated rules about rest times are already having an enormous impact on hospitals' ability to staff relatively small services.

Improved efficiency. Hospitals are under pressure to reduce costs, particularly through the introduction of reimbursement systems that are based on case mix. There are also initiatives to cut costs by eliminating duplicated services and reducing fixed costs. Business process re-engineering has provided managers with tools to improve productivity and reduce system costs. These changes create incentives to rely less on buildings and other high cost assets.

Quality and volume. The presumption that there is a strong relationship between volumes and outcomes has been a major driver of centralisation. Yet there is no compelling evidence for such a relationship, except in a relatively small number of specialties. However, and perhaps more importantly, there is evidence that multidisciplinary approaches produce better results, and such coordinated efforts also require larger teams – though in some cases they need not require centralisation and can be achieved through clinical networks instead.

Safety and quality. Hospitals are increasingly hazardous places. Not only do a significant number of patients experience untoward incidents while they are in hospital, but the incidence of multi-resistant infections acquired there is also growing. Concerns with patient safety and patient outcomes have become important drivers of change in medicine and in the role of clinical staff. Together with the increasing complexity of many treatments, these factors will increasingly lead individual hospitals to question whether they should continue to offer certain specialist services, such as:

- surgery on very small children
- care for certain types of major trauma
- vascular surgery
- the management of some cancers.

Hospital services in both parts of the island have experienced fairly gradual change since the early 1990s. In Northern Ireland, an expansion of day surgery together with reductions in the length of inpatient stays has resulted in a decrease in the number of beds and an increase in the numbers of patients treated. By contrast, in the Republic of Ireland, bed numbers have increased over the last 10 years from an historic low. These changes are set in the context of a growing population with increased ethnic diversity.

In some instances, decisions about a hospital's future status have been driven, not by strategic planning, but by concerns about the viability of key specialties provided. At a strategic level there have been periodic reviews of the optimal configuration of hospital services in both jurisdictions.

Northern Ireland

Hayes Report

The Acute Hospitals Review Group, chaired by Dr Maurice Hayes, was established in 2000 by the then Minister for Health, Social Services and Public Safety, Ms Bairbre de Brún, to provide her with "measured, informed and objective advice"^a on the future pattern

^a Ministerial statement



of acute services. The group engaged in an exhaustive round of consultations with patients, the public, health service professionals and local politicians. It commissioned academic research and drew on the findings of existing research into service quality and accessibility, including on the relationship between volume (the number of procedures or patients with a particular condition treated by an individual or hospital) and outcomes (e.g. side effects, complications of surgery, survival rates for cancer operations).

The Hayes group acknowledged the importance of striving to achieve equity in accessibility to hospital services. It had regard to the implications for acute hospital services of the European Working Time Directive which mandated the introduction of a 48-hour working week for non-consultant hospital doctors by 2009. Above all it recognised that the problem of maintaining quality services in smaller hospitals in remote locations required special consideration.

The group's report, published in 2001⁹, foresaw "a service in which quality and safety are paramount and standards are maintained by retraining and revalidation, by audit, inspection and public accountability, a service where the voice of the patient and the community are heard at the planning stage and in determining the arrangements for the delivery of services, where there is lay participation in decision-making at all levels, and where complaints are dealt with quickly, frankly and effectively".

On North/South co-operation the group envisaged the development of complementary emergency and elective services for the benefit of patients on either side of the border and the provision of services that require a population base of five million on an all-Ireland basis.

On accessibility, the overriding consideration adopted by Hayes was that the whole population should normally expect to be able to reach key hospital services (emergency care and inpatient maternity services) within one hour. This led to a proposed configuration of nine hospital sites, ensuring that the entire population had access to those services within the one hour threshold and 98% of them within 45 minutes. The group recognised the vulnerability of some of the hospitals concerned but insisted that every effort should be made "to ensure their long term viability".

Developing Better Services

The Hayes report was effectively endorsed by the Department in February 2003¹⁰ with the publication of *Developing Better Services*. This provided for the then configuration of 15 acute hospitals to be replaced by “a network of nine acute hospitals supported by seven local hospitals, with additional local hospitals in other locations, as appropriate”.

