The Royal Hospital Donnybrook

DRAFT THREE YEAR STRATEGIC PLAN

2017 – 2019

Draft for Consultation with the HSE

Contents

1. Executive Summary

This Strategic Plan sets out the key strategic objectives of The Royal Hospital Donnybrook (RHD) for the next three years and is intended to build a platform for the provision of services to meet future patient needs and health sector requirements.

The Royal Hospital Donnybrook (RHD) provides hospital care for people requiring rehabilitation, respite, day hospital services and complex continuing care. The total service provided is characterised by a multidisciplinary team approach involving medical, nursing and therapy expertise including physiotherapy, occupational therapy, medical social work, speech and language therapy, dietetics and clinical psychology.

The Day Hospital provides consultant-led multidisciplinary care to older persons. Through the Day Hospital rehabilitation programmes, patients maintain their independence and ability to remain at home. The hospital's complex continuing care beds are within a ward setting. The hospital is a teaching hospital that provides for education of medical, nursing and health and social care professions through the university schemes.

Complex Continuing Care

Following analysis of all the hospital's strategic options, it was determined that the hospital cannot sustain the provision of complex continuing care services. Therefore, the difficult decision was made that this service would not be part of the long term strategic plan. A hospital ward based setting is not in line with the Health Information and Quality Authority environmental standards. The emphasis on integrated care focuses on rehabilitation, maximising patient independence, with the ultimate aim of patients returning to their own home. This is in line with one of the core objectives for the HSE Social Care Plan. The hospital concluded that its Strategic Plan should not include ongoing complex continuing care given the following:

- The aim of an integrated care campus is to create a clear pathway for patients as quickly as possible from the acute environment and back into their own homes and then provide community support rather than complex continuing care.
- There is an unduly large investment required to change the RHD hospital physical infrastructure into a residential care unit to meet current and future residential care standards.
- The hospital cost of care per bed is cost prohibitive on a long-term basis due to the constraints of the building.

Throughout the review and analysis stage of the Strategic Plan, all aspects of complex continuing care were examined. It is recognised that there is a requirement for complex continuing care beds within the region. A key element of the orderly transition from complex continuing care is to agree a scaling down through planned restriction of admissions to continuing care beds agreed through consultation and strategic planning with the HSE and associated community partners.

Our vision is to provide a medical centre of excellence in healthcare rehabilitation within an integrated care campus which leads to the RHD becoming:

- The leading post-acute rehabilitation hospital in the Dublin area for older people; and
- A model primary care centre in partnership with the University College Dublin (UCD) Medical School, the Health Service Executive (HSE) and local General Practitioners (GPs).

The key fundamental principles behind this vision are:

- The enablement of patients to have the appropriate rehabilitation care in the most appropriate setting.
- Meeting the needs for more rehabilitation beds at a time when the demographics are changing significantly.
- To be recognised as a service that provides integrated care pathways from the Acute Sector to the Community.
- To grow and gain a reputation for excellence in rehabilitation and integrated care.

The hospital, through this Strategic Plan, intends to provide an integrated care campus that provides a community based approach to healthcare through Inpatient Rehabilitation Services, Outpatient and Day Hospital Services and Primary Care Services.

In addition to the synergies of an integrated approach to the above services on a hospital healthcare campus, there are also benefits of access to the services for the wider community.

The hospital conducted research and analysis to effectively identify the right avenues of strategic direction to best meet the needs of the patient population and the national health strategy and to match them with the skills and expertise provided by the hospital.

Integrated Care

It is the intention of this Strategic Plan to provide one of the first voluntary publicly-funded bodies to provide a community based integrated care campus that also includes university education for healthcare professions.

The integrated care campus, aligned with the wider regional services, provides the regional population with access to all appropriate services in the most appropriate setting.

The hospital's Strategic Plan provides for a campus that encompasses community based primary, day hospital and inpatient care. The analysis within this Strategic Plan highlights that the location and potential of the RHD site provides an ideal estates platform for the integration of care.

Ongoing support of, and consultation with, the HSE is key in developing true integrated services.

Rehabilitation

The hospital analysed its current service provision and the external and internal influences on that service including the HSE Corporate and Service Plans. In addition, a review from UCD focusing on rehabilitation services was commissioned by The Friends of the Royal Hospital Donnybrook. This review covered current RHD rehabilitation services, national and international best practices and recommendations on potential service provisions.

The recommendations arising out of this review and analysis results in the decision of the hospital to strategically plan expansion of inpatient rehabilitation to meet the growing needs of the population it serves.

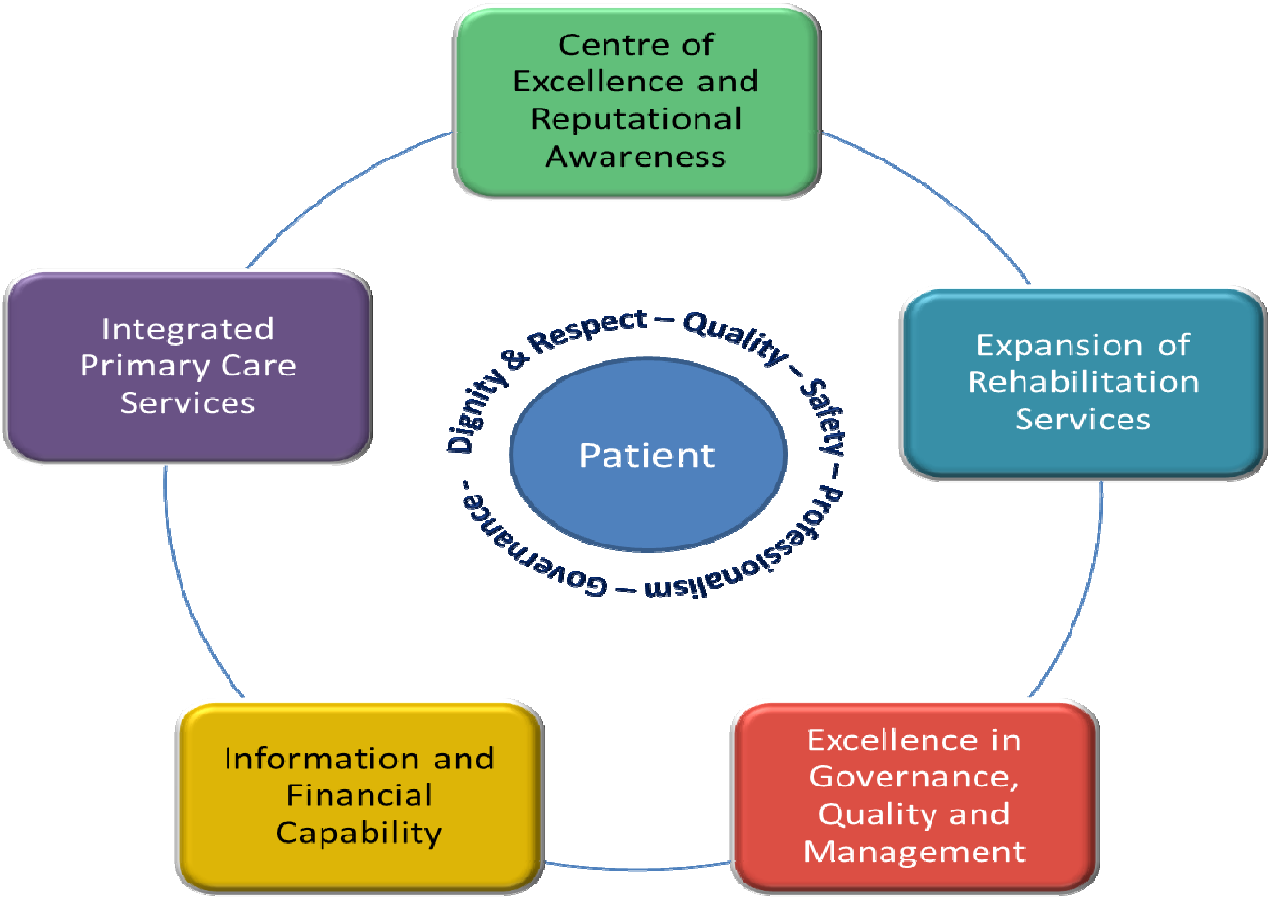
Quality of Care

The hospital has a demonstrated record of providing quality of care and proactivity in development of quality initiatives and roll-out of national initiatives. The skills and expertise within the hospital support the growth and development of services in line with health service needs.

In addition, the hospital's partnership with academic institutions has led to the development of education programmes and facilitates the rotation of students across the multiple disciplines.

