The Establishment of Hospital Groups as a transition to Independent Hospital Trusts

A report to the Minister for Health,
Dr James Reilly, TD

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Minister's Foreword

When I launched *Future Health: A Strategic Framework for Reform of the Health Service 2012-2015* on 15th November 2012, I stated that I am determined to press ahead with the key health system reforms that we promised in the Programme for Government. These reforms will improve the system, allow staff to work more effectively and, most importantly, deliver better healthcare for patients and all users of our health service. The future organisation of our acute hospitals is a part of those reforms and a major policy issue for the Government.

I am pleased to publish the Report on the Establishment of Hospital Groups as a transition to Independent Hospital Trusts. I wish to acknowledge the excellent work done by Professor Higgins, the Project Team and the Strategic Board in the preparation of this report. I would also like to express my appreciation to those organisations and individuals who contributed to the development of the report through the Project Team's extensive consultation process.

The overarching aim of the wider health system reform programme is to deliver a single-tier health system based on Universal Health Insurance (UHI), underpinned by the principle of social solidarity, with equitable access based on need and not on ability to pay. In preparation for the introduction of UHI, a new financing system, Money Follows the Patient (MFTP), will be introduced. The alignment of MFTP with the national clinical programmes will provide Hospital Groups with the tools to provide effective and efficient services within a clear national framework.

The establishment of Hospital Groups and, subsequently, Hospital Trusts, will enable hospitals to provide care in the right way, at the right location. This must be done in a manner that ensures a safe, high quality service for all, maximising and capitalising on the strengths of both larger and smaller hospitals, with best outcomes for patients paramount in every facet of their services.

Groups must manage their own affairs with good transparent governance. Each Hospital Group must operate with maximum autonomy to allow them to innovate and develop optimally, but also including all necessary inter-group co-operation. The report also emphasises the importance of academic linkages to focus on the research, innovation, education and training agendas that are so fundamental to improved patient care. These are key elements for providing an integrated system of which we can all be proud.

Future Health states that: "The first point of contact for a person needing healthcare will be primary care which should meet 90-95% of people's health needs*." (Department of Health, 2012*). Hospital Groups must enable and encourage this movement, working in close synergy with their colleagues in Primary Care. *Future Health* also recognises the need to develop a comprehensive Health and Wellbeing Policy Framework and this synergistic relationship between all aspects of preventative and curative care, regardless of where that care is to be delivered, will help to address this need.

All the policy initiatives I have referred to can and must be implemented in close concert to achieve the rightly ambitious goals that have been set by Government and me as Minister. This report challenges us to address the changes necessary in our hospital system to achieve that co-ordinated implementation on the way to UHI. In particular it outlines the rationale for establishing Hospital Groups and the principles required to effect this very significant change. It acknowledges that in the implementation phase over the next few years the governance systems and group compositions will be rigorously evaluated and reviewed to ensure they meet all the benchmarks set out in the Report. This will enhance and facilitate the Governments Health Reform Agenda to deliver more effective hospital based healthcare in an equitable, safe, high-quality system that ensures value for money.

All we do must be predicated on improving outcomes for patients. In this regard I am proud to say that we have some of the best health professionals in the world in this country. They deserve as much freedom as possible to deliver for the patient. The establishment of hospital groups will go a very long way to provide that freedom.

Dr James Reilly, TD
Minister for Health

Chairman's Foreword

The formation of hospital groups is a major project of change with far reaching consequences. It will require dedicated leadership over the next number of years to create effective hospital groups that can have realistic aspirations to qualify as independent competing hospital trusts, as outlined in the Programme for Government 2011.

The formation of hospital trusts will change how hospitals relate to each other and integrate with the academic sector. Over time, it will deliver:

- higher quality services
- more consistent standards of care
- more consistent access to care
- stronger leadership
- greater integration between the healthcare agenda and the teaching, training, research and innovation agenda.

In producing this report, we considered best practice, analysed current hospital activity from provider and user perspectives, engaged widely with hospitals and healthcare agencies and sought international advice. That advice has been brought to bear through the membership of the Strategic Board which includes international experts with a good understanding of our Irish health service who have hands on experience of managing and delivering acute care through stand alone hospital groups and hospital groups linked to academic institutions, as well as public service expertise in the development and implementation of policy. I am deeply grateful to all the members of the Strategic Board for their challenge and their wise counsel. The report is greatly strengthened by their input.

I would also like to acknowledge the work of the Sponsor Group and the Project Team including the administrative support to the team. We are particularly grateful to those who gave their time to share their views face to face as well as by way of written submission. The opinions and submissions received were invaluable in shaping the thinking and recommendations contained in this report.

Professor John R Higgins
Chair of the Strategic Board

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1. Executive Summary

1.1 Introduction

Quality, patient safety, access and value for money are the principles on which current health policy is based. Within that policy, health services aim to provide efficient and effective care, as close to the patient's home as possible, with a view to improved health outcomes and satisfaction for patients.

Ours is a small country with increasing demands on our healthcare system. These demands include demographic changes, increased public expectations and inequalities in access to care. The changing nature of healthcare - new technologies and clinical specialisation - and financial and regulatory pressures from national and international bodies - add further challenges.

The Irish healthcare system is being reformed to meet these challenges: primary, social and community delivered care is being optimised; the range of care delivered in hospitals and the manner of its delivery is changing. For instance, specialist and complex care is being centralised and there is an increasing use of day case procedures in all specialties. Also national clinical programmes have been established to improve and standardise patient care, by bringing together clinical disciplines and enabling them to share innovative ways of delivering greater benefits for patients.

Acute hospitals, the focus of this report, are but one element of the healthcare landscape. We have a large number and range of acute hospitals in Ireland, each held in high esteem and accessed primarily by its local population for most of their hospital care. However, it is difficult to achieve the necessary reform and developments required of our hospitals while they exist in isolation one from another. The provision of quality, safe healthcare requires increasing levels of co-operation and overarching systems of clinical governance and communication.

The formation of Irish acute hospitals into a small number of groups, each with its own governance and management, will provide an optimum configuration for hospital services to deliver high quality, safe patient care in a cost effective manner. Grouping hospitals will allow appropriate integration and improve patient flow across the continuum of care. Each grouping will include a primary academic partner which will stimulate a culture of learning and openness to change within the hospital group.

These groups will lead in the future to the establishment of hospital trusts on a statutory basis and the introduction of Universal Health Insurance (UHI), a key commitment in the Programme for Government 2011. The report recommends what these groups should be, sets out a governance and management framework and recommends an open and transparent process for the appointment of chief executives of future hospital trusts.

1.2 Overall Policy Context

1.2.1. Future Health

Future Health: A Strategic Framework for Reform of the Health Service 2012-2015 was launched on 15th November 2012. This provides the overarching policy framework for the establishment of hospital groups. Link: Future Health: A Strategic Framework for Reform of the Health Service 2012 - 2015 Explanatory Note for the Public

The strategic framework states:

> *"Public hospitals will be reorganised into more efficient and accountable hospital groups that will harness the benefits of increased independence and a greater control at local level."*

And

> *"The current system of governance in the Irish hospital sector is unsatisfactory. The distinction between the voluntary and statutory sectors has created an uneven terrain for optimising patient care and has restricted the development of the management systems and leadership we require to run a world-class national hospital network. We want to take the best of the governance and autonomy currently found in the voluntary sector and create a new governance system that can give the benefits of increased independence and greater control of local clinical and managerial leaders to every hospital in Ireland.*

> *"We cannot create the governance and leadership capability to achieve this in one move, so in 2013 administrative hospital groups will be created that will have increased autonomy and will incorporate every statutory and voluntary hospital. These arrangements will be transitional and will be formally reviewed in 2014 in the light of the emerging UHI model"*

This provides the overall context for hospital groups but this has to be taken together with the overarching policy direction as set out in Future Health in relation to the role of primary care. Future Health states:

> *"An integrated system of primary and hospital care will be key features under the new system. The first point of contact for a person needing healthcare will be primary care which should meet 90-95% of people's health needs…. Where a person needs hospital care, it will be provided by independent hospitals / 'not for profit' hospital trusts. An integrated payment system will allow incentives to be effectively aligned across different providers and will encourage collaboration in the provision of quality, continuous care across settings."*

The objective is to have a UHI system specifically tailored for Ireland implemented by 2016. In this regard, Future Health states:

"In implementing UHI, we recognise that there are many important building blocks to be put in place. We need to implement change step by step, on the basis of good evidence, so that an equitable, effective system can be achieved." (Department of Health, 2012)

1.2.2 Universal Health Insurance (UHI)

The Government is embarking on a major reform programme for the health system, with the aim of delivering a single-tier health system, supported by UHI. The system will be based on a multi-payer model and will be underpinned by the principle of social solidarity, with access based on need and not on ability to pay. Under UHI, everyone will be insured for a standard package of curative services. A new Insurance Fund will subsidise or pay insurance premia for those who qualify for a subsidy.

Key features of the reform programme which will pave the way for the introduction of UHI include:

- the strengthening of primary care services to deliver universal primary care with the removal of cost as a barrier to access for patients,
- the work of the Special Delivery Unit in tackling waiting times, and
- the introduction of a more transparent and efficient MFTP funding mechanism for hospitals.

Under the future UHI system, hospital care will be provided by independent, not-for-profit trusts and private hospitals, with hospitals paid according to the care they deliver.

1.2.3 National Clinical Programmes and Money Follows the Patient

The national clinical programmes offer the means to bring efficiency and effectiveness to the operation of hospital groups. To complement these programmes a new financing system, MFTP, will be introduced in 2014. Under this new system hospitals will no longer receive fixed budgets but will be paid instead for the services they provide and the number of patients they treat, thereby incentivising them to work harder and smarter.

The alignment of MFTP with the national clinical programmes will give hospital groups the incentive to design and provide their services within a clear national framework that will support the provision of local care through the smaller hospitals, allowing hospital groups to re-orientate services more effectively.

1.2.4 Integration between Primary Care, Personal and Social Services and Hospital Care

The integration between primary care and hospital care is vital in the implementation of hospital groups. Groups should be managed so that they enable and encourage this movement, working in close synergy with their colleagues in primary care as well as within and between hospital groups. How they are managed and run must acknowledge the direction of travel for healthcare across the developed world, where in the future most healthcare will be delivered outside traditional hospital settings.

Hospital group management will have to be familiar with and responsive to the frameworks being put in place to address social care needs, and the experience of implementing Fair Deal[1] should be built upon. Good relationships with social care providers are clearly essential. Arrangements for cross financing between hospital groups and social care providers, if required, will need to be clarified by the Department of Health to ensure a transparent business-like relationship, with sensitive well-targeted service provision. It is essential that hospital group operational policies are such that hospitals can work in close synergy with the social care providers, recognising and responding appropriately to the individual care plans that will guide the provision of services to patients in this area. The response of hospital groups to these requirements will be a component of the evaluation of the performance of hospital groups as part of the process of seeking trust status.

1.2.5 A National Hospital Service Policy Context to Foster Autonomy

The goal behind *Future Health* is to dismantle the 'command and control' system in health and replace it with a system of devolved autonomy, where increasing control is given to the frontline. Ireland has some of the best healthcare professionals in the world. They deserve as much freedom as possible to deliver for the patient. There does, however, still need to be a clear national operational policy context provided for hospital groups, which allows them the flexibility and autonomy necessary to deliver effective and innovative management.

1.2.6 Key Complementary National Hospital Service Policy

As a precursor to the formation of hospital groups, the Department of Health needs to set out at a high level the objectives and requirements for hospital service reorganisation with the aim of removing, as quickly as possible, the fragmentation in hospital services which has impeded reform to date. This must be quickly followed by a detailed operational policy developed by the Health Service Executive (HSE) in conjunction with the Department of Health. There must be a formal high level mechanism to ensure a coherent approach to progress the rationalisation and reconfiguration of services aimed at achieving the optimal hospital service nationally.

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[1] The Nursing Homes Support Scheme, '*A Fair Deal*' began on 27th October 2009. The purpose of the Scheme is to provide financial support for people assessed as needing long-term nursing home care. The scheme is founded on the core principles that long-term care should be affordable and that a person should receive the same level of State support whether they choose a public, voluntary or private nursing home. Since 27th October 2009, the Nursing Homes Support Scheme is the single funded means of accessing long-term nursing home care for all new entrants.

1.2.7 Relationship with the HSE and the Director of Hospitals

The Programme for Government states that public hospitals will become independent not-for-profit trusts with managers accountable to their Boards. Pending the enactment of legislation to give effect to this policy intent, Hospital Groups will continue to operate within the policy and accountability frameworks determined for the HSE as set out in the relevant legislation. In this context, the relationship with the HSE and the Director of Hospitals in particular must be clearly defined and operated in a way that provides support and guidance to hospital groups and their Boards, setting clear operational policy parameters which are derived seamlessly from *Future Health* and overall Government policy on health.

Hospital groups must operate in accordance with an agreed policy framework and process to:

- reduce fragmentation of service delivery,
- maximise efficiency in a framework of managed competition,
- contribute to the integration of services at national level, and
- create more effective links with primary care.

An annual budget and employment ceiling should be developed for hospital groups whilst allowing maximum autonomy and flexibility in organisation, staffing, research and development, as well as other aspects of how their services are organised and delivered subject to compliance with agreed policy framework and process. This must also enable hospital groups to maximise innovation in the way they do their business, whilst ensuring any benefits of that innovation are openly shared and promulgated across all the health services.

1.2.8 Future Hospital Licensing

Proposals are to be brought to the Minister for Health regarding the licensing of public and private healthcare providers. Many elements of the Irish health service are already regulated and the licensing proposals are intended to apply to areas not already covered by these systems.[2] The key objective of the licensing framework is to improve patient safety by ensuring that healthcare providers maintain and improve upon core standards that are applied in a consistent and systematic way. The proposed licensing framework will, it is envisaged, ensure mandatory standards and a legal structure through which the Health Information and Quality Authority (HIQA) can work with providers to ensure that these standards are met.

