Executive Summary

Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission

8 May 2012

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1 Introduction and background

This Report presents the findings of the Health Information and Quality Authority's (the Authority) investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (the Hospital) for patients who require acute admission.

Since 2009, the Authority has had extensive engagement with the Hospital due to concerns raised in relation to risks to the health and welfare of patients associated with a number of aspects of the systems of care provided to patients at the Hospital and, in particular, the clinical risks to patients who required acute admission being accommodated on the corridor adjacent to the Emergency Department (ED) while awaiting transfer to an inpatient bed at the Hospital. However, despite a number of actions having been taken by the Hospital, the Authority was not assured that the immediate clinical, health and welfare risks to patients being cared for on the corridor adjacent to the ED were being adequately controlled and managed by the Hospital.

In June 2011, the Authority received the report of the Hospital's internal review into the unexpected death of a patient in March 2011. The patient had been receiving care, initially in the ED, and subsequently on the corridor adjacent to the ED while awaiting admission to an inpatient bed. The Authority was concerned that the report of this review did not indicate that the Hospital was effectively identifying and managing the clinical, health and welfare risks to patients requiring acute admission to the Hospital despite the history of engagement with the Authority highlighting these risks.

On 24 June 2011, the Board of the Authority considered these risks, and the degree of assurances that had been provided by the Hospital, and took the decision to instigate an investigation into the quality, safety and governance of the care provided to patients who required acute admission to the Hospital. The investigation focused on the time period from 2010 to 2011 which included the latter part of the term of the Board that was in place at the commencement of the investigation.

In carrying out the investigation, the Authority looked in detail at the quality, safety and governance of the system of care in place for patients requiring both unscheduled (unplanned, emergency care) and scheduled (elective and planned) care in the Hospital and, in particular, those patients admitted through the Emergency Department.

The Authority also investigated the effectiveness of the Board of the Hospital and the corporate and clinical governance arrangements that it had in place to assure itself that risks to patients were being appropriately managed by the Hospital – particularly the risks to patients receiving care in the ED and requiring acute admission. In addition, the Authority investigated the effectiveness of the planning, accountability and oversight arrangements that were in place between the Health Service Executive (HSE) and the Hospital, as a service provider in receipt of State funds, with a focus on how the HSE held the Hospital to account for the quality and safety of the services that it was providing.

In addition, the Authority felt that it was important to consider the national context for patients receiving similar services across the country in order to compare the performance of the ED service in the Hospital with other hospitals in the same period and to inform national learning for the purposes of improving the quality and safety of care for these patients. Consequently, the HSE provided data for a 24-hour period on 23-24 August 2011 for all service providers in receipt of State funds providing emergency department services in the State.

At the commencement of the investigation, the Authority was contacted directly by individual members of the public who had received care themselves or had accompanied family members who had received care at the Hospital. Even though this represented a small sample of the experience of patients who received care at the Hospital, their accounts demonstrated the impact of the service from these patients' perspectives. Whilst the majority reported that staff were caring, their accounts highlighted the reality of long waiting times to be seen by a doctor, lack of communication and the indignity of being accommodated for long periods of time on a public access corridor.

2 Profile of the Hospital

The Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH), was established as an entity on 1 August 1996 by order of the Minister for Health in accordance with section 76 of the Health Act 1970 by means of an Order and the amendment of an existing Charter. The Hospital provided services, pursuant to Section 38 of the Health Act 2004, on behalf of the HSE.

The Charter provided that all the powers of the Hospital are vested in and exercisable by a 23-member Hospital Board. The general function of the Board was to manage the activities of the Hospital and the services provided by it.

The Hospital is an acute general hospital situated in a rapidly growing urbanised area with a predominately young population, providing services for un-differentiated patients (all types of patients with any degree of seriousness or severity). The hospital has 615 beds which includes adult and children's beds. It provides elective and emergency adult and children's services on an inpatient, day case and outpatient basis.

3 Summary of findings

3.1 Unscheduled care

The adult emergency services at the Hospital provided services 24 hours a day, seven days a week for un-differentiated patients with acute and urgent illnesses or injuries. The patient referral pathway to the ED of the Hospital was considered to be similar to those of other hospitals in Ireland with a similar profile and with the majority of patients being self-referrals. The lack of an out-of-hours general practitioner (GP) service or primary care service in the area meant that patients and/or their GPs may have felt that they had no other option but to attend or refer the patient to the Hospital's ED to accelerate their treatment.