The five key areas outlined in the Strategic Plan are:

- Centre of Excellence and Reputational Awareness
- Expansion of Rehabilitation Services
- Excellence in Governance, Quality and Management
- Information and Financial Capability
- Integrated Primary Care Services



STATEMENT OF THE ROYAL HOSPITAL DONNYBROOK'S STRATEGY 2017				
Charter Extract				
The purpose of The Royal Hospital Donnybrook (Charter Order Amendment) Order, 1990, is to provide for the care (including the provision of medical, nursing and other necessary services) of persons who are declared by qualified medical authority to need the care and medical attention which the hospital can provide. **Original purpose:** ***".....to benefit the Poor in and near our said City who are afflicted with Disorders declared to be Incurable, by dieting, lodging, clothing and***				
Mission Statement for 2017				
To provide a medical centre of excellence in healthcare rehabilitation within an integrated care campus which leads to the RHD becoming the leading post-acute rehabilitation hospital in the Dublin area for older people; and A model primary care centre in partnership with key education and healthcare providers.				
Strategy Priority A	**Strategy Priority B**	**Strategy Priority C**	**Strategy Priority D**	**Strategy Priority E**
Expansion of Rehabilitation	**Centre of Excellence and Reputational Awareness**	**Integrated Primary Care Services**	**Excellence in Governance, Quality and Management**	**Information and Financial Capability**
Improve the patient flow and management of existing rehabilitation services and enhance production of data on outcomes and performance.	Pursue a strategy of enhancing the awareness and distinctiveness of the hospital through appropriate media.	Facilitate the development of a fit for purpose primary care centre facility for community and day care providers.	Maintain a high standard of corporate and clinical governance from Board level to hospital internal structures.	Identifying all elements of the service and detailed costing of these elements to enable effective demonstration of funding requirements.
Expand Rehabilitation Services to meet the strategy, demographic growth and epidemiological indicators and patient needs.	Develop services and performance in line with national and international standards to enable continuous improvement of quality of care to patients.	Establish a unique inter-party quality forum, guided by effective terms of reference that focuses on standard and quality of care for all patients.	Continuously engage and empower staff through reinforcing the culture and purpose of the hospital in all aspects of staff working environment.	Enhance capture of data to facilitate clarity on activity definitions and therefore enhance demonstration of performance.
Enhance Rehabilitation Services through optimum use of technology and innovative services.	Enhance the hospital's reputation and education presence as a teaching hospital and an education centre.	Establishing integrated patient pathways from the primary care providers into and out of the hospital and surrounding healthcare partner services.	Drive continuous quality improvement through quality and safety improvement programmes, effective risk management and transparent reporting mechanisms.	Developing an Information Communication Technology (ICT) Strategy to best position the hospital for Activity Based Funding.

2. Introduction and Current Profile

2.1. The Royal Hospital Donnybrook Mission

Since 1743, the hospital has adapted to the needs of the community and the current purpose of The Royal Hospital Donnybrook (Charter Order Amendment) Order, 1990, is to provide for the care (including the provision of medical, nursing and other necessary services) of persons who are declared by qualified medical authority to need the care and medical attention which the hospital can provide.

2.2. The Royal Hospital Donnybrook Vision

Our vision is to provide a medical centre of excellence in healthcare rehabilitation within an integrated care campus which seeks to become:

- The leading post-acute rehabilitation hospital in the Dublin area focusing on the older person; and
- A model primary care centre in partnership with the UCD Medical School, the HSE and local GPs.

2.3. The Royal Hospital Donnybrook Values

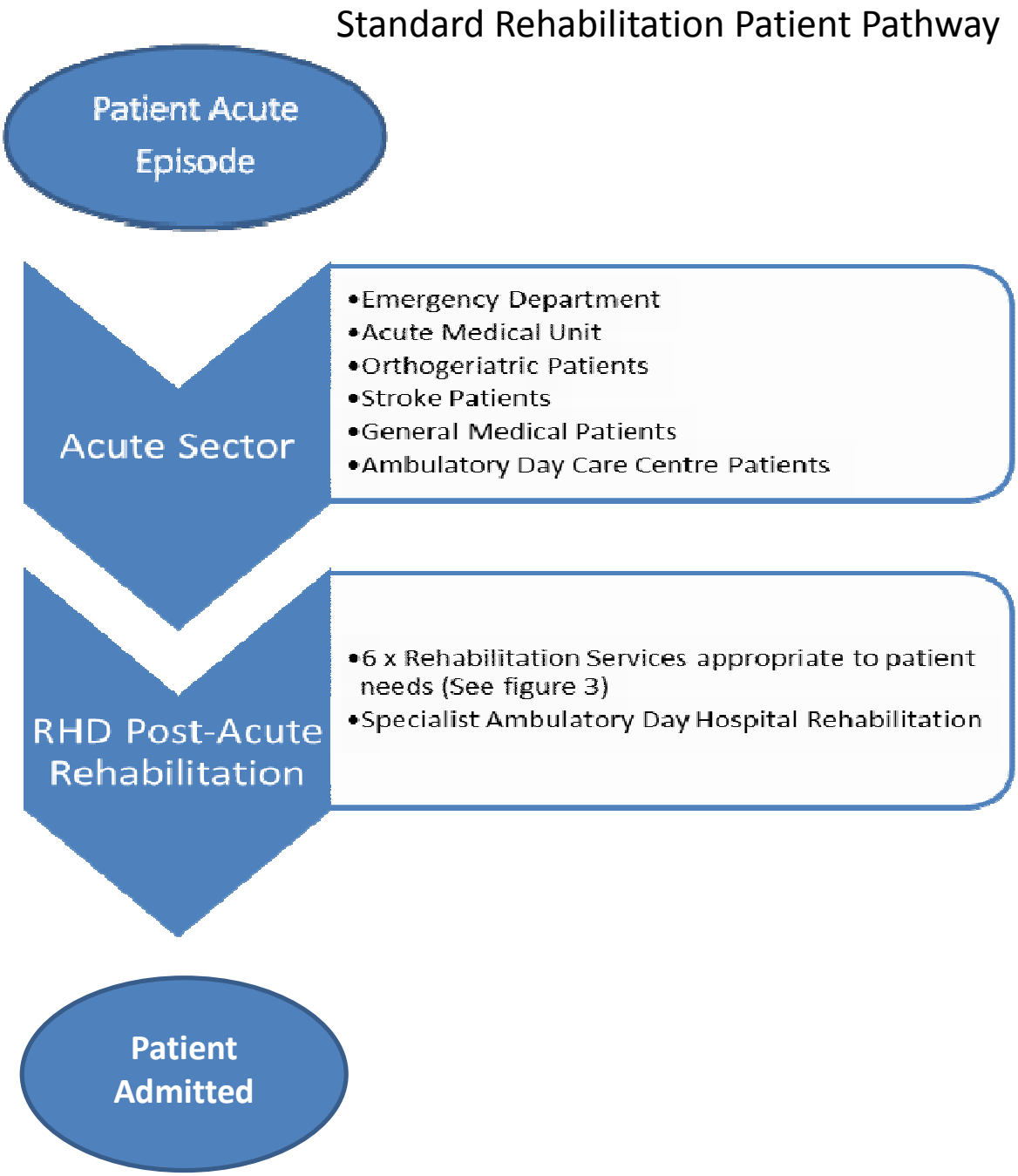
The care provided to our patients is value driven and all services are based around our core values.

- Patient-Centred Care
- Dignity and Respect
- Quality
- Safety
- Professionalism
- Governance

3. The Current Service

The hospital currently provides a post-acute and general rehabilitation service for older persons, a specialist stroke rehabilitation programme, a specialised neurorehabilitation stream for patients under 65 years of age and a complex continuing care service.

Figure 1



The hospital also provides complex continuing care for residents in three separate ward areas.