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[2] For example, mental health residential services must be registered by the Mental Health Commission under the Mental Health Act 2001, the Health Act 2007 provides for the registration of private and public nursing homes, children's residential centres and residential centres for people with disabilities (some provisions are not yet commenced), pharmacies are regulated by the Pharmaceutical Society of Ireland under the Pharmacy Act 2007 and there is legislative provision for statutory registration for a range of health professionals.

In the context of the introduction of UHI, a licensing system and an independent regulator for the licensing system will help assure both service providers and patients that the service they contract and consume are of the requisite standard. The establishment of hospital groups is intended to permit greater autonomy for providers of hospital care and to allow hospitals to be more responsive to the needs of their locality. Devolution of autonomy for hospital services to hospital groups will be a significant challenge that will require oversight to ensure that its operational criteria are met.

The introduction of licensing can help hospital groups to move to a point of preparedness for the establishment of hospital trusts on a legal basis by providing a framework to ensure that licensed hospitals/hospital groups are complying with core standards and other requirements under the licensing legislation. The mechanism for licensing hospitals, particularly in the context of groups/trusts, is currently under consideration. The Department of Health intends to ensure the appropriate alignment of the objectives for optimally effective hospital groups within the legislative framework for licensing.

1.2.9. Inter-group and Cross Boundary Working

The removal of fragmentation and the concomitant reorganisation of the hospital service required for optimal effectiveness and efficiency in the delivery of high-quality, safe care requires successful inter-group working.

Managed competition, guided by overarching national policies, as well as co-operation between groups can incentivise and lead to the necessary reorganisation of services removing any fragmentation or unnecessary duplication in hospital service provision that exists. We should be mindful that, as *Future Health* states, up to 95% of care can, in future, be delivered in the community.

In relation to national and regional specialty services, inter-group working is as vital as the rationalisation of services within groups. Successful delivery of required inter-group services will be a crucial factor in the evaluation of the performance of hospital groups seeking trust status.

MFTP will incentivise the rationalisation of services by the hospital groups and encourage the delivery of care at the most efficient point within and between groups. Undoubtedly, inter-group contracting for services both clinical and non-clinical will be needed. This will be actively required and sought by the HSE and its successors in the context of service commissioning. This is at the boundary of managed competition and co-operation and the correct balance must be struck here. It will be a feature of Service Level Agreements and the Department of Health will need to set out a very clear policy and a regulatory framework to enable this to work smoothly.

1.3 Options for Hospital Groups

A range of options for the possible number and composition of hospital groups was extensively explored and considered by the Project Team, the Strategic Board, and in discussions with hospitals. There are a number of ways in which the 49 acute hospitals in Ireland could be arranged into a small number of hospital groups. As few as four and as many as eight groups were considered (see Appendix 1). Much of the consideration focused on assessing the advantages and disadvantages of various options.

Ultimately, the Strategic Board has recommended a **six hospital group model** as detailed in 1.6[3]. Two variants of this option were also considered (see Appendix 1). The recommended model builds on established relationships between a number of hospitals and is capable of being implemented quickly. In some instances, existing networks will change in order to build other alliances to the best advantage of patients in those areas and without disrupting local service provision.

It has been argued that the recommended option is not, however, as radical as it could be and doesn't achieve the rationalisation of services required, particularly in the Dublin area. The considered opinion of the Strategic Board is that building on willing partnerships offers the best promise of effective reform.

1.4 Criteria for Assigning Hospitals to Groups

In proposing a small number of relatively large hospital groups the Strategic Board sought to ensure that as many of the following criteria as possible were met:

- Align hospitals, in contiguous geographical areas, into groups to meet the acute hospital care requirements of the population.

- Create hospital groups which are consistent with existing acute hospital care pathways for the population, with an emphasis on maximising care available locally.

- Combine varying model, size and specialty hospitals to maximise the range of services available to populations. Each group must have at least one major university teaching hospital, a National Cancer Control Programme (NCCP) centre and a maternity service. The selected combinations should allow centralisation of complex care which has volume sensitive outcomes to larger centres, while maximising the use of smaller hospitals consistent with *The Framework for Development - Securing*

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[3] The acute paediatric services in Dublin – Our Lady's Children's Hospital Crumlin, Children's University Hospital Temple Street and the paediatric service in AMNCH – should also function as a single cohesive entity with appropriate governance arrangements (in line with hospital group proposals).

the Future of Smaller Hospitals (Department of Health, 2013)

- Ensure groups form single cohesive entities that together provide an overall hospital system which is in optimal balance. The necessary rebalancing, rationalisation and reorganisation of services, particularly in the Dublin area, between and within groups will begin with the establishment of hospital groups but must be enabled to continue through the process of transitioning into hospital trusts.

- Ensure a population base and infrastructure to maintain the viability of each group in relation to other groups.

- Create hospital groups large enough to gain efficiency from common business processes.

- Enable groups to co-operate with each other in an environment of managed competition. This should incentivise excellence whilst maintaining the utmost synergy and integration between each group and the rest of the health system nationally.

- Create hospital groups with robust academic linkages. Academic linkages are essential to integrate teaching, training, research and innovation in the acute hospital system. This will maximise the economic potential for the wider community and optimise synergy between academic medical function, clinical leadership and service management.

- Attract and retain sustainable numbers of high quality consultants, trainees and post–graduates across the full range of healthcare specialties and professions, across all hospitals in a group and across all groups.

- Maximise cross-border health service arrangements in the best interests of patients.

- Deliver internationally comparable quality care for patients, regardless of where they live.

- The recommended groups should be broadly comparable to facilitate competition under UHI and to ensure that no group is disadvantaged in the recruitment of clinical staff.

1.5 Recommendations for Hospital Groups

1.5	Recommendations For Hospital Groups
i	Each hospital group must agree a new name by which it will be known.
ii	The Chief Executive Officer (CEO) and interim group board will act to deliver safe equitable access to high quality care for the population they are employed to serve. It will support the key roles of Model 2 and Model 3 hospitals, as defined by the *Report of the National Acute Medicine Programme*, (HSE et al, 2010) within the policy framework set by government, particularly respecting the principles of *The Framework for Development - Securing the Future of Smaller Hospitals* and recognising the geographic distribution of services for local communities. This is aimed at ensuring high-quality, safe care and treatment, delivered as close to patients' home as practicable with more complex care delivered in larger hospitals as required for optimal safety and quality outcomes for patients and families. (ref section 6.3.3)
iii	The CEO of the hospital group will, within one year of appointment, present to his/her board a strategic plan for service configuration and integration consistent with national objectives for the delivery of patient services. The role of each hospital must be outlined under this plan in line with national policy including *The Framework for Development - Securing the Future of Smaller Hospitals* and National Clinical Programmes of Care.
iv	The HSE or its successors must ensure appropriate co-operation and balance between hospital groups and other elements of the health and personal social services system nationally.
v	Hospital groups may acquire or where necessary purchase services from other groups.
vi	All staff, clinical and non-clinical, should be appointed to groups with maximum flexibility in deployment - a key instrument to maximise effectiveness in service provision.
vii	Joint liaison structures with primary and community care practitioners should be established to ensure that community hospitals operate to their full potential as key linking institutions between hospital and community care. Each hospital group must consider the inclusion of community hospitals in their group.
viii	The Strategic Board and Project Team consider that the effectiveness of each hospital group must be evaluated in advance of statutory trust formation.
ix	Existing cross-border service level arrangements should be enhanced, initially by way of well-targeted commissioning contracts, with the potential to develop formal cross-border hospital networks.

x	Each hospital group has a primary academic partner. This relationship must be of sufficient depth to ensure the capability of the hospital group to deliver the healthcare teaching, training, and research and innovation agenda in a joined up way. This should not prevent groups from providing clinical educational services to other third level institutions.
xi	**It is recommended that there should be six hospital groups in Ireland.** Groups will be of varying sizes with a geographic or functional connection - large enough to operate efficiently and provide a reasonable range of services and small enough to be effectively managed, in order to deliver safe, high-quality patient services.

1.6 Recommended Composition of Hospital Groups

This report recommends the six hospital option outlined below for the following reasons:

- The six hospital groups are of sufficient scale, numbers of hospitals and range of services to be able to deliver meaningful reform prior to the creation of independent hospital trusts.

- Each group has a strong tertiary capacity, maximising the range of tertiary services for the population within each group and minimising intergroup referrals.

- There is the optimum alignment of existing relationships between hospitals with academic partners, thus creating the grounds for the rapid establishment of groups.

- Groups are of an appropriate size for good governance and effective management.

- Each group has to address a common range of challenges in relation to building corporate and clinical governance, addressing rural/urban issues of equity and access, meeting the clinical staffing needs of smaller hospitals and linking with a primary academic partner.

- Each group has broadly coherent geographic boundaries built on patient flows and referral patterns commensurate with key established relationships.

1.6	**Recommended Composition of Hospital Groups**
i	**Dublin North East:** Beaumont Hospital; Our Lady of Lourdes Hospital, Drogheda; Connolly Hospital; Cavan General Hospital; Rotunda Hospital; Louth County Hospital; Monaghan Hospital.
ii	**Dublin Midlands:** St James's Hospital; The Adelaide & Meath Hospital, Dublin, including the National Children's Hospital; Midlands Regional Hospital Tullamore; Naas General Hospital; Midlands Regional Hospital Portlaoise; the Coombe Women & Infant University Hospital.
iii	**Dublin East:** Mater Misericordiae University Hospital; St Vincent's University Hospital; Midland Regional Hospital Mullingar; St Luke's General Hospital Kilkenny; Wexford General Hospital; National Maternity Hospital; Our Lady's Hospital Navan; St Columcille's Hospital; St Michael's Hospital Dun Laoghaire; Cappagh National Orthopaedic Hospital; Royal Victoria Eye and Ear Hospital.
iv	**South/South West:** Cork University Hospital/CUMH; Waterford Regional Hospital; Kerry General Hospital; Mercy University Hospital; South Tipperary General Hospital; South Infirmary Victoria University Hospital; Bantry General Hospital; Mallow General Hospital, Lourdes Orthopaedic Hospital, Kilcreene.
v	**West/North West:** University Hospital Galway and Merlin Park University Hospital; Sligo Regional Hospital; Letterkenny General Hospital; Mayo General Hospital; Portiuncula Hospital; Roscommon County Hospital.
vi	**Midwest:** Mid-Western Regional Hospital, Limerick; Ennis General Hospital; Nenagh General Hospital; St John's Hospital Limerick; Mid-Western Regional Maternity Hospital; Mid-Western Regional Orthopaedic Hospital.
	Note: *The acute paediatric services in Dublin – Our Lady's Children's Hospital Crumlin, Children's University Hospital Temple Street and the paediatric service in AMNCH – should also function as a single cohesive entity with appropriate governance arrangements (in line with hospital group proposals).*

HEALTH DUBLIN NORTH EAST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Beaumont Hospital	238270	2954	21890	46121		49337	NCCP
Our Lady of Lourdes Drogheda	113384	1495	20138	7422	3808	53817	
Connolly Hospital	85220	1054	10455	9893		31922	
Cavan General Hospital	67153	743	14674	9075	2054	27099	
Rotunda Hospital	44979	739	17030	3645	9319		
Louth County Hospital	20701	278	437	8065			
Monaghan Hospital	12110	168		4881			
	581817	7431	84624	89102	15181	162175	
28% Dublin, Cavan, Monaghan, Louth, Meath, Estimated Population, 800,000							

- This group contains the following hospitals: Beaumont Hospital, Our Lady of Lourdes Hospital Drogheda, Connolly Hospital Blanchardstown, Cavan General Hospital, Rotunda Hospital, Louth County Hospital and Monaghan Hospital.
- There is an NCCP centre at Beaumont Hospital.
- There are maternity hospitals/units at the Rotunda Hospital in Dublin, Drogheda and Cavan.
- The primary academic partner is the Royal College of Surgeons in Ireland (RCSI).

Commentary

Beaumont and Connolly Hospitals have undertaken considerable preparatory work with this group's primary academic partner, RCSI, to develop a strategic alliance. This preparatory work will serve the new hospital group well.

The Rotunda Hospital will provide leadership in maternity services (obstetrics, midwifery and neonatology) and gynaecology services to all of north Dublin and the northeast. This will require the continuation of strong clinical links with the Mater Misericordiae University Hospital with which it will continue to have joint consultant appointments. The Rotunda hospital will be the only hospital in North Dublin to retain their current paediatric services. This proposal brings many of the hospitals between Dublin and the border into one group. Services for the region should develop cognisant of cross-border linkages and retain the potential to develop formal cross border hospital networks.

HEALTH DUBLIN MIDLANDS						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
St. James's Hospital	317095	3503	25153	93552		45760	NCCP
AMNCH - Tallaght	178027	2544	18731	30288		72995	
MRH Tullamore	81453	945	9546	16769		28047	
Naas General Hospital	56474	670	8999	4821		24494	
Coombe Women & Infant Hospital	46932	725	19453	20354	8749		
MRH Portlaoise	44922	591	13792	5000	2261	41019	
	724903	**8978**	**95674**	**170784**	**11010**	**212315**	
35% Dublin, Laois, Offaly, Kildare, Estimated Population, 800,000						

- This group contains the following hospitals: St James's Hospital; The Adelaide & Meath Hospital, Dublin, incorporating the National Children's Hospital (AMNCH); Midland Regional Hospital Tullamore; Naas General Hospital; Coombe Women & Infant University Hospital and the Midland Regional Hospital Portlaoise.
- There is a National Cancer Control Programme (NCCP) centre at St James's Hospital.
- There are maternity hospitals/units at the Coombe Women & Infant Hospital and at the Midland Regional Hospital Portlaoise.
- The primary academic partner is Trinity College Dublin (TCD).

Commentary

This grouping is at an advanced state of readiness. St James's and AMNCH - Tallaght, in conjunction with the Coombe Hospital, have undertaken considerable preparatory work with this group's primary academic partner TCD, to develop a strategic alliance. This preparatory work will serve the new hospital group well.

This group includes the largest hospital in the country and serves a large population base. It has recently been announced that the National Paediatric Hospital (NPH also now known as the New Children's Hospital) is to be located at the St James's campus. Despite the NPH having a separate governance structure, and the fact that the existing Dublin paediatric hospitals will operate as a separate group, this will have significant positive effects for this hospital group. Two hospitals from the Midlands are included in the group. Hospitals in the group have established clinical links with shared clinical appointments and established referral patterns between many of the hospitals. They also share a common population referral base in southwest Dublin and the Midlands.

