

Experiments in system re-design: a typology of models for changing urgent and emergency care services in one country.

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Background

- The Health Service Executive has embarked on a series of regional system re-designs to change the organisation of urgent and emergency care delivery in Ireland.
- Purpose of these programmes is to “develop integrated services across all stages of the care journey” with the goal of increasing efficiency and improving performance.

Results

- Planning documents identified by documentary analysis reveal emphasis on ‘hub and spoke’ models of care.
- In re-designs carried out to date, there is a movement towards centralisation and re-definition of hospital roles.
- Three models (see Fig. 1) have been identified that reflect the continuum of system re-design programmes.

Aim and Key Questions

- **Aim: Identifying and describing the typology of models employed in re-designing urgent and emergency care services.**
- What are the current and planned boundaries in place for systems of urgent and emergency care in Ireland?
- What is the model of care proposed for each region?
- Relationship between hospitals/professionals and the governance structures that will implement the model?
- To what extent have these models been implemented, as perceived by stakeholders?

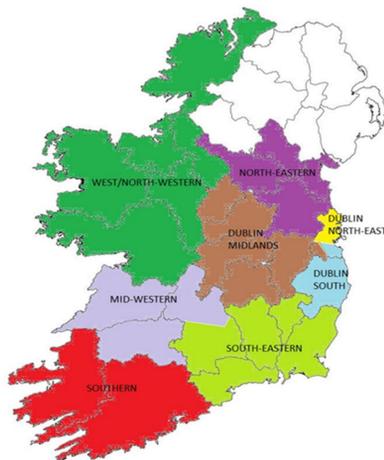


Figure 1. Typology of models for system re-design

Type A: Loosely Defined

- No apparent plan to re-design regional model of care.
- Limited hospital hierarchy in place. Patient pathways loosely defined but well understood by stakeholders.
- Limited integration of governance structures at regional level.
- Dublin Midlands, Dublin North East.

Type B: Regional Hub and Spoke

- Large-scale regional system re-design completed or in progress.
- Identified hub hospital with defined patient pathways from other hospitals/services.
- Central governance structure in place.
- South, Mid-West, West.

Type C: Partial Hub and Spoke

- Some regional system re-design carried out.
- Identified hub hospital with defined patient pathways for some services.
- Limited integration of governance structures.
- Subject to boundary changes potentially affecting network of care.
- North East, South East, Dublin South.

Methods

- Documentary analysis was conducted of national and regional policy documents.
- Approx. 120 semi-structured interviews were conducted with stakeholders (healthcare providers, hospital campaign groups, politicians, etc.) in eight different regions.
- Framework analysis approach (Ritchie and Spencer, 1994).
- Yin’s multiple case study methodology employed in order to compare and contrast across the eight study regions.
- Typology informed by health system taxonomy of Dubbs et al. (2004) and work of Spurgeon et al. (2010).

Discussion & Conclusions

- While the typology provides a useful snapshot of models of care currently in operation in Ireland, it is important to note the ongoing and multi-faceted nature of system re-designs.
- The frequently shifting nature of policy, availability of resources and buy-in from relevant stakeholders will influence the eventual configuration of urgent and emergency care systems across the country.
- Some progress has been made towards development of ‘hub and spoke’ models but argument has been made that “easy” reconfigurations have already been completed.

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Study of the Impact of Reconfiguration on Emergency and Urgent Care Networks



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