Figure 2

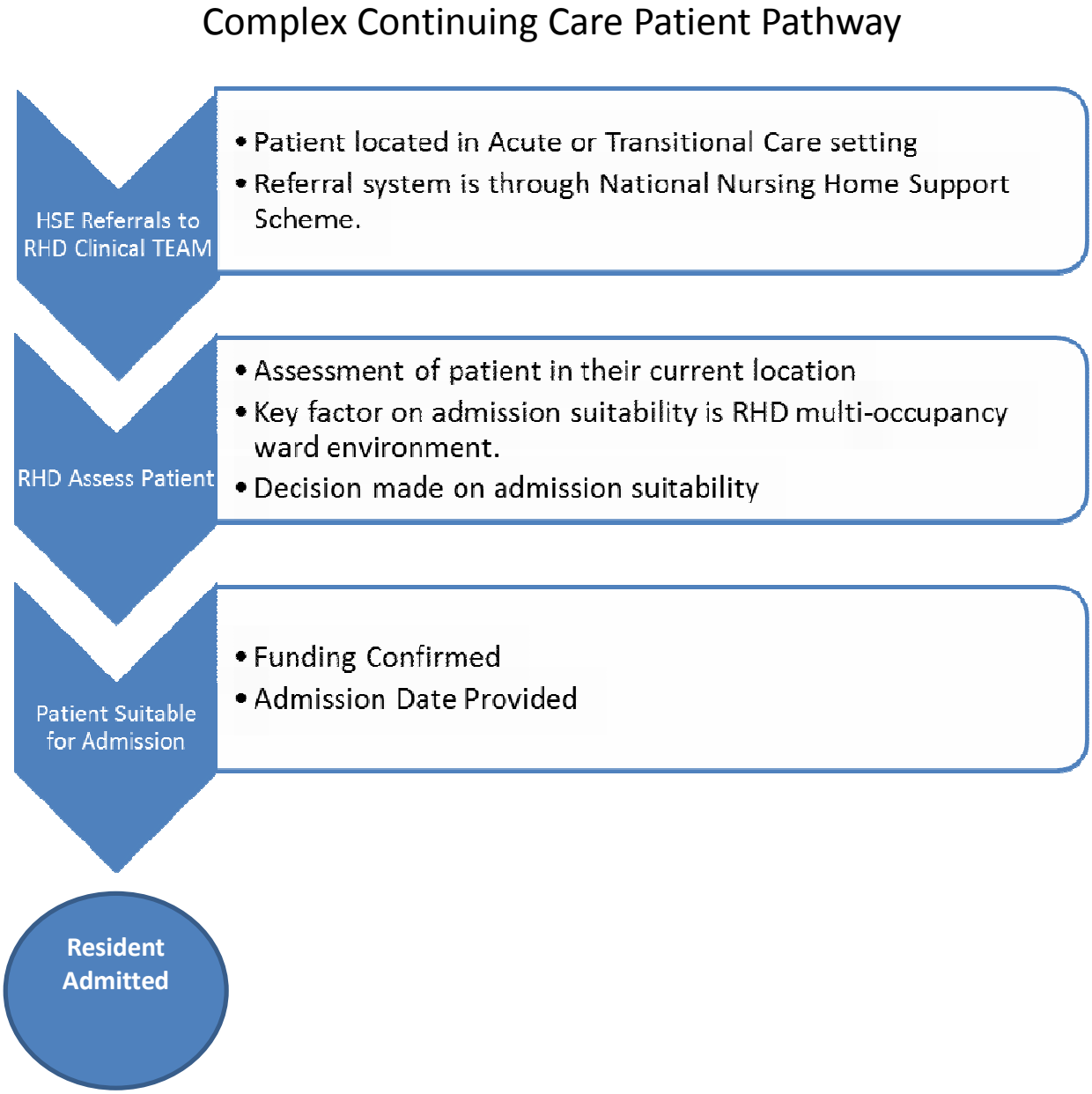


Figure 3 – Current Hospital Services

	Short-term Post-Acute Rehabilitative Care (SPARC) (>65)	Post-Acute Rehabilitative Care (>65)	General Rehabilitation Services including Complex Care (>65)	Specialist Stroke Rehabilitation (>65 & <65)	Specialist Neurorehabilitation (<65)	Day Hospital Rehabilitation Services (>65)	Complex Continuing Care Services (>65 & <65)	Respite Care (>65 & <65)
No of Beds	27 Beds	15 Beds	36 Beds	18 Beds	12 Beds	25 places per day	66 Designated Beds (56 x >65 & 10 x <65)	4 Beds (2 x >65 & 2 x <65)
Predicted Length of Stay	4 to 6 Weeks	3 to 6 Months	4 to 9 Months	4 to 9 months	4 to 12 weeks	Varying Rehabilitation Streams	Permanent Residents	Not applicable
Discharge Destination	- Home	- Home - Home with intense Community Home Care Package - Appropriate Nursing Home	- Home - Home with intense Community Home Care Package - Appropriate Nursing Home	- Home - Home with intense Community Home Care Package - Appropriate Nursing Home	- Home - Home with intense Community Home Care Package - Appropriate Nursing Home	Patients are in their own home and maintained on a rehabilitation programme to increase mobility and quality of life	N/A	Home
Service	Consultant geriatrician-led multidisciplinary rehabilitation.	Consultant geriatrician-led multidisciplinary rehabilitation maintenance programme.	Specialist geriatrician-led rehabilitation for frail older adults with complex needs requiring a long period of rehabilitation.	Consultant geriatrician-led specialist stroke rehabilitation, admitting patients with specialist stroke needs in the domains of mobility, cognition and communication.	Specialist rehabilitation consultant-led service. Provides goal-specific continuing neurorehabilitation. Conditions treated include multiple sclerosis and acquired brain injury.	Consultant geriatrician-led, multidisciplinary service. Ambulatory specialist services for older people. Patient education & training for management of their health conditions.	Consultant geriatrician-led multidisciplinary team providing continuing care for residents with highly complex medical and nursing needs.	Respite is managed through Public Health Nurse referral from the community and referral from our Day Hospital.

A key feature that differentiates the Hospital from most other providers is that care is delivered by a Consultant Geriatrician or by a Rehabilitation Consultant, supported by a wide range of multidisciplinary professionals.

4. Situational Analysis

Research was undertaken to provide the hospital and its Board of Management with evidence of trends, best practice and national developments to determine the best strategic path forward. Included in this research and analysis was a consultative process with the hospital's Board of Management, University College Dublin, the Hospital Management Team and members of the HSE.

4.1. PESTEL Analysis

This analysis reviews the external factors which impact on the hospital.

Environment	Impact on The Royal Hospital Donnybrook
Political	• Department of Health – Changes in ministerial influence can impact on the focus of health policy • HSE agreement to changes in services • Definition of Hospital Groups and Community Health Organisations and the area in which the hospital is designated
Economic	• Funding stream silos within the HSE • Allocation and securing of funding in line with service provision • Restrictions of Nursing Home Support Scheme (Fair Deal) • Activity Based Funding
Social	• Demographic changes, e. g., ageing population resulting in increased demands for healthcare • Charter responsibilities • RHD position within community and HSE • Lifestyle changes and trends • Public perception of services within the RHD
Technology	• Changes in rehabilitation management • Information Communication Technology (ICT) infrastructure required for a dynamic approach to service provision • Defining rehabilitation outcomes in data
Environmental	• RHD current hospital physical layout • Application of planning legislation • Limited access and egress routes to the campus
Legislative	• HIQA Standards o National Standards for Residential Care Settings for Older People in Ireland o National Standards for Safer Better Healthcare • National and international standards and benchmarking of services • Hospital Charter • Health Acts

4.2. Rehabilitation Research Project

UCD was commissioned by the Friends of The Royal Hospital Donnybrook to review rehabilitation services provided, future rehabilitation needs and recommendations on strategic paths for the hospital. The report set The Royal Hospital Donnybrook's services in a national and international context, analysed emerging trends and how these have been and could be responded to, presented the perspectives of key stakeholders, and made a number of recommendations.

The report outlined demographic and epidemiological patterns related to ageing and disability in Ireland. It then reviewed current Irish health policy relating to the provision of rehabilitative care and international literature on rehabilitation focusing on best practice in rehabilitative care. The provision of rehabilitative care at the RHD was explored in the presentation of the findings from stakeholders' consultation. The report concluded with recommendations from the findings.

4.2.1. Findings of the Rehabilitation Report

The RHD is located in Community Healthcare Organisation (CHO) 6 of the HSE, a catchment area that covers a population of 364,464 across Dublin South East, Dun Laoghaire and Wicklow. As a major provider of rehabilitation services in the South East Dublin catchment area, the RHD is ideally placed to provide a considerable proportion of the additional rehabilitation service capacity needed in the medium and long term. The RHD possesses substantial expertise in the field of rehabilitation and its services are located on a large campus with the potential for expansion of its existing infrastructure.

The RHD is located in Dublin where the population of older people is expected to double in the next 20 years (Central Statistics Office 2013). In addition to this, there has been a significant increase (54%) in the number of people living with a disability in the catchment area of the RHD in recent years. It is reasonable to assume that these two demographic changes alone will place a significant burden on national and local health services for older people and people with disabilities, in particular, rehabilitation services.

Two conditions that are predicted to increase exponentially with the ageing of the population are hip fracture and stroke (Balanda et al., 2010) (Dodds et al., 2009). Both these conditions can result in loss of independence and significant health deficits, and in many cases rehabilitation is warranted.