Four of the nine acute hospitals are in the border area: Altnagelvin (L'Derry), Daisy Hill (Newry), Craigavon and the new South West Hospital in Enniskillen, and among the local hospitals are South Tyrone (Dungannon) and Omagh. Among the other provisions in *Developing Better Services* were:

- Orthopaedic inpatient services to be developed at Antrim and Craigavon, with fracture clinics at all acute hospitals;
- Consultant-led maternity services to be provided at the nine acute hospitals;
- Protected elective capacity to be developed at Lagan Valley, South Tyrone, the new South West hospital and elsewhere, as appropriate;
- Increasing availability and access to day surgery to be a priority.

It has subsequently been announced that the new local hospital in Omagh will provide outpatient and diagnostic services, renal dialysis, day surgery, some inpatient beds and urgent care. It will form part of the health care system for the area which will include the new acute hospital at Enniskillen.

Scotland

Kerr Report

A comprehensive report on the National Health Service in Scotland in 2005 (the Kerr report)¹¹ gave careful consideration to the future of hospital services, with particular regard to how best to serve rural populations.

Among the report's recommendations were to:

- Empower multi-disciplinary teams in community casualty departments to provide the **vast majority of hospital-based unscheduled care** – networked by telemedicine to consultant led emergency units;

- 
- Shorten waiting times and inform patient choice by **separating planned care from urgent cases**, treating day surgery rather than inpatient surgery as the norm, enabling better community based access to diagnostics, developing referral management services etc;
 - **Concentrate specialised or complex care** on fewer sites to secure clinical benefit or manage clinical risk;
 - Develop **networks of rural hospitals** to support remote communities.

The group found persuasive evidence of a positive effect of volume on outcomes in certain complex high risk procedures (some cancer surgery, coronary by-pass grafting, aortic and cerebral aneurysm surgery and paediatric cardiac surgery), providing a strong case for concentrating those procedures in a few locations. On the other hand the vast majority of routinely practiced operations and medical interventions could be performed in well supported local hospitals.

The report recommended that future decisions about the concentration of services on fewer sites should be:

- (a) informed by evidence to be gathered by an expert task force about the balance of clinical benefit and risk associated with varying volumes of clinical activity, and
- (b) limited, on the grounds of resource or workforce constraints, to services which:
 - are highly specialised and a clinical benefit can be demonstrated;
 - receive seriously ill patients 24 hours per day;
 - care for medically unstable patients throughout the night, and for which it can be demonstrated that service redesign will not achieve a sustainable outcome.

Republic of Ireland

Hanly Report

A National Task Force on Medical Staffing under the chairmanship of Mr David Hanly was established in 2002 by the then Minister for Health and Children in the Republic of Ireland, Mr Micheál Martin, to consider the implications of the European Working Time

Directive (EWTD). Also addressed were the related issues of a consultant-provided service, developments in medical education and training, and reorganisation of acute hospital services.

The report of the Task Force (Hanly report)¹², published in 2003, drew attention to concerns regarding patient volumes and activity in many hospitals in the South. It emphasised that these were not driven solely by the EWTD and referred to “convincing evidence” that the best treatment results were achieved when patients were treated by staff working as part of a multi-disciplinary specialist team and that better clinical outcomes were achieved in units which had the required numbers of specialist staff, high volumes of activity and access to appropriate diagnostic and treatment facilities. No distinction was made (as above) between common high-volume procedures, and more specialised ones.

The model recommended in the report comprises a wide range of non-hospital services including primary care; well developed local hospitals providing services to those who require routine/planned assessment and care; more specialised major hospitals providing emergency and specialist care, and supra-regional and national services for treatments which cannot be provided within a regional network. It also envisages the provision of continuing care services, rehabilitation and long-stay facilities.

Teamwork Report

A report by management consultants in 2006¹³ for the Republic's Health Service Executive on hospital services in the former North-Eastern Region made proposals for far-reaching change.