Whilst the patient was in the ED they were under the care of the emergency medicine consultant. However, at the commencement of the investigation, effective arrangements were not in place at the Hospital to ensure the seamless transfer of clinical responsibility for a patient from their clinical assessment in the ED, to their clinical assessment by the relevant speciality Hospital team through to their admission to a Hospital ward. This raised a significant concern about the Hospital's ability to ensure that patients, at all times, had a designated consultant who was clinically responsible and accountable for their care. This deficit was subsequently addressed by the Hospital in November 2011.

Of the total number of patients who attended the ED at the Hospital for the first six months of 2011, 14% left without completing their care. Recording the number of patients who leave the ED without completing their treatment, and the number of patients who re-attend the ED with the same clinical condition within seven days, are internationally recognised patient quality indicators for ED services. The Authority was not provided with information that the Hospital had effective systems in place to monitor and manage these patient indicators. In identifying this shortfall, the Authority highlighted the requirement for the HSE to set national key performance indicators which should be publicly reported and used to comparably benchmark EDs with a similar casemix.

The mean waiting time in the ED for a non-admitted patient at the Hospital from January to August 2011 was within the spectrum of 6 –7 hours and the Authority found that some patients were waiting within the ED for up to 61 hours before being discharged. However, unscheduled patients who attended the ED, and subsequently required inpatient admission whilst awaiting transfer to an inpatient bed, were accommodated either within a designated area within the ED or on the corridor adjacent to the ED. Over 80% of the admitted patients were accommodated on the corridor adjacent to the ED and waited, on average, a further 13 hours for an inpatient bed, with the longest waiting reported as 140 hours. This was an unacceptable situation for patients.

The Authority found a number of serious issues specific to the use of the corridor adjacent to the ED as a waiting area for admitted patients awaiting an inpatient bed. These issues had the potential to compromise the quality and safety of care for these patients and the capacity of the ED staff to provide a timely assessment of newly arriving patients in the ED. Following an unannounced inspection by the Investigation Team on 24 August 2011 which highlighted these risks, the Chief Executive of the Hospital confirmed that the use of the corridor adjacent to the ED ceased on 29 August 2011. The cultural belief by individuals in any hospital that the routine practice of accommodating patients on trolleys in corridors is acceptable should not be tolerated. This is not satisfactory for patients and the public and should cease.

3.2 Emergency services from a national perspective

Waiting times for patients in Ireland's emergency departments has been a longstanding concern from a patient safety and quality perspective. From a national viewpoint, the Authority compared the performance of EDs across the country for the same 24-hour period on 23-24 August 2011 and, through the data provided by the HSE, found that patients attending the majority of EDs in Ireland experienced waiting times of greater than six hours, with the longest waiting times of up to 115 hours for discharge and 137 hours for admission.

In addition, the Authority found inconsistencies in the level and quality of data that was provided by the HSE in relation to the 33 public hospitals delivering emergency care, and the adequacy of the information gathering and analysis processes in place to performance manage EDs from a patient experience and timeliness perspective.

These findings are serious issues of quality of care and patient safety and raise serious concerns in relation to how these services are currently being managed. The HSE has identified national initiatives, including the Clinical Care Programmes (particularly those in relation to acute medicine and emergency medicine services) which should contribute to solutions to improve key points of the patient journey. However, it is imperative that the HSE nationally, and the Special Delivery Unit (SDU), ensure that there is a nationally integrated programme-managed approach to the implementation of the HSE Clinical Care Programmes across the country, and at local hospital level, which is effectively led, governed, managed and monitored in order for such initiatives to bring about the improvements required.

3.3 Scheduled care

The Authority found that work was ongoing in the Hospital to improve the Outpatient Department (OPD) services, as a result of the recommendations of the Hayes Report.

The Authority found that the resource capacity for the radiology services was under pressure to efficiently respond to the demand from unscheduled, scheduled, OPD and community care services. The Hospital had contracted a third-party provider to reduce the waiting time for ultrasound scans. However, it was reported to the Authority that some patients were waiting long periods for imaging tests. For example, it was reported that OPD patients could be waiting up to nine months for a computed tomography (CT) scan or a magnetic resonance imaging (MRI) scan. The Authority concluded that the extended waiting times for reporting, for both inpatient and outpatient diagnostic imaging tests, required further review and improvement.

Timely access to diagnostics is a requirement of all safe, efficient and effective health services. In the context of providing timely access for patients, and managing resources in the most efficient way, the Authority considers that access to certain types of high demand, low capacity diagnostic imaging should be considered from a regional and national perspective. This arrangement should be developed, managed and coordinated as a shared resource across all hospitals and primary care – particularly for patients waiting for long periods.