Hip fracture has been identified as the most common serious injury affecting older people in Ireland, resulting in significant morbidity and mortality (Ellanti et al., 2014). It is estimated that 3,000 people per annum sustain a hip fracture, the majority of whom are older adults (Ellanti

et al., 2014). The Irish Hip Fracture Database was established in 2012 and presented data on 1,950 cases of hip fracture discharged from Irish hospitals between January and December (National Office of Clinical Audit, 2013). Seventy one per cent of those sustaining a hip fracture were female and the highest proportion of fractures (45%) were recorded in the 80-89 year old age group (National Office of Clinical Audit, 2013). It is predicted that in line with the ageing population, the annual incidence of hip fractures will increase by 100% by 2026, presenting major challenges for the health system (Dodds, Codd, Looney, & Mulhall, 2009).

Stroke has been identified as the third leading cause of death and the leading cause of severe disability in Ireland (Neurological Alliance of Ireland, 2010). It is estimated that 7,000 people per year are admitted to hospital following a stroke. Those sustaining a disability, some 5,000 to 6,000 annually, require rehabilitation (Economic and Social Research Institute & Royal College of Surgeons in Ireland, 2014). The Dublin/Mid-Leinster region (one of the four HSE's regions in the alignment of services prior to the latest reform) had the highest number of acute stroke discharges in 2011 (Economic and Social Research Institute & Royal College of Surgeons in Ireland, 2014). The Institute of Public Health in Ireland predicts a 48% increase in the number of people sustaining a stroke in the Republic of Ireland between 2007 and 2020. In actual numbers, this is an increase from 59,000 people to 87,000 people (Balanda et al., 2010).

Stroke presents the greatest demand for neurorehabilitation services in Ireland and development of these services is within the remit of the National Cardiovascular Health Policy 2010-2019 (HSE, 2011). Stroke rehabilitation services should include a range of disciplines including medicine, nursing, physiotherapy, occupational therapy, speech therapy, psychology, dietetics and social work.

In addition, the prevalence of idiopathic Parkinson's disease in the Irish population is estimated at above 7,000. Multiple Sclerosis has a similar population prevalence of approximately 7,000 (Health Service Executive & Department of Health, 2011).

4.2.2. Main Recommendations of the Rehabilitation Report

Recommendation 1: *Maintain the existing range and quality of consultant delivered rehabilitative services*

The RHD should continue to provide its well established inpatient and Day Hospital rehabilitative services that have demonstrable effectiveness in the rehabilitation for frail older people and for such conditions as hip fracture, stroke, Parkinson's disease and Multiple Sclerosis.

Recommendation 2: *Prepare for planned developments in the Irish health service*

In preparation for the national roll out of the Activity Based Funding (ABF) model and purchaser-provider separation, the RHD should develop and present its own ABF costs, based on its rehabilitation services and activities, but taking into account developing international practices in respect of service delivery and measurement of outcomes. Each service type, including rehabilitation for hip fracture, stroke rehabilitation, and so forth, should be carefully costed with the expertise of a health economist. The hospital must be able to objectively demonstrate the cost-benefit of the services that it delivers.

Recommendation 3: *Pursue cross-sectoral integration of existing services for the benefit of current patient groups*

In recognition of the importance of integrated care for optimal patient outcomes, the RHD should actively ensure that its patient care activities are fully integrated with and aligned to Community Health Organisation and acute hospital needs. Collaborative service delivery, building upon the respective strengths of each organisation, will lead to more patients receiving appropriate care in the most resource-appropriate setting. Service integration should be underpinned by use of appropriate information technologies.

Recommendation 4: *Plan for expansion for key patient groups*

In line with current and anticipated trends in epidemiology of disability and population demography, the RHD should also plan for the expansion of inpatient, outpatient and Day Hospital rehabilitative services for all its current patient groups over a 10 year period. The hospital should consider adopting a key leadership role in advocating for the appropriate and consistent application of the label 'Rehabilitation'. It is evident from the literature that if patients are to receive the appropriate service rehabilitation, services must be consultant-led and appropriately resourced with equipment and staff professionally trained and experienced in rehabilitative care.

Recommendation 5: *Develop governance arrangements as required*

Governance structures may need to be revised in response to new or expanded services, or with changed stakeholder relationships and new funding arrangements. It is essential that sufficient funding streams are available to maintain existing services and to support any transitional arrangements. Where collaborative services are established, new governance and administrative structures may be required.

4.3. RHD Impact on Acute Discharges

Based on the national performance indicators of rehabilitation beds being 95% occupied at any one time, figure 4 and 5 below is for demonstrable purposes only. Figure 4 indicates the number of beds available for acute patient discharge to RHD rehabilitation beds within the existing RHD bed profile, and then figure 5 demonstrates a redistribution of RHD residential beds to rehabilitation beds and its impact on capacity. It is important to note the number of beds is variable depending on which rehabilitation service the additional beds are allocated to.

Figure 4

Existing RHD bed profile					
Care Stream	**Current bed Profile**	**95% Occupancy**	**Average Length of Stay (Days)**	**Average Bed Turnover per year**	**Average No. Patients per year**
Complex Continuing Care	66	63	365	1	63
SPARC	28	27	42	9	231
PARC	15	14	70	5	74
Stroke Rehabilitation	18	17	65	6	96
Neurorehabilitation	12	11	65	6	64
General Rehabilitation	35	33	80	5	152
Respite	4	n/a	n/a	n/a	n/a
Totals	**178**	**165**	**687**	**31**	**680**

Figure 5

Redistribution of RHD Residential beds to Rehabilitation beds and its impact on releasing beds in the acute hospitals					
Care Stream	**Redistribution of 66 Complex Continuing Care beds**	**Resulting in New No. of rehabilitation beds only**	**95% Occupancy**	**Average Bed Turnover per year**	**Increased Average No. Patients per year**
Complex Continuing Care	0	0	0	0	0
SPARC	30	58	55	9	496
PARC	20	35	33	5	166
Stroke Rehabilitation	10	28	27	6	160
Neurorehabilitation	0	12	11	6	68
General Rehabilitation	6	41	39	5	195
Respite	n/a	4	4	n/a	n/a
Totals	**66**	**178**	**169.1**	**31**	**1085**

Assumptions
All figures based on the average length of stay for the specified rehabilitation stream.
Redistribution of all 66 complex continuing care beds into rehabilitation streams.

Potential impact: 1,085 less 680 = 405 extra patients per annum or 60% more admissions.

4.4. RHD Rehabilitation

Appendix 1 highlights the current profile of patients and performance of our SPARC and PARC units for 2015.
Appendix 2 demonstrates the discharge destinations for the Specialist Stroke and General Rehabilitation units in 2015.

4.5. Health Service Executive Corporate and National Service Plans

4.5.1. HSE Corporate Plan 2015-2017

A key goal within the HSE's Corporate Plan is the provision of a health service that makes it easy for people to access the service through alternative models of care. This is to provide people with access to appropriate care without the requirement to attend acute hospitals and enable them to be treated in the community in a timely manner.

The HSE Corporate Plan outlines key deliverables that can be provided by The Royal Hospital Donnybrook.

- Strengthen primary care services.
- Improve access to hospital, outpatient and community services and reduce waiting times.
- Implement a number of key integrated care programmes including older persons and improve patient flow.

4.5.2. HSE National Service Plan 2016

Our analysis of the HSE National Service Plan for 2016 identified the key elements that influence the strategic direction of the service provision of the RHD to assist the healthcare system in achieving national objectives:

4.5.2.a. *Primary Care* – The core objective for the HSE in relation to Primary Care is to achieve a more balanced health service by ensuring that the vast majority of patients and clients who require urgent or planned care are managed within primary and community based settings.

A key deliverable highlighted to obtain this objective is to provide an integrated response with acute services and social care services to relieve pressure in Emergency Departments (ED), incorporating hospital admission avoidance and facilitating early discharge.

4.5.2.b. *Social Care* – One of the core objectives for the HSE in relation to Social Care is to maximise the potential of older people, their families and local communities to maintain people in their own homes and communities.

A key deliverable highlighted to attain this objective is to prioritise services to all patients requiring discharge from acute hospitals; specifically, the Integrated Care Programme for Older Persons where the Social Care Directorate has

committed to augment primary and secondary care services for older people in the community enabling a shift from a model of acute hospital based episodic care to a model that reflects increased coordination and care planning based on the needs of the patient.

4.5.2.c. *Acute Care* – A key objective outlined within the Acute Care Directorate is to improve patient access and experience by the provision of integrated care in collaboration with social care, primary care and mental health services.

A key deliverable highlighted to attain this objective: The acute care division intend to reorganise hospital group services with an increased focus on small hospitals managing routine, urgent or planned care locally and more complex care managed in larger hub hospitals. This is in addition to continuing to implement the Emergency Department (ED) task force recommendations that have increased emphasis on moving patients out of the acute setting through integrated care pathways.