The report, which appears to have been accepted as the basis for reconfiguring acute hospital services in the Republic of Ireland as a whole, found that the present system of five local hospitals in the region^b had exposed patients to increased risks, notably in A&E, critical care and general surgery. The populations served were not generating enough emergency work to justify a full team of consultants ‘on the doorstep’ and, if such a team were to be placed

a The region covers the counties of Louth, Meath, Cavan and Monaghan extending from the Fermanagh/Tyrone/Armagh border in the north to the boundary with Dublin in the South.

b Cavan, Monaghan, Navan, Dundalk and Drogheda



in such circumstances, they would progressively lose their skills due to lack of work.

The report adopted a model made up of a small number of highly specialised regional hospitals along with a larger number of local hospitals and new local centres, so that many more patients are safely managed at home or in the community.

Typically, acute regional hospitals would provide co-located 24/7 services for:

- Accident and emergency, trauma and critical care;
- Emergency medicine, including cardiology, gastro-enterology, respiratory medicine, endocrinology, rheumatology;
- Emergency surgery, including general, trauma, urological, vascular, ENT and ophthalmology;
- Complex planned surgery, applicable to all acute surgical specialties;
- Cancer services;
- Maternity, paediatrics and neonatology; and
- Acute psychiatry.

They would have a full range of 24/7 clinical support services, in particular 'high tech' diagnostics and pathology services and would provide 'round the clock' specialist support and advice across the region through clinical networks.

Adopting 'international norms' for the catchment population of a regional hospital of between 300,000 and 500,000 and projecting a population for 2015 of just over 430,000, the report proposed one such public hospital in the North East.

Importantly, this was on the basis that a substantial amount of projected inpatient and day case work involving patients from the former North Eastern region would transfer from Dublin hospitals to the new regional hospital and to 'stand alone' day case facilities in the North East, some of which would be on current local hospital sites.

Although the team undertaking the exercise was originally asked to take account of the availability of services in adjacent areas, this was only done for the interface with Dublin (not with the former North Western Health Board region or with Northern Ireland).

The report studied current patient flows, mainly into Dublin, and identified factors influencing choice of hospitals by people in the North East including:

- Perceptions and knowledge about the 'best' consultant and hospital for their particular condition;
- Traditional patterns of family access to hospitals, including people who have moved into the North East from Dublin;
- Patients accessing healthcare close to their place of work, which may apply to the substantial number of residents commuting to Dublin;
- Natural geography and the extent to which part of the North East is effectively part of north Dublin;
- The impact of improvements in the road network.

The report places at the centre of improving emergency services new lead roles for ambulance paramedics and nurse practitioners in providing an immediate, tailored local response, managed by an Emergency Care Network for the region and supported by real time telemedicine links to expert clinicians based at the regional specialist hospital. This is related to a number of factors such as the availability of services from such hospitals in adjacent areas like north Dublin, and the location of existing and future public regional hospital in the North East.

England

Hospital reconfiguration in England remains politically contentious, with a new wave of rationalisation exercises paving the way for even larger, more highly specialised acute hospitals in line with guidance from the Royal Colleges¹⁴. On the other hand a recent UK White Paper¹⁵ stated the Government's intention to create many new local community hospitals in England offering day case surgery, outpatient services and diagnostic tests.

Current provision in the border area including data on medical staffing, workload, throughput and population

Introduction

This section contains some basic data from the two jurisdictions on border populations, hospital bed numbers, admissions (discharges and deaths), A&E attendances etc. We were also provided with data on consultant numbers by specialty and hospital in Northern Ireland but confidentiality reasons prevent their publication. In the Republic of Ireland, given the time available, we were only able to obtain overall consultant numbers by hospital, which are of limited value.

Population

The border area is difficult to define, with eleven of the 32 counties lying on or adjacent to it yet with some parts of those 11 counties up to 40 miles from the border itself. Tables 1 and 2 give the populations of the 'Border Counties'.