HEALTH DUBLIN EAST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Mater Misericordiae University Hospital	213608	2597	16802	39006		48348	NCCP
St. Vincent's University Hospital	203622	2377	14631	52395		40106	NCCP
MRH Mullingar	58035	750	19365	7397	2782	31339	
St. Luke's Hospital, Kilkenny	56639	825	13905	11968	2042	31065	
Wexford General Hospital	49047	802	16544	8791	2232	34212	
National Maternity Hospital	44482	725	17779	3080	9459		
Our Lady's General Hospital, Navan	40514	440	4651	4953			
St. Columcille's Hospital	37538	446	3726	2495		19874	
St. Michaels Hospital, Dún Laoghaire	26285	391	2579	5803		13704	
Cappagh National Orthopaedic Hospital	25428	301	2195	9041			
Royal Victoria Eye and Ear Hospital	20865	268	2415	7251			
	776063	9922	114592	152180	16515	218648	
37% Dublin, Longford, Westmeath, Kilkenny, Carlow, Wexford, Wicklow, Estimated Population 1,000,000							

- This group contains the following hospitals: Mater Misericordiae University Hospital; St Vincent's University Hospital; Midland Regional Hospital Mullingar; the National Maternity Hospital; Our Lady's General Hospital Navan; St Columcille's Hospital; St Michael's Hospital Dún Laoghaire; Cappagh National Orthopaedic Hospital; the Royal Victoria Eye and Ear Hospital

  Wexford General Hospital and St Luke's Hospital, Kilkenny.

- There are National Cancer Control Programme (NCCP) centres at St Vincent's University Hospital and the Mater Misericordiae University Hospital.
- There are maternity hospitals/units at the National Maternity Hospital Dublin, the Midland Regional Hospital Mullingar, Wexford General Hospital and St Luke's Hospital, Carlow/Kilkenny.
- The primary academic partner is University College Dublin (UCD).

Commentary

This will be the largest of the hospital groups. The Mater Misericordiae University Hospital and St Vincent's University Hospital have undertaken considerable preparatory work with this group's primary academic partner, UCD, to develop a strategic alliance. This preparatory work will serve the new hospital group well₂₂

The Mater Misericordiae University Hospital will continue to have strong links with the Rotunda Hospital and to have joint consultant appointments.

The group includes one hospital from the Midlands, the Regional Hospital, Mullingar, and one hospital from the northeast, Our Lady's General Hospital, Navan.

This group includes two hospitals from the southeast; St Luke's Hospital Kilkenny and Wexford General Hospital. There is an absence of a consensus/shared vision amongst all the hospitals in the current southeast hospital network. The patterns of hospital usage for the catchment population of St Luke's Hospital Kilkenny and Wexford General Hospital indicate a strong utilisation of services in Dublin; for instance 10% of the acute hospital discharges for the population of County Wexford are from St Vincent's University Hospital.

Wexford General Hospital, because of its geographic location, similar to Kerry and Letterkenny General Hospitals, should retain its full range of Emergency Department (ED), medical, surgical, maternity and paediatric services.

HEALTH SOUTH / SOUTH WEST							
	Approved			Day		ED	NCCP
	Budget	WTE	Inpatient	Cases	Births	Attendance	Centre
Cork University Hospital	264081	3223	29472	54437		56709	NCCP
Waterford Regional Hospital	141673	1720	22925	20350	2439	49984	NCCP
Kerry General Hospital	71097	964	14083	10361	1753	30290	
Mercy University Hospital	55978	923	9374	18945		26634	
South Tipperary General Hospital	46445	708	12882	7138	1247	28668	
SIVUH	43663	704	7898	16193		18336	
Bantry General Hospital	17574	234	1889	1725			
Mallow General Hospital	16524	238	3887	2728			
CUMH	-	-	14067	5362	8784		
Lourdes Orthopaedic Hospital, Kilcreene	-	70	845	919			
	657035	**8784**	**117322**	**138158**	**14223**	**210621**	

Cork, Kerry, South Tipperary, Waterford, estimated population 850,000

- This group contains the following hospitals: Cork University Hospital, incorporating Cork University Maternity Hospital; Waterford Regional Hospital; Kerry General Hospital; Mercy University Hospital; South Tipperary General Hospital; South Infirmary Victoria University Hospital; Bantry General Hospital; Mallow General Hospital and Lourdes Orthopaedic Hospital, Kilcreene.
- There are NCCP centres at Cork University Hospital and Waterford Regional Hospital.
- There are maternity hospitals/units at Cork University Maternity Hospital, Waterford Regional Hospital, Kerry General Hospital and South Tipperary General Hospital.
- The primary academic partner is University College Cork (UCC).

Commentary

Hospital reconfiguration is at an advanced stage in the south western part of this group, and the implementation of the *Reconfiguration of Acute Hospital Services, Cork & Kerry Region; a Roadmap to develop an integrated university hospital network* (2010) will continue under the group structure. However, there is an absence of a consensus/shared vision amongst all the hospitals in the current southeast hospital

network.

Waterford Regional Hospital will continue to be an NCCP centre, retaining its current population referral base for cancer patients. Joint consultant appointments, such as general surgery shared with Wexford, across the groups will continue to support the specialist cancer services it provides.

Waterford Regional Hospital will continue to be the hub for the South East renal services which include a centre of haemodialysis, renal home therapies (peritoneal dialysis/home haemodialysis) and renal transplant follow up.

Waterford Regional Hospital will continue to be a regional trauma centre, including ED, Ear, Nose and Throat (ENT) and Ophthalmology. To ensure WRH continues to provide the full range of elective and trauma orthopaedics services, Lourdes Orthopaedic Hospital, Kilcreene will be managed from WRH within the new South/South West group structure. (It is currently managed by St Luke's Hospital, Carlow/ Kilkenny.)

Waterford Regional Hospital will continue to provide invasive cardiology services for the South East population. Working in collaboration with the cardiology service in Cork the current service should be extended with new joint appointments of cardiologists.

As part of the review of the transitional hospital groups the Health South/South West should be able to demonstrate that at least one regional subspecialty will be based at WRH.

Kerry General Hospital, because of its geographic location, similar to Letterkenny and Wexford General Hospitals, should retain its full range of ED, medical, surgical, maternity and paediatric services.

HEALTH WEST/NORTH WEST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
UHG/Merlin Park	251624	3086	35179	66102	3428	59349	NCCP
Sligo Regional Hospital	98011	1354	15924	26467	1582	31622	
Letterkenny General Hospital	97007	1370	20927	17586	2003	32100	
Mayo General Hospital, Castlebar	76293	979	16594	16258	1835	32762	
Portiuncula Hospital, Ballinasloe	41095	657	11022	8046	2148	19366	
Roscommon County Hospital	18914	284	3565	3789		6722	
	582944	7730	103211	138248	10996	181921	
Donegal, Sligo, Leitrim, Mayo, Roscommon, Galway, Estimated Population, 700,000						

- This group contains the following hospitals: University Hospital Galway/Merlin Park; Sligo Regional Hospital; Letterkenny General Hospital; Mayo General Hospital; Portiuncula Hospital and Roscommon County Hospital.
- There is an NCCP centre at University Hospital Galway.
- There are maternity hospitals/units at Galway, Portiuncula, Letterkenny, Mayo, and Sligo.
- The primary academic partner is National University of Ireland, Galway (NUIG).

Commentary

This group was partially pre-determined by the appointment of a CEO to the Galway Roscommon group and the appointment of a chair to the interim board for the group. This group will serve the western seaboard, stretching from Galway to Donegal, a geographically dispersed and relatively sparsely populated region.

In recognition of the geography of the region, Sligo and Letterkenny General Hospitals will be managed as a distinct unit within the West/North West. The precise management arrangements will be determined and agreed by the interim board of the group. The synergistic service model developed between Sligo and Letterkenny hospitals should be retained.

Letterkenny Hospital, because of its geographic location, similar to Kerry and Wexford General Hospitals,

should retain its full range of ED, medical, surgical, maternity and paediatric services.

Services for the region should develop cognisant of cross-border linkages and retain the potential to develop formal cross-border hospital networks.

There are plans to locate a rehabilitation centre at Roscommon County Hospital as part of the National Clinical Programme for Rehabilitation.

HEALTH MIDWEST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
MWRH Limerick	138059	1826	25053	20401		57916	NCCP
Ennis General Hospital;	19653	231	3607	2825		13399	
Nenagh General Hospital	17976	232	2687	4888		9556	
St. John's Hospital, Limerick	17626	279	3892	7754		15492	
MWR Maternity Hospital	15705	298	8331		5167		
MWR Orthopaedic Hospital	9824	163	1801	2780			
	218843	3029	45371	38648	5167	96363	
Limerick, Clare, North Tipp, Estimated Population 400,000						

- This group contains the following hospitals: Mid-Western Regional Hospital Limerick; Ennis General Hospital; Nenagh General Hospital; St John's Hospital Limerick; Mid-Western Regional Maternity Hospital; Mid-Western Regional Orthopaedic Hospital.
- There is an NCCP centre at the MWRH, Limerick.
- There is a maternity hospital in Limerick.
- The primary academic partner is the University of Limerick (UL).

Commentary

This group was partially pre-determined by the appointment of a CEO to the Mid-Western group and the appointment of a chair to the interim board for the group. It has the smallest natural population base. It has a limited range of tertiary referral specialties. However, it has the advantage of being very cohesive and there is the potential to develop a strong shared regional identity with its partner University of Limerick. It also has the advantage that hospital reconfiguration is at an advanced stage with the centralisation of cancer services and all emergency surgery at the Mid-Western Regional Hospital Limerick.

This group should develop structured collaborations with Health West/North West and Health South/South West in order to provide a full range of services, including many specialist services, for the people of the Midwest. The success of these, and any similar arrangements in other regions, can be evaluated as part of the national evaluation process preparatory to the establishment of Hospital Trusts.

1.7 Map of Hospital Groups

Recommended Hospital Groups

Dept. of Public Health; Cork, HSE-South. Ref: SR M00612i. Date prepared: 4th Dec. 2012
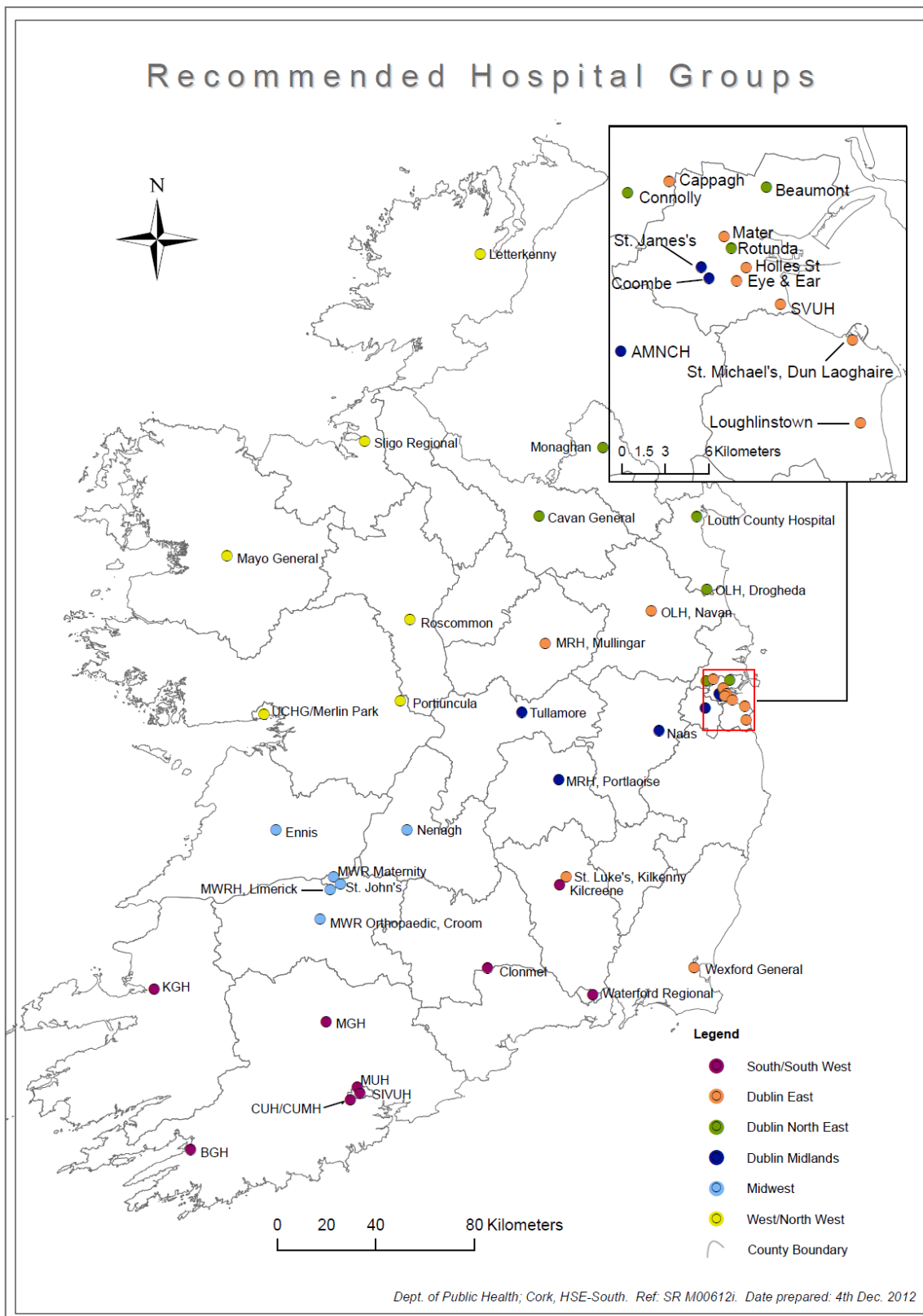
1.8 Recommendations on Governance

In framing its recommendations on governance for hospital groups, the Strategic Board has taken cognisance of the recommendations of the May 2012 Health Information & Quality Authority (HIQA) *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* (HIQA, 2012) particularly recommendations 3 to 29 which are applicable to hospital group boards.