4.6. RHD Review of Integrated Primary Care Services

The burden of care for persons with multiple chronic diseases is considerable and falls largely on the primary health care provider. Continued investment in primary health care is needed both to care for those with multiple diseases and to prevent the accumulation of chronic diseases with aging. (Ref: Muggah et al, BMC Health Services Research 2012)

A Primary Care Centre on campus provides for primary and social care services including GPs, Public Health Nurses and a range of other services. As a result it provides a single point of contact to the health system. Integrating the Primary Care services on campus facilitates the enablement of access to and from the Day Hospital and inpatient services. This creates integrated care pathways for patients with the aim of minimising admissions to acute services.

It is acknowledged that the link to integrated care pathways from the acute services to home is the provision of effective patient-centred primary care. The World Health Organisation (WHO) published a paper on primary health care in 2008 where it outlined that the aspects of care that distinguishes people-centred primary care from other aspects of care are:

- Focus on health needs
- Enduring personal relationship
- Comprehensive, continuous and person-centred care
- Responsibility for the health of all in the community along the life cycle, responsibility for tackling determinants of ill health
- People are partners in managing their own health and that of their community

The report highlighted that Primary Care is needed now more than ever in the provision of a comprehensive and integrated response to health needs and challenges. The report outlined that Primary Care should be the entry point to the system and the diversity of health needs and challenges that people face call for the mobilisation of a comprehensive range of resources that include health promotion as well as diagnosis and treatment or referral, chronic or long term home care and social services.

(Chapter 3, WHO report Primary Health Care 2008).

4.7. S.W.O.T Analysis of the RHD

<table>
<tr><td colspan="4">Internal Issues</td></tr>
<tr><td rowspan="2">Positive Issues</td><td>Strengths
Positive patient outcomes and feedback
Consultant-led clinical care
Diverse multidisciplinary teams
Effective patient pathways from the acute sector
Community links
Education pathway for medical, nursing and allied therapy disciplines
Clarity of the mission through the hospital’s Charter
Capacity on RHD site for expansion
Clinical and corporate quality culture</td><td>Weaknesses
Lack of internal data
Ageing hospital IT infrastructure
Limited capability of financial software
Physical configuration restrictive
Restrictive access and egress routes
Lack of innovative rehabilitation technology and equipment, e.g., hydrotherapy
Lack of in-house public relations expertise</td><td rowspan="2">Negative Issues</td></tr>
<tr><td>Opportunities
Patient demographics indicating future need for rehabilitative care
Health Policy on Integrated Care – National Clinical Care Programmes on Integrated Care and Care of the Frail Elderly
Activity Based Funding
Relationships within the health sector
Educational and research links
National quality initiatives</td><td>Threats
Funding of the services
Not securing HSE agreement on Strategic Plan
Fair Deal process restrictive
Misalignment with HSE financial category
Voluntary organisations’ role in national healthcare strategy
New post-acute facilities
HIQA environmental standards for Residential Care Settings for Older People</td></tr>
<tr><td colspan="4">External Issues</td></tr>
</table>

5. Key Issues Identified

Based on the analysis outlined at 4.6, the key issues facing the hospital are:

- **Funding & Resources**
  There is a requirement to secure funding and resources for services currently provided by the hospital and for future services as outlined in the Strategic Plan. There is a growing requirement to retain skills and expertise which, within financial and resource constraints, is challenging.

- **Service Changes**
  In line with the hospital's Service Arrangement with the HSE, there is a requirement for the hospital to secure HSE approval for change of purpose and/or expansion of services. In order to meet patient requirements and positively impact on the provision of healthcare across the sectors, effective patient pathways from acute to the community need to be further developed.

- **Physical Environment**
  The hospital's physical layout for designated complex continuing care beds is not compatible long term with HIQA environmental Standards for Residential Care for Older People.

Short Term:	Financially sustaining current complex continuing care beds
Medium Term:	Capital investment required to meet interim standards by 2017- 2021
Long Term:	Post 2021 additional changes to environmental standards, likely to impact on both rehabilitative care as well as continuing care

- **IT Infrastructure**
  A progressive, dynamic and flexible IT platform is required to improve data gathering and reporting.

- **Recognition and Reputation**
  Recognition of innovation, the quality of care provided and positive impact on patients is required to move the strategy forward. The hospital needs to proactively achieve recognition for the care and services provided to patients and their families.

6. Strategic Options

Arising out of the analytical stage of the Strategic Plan, several different Strategic Options emerged which are outlined below.

- Development of additional Rehabilitation Services
- Introduction of a Primary Care Service with integrated patient pathways
- Expansion of Complex Continuing Care Service
- Building of relationships and alliances
- Development of Financial Strategy to maximise income
- Increase market awareness and the hospital's brand

To focus on the key Strategic Options available to the hospital and determine the most appropriate avenues, two specific tools were used - details in Appendix 3. A summary of the conclusions of the determinations from these are outlined below.

Hambrick and Frederickson - Five Elements

Elements	**Strategic Options**
Arena	Hospital skills and expertise specialising in the care of the elderly and related illnesses. Multidisciplinary led rehabilitation: • Inpatient rehabilitation beds • Ambulatory day hospital services Community based hospital - expansion of the services provided to the community • GP services • Primary Care based services • Day Hospital services
Vehicles	Development of funding streams through • HSE • Third parties, e.g., GPs • Fundraising Relationships with healthcare partners
Differentiators	Skills and demonstrable evidence of good patient outcomes. The hospital's multidisciplinary services are compatible with Primary Care services to provide ease of integration.
Staging	Rehabilitation beds, Ambulatory Day Care and Day Hospital services are in place and therefore facilitate expansion and reconfiguration. Residential accommodation is a long term programme of works and investment.
Economic Logic	All elements are required to be self-sustaining. Fair Deal process cannot sufficiently fund the long term care service provided in a hospital environment.

Zimmerman & Bell Matrix

Service	Matrix Quadrant
Development of Rehabilitation Services	
Introduction of a Primary Care Service	
Expansion of Complex Continuing Care Service	
Building of Relationships and Alliances	
Increase market awareness and the hospital's Brand	
Development of Financial Strategy to maximise income	

The most difficult decision from the analysis above was to determine that expansion or continuation of complex continuing care services was not a good strategic option for the hospital. The matrices above demonstrate that although our expertise and knowledge lie with the management of elderly patients, and the complex continuing care provided in the hospital setting has a strong cultural hold, based on all the analysis carried out, complex continuing care was no longer a viable option. This was based on:

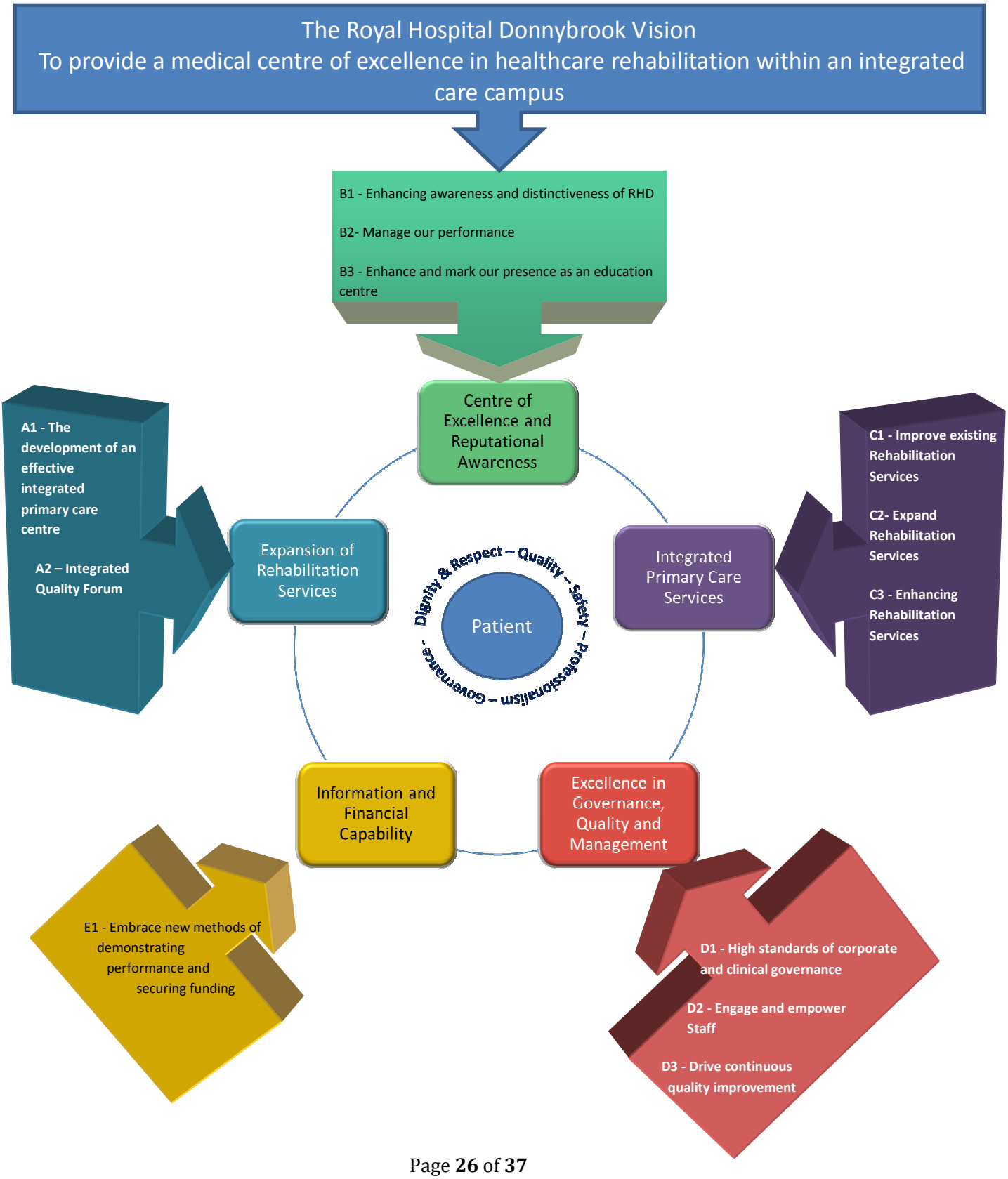
- Complex continuing care predominately requires high healthcare assistant input and medium nursing requirements with periodic medical input. The skills mix within the hospital is provided by a specialist team of medical, nursing and healthcare & social professionals and is more suited to rehabilitation services.
- The provision of a complex continuing care service; in order to make the service cost effective, there would be a requirement for a mix of low complex and high complex care residents. This mix requires a new setting, and therefore a new building to cater for both care complexities and must be in compliance with current and future HIQA standards. There would also be a need for two separate funding mechanisms to reflect the two levels of care.
- The current funding mechanism does not meet the current costs of high dependency residents. The hospital has traditionally taken on highly complex residents; however, the funding mechanism is capped and results in the hospital incurring additional costs to maintain and care for these patients.

7. Strategic Areas Identified

The hospital is at a service crossroads. To address the key issues facing the hospital and to provide current sustainability and expand the service to meet ongoing patient and health sector needs, the following five strategic areas have been identified.

Five Strategic Areas
A - Expansion of Rehabilitation Services
B - Centre of Excellence and Reputational Awareness
C - Integrated Primary Care Services
D - Excellence in Governance, Quality and Management
E - Information and Financial Capability

8. Strategic Map



9. Proposed Strategic Objectives

Strategic Priority Areas	Strategic Objectives	To be Achieved by
A – Expansion of Rehabilitation Services	A1 - Improve the management of existing rehabilitation services and data flow on outcomes.	• Clearly defining existing rehabilitation streams, patient pathways and patient outcomes. • Predetermining parameters of performance measurement of these rehabilitation streams and measuring against same. • Focussing on the movement of patients through defined pathways from the acute hospital services to the RHD and home.
	A 2- Expand Rehabilitation Services	• Expanding the hospital's rehabilitation bed base by a minimum of 30 beds by 2018 to meet the demographic growth and epidemiological indicators. Focusing on post-acute rehabilitation and stroke rehabilitation. • Developing outpatient services – a consultant-led ambulatory day care facility within the Day Hospital. • Developing stronger links with other hospitals and the HSE to improve patient pathways.
	A 3 - Enhancing Rehabilitation Services	Effective business planning and sourcing additional funding for • Increasing our technology based equipment in rehabilitation services. • The introduction of innovative services e.g., hydrotherapy

Strategic Priority Areas	Strategic Objectives	To be Achieved by
B - Centre of Excellence and Reputational Awareness	B 1 - To pursue a strategy of enhancing the awareness and distinctiveness of the RHD	• Defining and publishing the hospital's distinctiveness and the service it delivers, through the Governors' Update, Annual Report, Website and publicly available hospital documentation. • Identifying and promoting the patient profile and service outcomes within the health sector. • Scanning the media and communication forums to seize additional opportunities to promote the hospital and its services to patients.
	B 2- To manage our performance in line with national and international standards	• Measuring against internal performance indicators and demonstrating delivery of excellent care. • Benchmarking our services against appropriate national/international standards and publishing same. • Leading out the demonstration of the effectiveness of integrated care.
	B 3 - To enhance our presence as a teaching hospital and an education centre	• Promoting and enhancing our student programmes in Medicine, Nursing and Healthcare & Social Professionals. • Providing the facility to educate in rehabilitation. • Establishing linkages with academic centres to study and evaluate our care delivery in a systematic way. • Supporting the endeavours of staff to undertake structured research leading to publications in scientific journals and in production of general press articles of interest.

Strategic Priority Areas	Strategic Objectives	To be Achieved by
C Integrated Primary Care Services	C1 - To facilitate the development of an effective integrated primary care centre	• Providing a fit for purpose facility for community and day care providers. • Enabling the provision of integrated services through appropriate third party arrangements. • Establishing patient pathways from the primary care providers into and out of the hospital and surrounding healthcare partner services. • Providing an education centre in primary care and integrated care.
	C 2 - To establish an inter-party quality forum for primary care	• Providing a unique inter-party quality forum, guided by effective terms of reference that focuses on standard and quality of care for all patients. • Facilitating the integration of all parties involved in the primary care centre. • Using that forum to continuously improve the quality of care to patients.

Strategic Priority Areas	Strategic Objectives	To be Achieved by
D- Excellence in Governance, Quality and Management	D1 - To have a high standard of corporate and clinical governance	• Formalising Board of Management reviews. • Ongoing review of terms of reference of all committees. • Ongoing Board of Management review of the hospital's Risk Register.
	D 2 - To engage and empower staff	• Ongoing communication with staff on the overall strategy and performance of the hospital. • Reinforcing the culture and purpose of the hospital in all aspects of staff working environment. • Encouraging staff involvement in policies and procedures. • Opening communication channels to encourage feedback.
	D3 - To drive continuous quality improvement	• Having quality and safety functions of the hospital reported to the Board of Management. • Developing and implementing appropriate quality and safety programmes. • Managing and monitoring all risks within the hospital through the effective use of risk registers.
E – Information and Financial Capability	E1 - To enable the hospital to embrace new methods of demonstrating performance and securing funding	• Identifying and costing all elements of the service. • Determining data sets that accurately reflect the activity of the hospital. • Reviewing capacity of existing systems to capture and report data. • Developing an Information Communication Technology (ICT) Strategy to best position the hospital for Activity Based Funding.