Northern Ireland

Table 1 Estimated Population of District Councils in Border Counties 2005

District Council	Population
Armagh	56,600
Banbridge	34,100
Craigavon	31,100
Dungannon	41,800
Newry and Mourne	16,500
Fermanagh	80,800
Derry	44,800
Omagh	84,700
Strabane	50,700
TOTAL	411,100

Source: NI Statistics and Research Agency (figures rounded)

Republic of Ireland

Table 2 Estimated Population of Border Counties 2006

County	Population
Cavan	64,000
Donegal	147,300
Leitrim	29,000
Louth	111,300
Meath	162,800
Monaghan	56,000
Sligo	60,900
TOTAL	631,300

Source: Central Statistics Office Ireland (figures rounded)

The total population of the border counties is just over one million.

Hospital data

Northern Ireland

Table 3. Bed and activity data by specialty and hospital (2005-6)

		Altnagelvin	Tyrone County	Erne	Craigavon	Daisy Hill, Newry
Medical Specialties^a	Beds	177.1	56.2	41.8	151.1	86.0
	Admissions	10,263	17,958*	3,441	9,909	4,949
	Procedures	5,498	14,926*	1,338	2,297	648
Surgical Specialties^b	Beds	77.1	26.2	29.8	122.7	54.0
	Admissions	8,889	3,516	3,808	11,448	6,270
	Procedures	7,761	2,948	2,639	8,816	4,059
Obstetrics & Gynaecology	Beds	57.9		37.3	66.8	34.4
	Admissions	4,860	223	3,353	7,008	3,638
	Procedures	8,303	411	3,889	10,391	4,652
	Births	2653		1230	3144	1928
ENT Surgery	Beds	6.7	7.9		18.6	3.8
	Admissions	1,742	1,150		2,788	390
	Procedures	2,030	1,588		2,920	360
Accident & Emergency	New Attendances	43,752	19,674	18,591	63,970	30,231
	Follow-up Attendances	6,137	2,518	2,708	6,480	4,906
	Total Attendances	49,889	22,192	21,299	70,450	35,137

* including renal dialysis

Source: Department of Health, Social Services and Public Safety, Northern Ireland

a The region covers the counties of Louth, Meath, Cavan and Monaghan extending from the Fermanagh/Tyrone/Armagh border in the north to the boundary with Dublin in the South.

b Cavan, Monaghan, Navan, Dundalk and Drogheda

Hospital data

Republic of Ireland

Table 4. Bed and activity data by speciality and hospital (2005-6)

		Letter-kenny	Sligo	Cavan	Monaghan	Louth County	Lourdes Drogheda
Medical	Beds (2003)	92	99	52	52	78	78
Specs.	Admissions	6,370	5,731	4,949	2,789	3,721	3,390
Surgical	Beds (2003)	73	44	43	33	34	45
Specs.	Admissions	3,796	2,992	2,916	3	1,732	2,637
Obs & Gynae	Beds (2003)	56	42	38	6		72
	Admissions	3,856	2,992	3,183		4	8,298
	Births	1,813	1,482	1,516			3,889
ENT	Beds (2003)		28				NS
Surgery	Admissions		1,593				230
A & E	New Attendances	29,932	27,441	21,534	7,949	18,613	37,363
	Return Attendances	2,600	2,906	1,464	3,846	904	2,716
	Total	32,532	30,347	22,998	11,795	19,517	40,079

Source: Department of Health and Children; National Hospitals Office

Table 5. New A&E Attendances (2004)

	New Attendances	Consultant staffing
Drogheda	35,858	2
Dundalk(*)	18,754	0.5 (from Drogheda)
Cavan	18,101	1 (long
Navan(*)	15,323	0.5 (from Drogheda)
Monaghan(**)	7,812	0
TOTAL	95,848	4

(*) These A&E services are sub-contracted to a commercial medical staffing agency

(**) Operates as a 'Treatment Room' service, receiving minor injuries and illnesses

Source: Teamwork report

We will refer to these data in subsequent sections. For the moment it should be noted that hospitals in Northern Ireland in the border area are generally larger in terms of bed numbers and have a somewhat broader range of specialties (particularly when, as planned, activity in Tyrone County and the Erne is combined) than those in the Republic of Ireland.