The four main functions of a board are:

1. strategic planning
2. policymaking
3. supervision and challenge of executive management, and
4. accountability to stakeholders.

1.8	Recommendations for the Governance of the Transitional Hospital Groups
i	Each hospital group will be established on an administrative basis. These arrangements are transitional and will need to be formally evaluated in light of the emerging UHI model before the establishment of independent hospital trusts.
ii	Hospital groups can utilise an Academic Healthcare Centre (AHC) model to provide overarching governance structures for the relationship between hospitals within a group and their relationship to their primary academic partner. Within the AHC model, any proposed over-arching board must meet the criteria outlined in the recommendations below for interim group boards.
iii	There is a legitimate concern that emphasis on the Academic Healthcare Centre agenda may not fully recognise the urgent need for the reorganisation of acute hospital service provision. Therefore, hospital groups must demonstrate a capacity to respond effectively to national imperatives on service reorganisation within and between groups.
iv	Each hospital group will establish an interim group board to which the management team reports. Ideally, this board should have a minimum of six and maximum of nine members.
v	In a hospital group where there are pre-existing voluntary boards with statutory authority, it is critical that these boards fully support the decisions of the interim group board during the transition phase. Common membership should be considered as a way of

	securing this support.
vi	The primary function of the interim group board is to oversee the delivery of high quality, safe patient care to meet the needs of the population it is appointed to serve.
vii	Pending the enactment of legislation establishing independent hospital trusts, the interim group board will provide regular reports through the CEO/Chair, to the Director General of the HSE/Director of Acute Hospitals or the equivalent in any successor to the HSE.
viii	The Chair of the interim group board will be appointed by the Minister.
ix	The Chair will nominate the interim group board membership for ministerial appointment.
x	The role of the Chair and CEO will not be combined.
xi	The interim group board will comprise the necessary skills, competencies and experience which will enable them to make a contribution to the performance of the hospital group. Membership must ensure demonstrable expertise including but not limited to at least the following domains: Clinical; Business; Social; Legal; Medical Academic; Patient Advocacy. (HIQA, 2012)
xii	Each hospital group will agree an annual business plan / memorandum of understanding (MoU) with the Director General of the HSE/Director of Acute Hospitals or the equivalent in any successor to the HSE. The business plan / MoU will outline the national strategies to be incorporated in delivering on its commitments and specify within clearly defined budget and employment ceilings which services will be funded, and where those services will be provided within the hospital group. It will state the performance and outcome targets to be met within a defined timeframe and what nationally agreed measures will be used in order to monitor performance.
xiii	The interim group board will develop a Quality Improvement Framework to monitor the delivery of high-quality, safe patient care at all levels and on all sites across the group. Hospital groups will be required to comply with clearly articulated national performance requirements in relation to issues such as quality, access, and financial management.
xiv	Governance training will be offered to members of the interim group board early in the first term of their appointment.
xv	Board members must exercise their responsibilities in a professional and independent manner. Individual members, when carrying out their duties, must not act as representatives for different constituencies.

xvi	The Interim group board must proceed towards full implementation of the governance recommendations in the *HIQA Tallaght Hospital Investigation Report* (HIQA, 2012) and other recommendations as contained in but not limited to the Ethics in Public Office Act (1995).
xvii	Evaluation of board performance should be the responsibility of the Chair of the board and carried out according to evolving best practice.
xviii	The CEO and Executive Management Team of the hospital group will attend board meetings, but will not be members of the group board.
xix	Hospital groups will adhere to the terms of Business Plan/MoU (for the group) or contracts for the provision of services set out for them by the HSE or its successors as a component of the national service plan agreed with the Minister. These Business plans/MoUs and/or contracts must give maximum flexibility to the hospital group whilst ensuring all necessary synergy and linkages required for the overall national health plan to be implemented.
xx	The HSE or its successor will ensure the accountability of hospital groups by auditing service delivery against the Business Plan/MoU and/or other contracts or modifications thereto under the existing legal framework. Such auditing by the HSE or its successor will be done in a way that maintains the group's flexibility and independence in deciding the most effective means of delivery.
xxi	The interim group board will appoint sub-committees to oversee specific functions, as outlined in the *HIQA Tallaght Hospital Investigation Report*. (HIQA, 2012)
xxii	Where a hospital group has one or more pre-existing hospital boards, the hospitals in the group must work, through voluntary delegation of powers and common membership, to reach a position where the interim group board is the effective decision-making body for all hospitals in the group.

1.9 Recommendations for Key Leadership Posts within the Management Team

1.9	Leadership Posts within the Transitional Management Team
i	The consolidated management team of transitional hospital groups must comprise at least the following key posts: Chief Executive Officer, Chief Clinical Director, Chief Academic Officer, Chief Director of Nursing, Chief Finance Officer and Chief Operations Officer.
ii	The Chief Executive Officer will provide leadership for the hospital group and prepare it for trust status. S/he will lead group formation on the basis of an agreed strategic vision and will direct the corporate activity of the whole group. S/he will be appointed by way of expressions of interest from staff in publicly funded health agencies.
iii	The Public Appointments Service (PAS) will recruit for appointment for the Hospital Groups, the Chief Clinical Director, from within the consultant medical staff in the group, and in accordance with Section 62 of the Health Act 1953.
iv	The Chief Academic Officer's remit will be education, research and innovation in the group. The CAO should have a senior executive role in both the hospital group and the primary academic partner institution. The Chief Academic Officer will be appointed by open competition.
v	The Chief Director of Nursing will be appointed by way of expressions of interest from staff in publicly funded health agencies.
vi	The Chief Finance Officer will be appointed by way of expressions of interest from staff in publicly funded health agencies.
vii	The Chief Operations Officer will be appointed by way of expressions of interest from staff in publicly funded health agencies.
viii	Each group must identify a leading international hospital of international repute with the experience and expertise to provide on-going support, organisational mentoring and advice to the group.
ix	The establishment of hospital groups must be achieved within the existing framework of public service human resources and pay policy. To this end the formation of the transitional management teams must fully utilise all the management potential as it exists in the wider public health service.
x	Advertising and recruitment of leadership posts within the transitional management team will comply with all relevant legislation and codes of practice (see section 8.1.7)

1.10 Recommendations on Key Management Functions of Hospital Groups

	1.10	Recommendations on Key Management Functions of Hospital Groups
i		Hospital groups will be led by a group Chief Executive Officer (CEO) who, under current legislation, will be legally accountable to the Director General of the HSE/Director of Acute Hospitals or equivalent. Powers are delegated by the CEO so all personnel in the group are ultimately accountable, and report to, that officer and s/he reports on an administrative basis, fully and frequently, to the Chair of the interim group board.
ii		The requirement for individual hospital management teams will be determined by the size of the hospital and the range of services provided at each site. For instance, it is envisaged that large Model 4 hospitals would have their own management teams while Model 2 hospitals may be under the direct management of a Model 4 hospital.
iii		The key role of the management team is to deliver high-quality, safe patient care to meet the needs of the population it is appointed to serve. They will prepare the group for trust status. Early work will target the sharing of common corporate business platforms such as Human Resources (HR) and Information Communication Technology (ICT) and the rationalisation of support activities to achieve maximum cost savings. Achieving common corporate business platforms will reduce duplication and minimise bureaucracy. The hospital groups will also be required to comply with evolving policies on shared services in the public services in areas such as procurement, payroll and recruitment.
iv		Where hospitals have been governed under different arrangements (HSE or voluntary/joint board hospitals) in the transition phase, the hospital managers within the group will continue to manage their own hospitals but will also be accountable to the CEO of their Hospital Group either directly (HSE hospitals) or via their board (voluntary/joint board hospitals).

1.11 Preparing for Future Hospital Trusts

1.11.1 Review of transitional hospital groups

As part of the review of hospital groups in 2014 progress made by the hospital group in advancing the appropriate configuration of services within the group needs to be considered. Progress in implementing the high level service objectives and requirements for overall national hospital service reorganisation, as set out by the Department of Health, must be demonstrated. Individual hospital groups can only develop into trusts once it is proven by the group that it is independently viable and capable of providing the relevant services to its population. The concept of a trust being formed by more than one group, or by a revised grouping of hospitals, should also be considered.

1.12 Recommendations for the Recruitment and Role of the CEO of a Hospital Trust

Anticipating the establishment of hospital trusts on a statutory basis, a recruitment process is defined that will ensure the best possible competition for this key leadership appointment in the trust. This transparent process will be essential to reassure the public and staff that hospital trusts represent a new beginning.

1.12a	Recruitment of the CEO of a Hospital Trust
i	Under the auspices of the Public Appointments Service (PAS), there will be an open international competition for the post of CEO.
ii	The process will involve the establishment of a search and selection committee to recruit nationally and internationally. The committee will include: two nominees by the Minister for Health, one to be an international expert in health service leadership/management; two nominees by the primary academic partner, one to be international; and two nominees by the board of the hospital trust. The search and selection committee will be chaired by the chairman of the board of the hospital trust. This selection process will be designed and will operate in accordance with all relevant legislation and codes of practice (see section 8.1.7)
iii	The CEO will be appointed for a period of five years, renewable only on the basis of a performance review by the board.

The role of the CEO of a hospital trust will be established in legislation. However, as this will be the key leadership role in each trust, the Strategic Board believe the following elements will need to be considered

when addressing this role definitively.

1.12b	Role of the CEO of a Hospital Trust
i	The CEO will be empowered to lead the group and manage their resources, assets and staffing levels (including recruitment) cognisant of Government policy.
ii	The CEO will be responsible for adhering to national and EU public procurement/competitive tendering requirements and will also play a full part in relevant national procurement and materials management initiatives.
iii	The CEO will ensure that site specific services will be merged in order to reduce duplication of personnel (including Finance, ICT, Risk Management, HR) and non-pay costs (such as advertising, training).
iv	The CEO will ensure maximum sharing of information (within existing legal frameworks) with ICT systems communicating within and between groups and with other health and personal social services (in particular primary care) and other public services to enable maximum health benefits.
v	The CEO will be responsible for managing risk across the hospital group. The hospital group will develop a risk management framework and monitor its effectiveness. Risk management will be a standing item on each board's agenda.
vi	In order to ensure compliance with best practice, government policy, regulatory and statutory requirements, a robust and transparent audit process must be put in place. This will be an essential duty of the CEO.
vii	Any significant capital spending or service development must be supported by a business case to the Department of Health and Director General/Director of Acute Hospitals of the HSE or its equivalent. Transparency and equity must be evidenced in the approval and allocation of new services both to and within hospital groups.
viii	The CEO will develop a quality and safety framework to monitor quality and patient safety in accordance with published guidelines and national policy.
ix	Professional Codes of Conduct, Ethics in Public Office, disclosure obligations etc. must be complied with in order to avoid conflicts of interest.

1.13 Executive Summary - Concluding Remarks

The formation of six hospital groups is the initial step in the creation of statutory hospital trusts, and thus in the implementation of a key pillar of government policy on transforming the Irish health service.

All who work in the Irish health service are aware of the challenges we face. We can only meet them successfully if we act together in a co-ordinated and planned way. Hospitals in the future will be different from now. The link with an academic partner will assist hospital groups to envision and appraise that future and work towards it in a proactive way. We have to move on to shape that future and we have to start now.

2. Setting the Context

2.1 Irish Health Service Reform

Quality, patient safety, access and value for money are the principles on which current health policy is based. Within that policy, health services aim to provide efficient and effective care, as locally as is possible, with a view to improved health outcomes and satisfaction for patients.

Ours is a small country with increasing demands on our healthcare system. These demands include demographic changes, increased public expectations and inequalities in access to care. The changing nature of healthcare - new technologies and clinical specialisation - and financial and regulatory pressures from national and international bodies - add further challenges.

The Irish healthcare system is being reformed to meet these challenges: primary, social and community delivered care is being optimised; the range of care delivered in hospitals and the manner of its delivery is changing. For instance, specialist and complex care is being centralised and there is an increasing use of day case procedures in all specialties. Also national clinical programmes have been established to improve and standardise patient care, by bringing together clinical disciplines and enabling them to share innovative ways of delivering greater benefits for patients.

Acute hospitals, the focus of this report, are but one element of the healthcare landscape. We have a large number and range of acute hospitals in Ireland, each held in high esteem and accessed primarily by its local population for most of their hospital care. However, it is difficult to achieve the reform and developments required of our hospitals while they exist in isolation one from another. The provision of quality, safe healthcare requires increasing levels of co-operation and overarching systems of clinical governance and communication.

The formation of Irish acute hospitals into a small number of groups, each with its own governance and management, will provide an optimum configuration for hospital services to deliver high quality, safe patient care in a cost effective manner. Grouping hospitals will allow appropriate integration and improve patient flow across the continuum of care. Each grouping will include a primary academic partner which will stimulate a culture of learning and openness to change within the hospital group.

These groups will lead to the establishment of future hospital trusts on a statutory basis and the introduction of UHI, a key commitment in the joint Programme for Government 2011.

The report recommends what these groups should be, sets out a governance and management framework and recommends an open and transparent process for the appointment of chief executives of future hospital trusts.

2.2 National Health Policy

2.2.1 Future Health

Future Health: A Strategic Framework for Reform of the Health Service 2012-2015 was launched on 15th November 2012. This provides the overarching policy framework for the establishment of hospital groups, see: [Future Health: A Strategic Framework for Reform of the Health Service 2012 - 2015 Explanatory note for the Public](#)

Future Health states:

> "*Public hospitals will be reorganised into more efficient and accountable hospital groups that will harness the benefits of increased independence and a greater control at local level.*
>
> *The current system of governance in the Irish hospital sector is unsatisfactory. The distinction between the voluntary and statutory sectors has created an uneven terrain for optimising patient care and has restricted the development of the management systems and leadership we require to run a world-class national hospital network. We want to take the best of the governance and autonomy currently found in the voluntary sector and create a new governance system that can give the benefits of increased independence and greater control of local clinical and managerial leaders to every hospital in Ireland.*
>
> *We cannot create the governance and leadership capability to achieve this in one move, so in 2013 administrative hospital groups will be created that will have increased autonomy and will incorporate every statutory and voluntary hospital. These arrangements will be transitional and will be formally reviewed in 2014 in the light of the emerging UHI model.*"

This provides the overall context for hospital groups, but this has to be taken together with the overarching policy direction as set out in *Future Health* in relation to the role of primary care.