At the time of the investigation, an Outpatient Turnaround Project was in progress at the Hospital which included addressing the issue of OPD waiting lists. In June 2011, 52% of all patients were waiting beyond 90 days to be seen in the OPD by a specialist team. Excessive waiting times for outpatient appointments can result in GPs referring patients, or patients self-referring, through alternative pathways in order to access care – including patients being referred or self-referring themselves to the ED.

The Hospital had exceeded the national overall figure for day case patients waiting less than six months and was in line with other hospitals in relation to patients waiting less than six months for elective admission and same day admission. The Authority found that the Hospital was outside the national average of 5.9 days for the average length of patient stay.

The length of a patient's stay can be safely and significantly reduced by hospitals ensuring that structured early morning ward rounds by senior clinical decision makers are undertaken. The Authority found that proactive patient discharge planning, to include early morning ward rounds, use of estimated date of discharge and timely patient discharge planning were not consistently supported by the range of clinical disciplines in the Hospital. In addition, the Authority found that the historic lack of an integrated approach to patient admission and discharge planning had contributed to challenges at the Hospital with the timely discharge of patients.

In June 2011, 69% of scheduled patients at the Hospital were waiting less than six months for an inpatient appointment. Nationally, at the time of the investigation, no hospital's waiting times for inpatient waiting lists had been published. This is of concern to the Authority and it recommends that these figures are nationally published and that all service providers should, as a priority, ensure that they have the appropriate arrangements in place to formally review and prioritise patient waiting lists in a structured manner.

It is crucial that elective surgery and scheduled diagnostic and therapeutic access for patients is managed, protected and that waiting times are informed, based on patients' needs. If it is not, it is of concern that patients may be at risk and perceive they have no other option but to seek alternative means of accessing healthcare. It is imperative that hospitals, the HSE and SDU implement and monitor efficiency strategies to actively manage timely patient access to scheduled and unscheduled care.

Older persons are the largest consumer of healthcare services in Ireland. Consequently, it is imperative that the system and arrangements at hospital and community level are appropriately organised to respond to their needs. The Hospital reported a monthly average of 63 patients over 65 years of age awaiting discharge to a step-down, rehabilitation or long-term care placement facility. Notwithstanding the efforts to enhance these processes at a local level, the Authority found that a more focused regional and national response is also required, for example, in the context of timely access to diagnostic and therapeutic services, to community intervention services and intermediate/short-term step-down support, rehabilitation and respite facilities.

3.4 Leadership, governance and management

3.4.1 Board Governance

The Authority found that the Board of the Hospital did not have effective arrangements in place to adequately direct and govern the Hospital nor did it function in an effective way. The Charter was not in line with modern corporate governance principles. The amalgamated organisation, into which three separate hospitals were merged in 1996, continued to embrace a number of different legacy beliefs, activities and cultures, lacked an organisation-wide strategic vision and culture and failed to adequately respond to the significant changes in healthcare delivery and advances in modern corporate governance. The collective membership of the Board did not reflect the relevant diversity of knowledge, skills and competencies required to carry out the full range of oversight responsibilities necessary for the Hospital at this juncture. Nor was the appointment process in line with modern governance principles.

The Charter provided for the establishment of a number of committees which were required to report to the Board in relation to their activities. These committees included clinical governance, resource and audit. In 2009, the Board commissioned an external review of the governance arrangements in the Hospital. As a result of this review, a Transitional Board of Management, which was a sub-committee of the main Board of the Hospital, was established in 2010 to manage the activities of the Hospital.

These Board committees, with the exception of the Transitional Board of Management, had no executive powers but rather advised, reported to and made recommendations to the Board. The Authority found little information as to how the Board, or any of its committees, oversaw and sufficiently assured themselves that the Hospital was delivering services in line with the service plan agreed with the HSE as articulated in the Section 38 Service Agreement for the resources provided. In addition, during the course of the investigation, information came to the attention of the Authority that raised concerns about the effectiveness of the governance arrangements in place for financial management, financial transparency and commitment control. In particular, the Authority was concerned that the Hospital did not have the internal controls in place to ensure its compliance with public procurement legislation.

In October 2011, the Authority had significant concerns in relation to the corporate and clinical governance arrangements in place at the Hospital and, in particular, the effectiveness of the Board's governance arrangements. The Authority met with the Minister for Health to advise of these concerns and subsequently issued preliminary draft recommendations to the Minister to help mitigate the risks at that time. The Hospital also had substantial financial difficulties with a significant budgetary overrun at that time.