Quality and accessibility criteria in the two jurisdictions

Introduction

The purpose of this section is to examine existing quality standards for health and social care produced by or on behalf of the two Departments to provide the basis for comparisons between the two jurisdictions. Such standards can either be explicit, i.e. promulgated as such by the Department concerned, or implicit, i.e. discernible through examining decisions (e.g. on hospital rationalisation) taken on grounds of quality of care.

Northern Ireland

Quality Standards for Health and Social Care

The Department of Health, Social Services and and Public Safety's Quality Standards were published in 2006¹⁶ following the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 which imposed a "statutory duty of quality" on Health and Social Services Boards and Trusts. The standards were said to:

- Give the Health and Personal Social Services (HPSS)^a and other organisations a measure against which they can assess themselves and demonstrate improvement;
- Help service users and carers to understand what quality of service they are entitled to;
- Help to ensure implementation of the duty the HPSS has in respect of human rights and equality of opportunity for the people of Northern Ireland;
- Enable formal assessment of the quality and safety of health and social services.

The standards are built around five "key quality themes":

- Corporate Leadership and Accountability of Organisations
- Safe and Effective Care
- Accessible, Flexible and Responsive Services

a In Northern Ireland, Health and Social Services are integrated and delivered jointly under the umbrella of Health and Personal Social Services (HPSS)

- 
- Promoting, Protecting and Improving Health and Social Well-being;
 - Effective Communication and Information

The implementation of these standards is currently being assessed in a three-year programme by the Regulation and Quality Improvement Authority, the body responsible for monitoring and inspecting the availability and quality of health and social services in Northern Ireland and encouraging improvements in quality.

The Quality Standards set down the types of administrative process that one would expect to see in an HPSS body commissioning or providing quality care. They do not address questions of particular relevance to the strategic planning of acute hospitals or other HPSS facilities.

Hayes and Developing Better Services Reports

The recommendations of the Acute Hospitals Review Group (Hayes Report) were based on a small number of key principles which can be summarised as follows:

- Concentration on fewer sites, but access to key services (emergency care and inpatient maternity services) within one hour
- This to be facilitated by the establishment of a number of managed clinical networks that would, inter alia, support smaller hospitals.

In its subsequent policy paper – *Developing Better Services* – the Department implicitly endorsed the principles and analysis underpinning the Hayes report.

Republic of Ireland

Quality Standards

A set of quality standards for the Republic of Ireland has been published by the Irish Health Services Accreditation Board (IHSAB) which was established in January 2001 by the Dublin Academic Teaching Hospitals Chief Executives group and now includes all major academic teaching hospitals in the state. Specific standards have been identified for the purposes of hospital accreditation which are grouped into five categories:

- Care/Service Standards
- Environment and Facilities Management Standards
- Human Resources Management Standards
- Information Management Standards
- Leadership and Partnerships Standards.

These standards are validated internationally by the International Society of Quality in Healthcare (ISQua). The ISHAB has recently been subsumed into the new Health Information and Quality Authority (HIQA), whose role is as follows:

- Ensuring that evidence informs decision-making at every level within the system by supporting the Department of Health and Children in the development of performance standards and indicators;
- Analysis to inform the service planning process between the Department of Health and Children and the Health Service Executive^a;
- Ensuring health professionals and the public have access to information to make informed decisions;
- To facilitate the development of appropriate information, quality and ICT initiatives within the wider health system.

Unlike in Northern Ireland, quality standards in the Republic of Ireland do play a role – albeit a minor one – in the strategic planning of hospital services: for example the Teamwork Report indicated that none of the five hospitals in the North-East had been accredited by IHSAB. The Royal College of Surgeons of Ireland accredits only one of the five hospitals, Our Lady of Lourdes Hospital, Drogheda, as suitable for training in general surgery, and was reported to be planning to withdraw accreditation for A&E training from Cavan General Hospital, effective from July 2006. The Royal College of Physicians of Ireland accredits four hospitals for the purposes of general medicine training, but none for sub-specialty training.

a The Health Services Executive is responsible for delivering health and personal social services nationally, replacing the old complex structure of ten regional Health Boards, the Eastern Regional Health Authority and a number of other different agencies and organisations.