Future Health states:

> "*An integrated system of primary and hospital care will be key features under the new system. The first point of contact for a person needing healthcare will be primary care which should meet 90-95% of people's health needs.... Where a person needs hospital care, it will be provided by independent hospitals/ 'not for profit' hospital trusts. An integrated payment system will allow incentives to be effectively aligned across different providers and will encourage collaboration in the provision of quality, continuous care across settings.*"

The objective is to have a Universal Health Insurance (UHI) system specifically tailored for Ireland implemented by 2016. In this regard, *Future Health* states:

> *"In implementing UHI, we recognise that there are many important building blocks to be put in place. We need to implement change step by step, on the basis of good evidence, so that an equitable, effective system can be achieved."*

<div align="right">(Department of Health, 2012)</div>

2.2.2 Universal Health Insurance

The Government is embarking on a major reform programme for the health system, the aim of which is to deliver a single-tier health system, supported by UHI. The system will be based on a multi-payer model and will be underpinned by the principle of social solidarity with access based on need and not on ability to pay. Under UHI, everyone will be insured for a standard package of curative services. A new Insurance Fund will subsidise or pay insurance premia for those who qualify for a subsidy.

Key features of the reform programme which will pave the way for the introduction of UHI include:

- the strengthening of primary care services to deliver universal primary care with the removal of cost as a barrier to access for patients;
- the work of the Special Delivery Unit in tackling waiting times; and
- the introduction of a more transparent and efficient MFTP funding mechanism for hospitals.

Under the future UHI system, hospital care will be provided by independent, not-for-profit trusts and private hospitals, with hospitals paid according to the care they deliver.

2.2.3 National Clinical Programmes and Money Follows the Patient

The national clinical programmes offer the means to bring efficiency and effectiveness to the operation of hospital groups. To complement these programmes a new financing system, MFTP, will be introduced in 2014. Under this new system hospitals will no longer receive fixed budgets but will be paid instead for the services they provide and the number of patients they treat, thereby incentivising them to work harder and smarter.

The alignment of MFTP with the national clinical programmes will give hospital groups the incentive to design and provide their services within a clear national framework that will support the provision of local care through the smaller hospitals, allowing hospital groups to re-orientate services more effectively.

2.2.4 Integration between Primary Care, Personal and Social Services and Hospital Care

The integration between primary care and hospital care is vital in the implementation of hospital groups. Groups should be managed so that they enable and encourage this movement, working in close synergy with their colleagues in primary care as well as within and between hospital groups. How they are managed and run must acknowledge the direction of travel for healthcare across the developed world, where the majority of healthcare will be delivered outside traditional hospital settings.

Hospital group management will have to be familiar with and responsive to the frameworks being put in place to address social care needs and experience gained in the implementation of Fair Deal (see footnote 1. page 13) should be built upon. Good relationships with social care providers are clearly essential. Arrangements for cross financing between hospital groups and social care providers, if required, will need to be clarified by the Department of Health to ensure a transparent business-like relationship, with sensitive well targeted service provision. It is essential that the hospital group operational policies are such that hospitals can work in close synergy with the social care providers recognising and responding appropriately to the individual care plans that will guide the provision of services to patients in this area. The response of hospital groups to these requirements will be a component of the evaluation of hospital groups' performance as part of the process of seeking trust status.

2.2.5 A National Hospital Service Policy Context to Foster Autonomy

The goal of *Future Health* is to dismantle the 'command and control' system in health and replace it with a system of devolved autonomy where increasing control is given to the frontline. Ireland has some of the best healthcare professionals in the world. They deserve as much freedom as possible to deliver for the patient. There does, however, still need to be a clear national operational policy context provided for hospital groups which also allows them the necessary flexibility and autonomy to deliver effective and innovative management.

2.2.6 Key Complementary National Hospital Service Policy

As a precursor to the formation of hospital groups, the Department of Health needs to set out at a high level the objectives and requirements for hospital service reorganisation with the aim of removing, as quickly as possible, the fragmentation in hospital services which has impeded reform to date. This must be quickly followed by a detailed operational policy developed by the HSE in conjunction with the Department of Health. There must be a formal high level mechanism to ensure a coherent approach to progress the rationalisation and reconfiguration of services aimed at achieving the optimal hospital service nationally. This mechanism will provide a forum to engage in consultation with staff representative organisations to ensure that staff concerns are addressed. The operational policy will also be required to be cognisant of the requirements of the European Working Time Directive.

2.2.7 Relationship with the HSE and the Director of Hospital Services

The Programme for Government states that public hospitals will become independent not-for-profit trusts with managers accountable to their Boards. Pending the enactment of legislation to give effect to this policy intent, Hospital Groups will continue to operate within the policy and accountability frameworks determined for the HSE as set out in the relevant legislation. In this context, the relationship with the HSE and the Director of Hospitals in particular must be clearly defined and operated in a way that provides support and guidance to hospital groups and their Boards, setting clear operational policy parameters which are derived seamlessly from *Future Health* and overall Government policy on health.

Hospital groups must operate in accordance with an agreed policy framework and process to:

- reduce fragmentation of service delivery,
- maximise efficiency in a framework of managed competition,
- contribute to the integration of services at national level, and
- create more effective links with primary care.

An annual budget and employment ceiling should be developed for hospital groups whilst allowing maximum autonomy and flexibility in organisation, staffing, research and development, as well as other aspects of how their services are organised and delivered subject to compliance with agreed policy framework and process. This must also enable hospital groups to maximise innovation in the way they do their business, whilst ensuring any benefits of that innovation are openly shared and promulgated across all the health services.

2.2.8 Future Hospital Licensing

Proposals are to be brought to the Minister for Health regarding the licensing of public and private healthcare providers. Many elements of the Irish health service are already regulated and the licensing proposals are intended to apply to areas not already covered by these systems.[4] The key objective of the licensing framework is to improve patient safety by ensuring that healthcare providers do not operate below core standards that are applied in a consistent and systematic way. The proposed licensing framework will, it is envisaged, ensure mandatory standards and a legal structure through which HIQA can work with providers to ensure that these standards are met.

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[4] For example, mental health residential services must be registered by the Mental Health Commission under the Mental Health Act 2001, the Health Act 2007 provides for the registration of private and public nursing homes, children's residential centres and residential centres for people with disabilities (some provisions are not yet commenced), pharmacies are regulated by the Pharmaceutical Society of Ireland under the Pharmacy Act 2007 and there is legislative provision for statutory registration for a range of health professionals.

It would be most helpful if licensing legislation can be enacted, the effect of which is supportive of, and incentivises, the key objectives of hospital groups (and their successor trusts) in line with government policy. In the context of the introduction of UHI, a licensing system and an independent regulator for the licensing system will help assure both service providers and patients that the service they contract and consume are of the requisite standard. The establishment of hospital groups is intended to permit greater autonomy for providers of hospital care and to allow hospitals to be more responsive to the needs of their locality. Devolution of autonomy for hospital services to hospital groups will be a significant challenge that will require oversight to ensure that its operational criteria are met. The introduction of licensing can help hospital groups to move to a point of preparedness for the establishment of trust hospitals on a legal basis, by providing a framework to ensure that licensed hospitals/hospital groups are complying with core standards and other requirements under the licensing legislation. The mechanism for licensing hospitals, particularly in the context of groups/trusts, is currently under consideration. The Department intends to ensure the appropriate alignment of the objectives for optimally effective hospital groups within the legislative framework for licensing.

2.2.9 Inter-group and Cross Boundary Working

The removal of fragmentation or unnecessary duplication and the concomitant reorganisation of hospital services required for optimal effectiveness and efficiency in the delivery of high quality safe care is critical to successful inter-group working.

Managed competition (guided by overarching national policies) as well as co-operation between groups can incentivise and lead to the necessary reorganisation of services, mindful that, as *Future Health* states, up to 95% of care can in future be delivered in the community.

In relation to national and regional specialty services, inter-group working is as vital as the rationalisation of services within groups. Successful delivery of inter-group services will be a crucial factor in the evaluation of the performance of hospital groups seeking trust status.

MFTP will incentivise the rationalisation of services by the hospital groups and encourage the delivery of care at the most efficient point within and between groups; inter-group contracting for services both clinical and non-clinical will be needed. This will be actively required and sought by the HSE and its successors in the context of service commissioning. This is at the boundary of managed competition and co-operation and the correct balance must be achieved. It will be a feature of Service Level Agreements (SLA) and the Department of Health will need to set out a very clear policy and a regulatory framework to enable this to work smoothly.

2.3 International Overview Applied to Ireland

The key objectives of the Irish healthcare and hospital systems are to deliver access to high quality, safe patient care and value for money. In considering how best this may be realised in the provision of acute hospital services, consideration has been given to national reviews and reports on various aspects of the hospital system and to international academic literature on the issues of hospital reform, quality healthcare provision, financial management of healthcare, academic health linkages, political influence and organisational reform.

2.3.1 Policy Development in Hospital Reform

A search of the literature in relation to hospital autonomy and autonomising hospital reforms reveals a significant number of studies examining the hospital reforms that took place in many countries during the 1990s and 2000s. The range of reforms introduced has seen the traditional 'command and control' model replaced with greater or lesser autonomy, along with some degree of market-like incentives (Saltman et al, 2002). However, tension may develop between the rhetoric of devolution and the reality of large-scale organisational change, due to what the healthcare management scholar Henry Mintzberg refers to as the 'disconnected hierarchy' of healthcare; that is the fundamental gap between healthcare policy-makers and managers and those engaged in a clinical or operational capacity. Examination of the literature in the context of this report therefore aims to investigate and illuminate the thinking behind the policy direction indicated. (Mintzberg in Best, 1996)

2.3.2 Access

The Health Research Board (HRB) in a review of independent hospital trusts noted the disparity between the numbers of hospitals in each trust. The report concluded that this was caused by "the geographical spread of the specific trust; the distribution of services across a range of hospital locations and the provision of specialised services at some locations." (McCarthy, 2012: 7). It is anticipated that similar considerations will affect the formation of groups in Ireland, given variances of population density, existing services and the provision of supra-national specialist services at designated sites.

2.3.3 Quality of Care

Early hospital reforms in both Sweden and England were triggered by concerns for both efficiency and quality, with quality considered to be an important goal for public healthcare systems. Øvretveit and Gustafson (2002) define quality management as "a range of interventions which are more complex than a single quality improvement team project or the quality activities in one department" - underscoring its systemic nature. The importance of quality healthcare provision to patients is recognised by Saltman et al (2011), who note that, apart from financial sustainability, change is being driven by growing patient

expectations regarding quality, safety, responsiveness, and choice concerning healthcare providers. The preliminary findings of a major international study, conducted by the Leadership, Innovation and Knowledge Centre at Dublin City University (DCU) Business School, of approaches to systemic quality and safety identify four key supports for the provision of safe, quality care in hospitals:

- a facilitative culture,
- focused and influential quality and safety departments and committees,
- clear responsibility and accountability, and
- effective reporting systems.

(Dublin City University, 2012)

The provision of quality care will require commitment at the micro (ward), meso (individual hospitals) and macro (hospital group) levels in order to become successfully embedded. However, the formation of hospital groups linked strongly to an academic partner will also afford a unique opportunity for the development of supportive cultures and learning opportunities, supported by the Quality and Patient Safety Directorate of the HSE and targeted towards compliance with HIQA standards[5].

2.3.4 Financial Sustainability

Hospitals account for a major proportion of healthcare costs and thus are a key target for policy in this area. In Ireland in 2012 the approved allocation for acute hospital services was €3.58 billion. (HSE, 2012)

Some of the areas that have been targeted in the drive for greater efficiency in hospitals in Ireland include shifting from inpatient to day-case treatment ('stay today') and shortening the average length of stay (ALOS) having regard to clinical need. Furthermore, there is a focus on delivering care in the most appropriate setting and thus shifting more care from hospital to primary or community settings. Many of these approaches are common in other countries. In their study of hospitals in a changing Europe, McKee and Healy (2002: 49) observe that "It is widely believed that [hospitals] can be made to function more efficiently and that many patients can be treated more cost-effectively in other settings." It is clear from the literature that the implementation of public service (including hospital) reforms in general has been driven by the issue of costs, albeit in the context of other goals. This is evidenced in the Programme for Government 2011, which states "In the Irish context, we have seen the espousal of market-like reforms as a means of driving efficiency, and structural reforms as a means of underpinning equity and solidarity". This is supported by the contention that "Publicly operated healthcare systems could only afford to maintain solidarity by dramatically ramping up the efficiency with which public institutions operate." (Saltman et al, 2011: 20).

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[5] National Standards for Safer Better Healthcare, HIQA June 2012

Greater autonomy for hospitals is expected to lead to greater efficiency, thus helping to bring about financial sustainability. However, the international experience suggests that hospital autonomy does not necessarily result in better financial performance or bring an end to the need for injections of funding to cope with pressures. It will be important to examine whether hospitals are financially viable. It will also be important to have strong oversight of hospitals' financial performance.

The taxonomy of Verhoest et al. (2004) draws a distinction between financial management autonomy (how hospitals apply the resources they have) and financial autonomy (to what extent their financial resources are independent of public funding). The freedom to borrow holds out the benefit of attracting private financing to capital projects, and is one method of dealing with the funding constraints that are likely to be experienced in the system for some time to come. However, evidence from the countries studied is that hospital debt results in substantial risk for the public purse. Research indicates that considerable caution is required in regard to whether hospitals may be allowed to acquire debt and that the risk-reward trade-off should be balanced on the side of reducing risk. (Verhoest et al, 2004:101-118)

The separation of purchaser and provider functions within health systems, as well as the establishment of market-type conditions to a greater or lesser degree, are intended to incentivise or encourage hospitals to behave more like private enterprises in terms of efficiency. This is supported by the literature analysis, which indicates that private patient income may also be considered as a way of enhancing financial sustainability. Given the Government's commitment to the introduction of UHI in 2015, due regard must be accorded to the freedom to generate private patient income, having regard to the implications for equity.