10. Current Patient Pathways

Figure 1

Current Rehabilitation Patient Pathway

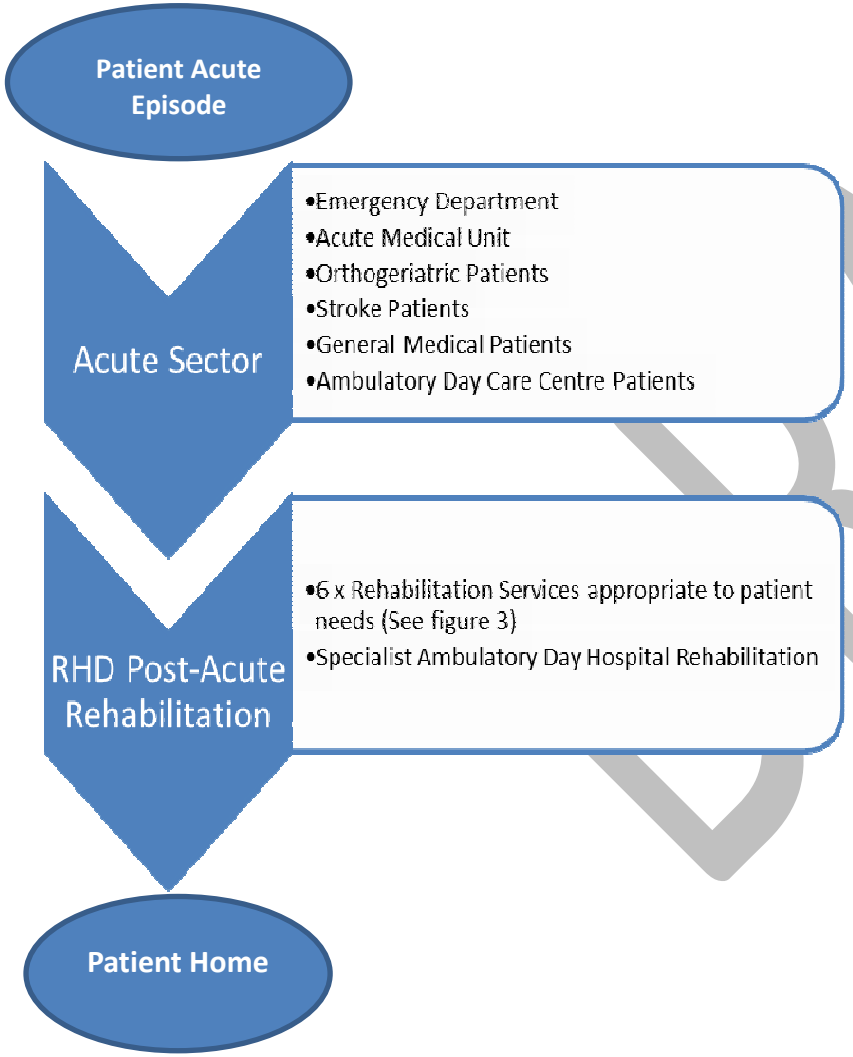
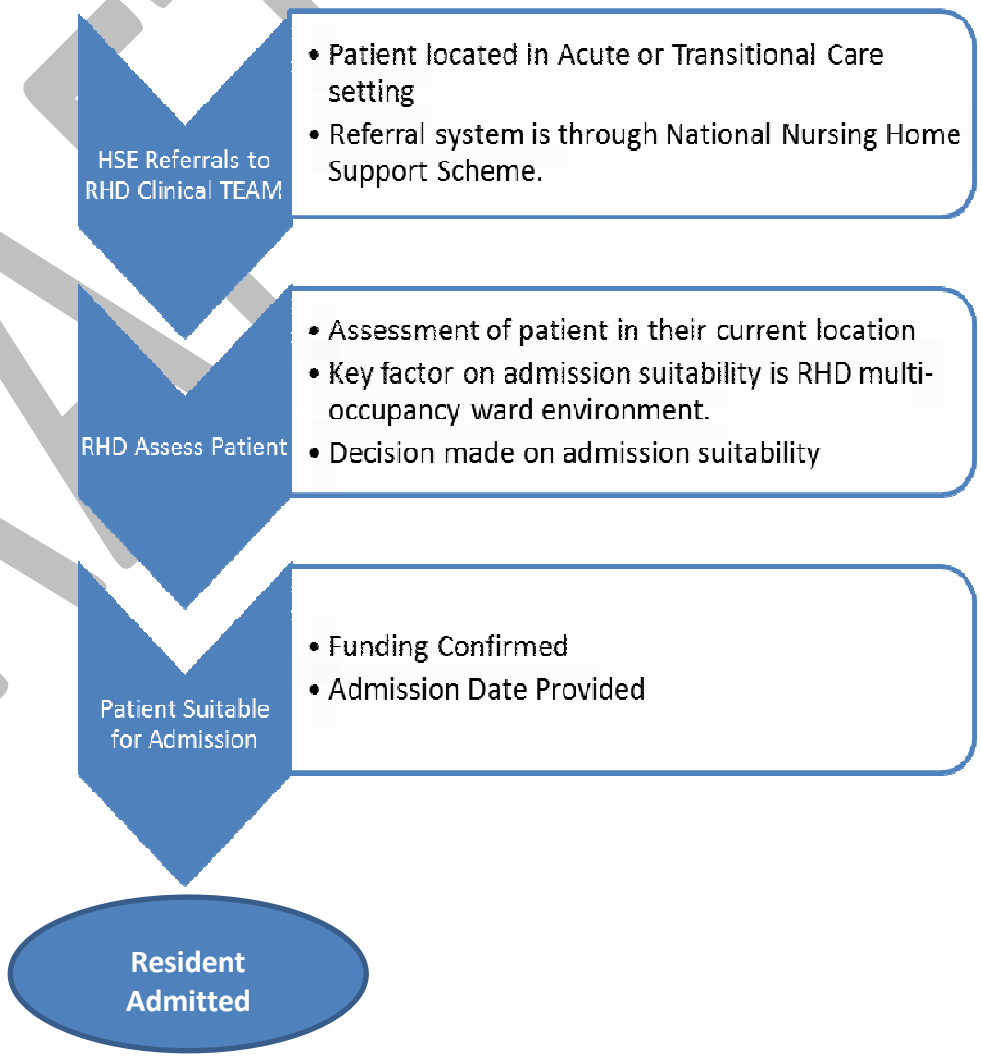


Figure 2

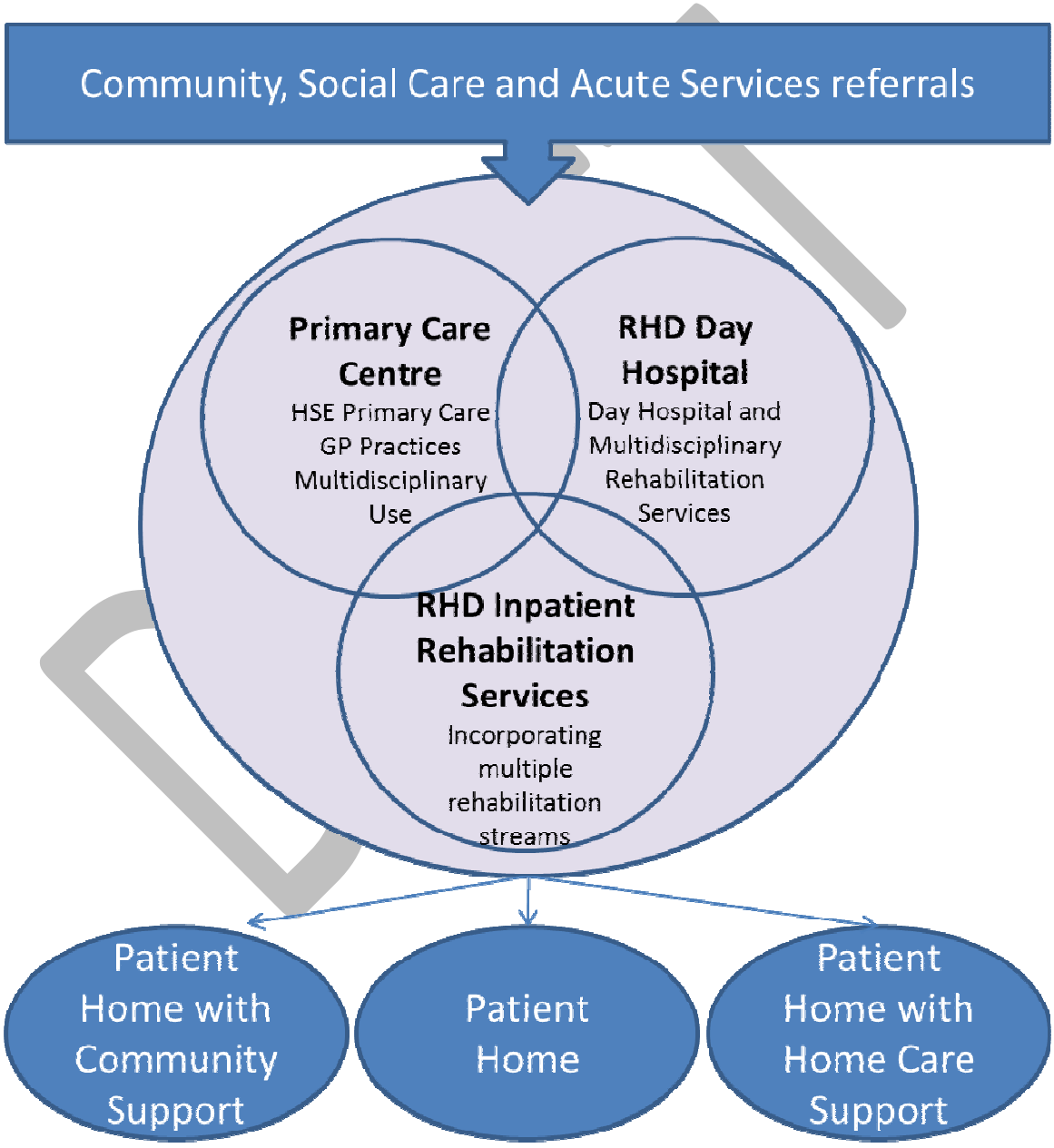
Current Complex Continuing Care Patient Pathway



11. Proposed New Patient Pathways

On implementation of this Strategic Plan, current patient pathways into the RHD (see Figure 1 & 2 previous page) will be reconfigured as per Figure 5.