On 9 November 2011, the Minister for Health, and the Church of Ireland Archbishop of Dublin, announced a series of new initiatives to reform and modernise the governance structures of the Hospital over two phases. The first phase was a further reduction in the size of the Hospital Board occurring through the appointment of an interim Board and, in the longer term, the Charter was to be replaced. The first meeting of the new interim Board of the Hospital took place on 21 December 2011 with new members of the Board being nominated with consideration of their competencies to undertake the role.

3.4.2 Executive Management

The Executive management arrangements at the Hospital had, over the last three years, gone through a number of significant changes with four members of staff acting in the role of Chief Executive. There was no clear scheme of delegation from the Board to the Chief Executive or to the Executive Management Team for delegating accountability in relation to the delivery and performance of the Hospital's functions.

It was of concern to the Authority that there was a reported ambiguity as to who had overall executive accountability for the quality and safety of the services delivered, and an apparent lack of integration across the corporate and clinical governance arrangements that were in place. The effective management arrangements that were needed to facilitate the delivery of high quality, safe and reliable care and support, by allocating the necessary resources through informed decisions and actions, were not sufficiently in place.

At the time of the investigation, the Authority found that historically, there was evidence that the Hospital had not adequately planned or controlled the scope or expansion of the clinical services provided. However, there was evidence that the Hospital was developing programmes for improvement including policies and programmes to deliver improvement in OPD turnaround times, bed management and patient discharge planning.

The turnover of senior executives in the Hospital, and the ongoing 'acting' status of individuals in key positions, created challenges in leadership, management, stability, decision making, confidence and authority. This had the potential to impact on the ability of the Hospital to effectively address the quality, safety and financial challenges that it faced.

3.4.3 Planning, Accountability and Oversight Arrangements

At the time of the investigation, the Authority found that the accountability and oversight arrangements in place to govern the relationship between the HSE and the Hospital were not sufficiently effective. Similarly, the Service Arrangement was not sufficiently effective, or used by the HSE to its full potential, as a framework to seek the necessary assurances from the Hospital that the services that it was funded to provide, on behalf of the HSE, improved, promoted and protected the health and welfare of patients in the most efficient and effective manner possible.

In addition, it did not appear to the Authority that there was reconciliation between the funds available, the budgetary overspend, catchment areas, innovation and research, demand and capacity and the core business of delivering high quality safe care to patients.

There was no evidence available to the Authority to demonstrate a clear understanding of the collective roles and responsibilities of each statutory and non-statutory hospital's contribution to the overall delivery of the HSE's Dublin Mid Leinster service plan as part of the HSE's National Service Plan. The HSE did not describe a service model and there was no clear direction provided for the Hospital.

The Authority concluded that there was a multiplicity of factors present in the actual oversight arrangements between the HSE and the Hospital that may have contributed to the failures that led to weak governance, substantial and longstanding budgetary overrun and ultimately, care being persistently provided to patients in the corridor adjacent to the ED in the Hospital.

3.4.4 The National Perspective

In order to ensure that existing and future individual hospitals, or network of hospitals, are led and governed effectively in a way that reflects the requirements of good corporate and clinical governance, it is imperative that the composition, membership, competencies and focus of a Board are suitable for its purpose.

It is equally essential that the capacity and capability of leaders and senior managers in healthcare organisations, and the wider health system, have the core competencies and capabilities to successfully lead, manage and execute the challenges and requirements of running a healthcare organisation.

Given the substantial amount of public money that is entrusted to service providers that are in receipt of State funds, there should be a robust mechanism in place to oversee the recruitment, appointment, performance and replacement of Board members, chief executives and other executives of these service providers. In addition, there should be greater involvement in the performance management of the chairperson of a board by the State, and of the chief executive by the chairperson of the board and also by the State, to ensure that any service provider in receipt of State funds is providing good, safe services within the resources available.

To invest in our leaders and managers of the future, there should be clear managerial career progression pathways and training and development programmes established, for both clinical and non-clinical leaders and managers.

In a system that is facing considerable challenges, the effectiveness of the governance arrangements through which public funds are allocated, defined and performance managed is critical. This requires the establishment of a clearly defined 'Operating Framework' for the State that outlines the key elements of the effective governance and operation of a high quality, safe and reliable health and social care service which is optimally designed to deliver the most accessible service in the most cost and clinically effective way within the resources available and in keeping with national policy.

Currently, there is no nationally deployed resource to support hospitals (and other health and social care organisations) that are challenged and struggling in relation to areas such as leadership, governance, management, quality and safety, access, service design and financial management. This type of support should be able to provide development and interventions that include coordinating and supporting interim management where required, and providing tailored development programmes to build capacity and capability within such organisations.