2.3.5 The Tension between Quality and Costs

The literature review revealed that, when it comes to healthcare reform and hospital reform in particular, policymakers have in general cited both quality and cost as goals of any reform. Tension between these two objectives is present regardless of the hospital's structure. Where hospitals have greater autonomy, however, the evidence clearly points to the tendency for hospitals to focus on cost more than quality. The experience of both the Netherlands and England suggest that it is relatively easy for cost to trump quality when these two goals compete. It is important, therefore, to consider the issues of quality and cost in the Irish context and to consider how quality can be maintained, even where costs are constrained.

The need for managerial and operational autonomy over the use of resources, including staffing and employment, is highlighted in much of the literature examined. Balancing quality and cost has implications for the extent to which goals and objectives are set and monitored. This underlines the importance of a strong quality framework in Irish hospitals with effective oversight of quality and sanction where hospitals fail to meet quality objectives.

2.3.6 Governance and Autonomy

The level of autonomy which will be appropriate for hospital groups also requires careful consideration. According to Harding and Preker (2003), three sets of elements are said to jointly determine the behaviour of publicly run health services. These are: alterations to the relationship between healthcare providers and governments (governance); the market environment to which such organisations are exposed; and the incentives embedded in the funding or payment mechanisms (provider payment systems). Harding and Preker (2003) identified four types of hospitals: budgetary, autonomised, corporatised and privatised. Budgetary hospitals receive a line-item budget within which they operate, with managers being essentially administrators. This type clearly aligns most closely with the current model of HSE hospitals.

Both autonomised and corporatised models have some decision-making autonomy. Autonomisation is defined as "increasing the management autonomy of the organisation" while corporatisation is "transforming the hierarchical bureaucracy into parastatal corporations that are exposed to market-like pressures." Using Harding and Preker's model, the proposed trusts, as envisaged in the Programme for Government 2011, appear to align most closely with the corporatised hospital type, as do NHS trusts and Dutch not-for-profit hospitals; both with a strong focus on financial accountability and exposed to some market-like pressures. In this type, managers tend to have virtually complete control over all inputs and issues relating to the production of services. Indeed, the importance of giving hospitals control over operational matters, in order to allow them to respond effectively to external incentives, was clear from the literature review.

Corporatised hospitals also have a budget constraint or financial bottom line. Liquidation is the ultimate consequence of not remaining within budget. Hospital reforms have tended to be stepwise, with budgetary hospitals becoming autonomised and autonomised hospitals becoming corporatised (Rathwell, 1992).

The Irish approach so far to hospital reform seems to reflect the international experience in this regard. Hospital groups are a precursor to the establishment of trusts and will be required to prove their capacity and capability to move from the autonomised to the corporatised hospital type.

2.3.7 Management Framework

Health management and health reform literature emphasises the importance of operational control over resources and inputs. While a national approach to planning, service configuration and performance targets is seen as necessary, decision-making control over hospital-level resources and, in particular, staffing, is seen as crucial to effective management. The literature reflects a general belief that centralised staffing control adversely affects costs and efficiency.

The calibre, ability and motivation of managers will be critical in managing the tensions that arise between autonomy and accountability. Autonomy will not result in effective management without effective managers. How managers are appointed and supported, the nature of the skills required and the consequences for poor performance, will all require careful consideration.

2.3.8 Academic Linkages

Academic Health Centres seek to encourage closer collaboration between healthcare, education, innovation and research. The British Medical Association (British Medical Association Consultants, 2008) describes the benefits that academic medicine can bring to health services:

- questioning and critical appraisal of established knowledge;
- delivery of financial gain and contribution to economic growth;
- provision of new ideas, evidence and products, which bring about improved patient care and reductions in the cost of healthcare;
- direct benefits to patients treated;
- active contribution to a culture of high quality clinical services, and
- contributions to international healthcare.

The UK government outlined the principles underpinning the Academic Health Science Centre model as:

- excellence in biomedical, clinical and applied health research – this should be of international standing across a range of disciplines and have critical mass;
- excellence in patient care;
- excellence in undergraduate and postgraduate medical education and (as appropriate) in other areas of healthcare and health science education. (Department of Health, 2008)
- vision, ambition and partnership arrangements for delivering benefits in patient care, with an emphasis on benefits for the local community (National Health Service, 2009)

In Ireland, the potential efficiencies to be realised in undergraduate medical education and training by introducing "conjoint management, administration and logistical structures" were recognised in the Report of the Working Group on Undergraduate Medical Education and Training *Medical Education in Ireland: A New Direction* (the Fottrell Report) in 2006.

Separately in 2006, the report of the Postgraduate Medical Education and Training Group, *Preparing Ireland's Doctors to Meet the Health Needs of the 21st Century* (the Buttimer Report), recommended that "universities/medical schools/third level institutions should, in co-ordination with the postgraduate Training Bodies, have a central role in postgraduate medical education and training in the areas

complementary to clinical practice". It also suggested that more "collaborative links be developed between the universities, other third level institutions and the Training Bodies to underpin clinical research."

The Advisory Council for Science, Technology and Innovation also supported closer linkages between clinical and academic institutions, recommending in its report *Strategy for Science, Technology and Innovation 2006-2013* that "health research be developed as a frontline health service to guarantee world class healthcare for patients, to resolve health problems facing the population, and to attract and retain health professionals of the highest quality and to improve efficiency and effectiveness to the health sector."

A second report from the Advisory Council in 2006 - *Towards Better Health: Achieving a Step Change in Health Research in Ireland* - focused on developing the "quality and quantity of health-related research in Ireland", recommending that hospitals and universities should have "joint governance structures to ensure clinically-trained academic scientists have clinical time in hospitals, and also protected time for research" and that in the case of selected major teaching hospitals, "a single governance model between the hospital and its associated university should be explored".

The Advisory Council sought the promotion of academic leadership of research and the integration of research and clinical practice, with research as a "clearly stated component" of the mission of academic teaching hospitals and of the HSE, with each teaching hospital required to have a research strategy. The report takes cognisance of these varying but interlinked recommendations.

2.3.9 Other Key Challenges

In their book on *Organizing for quality: Journeys of improvement at leading hospitals and healthcare systems in Europe and the United States*, Bate, Mendel and Robert (2008*)* identify six key challenges: politics, culture, education, emotion, physical/technical and structure. Whereas challenges relating to structure, physical and technical enablement and education are quantifiable and relatively objective, the dimensions of culture, emotion and politics are perhaps less objective but nonetheless worthy of consideration.

2.3.10 Culture

Hospitals are one element in a healthcare system that also includes primary and community care delivery. They are essentially indivisible from other parts of the system: "No hospital can be autonomous and self-sufficient any longer in all spheres. Work has to be co-ordinated with other levels of care and across institutions in the interests of high-quality scientific research, for instance." (Saltman et al, 2011) In considering the formation of hospital groups, due regard must therefore be given to enhancing existing and/or forging new linkages across all spheres of activity, to foster a culture that is co-operative, positive and ultimately beneficial to both service providers and recipients.

2.3.11 Emotion

The role of the hospital is not limited to its participation in the healthcare system. McKee and Healy (2002) identify a number of societal roles for hospitals, including the creation of state legitimacy, the notion of the hospital as a civic asset and the hospital as a signifier of political ideology. Certainly, hospitals in Ireland and the level and nature of the services they provide are viewed as very significant by citizens. Hospitals can also be seen as social care providers (McKee and Healy, 2002) when social care elsewhere may not be available for a patient at a particular time. This is clearly a factor in the Irish system where the impact of delayed discharges of patients who are no longer acutely ill has long been a feature of public discourse. There appears to be a strong identification with the idea of the local hospital providing comprehensive services and of the local hospitals as part of the local community, contributing to the local economy. This can engender strong loyalty from local populations as well as from the specific hospital employee cohort. Hence, the maintenance and protection of local hospitals is an emotive issue in Ireland, as evidenced by local campaigns aimed at the retention of local hospital services.

2.3.12 Politics

In Ireland, ultimate political accountability for the healthcare system including hospitals is seen as necessary and right. However, this may give rise to tension between central government policy and local interests. De Vries maintains that "to restore the legitimacy of the state, we need to think about changes in government and bureaucracy in relation to serious long-term societal problems and the day-to-day problems of citizens". (De Vries, 2010: 4). The Irish public view Government as having a key role in both setting expectations and in major decisions that address national or system-wide issues. In terms of hospital services, this translates into a belief that the political centre should set out what is required from the hospital system and that it is then up to hospitals to deliver. This is similar to the ethos which prevails in both the Netherlands and England, where the aim is for the political system to provide oversight but to step back from direct control of the system. This is reflected in the literature review as a key tension between autonomy and political accountability, with autonomy being threatened when hospitals do not perform as expected. As expressed by Verhoest et al (2004), "autonomy produces a loss of public accountability and political control." Ideally, the move to hospital groups and thereafter to trusts needs to be supported by a suitably graduated level of autonomy to both reassure the public and to allow hospital groups, and subsequently trusts, to manage hospital services in a way that will drive service reforms and provide the maximum possible benefit to patients.

2.3.13 Work to Date on Hospital Service Reorganisation

When the Health Service Executive was established in 2005 it inherited a complex hospital structure that was poorly configured to meet the needs of twentieth century Ireland. *The Report of the National Task Force on Medical Staffing (2003)*, in summarising a number of drivers towards changed delivery of service,

stressed the importance of a safe, high-quality service to patients and saw the move to team-based consultant-provided service provision as key to achieving this. Critical mass was seen as an essential determinant to service provision as evidence in support of better patient outcomes when patients were treated in units with appropriate numbers of specialist staff, with high volumes of activity and access to the right diagnostic and treatment facilities. The report recommended that health professionals should work as part of multi-disciplinary teams, centred on delivering quality patient care on a 24/7 basis within an integrated network of hospitals.

The focus on the reorganisation of our hospital services in recent years has been informed by a number of strategic service reviews and programme developments including:

- PA Consulting review of acute hospital bed utilisation;
- PA Consulting review of acute bed capacity requirements for Ireland until 2020;
- Prospectus review of adult critical care;
- KPMG review of maternity and gynaecology services in the greater Dublin area;
- 2006 Teamwork *Improving Safety and Achieving Better Standards - An Action Plan for Health Services in the North East;*
- Horwath and Teamwork *Review of Acute Hospital Services in HSE Mid-West - An Action Plan for Acute and Community Health Services;*
- Howarth and Teamwork, (2009) *A Review of Acute Services in HSE South* followed by *Reconfiguration of Acute Hospital services, Cork and Kerry- A roadmap to develop an integrated university hospital network* (2010*);*
- The National Acute Medicine Programme; and
- The National Emergency Medicine Programme.

In implementing service changes informed by these reviews and reports the overall objective is to ensure that:

- the majority of patients, those who require only a routine, straightforward level of urgent or planned care, will be safely managed locally, with treatment being delivered at home or as close to home as possible;
- the minority of patients, who require true emergency or more complex planned care, will be safely managed in designated acute regional centres of excellence, where all the relevant clinical expertise is concentrated so that consultant-delivered, high-quality care is available around the clock;
- patient outcomes are the optimum that can be achieved and compare well with international standards; and

- the role of smaller hospitals has been changing but will still involve them in the delivery of significant volumes of less complex care, especially in day surgery, medicine, diagnostics and outpatient services.

The focus on the reconfiguration of acute hospital services has also been driven by concern regarding:

- patient safety: there are concerns about the safety of some services, largely where patients have complex needs;
- treatments in hospitals that have an insufficient volume of cases to achieve the best outcomes;
- quality: demonstrably better outcomes can be achieved for patients (as already demonstrated and broadly accepted by the public in the case of cancer treatment);
- cost: there is currently too much wasteful duplication of services;
- feasibility: compliance with the European Working Time Directive cannot be achieved unless we can rationalise 24-hour service arrangements.

The introduction of hospital groups has the potential to be a key enabler to drive service quality improvements and to progress the required service reconfiguration.

2.3.14 Conclusion

The comparative review carried out by the Health Research Board (HRB) of independent hospital trusts in the UK, Australia, Canada, France, the Netherlands, New Zealand and Spain found that the factors which contribute most to successful trusts are:

- united vision,
- large stable pool of funding,
- successful internal market as a result of population density,
- number of services which could provide same treatment within easy reach,
- clearly designed process for establishing, governing, developing and monitoring trust(s), and
- significant legal and regulatory supporting structures & instruments created.

The realisation of most of these factors is outside the remit of this initial phase of making recommendations on the establishment of hospital groups. Nonetheless, it provides a direction of travel upon which the formation of hospital groups will take the first steps.

3. The Formation of Hospital Groups – Project Overview

3.1 Objectives

The objectives of this project are to:

- create a small number of hospital groups nationally;
- provide them with a governance and management framework;
- include in each group a primary academic partner to facilitate well organised education, training, research and innovation activity in the group;
- define the process and criteria for the appointment of interim chief executives of hospital groups, and
- recommend a process and criteria for the appointment of chief executives of hospital trusts.

3.2 Process

On March 28th 2012, the Minister for Health wrote to the Chairman of the Health Services Executive under Section 10 of the Health Act (2004) to provide him with a policy direction on the development of new management arrangements for public hospitals designed to support the move to universal hospital care (see Appendix 2). Specifically, he requested proposals on:

- the creation of hospital groups as quickly as possible this year on an administrative basis (ahead of the establishment of hospital trusts) with a single consolidated management team with responsibility for performance and outcomes within a clearly defined budget and employment ceiling for each hospital group;
- the establishment of executive teams for each group with the autonomy to reconfigure services across the group subject to an agreed policy framework and approval process; and
- the creation on an administrative basis of boards for each hospital group with suitable individuals being selected through an appropriate process for appointment as non-executive members of these boards.

Further to this letter, the Minister wrote to Professor John R Higgins on 1st June 2012 appointing him to chair a Strategic Board to assist the Department of Health in the design and establishment of hospital groups as a transition to independent hospital trusts. A Project Team was appointed to support this work. It was agreed that the completed report, on phase 1, would be presented by the Chairperson of the Strategic Board, to the Minister for Health by the end of November 2012. Membership of the Strategic Board and Project Team are provided in Appendix 3.