Teamwork Report

The criteria adopted in the Teamwork Report on hospital services in the North East were mainly based on standards in existence in England. They included the following:

- Acute specialties should have teams of at least eight consultants to provide a consultant driven service and to comply with the European Working Time Directive. The same trend applies to junior and supporting medical staff.
- Regional hospitals should have a catchment population of between 300,000 and 500,000
- A&E departments should:
 - treat at least 50,000 patients per year (Audit Commission¹⁷)
 - see 70,000 attendances per year (Royal College of Surgeons of Ireland)
 - be categorised as follows (British Association of Accident and Emergency Medicine¹⁸) according to annual new attendances:
 - Up to 40,000 = small hospital
 - 40,000 -70,000 = medium sized hospital
 - 70,000 - 100,000 = large hospital
 - be supplemented where appropriate with minor injuries units and urgent care centers, staffed by non-consultant career grade medical staff and emergency nurse practitioners (BAEM and College of Emergency Medicine).

On the basis of these criteria the Teamwork Report came down in favour of a regional A&E centre, with a multi-disciplinary team, led by a group of eight or more consultants providing 24/7 cover, managing 70-90,000 new attendances per year and geographically co-located with the acute secondary care specialties; along with an advanced paramedic workforce to deal with all major, life-threatening events, strategically deployed to be accessed locally by the whole population.

Conclusions and proposals for further work

Hospital rationalisation criteria

Both Northern Ireland and the Republic of Ireland have adopted, either explicitly or implicitly, criteria for hospital reconfiguration. Both jurisdictions favour concentrating specialist services on a smaller number of sites with smaller, local hospitals being used increasingly as diagnostic, outpatient, day surgery and minor injury centres.

However there are important differences between them. In the North a limit has been set to such concentration by the requirement that no element of the population should be more than 60 minutes driving time from a consultant-run A&E or obstetric unit. In the South, the standards used reflect those in England, where the overriding factor is the size of the catchment population, with 300,000 to 500,000 seen as being essential to the maintenance of a modern acute hospital. The A&E department of such a hospital would see 70-90,000 new patient attendances per year and would have at least eight consultants.

These criteria are not compatible. For example, if the population standard in the Republic of Ireland were to be applied across the border there would be only four or five acute hospitals (rather than nine or ten as planned) in the whole of Northern Ireland and large segments of the population would be more than an hour's distance from the nearest one.

On the other hand, applying the Northern accessibility criterion South of the border would mean that there would have to be more than one acute hospital in the former North East region. The Teamwork report concluded that to guarantee a catchment population of sufficient size there should only be one acute hospital and it would need to be located in the southern part of the region in order to attract sufficient patients from north Dublin. The distances to the new hospital from the northern parts of the region, adjacent to the border, would certainly be unacceptable in Northern Ireland (see Table 6).

Table 6.
Driving time to Drogheda in minutes^a from other 'hospital towns' in North West

Monaghan	Cavan	Navan	Dundalk
62	90	27	31

These driving times are from the centre of the towns concerned; times for the population served by each of those hospitals could be appreciably greater.

The requirement for an A&E unit to have at least 70,000 new attendances per annum would have major implications if applied in Northern Ireland. Table 3 shows that only Craigavon among the border hospitals in the North comes close to meeting that standard, and Altnagelvin would have difficulty even if the A&E department in Omagh were to lose its consultant cover. Notwithstanding that, unlike in the Republic of Ireland (Table 5) all the hospitals concerned in the North have close to the eight consultants regarded in the Teamwork Report as being necessary to handle such a workload.