In addition, a Special Measures Framework should be established to actively address and act on circumstances in which substantial and persistent poor performance of the board and/or executive management of a service provider in receipt of State funds occurs. This Framework should contain the provisions for intervention orders where the Minister for Health believes that a hospital (or other designated service provider) is not performing one or more of its functions adequately or at all, or that there are significant failings in the way it is being run (including quality of care, patient safety, financial management issues), and is satisfied that it is appropriate for him/her to intervene.

4 Conclusion

The findings of this investigation reflect a history of longstanding challenges in the leadership, governance, performance and management of the Hospital which were manifest in the persistent, and generally accepted, tolerance of a wholly unacceptable practice of patients lying on trolleys in corridors for long periods of time.

It also reflects a history of a Hospital providing care to a substantial number of the population, that was allowed to struggle on despite a number of substantial governance and management issues in relation to quality, safety, planning and budgetary management which were present over a number of years. Despite a number of attempts to address the governance of the Hospital, and a number of improvement reviews having been undertaken, sufficient action was not taken by the Hospital itself or the Health Service Executive to address these issues. This reflected a failure not only in the governance of the Hospital but also in the governance of the health system that should effectively hold a service provider in receipt of State funds to account in the performance, delivery and quality of the service it provides.

Every day there are patients who receive good, safe care at the Hospital and there are patients who could receive better and safer care at the Hospital. The staff whom the Investigation Team met were committed to providing good, safe care and to improving the services that the Hospital provides. Going into the future, the challenges for the Hospital will be to drive, inject and embed strong personcentred leadership throughout the Hospital, in order to establish and sustain a strong culture of patient safety where all individuals involved in the Hospital have the primary focus of providing good safe care for the community that they serve. And, in so doing, behaviours and practices that result in unacceptable care for patients are simply not tolerated and a culture of openness, transparency and driving continuous improvement is supported, actively managed and led into the organisation.

Since the investigation commenced, there have been significant changes and improvements in the Hospital which include the establishment of an interim Board (on the way to replacing the Charter) and establishing a modern and fit-forpurpose board that reflects good corporate and clinical governance, a changing leadership team that is taking initiative and driving change within the Hospital and tangible improvements in the system of care within the Emergency Department at the Hospital. These developments are referred to in Appendix 13 of the Report which has been submitted by the Hospital and outlines the progress reported by the Hospital since the investigation commenced.

This investigation is a seminal point in the journey to modernising the way we run our health system. The business of person-centred health care is far too important to be run, managed and governed in a way that does not reflect a high performance, high quality and high delivery mindset – from patient to policymaker.

Ignoring persistent poor performance and not having, or using, the levers and drivers in place locally and nationally to share good practice and to support and address poor performance is no longer acceptable in a modern day health system. This must change. The findings and recommendations from this investigation focus on the improvements required in the Hospital, those required in similar hospitals, the changes necessary to improve the provider/'commissioner' oversight and accountability relationship and, finally, the improvements necessary for effective governance of the health and social care system by the State.

5 Moving forward

This investigation includes recommendations for improvement that are specific to the Hospital and also apply nationally. The Hospital will be required to develop an implementation plan for the recommendations which should support the improvement programme currently in place at the Hospital. Other hospitals are also required to assess themselves against these recommendations and develop an implementation plan for improvement in order to meet them.

Specifically, in relation to the existing boards of service providers in receipt of State funds and the recommendations that relate to these boards assessing themselves against the relevant recommendations within the report, the Department of Health should establish a mechanism to review the assessment and arising action plans and consider the mechanism for modernising the constitutional basis and composition of such boards where applicable.

The HSE, as the 'commissioner' and provider of services, should monitor all hospitals in receipt of State funds against the implementation plans as part of the service arrangement and as part of its ongoing performance delivery reviews with each provider.

Following the approval by the Minister for Health of the *National Standards for Safer Better Healthcare*[(5)], and the subsequent commencement of a monitoring programme against the Standards, the Authority will be monitoring service providers against the implementation of these recommendations as part of that process. These Standards will be the first step in the trajectory of a licensing system being established in the Irish healthcare system. The recommendations of this report are consistent with, and indicative of, the objectives of the above National Standards, the future healthcare licensing requirements in Ireland and the progress towards self-governed Trusts as outlined in the Programme for Government.

Given the significant system-wide governance recommendations outlined in this Report, it will be imperative that there is the necessary political commitment to their managed implementation in order to drive further improvements in the quality, safety and governance of the care provided in our health system. The Authority therefore recommends that the Minister for Health should establish, as a priority, an oversight committee in the Department of Health to ensure the implementation of the governance recommendations in this Report. The committee should report to the Minister and include international expertise in the area of governance and also patient representation.