3.3 Phasing

Phase 1 (2012) addresses the formation of hospital groups and the provision of a governance and management framework for their establishment on an administrative basis. Phase 1 is addressed substantively in this report. In providing recommendations for a governance and management framework, the Strategic Board has taken cognisance of the recommendations contained in the *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* (HIQA, May, 2012) (also known as *HIQA Tallaght Hospital Investigation Report)* as they apply to hospital groups.

Phase 2 (2013-2015) will address the implementation of hospital groups and their evaluation prior to the establishment of independent hospital trusts on a legislative basis. It is anticipated that a national steering group will be required to monitor and drive implementation and devise an evaluation process to determine which groups qualify for trust status when the necessary legislation is in place.

3.4 Terms of Reference (Phase 1)

- To assist the Department of Health & Children in the design and establishment of hospital groups as a transition to independent hospital trusts.

- Establish a Project Team.

- Establish a Strategic Board.

- Develop criteria for the formation of hospital groups on an administrative basis.

- Make recommendations on the composition of hospital groups including the relationship with relevant universities.

- Develop the criteria to be met in order to form each group of independent hospital trusts.

- Agree a process for the appointment of definitive CEOs of hospital trusts.

- Make recommendations on specific arrangements to accommodate (i) stand-alone maternity and (ii) psychiatric hospitals.

- Define **governance** criteria with a view to the development of:

  o effective administrative alignment of services;

- high quality decision-making and leadership, including clinical leadership;

- clarity of accountability and reporting arrangements; and

- fostering a learning culture and links to universities.

- Define **management** criteria with a view to the development of:

    - clarity on the levels of management required for the hospital group and for individual hospital sites;

    - clarity on budgetary responsibility at group and site levels;

    - effective clinician involvement in management decision-making;

    - management structures for linking with third level institutions and training bodies;

    - establishing management systems which are not unduly bureaucratic;

    - management accountability to governing boards;

    - management responsiveness to patients and public; and

    - the qualifications and experience of interim transitional CEO.

- Present a report to the Minister for Health.

4. Methods of Communication and Engagement

Information gathered from national policy documents, international experience, meetings with hospital leadership teams and other health agencies, and from formal submissions, together with quantitative analysis of hospital activity and population distribution informed Project Team and Strategic Board deliberations and subsequent recommendations regarding group formation.

4.1 Communications Approach

The Project Team employed an open and inclusive approach to communication and engagement in recognition of varying stakeholder interests. This involved:

- direct face-to-face meetings,
- questionnaire completion by hospitals, and
- submissions from interested parties which outlined their views and suggestions regarding the formation of hospital groups.

Meetings commenced in June 2012 and continued until report completion in November. The breakdown of the groups engaged with is outlined below:

Category	Groups represented
HSE & HSE-funded hospitals	54
Independent Hospitals Association of Ireland	21
Association of Voluntary Hospitals CEOs	26
Voluntary Hospice Group CEOs	6
Regional Directors of Operations (RDOs)	4
Patient Advocacy	1
Medical Schools/University Deans	6
Regulatory Bodies	7
Post-Graduate Education	5
Clinical Care Programmes	8
Other agencies	8

The aims of the consultation process were to:

- Raise awareness and promote a shared understanding among hospital management of the vision and benefits of hospital groups/ trusts.

- Provide opportunities for management teams to contribute views, ideas and solutions to support the effective formation and functioning of hospital groups.

- Ensure that as many hospitals and healthcare agencies as possible are informed of plans, timelines, activities and developments necessary to deliver this project.

- Promote a shared commitment to the design and establishment of hospital groups in the best interest of patients and the wider community.

Face-to-face communication was the preferred choice of meeting and, when this wasn't feasible, video and teleconferencing was employed. There was a high level of awareness and enthusiasm among stakeholders for the design and establishment of hospital groups. The Project Team requested that each hospital be represented by Hospital Managers, Directors of Nursing, Clinical Directors, Chairs of the Hospital Boards, members of the EMB/Hospital Board and other senior staff and partners of the hospital.

4.2 Common Meeting Agenda

All meetings followed a similar format, with the agenda reflecting the project's terms of reference. Inevitably thinking evolved over the course of the consultations, informed by the views presented. Participants were encouraged to speak openly and freely. They were afforded the opportunity to make submissions where they wished to have their views recorded. It was an iterative process. The Project Team was open to all the views presented and is grateful to participants for their robust engagement. The Project Team endeavoured to capture the issues raised by them in subsequent meetings, to further develop thinking. When conflicting views emerged follow-up meetings were arranged.

The Chairperson outlined the project context and process including:

1. Overview of communication process.
2. Timelines.
3. Establishment of Project Team.
4. Establishment of Strategic Board.
5. Opportunity to make submissions to Project Team.
6. Views on hospital groups and what hospital(s) they thought they should or should not be grouped with.

7. Current management structure and how they saw it evolving in the new hospital group structure.
8. Current governance structure and how they saw it evolving in the new hospital group structure.
9. Current academic linkages and how such linkages could evolve.

4.3 Data Analysis

Detailed analysis of hospital activity was undertaken; see Appendix 4 for a summary.

The analysis considered:

*   hospital activity (Inpatient, Day-case, Elective, Emergency, Birth-rates, Maternity / Newborn activity[6] OPD[7] and ED[8] attendance);
*   catchment populations[9] and population patterns of acute hospital usage by county[5];
*   inter-hospital transfers[5];
*   travel times[10].

A questionnaire (see Appendix 5) was circulated to all hospitals which captured information such as:

*   range of services, specialty and subspecialty provision;
*   staff Whole Time Equivalent (WTE);
*   strategic and operational alliances with other hospitals, for example joint appointments, joint on-call rotas, cross-cover arrangements, referral arrangements, and so on, and academic linkages.

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6   HIPE data Table 2011 Health Intelligence Ireland, HSE
7   HSE, Performance Monitoring & Control Committee, Performance Monitoring Supplementary Report, Dec 2011
8   Performance Monitoring & Control Committee, Performance Monitoring Supplementary Report, Dec 2011,
9   Census 2011, CSO
10   Health Intelligence Ireland, HSE www.hse.ie/acutehospitaltraveltimes

5. Consultation Feedback

There was general consensus that hospital groups were consistent with:

- Better patient outcomes.
- A valid mechanism for delivering high quality safe patient care on a sustainable basis. Hospitals would be strengthened individually and collectively in order to achieve hospital group self-sufficiency.
- Efficient and effective timely access to care, in the appropriate location, with reduced duplication and maximum sharing of resources.
- Enhanced local care provision.
- More integrated care for patients as the entire spectrum of acute hospital care for a hospital group would be under single management. This should facilitate integration with other health services in the same region, e.g. intermediate care and primary care services.
- Creating more robust and productive academic alliances which would promote education, training, innovation and research.

There follows feedback particular to each sector (in alphabetical order).

5.1 Acute Hospitals

There is a strong desire among acute hospital management and clinical personnel to take responsibility for their own future, if given the scope and authority to do so. They are concerned by the lack of confidence, public and professional, in the 'system' as it exists. They acknowledge that the current acute hospital structure is unsustainable and recognise the benefits of hospital groups with strong university relationships. They also recognise the requirement for the reconfiguration of hospital services, but realise that hospital reconfiguration is not within the remit of this project. Some have already formed or considered alliances but, on the whole, they see the challenges of an integrated single management and governance structure if hospitals are to function as a group.

The common themes emerging from consultation with acute hospitals are summarised as follows:

- Hospital groups should exercise control and discretion over the allocated budget (this includes WTE management).
- There is a lack of clarity regarding strategic versus operational management and frustration at perceived 'micromanagement' of hospitals in the current system.

- Smaller hospitals, voluntary and HSE, are fearful of being subsumed by larger ones. Concern is centred on the risk of asset stripping of smaller hospitals and uni-directional flow of services to the centre.

- Hospitals are concerned at the loss of what they perceive to be their unique hospital culture (identity/values, and so on).

- Hospitals see representation on the group board as a means of addressing the concerns described above.

- Each new group needs a clear corporate identity.

- Hospitals suggested that groups be renamed to reflect the creation of a new entity.

- Strong leadership will determine the degree to which hospital groups succeed in building a group identity and advancing real reform of their clinical services.

- Relationships between and across hospital groups, primary care, and specifically Model 1 hospitals must be developed and supported. Hospitals are dependent on Model 1 hospitals to manage certain patient care pathways.

- There is a difficulty in recruiting and retaining staff, particularly Consultant Medical and Non-Consultant Hospital Doctors (NCHDs), outside the main population centres. Clinicians and managers see hospital groups as a means of addressing this problem.

- Inter-hospital patient transport should become a group responsibility. As the reconfiguration of services occurs within groups and more robust clinical governance is introduced, patient transfers will increase.

- Integrated ICT systems are a requirement of a functioning hospital group and will pose an operational challenge.

5.2 Critical Care Retrieval

The National Critical Care Programme is supportive of hospital group development, believing that connectivity between hospitals within a single clinical governance framework is key to effective inter-hospital transfer and retrieval of critically ill patients. It has developed a critical care model comprising (a) regulatory and professional standard inputs and (b) critical care programme outputs. The Critical Care Programme adopts the 'hub-and-spoke' structure that should work well in a hospital group of mixed Model 2, 3 and 4 hospitals. The model sees a Critical Care Service in a Model 3 hospital, Model 4 hospital and Model 4 super-regional hospital, no critical care service in a Model 2 hospital but bi-directional Critical Care Retrieval between Model 2 hospitals and Model 3/4 hospitals. Inter-hospital relationships should adhere to recommendation SOC.5 of the HIQA *Report of the Investigation into the Quality and Safety of Services and Supporting Arrangements Provided by the Health Service Executive at Mallow General Hospital* (April 2011) which calls for national mandatory patient transfer and acceptance protocols to ensure the immediate and safe transfer of critically ill patients to a unit providing the required level of intensive care. A single governance and management framework for each hospital group will facilitate implementation of this recommendation.

5.3 General Practice

The Irish College of General Practice (ICGP) is the body that is responsible for education, training and standards in General Practice. It had a strong view that, in order for hospital groups to function effectively, communication with local GPs at all levels of group activity is essential. The experience of the ICGP is that communication is not always easy and operates in varying ways and to varying effect across the country. Hospital groups should communicate at both individual hospital and group executive level. It is important that GP training and placement is not negatively affected by the creation of hospital groups. Another key area is access to diagnostics. Recent advances in ICT infrastructure (for example, electronic transmission of laboratory results) should be maintained and increased. The development of hospital groups is seen as an opportunity to standardise electronic hospital referral systems in each region.

The ICGP concurs with the view expressed by many hospitals that Community/Model 1 hospitals are an important resource that ought to be maximised. Shared clinical governance is already in place in many such institutions and permanent staff within them are generally either directly employed by the HSE or a HSE funded agency. Current utilisation of this resource needs to be enhanced and should be discussed by hospital group management and their local GPs on a case-by-case basis.

5.4 Healthcare Education, Post Graduate Training and Professional Regulatory Bodies

This is a time of unprecedented change in education, training and professional regulation in Ireland. Virtually all healthcare education, training and regulatory bodies are linked to the acute hospital sector, though not exclusively so, and to varying degrees. They were keen to preserve the hospital linkages necessary to ensure the quality of professional health practitioners. They were assured that the development of hospital groups would not impede this process and would not negatively impact on existing capacity across the full range of hospitals in the country. They recognised that posts and rotations may need to be restructured, particularly if services are reconfigured following the establishment of trusts.

The provision of postgraduate medical training shall remain the remit of the postgraduate training bodies under the auspices of the Medical Council. This is particularly important to ensure the maintenance of a single national standard for the provision of postgraduate medical training based around the specific requirements of each specialty, regardless of the location of delivery. It remains the responsibility of the relevant training body to define and ensure delivery of training programmes at Basic Specialist Training (BST), Registrar Training Programme (RTP) and Higher Specialist Training (HST) Level to meet the standards required for specialist certification by the Medical Council.

A training body may approve a hospital group as a suitable entity for the support of postgraduate medical training including individual posts and/or rotations within the group, or across groups, having regard to

meeting the following criteria: the requirements as set out in the curricula and assessment protocols; the structure and delivery of service as required to meet standards and experience of training; the approval and appointment of trainers; and the definition within each specialty training programme of elements to be delivered locally within the hospital group and centrally within the training body. Within this context, appointments of trainees by the training body to approved rotations/posts may be made at hospital group level. This will align with the decision to make all NCHD appointments at group level.

Training bodies will interface with group executive management teams to support the delivery of postgraduate training within the group. In particular, the training body will liaise with the Chief Clinical Director on matters relating to service structures and standards as they relate to the creation of an appropriate training environment, and in light of service models defined by National Clinical Programmes; and with the Chief Academic Officer to identify opportunities for co-ordination and support across undergraduate and postgraduate education and training.

5.5 Health Information and Quality Authority (HIQA)

Many of the recommendations in this report are based on the recommendations of the HIQA *Tallaght Hospital Investigation Report*, particularly those relating to corporate governance. HIQA clearly recommends a competency based board of limited size rather than a representative board of unlimited size. There is an acknowledgement that some hospitals perform better than others and that this should be addressed when deciding how to group hospitals. HIQA recommends a clear differentiation between the roles of a health service funder and a health service provider. This principle should be followed in the way hospital groups relate to their funders. All hospital groups should provide an assurance framework which would include key performance indicators for high-quality, safe patient care and patient perception.

5.6 Independent Hospitals Association of Ireland

The private hospital system in Ireland provides a significant amount of planned care and, increasingly, emergency care. As UHI is introduced, and a single tier health system emerges, the distinction between private and public healthcare will diminish and the relationship between the two will change.

There is a willingness in the private hospital sector to consult, co-operate and collaborate with hospital groups as acute care develops regionally. Private hospital representatives outlined examples of existing co-operation between the public and private sector and urged that private hospitals wishing to co-operate with the new hospital groups should be allowed to develop contractual care arrangements with one or more hospital groups and develop their services in a complementary way in the overall interest of patient care.