Implications

There have been a number of useful small-scale cooperation initiatives over the last 5-10 years involving hospitals in the vicinity of the border, including Daisy Hill in Newry and Altnagelvin in Derry/Londonderry. However major hospital rationalisation exercises (with the exception of the Hayes Report) appear to have proceeded independently of one another, as if each jurisdiction were 'an island unto itself' rather than conjoined along an increasingly permeable border. **This means that it is most unlikely that resources available for health care on the island are being used to maximum benefit for the population concerned, particularly in the border region.**

^a AA Route Planner (Ireland) (appears to pre-date opening of M1 between Dundalk and Drogheda)

In the North West, where there is very considerable potential for co-operation, a long-standing agreement effectively prohibits any beneficial initiatives that might be seen to diminish the status of either Letterkenny or Altnagelvin hospital. **It is at least arguable that the interests of particular institutions are being placed ahead of the health and safety of the population.**

In the North East of the Republic of Ireland, in apparent disregard of an explicit requirement to take account of adjacent regions, the current rationalisation exercise, based on the Teamwork Report, has effectively ignored the existence of Northern Ireland despite there being a long-standing pattern of patient flows from North Louth into Newry for maternity services and renal dialysis.

The Cerdagne region

The situation in Ireland contrasts markedly with that in some other parts of Europe, for example in the isolated Cerdagne border region in the eastern Pyrenees between France and Spain, 100km from Perpignan and 140km from Barcelona. The closest surgical or obstetric facilities in France are more than an hour's drive away.

For over a decade a well equipped hospital in Puigcerda on the Spanish side of the border has acted as a *de facto* emergency clinic for French patients. Agreements were signed in 2002 with the regional French hospital authority and in 2003 with the Languedoc Roussillon health insurers to ensure that the hospital would be reimbursed for emergency and obstetric care delivered to French patients.

More importantly, a project is now under way to build a cross-border hospital in Puigcerda which will serve the population of the entire border region and be jointly planned, funded and managed by the French and Catalan health authorities.

Conclusions

There is clearly scope for such hospital planning and rationalisation exercises in the border region of Ireland. In particular there is a need to revisit the Teamwork Report to investigate what difference might be made by allowing for a greater flow of patients into the North Eastern region from Northern Ireland and *vice versa*. The recommendation in the report was for a new regional hospital in the southern part of the region. As the report itself acknowledged, there would then be appreciable overlap between the new hospital's catchment population and those of the hospitals in north Dublin, and there must be considerable uncertainty about whether the net flow would be in a northerly or southerly direction. An alternative would be to locate the new hospital in the northern part of the region where it would cater for a portion of the residents of South Down and South Armagh. We recommend further detailed study of this option, while noting that clearly there would be major implications for Daisy Hill Hospital in Newry.

Similarly, there are options for hospital reconfiguration in the North West that have never been properly explored, involving a thorough examination of the roles of Letterkenny and Altnagelvin hospitals; and in the South West corner of Northern Ireland along with the adjacent area of the Republic, involving Sligo and Enniskillen.

However a fundamental prerequisite for further work would be to resolve the differences in strategic policy between the two jurisdictions, which, as we have seen, place a greater premium on accessibility in the North than in the South. This would involve a careful examination of whether the catchment population criterion in the Teamwork Report, which was developed in a society (England) with a very different settlement pattern to that in Ireland, is really appropriate for a sparsely populated rural region; also whether a different balance between benefit and risk should be struck.

It would also involve an unwelcome reconsideration of the requirement in Northern Ireland for every component of the population, no matter how small and how remote, to be within 60 minutes driving time of the nearest inpatient maternity or A&E unit, with clear implications for such painfully arrived-at compromises

such as the new hospital network arrangements in Tyrone and Fermanagh. However it should be acknowledged that there are widespread doubts among health service planners and practitioners about whether the application of such a rigid metric will result in expensive attempts to maintain a range of acute inpatient services in locations where the population size is insufficient to sustain these even in the short term.

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Centre for Cross Border Studies

39 Abbey St

Armagh BT61 7EB

Tel: +44 (0)28 3751 1550

Fax: +44 (0)28 3751 1721

Web: www.borderireland.info

and www.crossborder.ie