Figure 5



12. Implementation

The next steps are as follows:

12.1 Development of Three Year Implementation Plan

12.2 Development of yearly Action Plan in line with Implementation Plan

12.3 Costing of yearly Action Plan

12.4 On agreement with the HSE, secure funding from them for the implementation of the Strategic Plan

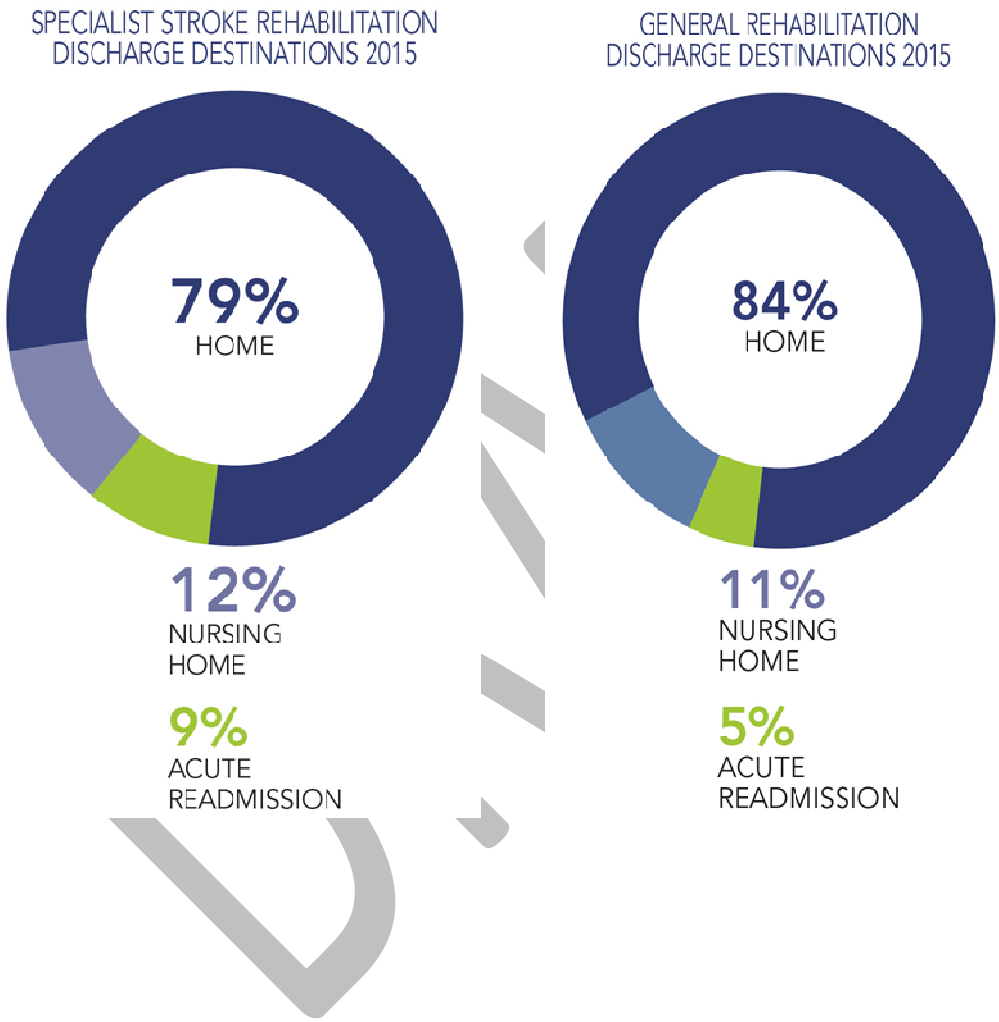
Appendix 1

SPARC and PARC Statistics for 2015

	SPARC 2015 (Jan- Dec 2015)	PARC 2015 – Opened in March 2015 (March to March 2016)
Number of beds	27	15
Number of patients	159	86
Mean age	80	80.3 years
Living Alone	45% (72 patients)	60% (46 patients)
Number of patients discharged home	144	77
% Discharged home	90.5%	90%
% Discharged to a Nursing Home	5% (8 patients)	6.4% (5 patients)
Medical destabilisation resulting in acute hospital admission	13.2% (21patients)	4.6% (4 patients)
% Discharged to a Nursing Home	5% (8 patients)	6.4% (5 patients)
RIP	2.5% 3 in RHD 1 in SVUH	None
Median Length of Stay	43 days	55 days
Mean Length of Stay	52 days	66 days
Acute Hospital Referral Team:		
Medical	29.5% (47 patients)	25.5% (21 patients)
Orthopaedic	64% (102 patients)	70.9% (61 patients)
Diagnosis:		
Median Admission Barthel	13	12
Median Discharge Barthel	18	17
Median improvement in Barthel	5 points	5 points

Appendix 2

Specialist Stroke and General Rehabilitation Discharge Destinations



Appendix 3

Tools Used to Review Hospital's Key Strategic Options

The first tool used to review the hospital's key strategic options was Hambrick and Frederickson's five major elements of a strategy. These five elements set out the five parts needed for a good strategy.

Arenas: Where will we be active?
On review of the situational analysis, all focus tended towards the care of the elderly; the demographic analysis clearly indicated where the population is going. Internal SWOT analysis demonstrates that the hospital's in-house expertise lies with caring for the elderly and related illnesses.

Vehicles: How will we get there?
This provided a more explorative perspective. Looking at the SWOT analysis internally, the hospital has the opportunity for expansion from a campus perspective. There is a requirement for HSE buy-in for services and funding. The potential changes in funding streams have a significant impact on strategic development.

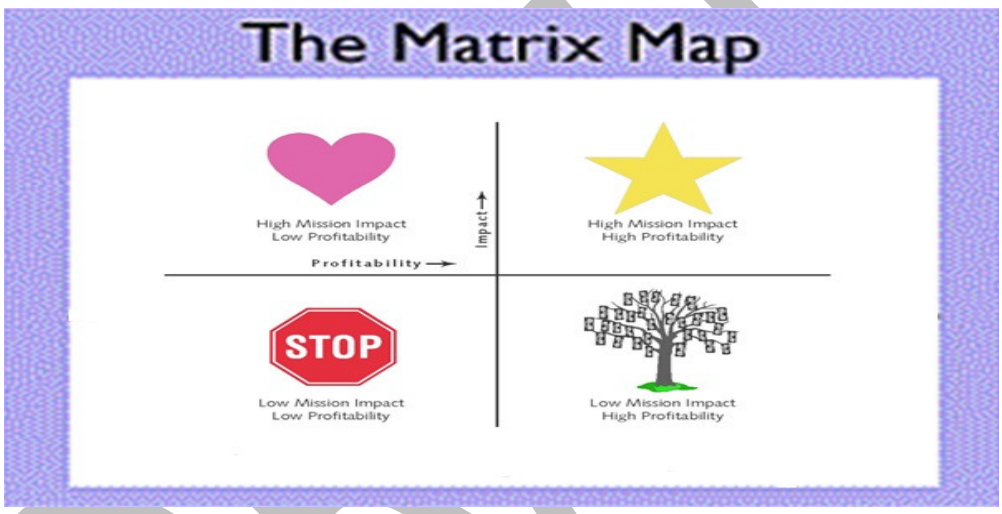
The relationships and agreed patient pathways between ourselves, other hospitals and the community services are key vehicles for the development of a good strategy.

Differentiators: How will we win?
This element focuses on what sector of the "market" is the key differentiator for the RHD. The hospital's complex continuing care service can no longer compete with private nursing home structures. The care of the elderly within rehabilitation services is our key differentiator.

Staging: What will be the speed of our strategy?
This is a key factor in determining the strategic avenues as the choices made need to be achievable and have the ability to provide a clear actionable plan.

Economic Logic: How will we obtain our returns?
From the hospital's perspective, the economic logic element is a focus on how can we develop a robust strategy that meets the needs of the population and sustains the services with adequate funding.

The second tool used to review the hospital's key strategic options was the Matrix Map outlined by Zimmerman & Bell 2014.



The Heart: Keep and Celebrate
This is an area that might assist in accomplishing the mission but not necessarily be cost effective. It is strategically imperative for the culture and ethos of the organisation to have these but management of costs are vital.

The Stars: High Mission Impact
It is recommended that the investment of time and energy is in what is done well and has a high value to as many of the key stakeholders as possible.

The Money Trees: Keep Watering
These are activities that generate income and funds for the institution that would support the Heart activities.

The Stop: Close or Give Away
Activities that are costly and resource intensive on the overall service have a low impact and minimum outcomes.