5.7 Irish Blood Transfusion Service (IBTS)

The IBTS is currently rationalising its model of service delivery. They propose to develop national distribution networks. An electronic blood tracking system will be introduced to each hospital. Individual hospitals will be designated as hubs, ideally at least one for each hospital group. Blood and blood products will be re-routed between hospitals in each hospital group. Eight networks have already been established but the current ICT system is flexible enough to accommodate the design of hospital groups.

5.8 Laboratory Medicine

The HSE engaged the services of DKM economic consultants who assisted in the twin tasks of:

1. cost benefit analysis of the various options for reconfiguring Laboratory Medicine Services, and
2. preparing an outline business case in support of the preferred approach to service reconfiguration.

The scope of this phase of the process was confined to blood science tests and excluded areas such as microbiology and histology. The outcome is a recommendation to reconfigure the service with a significant reduction in the number of laboratories processing cold laboratory tests. 'Hub and spoke' and 'cold and hot' service configurations have emerged. The strategic direction of travel that has emerged for Laboratory Medicine Services should be closely aligned with the establishment of hospital groups. A national transport/logistics solution is required for 'hub and spoke' delivery models to be effective. This solution will be sensitive to the design and establishment of hospital groups.

5.9 Maternity Services

High-quality maternity services are provided through variable structures in Ireland. There are three stand-alone maternity hospitals in Dublin, each with its own Master who combines the role of senior clinician and chief executive officer. These hospitals are linked to acute general hospitals for gynaecology services and act as local tertiary and national subspecialty referral centres for other obstetric units. Outside Dublin, maternity hospitals/units are integrated with acute hospital management, either on the same site (for example in Cork) or located off-site (as in Limerick).

The national clinical programme in obstetrics is of the view that maternity services should be formally organised nationally into a trust. This would ensure that maternity services are configured in a fashion complementary to the new hospital groups. The arguments offered to support this view included:

- The long standing success of the Dublin maternity hospitals and their unique (for Irish hospitals) international leadership role.
- The difficulty maternity services experience in protecting their budgets when they are integrated with acute hospitals.
- There is recent evidence in other countries of the successful co-location of maternity hospitals with acute general hospitals, while retaining separate governance structures.

While the Dublin maternity hospitals share these concerns regarding governance, they expressed a strong enthusiasm for the new group structures and for co-location. The issues listed above are as yet unresolved. They are likely to form the basis of further discussions with the maternity hospitals regarding their exact governance arrangements during the planning phase for hospital trusts.

5.10 National Ambulance Service (NAS)

The National Ambulance Service (NAS) responds to calls which can be separated into three broad categories:

- 999 emergency calls
- intermediate care patient transfer
- inter-hospital transfer of critically ill patients

The Ambulance Service has introduced a new grade of Intermediate Care Operative, the Emergency Medical Technician (EMT), trained in order to allow a tiered service provision to respond more effectively to service requirements as outlined above. The Intermediate Care Service (ICS) uses a double stretcher vehicle which can be used for routine patient transfers as well as critical care retrieval with appropriate clinical support and equipment on board. This tiered service provision provides benefits to patients and efficiency in the use of resources, specifically through freeing up of emergency resources to focus on emergency life-threatening calls.

There is a critical interdependency between the configuration of services within hospital groups and the ambulance service. Early engagement is required with the NAS as hospital groups align and transition to trust status. This is particularly the case if services reconfigure within a group. Ambulance resources currently linked to and/or based around hospitals must be evaluated as hospitals realign to ensure resources follow activity. The NAS wishes to be established as a trust in its own right. The establishment of a trust would afford it the flexibility to respond to changes within hospital groups while maintaining essential emergency response services for the country.

The service currently operates bypass protocols for Obstetrics, Paediatrics, Stroke ST Elevation Myocardial Infarction (STEMI) and Trauma, as determined by National Clinical Programmes. The NAS has developed Intermediate Care Vehicles (ICV) services on a limited basis in North West (Sligo/Letterkenny), South Dublin (to respond to ED changes in St Columcille's Hospital, Loughlinstown) the South (Mallow and Bantry), the West (Roscommon and Galway) and the Midwest Region. The service has a Service Level Agreement (SLA) with the Air Corps and the Irish Coast Guard for the provision of the air ambulance service. There are established relationships with the ambulance service in Northern Ireland and patients in border areas and in some instances; they are transported by the NAS to hospitals in Northern Ireland. For

instance, the NAS trauma bypass protocol has been implemented in the Inishowen peninsula, allowing multi-trauma patients to be transported to Altnagelvin Hospital rather than Letterkenny Hospital.

The NAS has an SLA with the Irish Air Corps for the provision of inter-hospital transfer via air ambulance. More recently, the NAS has agreed a MoU with the Irish Air Corps for the provision of an Emergency Aeromedical Service (EAS) for a pilot phase of one year with a review after nine months (February 2013). The Irish Coast Guard also provides emergency aeromedical assistance to the NAS. There is potential to build on cross-border relationships particularly in the provision of emergency aeromedical services. An emerging issue is helicopter access to hospitals, especially on the east coast. Hospital groups should include helipad construction in future development plans.

5.11 National Cancer Control Programme (NCCP)

The HSE National Cancer Control Programme (NCCP) was established in 2007 to reorganise cancer services to achieve better outcomes for patients. There are four designated cancer control networks and eight cancer centres, see below. The recommendations contained in this report are not in conflict with existing NCCP arrangements and do not propose to dismantle any of the existing NCCP centres or radiation oncology services.

Network	Hospitals
HSE Dublin – North East	Beaumont Hospital
	Mater Misericordiae University Hospital
HSE Dublin – Mid Leinster	St James's Hospital
	St Vincent's University Hospital
HSE South	Cork University Hospital
	Waterford Regional Hospital
HSE West	UCH Galway (satellite: Letterkenny)
	Mid-Western Regional Hospital, Limerick

The NCCP is working to ensure that designated cancer centres for individual tumour types have adequate case volumes, expertise and concentration of multidisciplinary specialist skills.

So far the Programme has:

- Reorganised all breast cancer diagnostic and surgical services into the eight cancer centres (plus an outreach service in Letterkenny General Hospital).

- Integrated referrals from BreastCheck and CervicalCheck screening programmes into hospitals' diagnostic and treatment pathways, nationally.

- In November 2012 implemented Colorectal Screening (BowelCheck) with co-ordinated colonoscopy services in hospitals.

- Established Rapid Access Diagnostic Clinics for prostate cancer and for lung cancer in all eight cancer centres.

- Established a national centre for pancreatic cancer surgery (operating on two sites).

- Centralised all lung surgery into four cancer centres.

- Developed a national service for ocular cancer.

- Developed a single national programme (operating on two sites) for the management of brain tumours and other central nervous system tumours.

- Developed a national programme for oesophogo-gastric cancers in one national centre with three satellites.

- Developed national GP referral guidelines and standard referral forms for breast, lung, and prostate cancers, making the referral process more seamless, safer and more efficient.

- Developed electronic cancer referral for breast, prostate and lung cancer, in collaboration with a broad range of stakeholders to ensure rapid referral of patients with suspected cancer in a secure manner.

- Developed a Community Oncology Nurse Programme, an initiative to integrate medical oncology care between acute hospital and community settings.

- A national medical and haematology hospital drug management programme is in the final phase of development for 2013.

- Developed and implemented a training programme for nurses who work in primary care, with a particular focus on practice nurses. This course covers cancer prevention, referral and patient assessment, treatment and post-acute care.

Radiation Oncology (Radiotherapy) Services

New radiation oncology facilities at St James's Hospital and Beaumont Hospital were completed and opened under Phase 1 of the National Plan for Radiation Oncology in 2011. The new centres reflect the latest advances, equipment and expertise available internationally and deliver an increase of 50% in the number of linear accelerators in the Eastern region (from eight to 12). For patients, this means improved access, the most advanced technology, increased professional staffing levels and a revised pathway, so that they now start treatment significantly sooner than before and in line with the best international standards. The Irish Government has committed to making a significant capital contribution to the provision of a satellite centre

for radiation oncology in Altnagelvin Hospital, linked to Belfast City Hospital. This contribution recognises the fact that approximately one third of the patients who will attend the proposed Altnagelvin Centre will be from Donegal and surrounding areas. Capital funding is now in place to build and equip new radiotherapy facilities to expand services in Cork University Hospital and Galway University Hospital, and planning for these is underway.

5.12 National Clinical Programmes

The Project Team engaged with national clinical programmes, meeting individual programme leads on request.

National clinical programmes have proved to be an effective means of co-ordinating the delivery of treatment for specific conditions to a consistent standard. The programmes' mission is to "deliver better care through better use of resources." Every programme has a set of objectives grouped under three headings:

1. Improve quality: for example, reduce the incidence of stroke, heart failure and blindness due to diabetes.
2. Improve patient access: for example, reduce outpatient wait time, reduce time to see senior doctor in an Emergency Department.
3. Reduce cost, including average length of stay, and so lessen bed utilisation.

These objectives are relevant to every hospital in the system and consistent with the development of Hospital Trusts. National clinical care programmes will continue to provide site-specific targets within hospital groups to improve patient access and avoid over concentration of resources in the main tertiary centre. In this way they can help to ensure equity of access and treatment to patients, the full and effective use of each site in the group and the development of good relations with primary care providers.

5.13 National Paediatric Hospital

The location of the National Paediatric Hospital (NPH) is outside the scope of this report. In November 2012 the government decided to develop the new children's hospital on the campus of St James's Hospital in Dublin, and it is expected to be completed in 2018. Before then the two paediatric hospitals in Dublin and the paediatric service in Tallaght will not be included in the hospital groupings, but will form a group of their own with appropriate governance arrangements. Outside Dublin, paediatric units are located in acute hospitals. These paediatric units will have strong clinical linkages with the National Paediatric Hospital as an integral part of a national model of care for paediatrics, in a framework provided by the National Paediatric Programme.

5.14 Northern Ireland

Hospitals near the border with Northern Ireland (N.I.) have SLAs with their N.I. counterparts. *The Compton Review* (2011) recommends that specialist services in N.I. should be networked with hospitals in the Republic "to ensure that the highest quality services are delivered" and that "services which have such a low volume that they cannot be sustained to a high quality in NI, even without networking to other tertiary centres, should continue to be delivered outside of Northern Ireland". (Compton Review, 2011) Stakeholders on both sides of the border were keen to preserve existing arrangements and to further develop targeted commissioning contracts with the potential to form formal cross-border hospital networks.

5.15 Patient Advocacy

Quality and patient safety should be at the core of all proposals regarding the design and formation of hospital groups. The focus is not merely on maintaining quality but also on achieving improvements in the quality of services available to patients. There is a requirement to achieve efficiency as part of any realignment. Resource allocation should focus on patient and population requirements and be allocated equitably across hospitals in groups, regardless of individual provider interests.

An assurance that the majority of care would continue to be provided locally was welcomed. A particular area of concern was the provision of cancer care and assurances were given that existing NCCP arrangements would continue. The patient advocate view was that research and training opportunities should be pursued so that patients could benefit from innovative treatments and procedures. Finally, the evaluation of hospital groups in advance of legislation to formally establish hospital trusts was commended.

5.16 Psychiatry

The reform agenda for the psychiatry services in Ireland is outlined in the HSE policy document *A Vision for Change.* There has been a substantial shift from large stand-alone psychiatric hospitals towards community based services. The provision of a high-quality acute in-patient unit based in a general hospital is an integral component of a community-based mental health service. Substantial and important services will continue to be provided by acute inpatient psychiatry units located in general hospitals. In addition, psychiatry provides essential liaison psychiatry services (child and adolescent, maternity, general and old age) and on-call service to Emergency Departments. A Vision for Change[11] notes the need for one acute 50 bed in-patient unit per catchment area of 300,000 population.

This acute in-patient unit should be located in the 'major' or 'regional' hospital, while taking into account the location of existing units; in some areas the 50 beds can be provided in two units of 25 beds each.

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11 A Vision for Change, HSE, (2006)

Governance of acute psychiatric units is informed by the provisions of the Mental Health Act 2001.

A strong view was expressed that, subsequent to the formation of hospital groups, the new group management team should ensure the psychiatric services are considered and consulted in advance of any proposed service changes to ensure that the psychiatric services are involved in decision-making.

5.17 Quality and Patient Safety Directorate

The focus of this directorate is on quality and patient safety as an integral component of all elements of service delivery. The HSE Code of Governance[12] determines its direction.

The objective is that every clinical and social care action is aligned within a clinical governance framework. The priorities of the directorate are to build clinical leadership capacity, develop cultures supportive of clinical governance and focus on systems and methodologies for clinical governance.

The role of the Clinical Director (CD) is central to clinical governance. The directorate envisages that clinical governance will be driven at an executive level by the Hospital Group CD and on each site where a CD exists, in addition to four specialty CDs for hospital groups: Women and Children, Perioperative Care, Diagnostics and Medicine.

5.18 Medical Rehabilitation

The National Rehabilitation Programme proposes the establishment of four managed clinical networks to achieve the delivery of Rehabilitation Medicine in Ireland. These networks would be run by a Network Manager and Clinical Lead to deliver services, predominantly via existing resources, across the full spectrum of the health services; for example, primary and continuing community care, acute general hospitals and specialist referral centres. Each network would be overseen by a steering committee. The National Rehabilitation Hospital (NRH) would be within one of the networks. Managed Clinical Networks would operate within and across hospital trusts.

The NRH is located in Dún Laoghaire, Co. Dublin, and is currently part of the Dublin Mid-Leinster region of the HSE. It provides local, regional and national level care. The strong preference of the National Rehabilitation Programme is that the NRH would not become part of a hospital group.

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12 HSE Code of Governance (2011)

5.19 Universities and Academic Linkages

Existing links between hospitals and academic teaching institutions have grown in an ad-hoc manner. Academic spheres of influence have developed through individual initiatives and traditional alignments. Different alignments exist for different clinical professions, nursing and medicine being obvious examples. There are often strong linkages between the main teaching hospitals and their partner medical schools, mainly through joint appointments and joint input into healthcare training. Existing undergraduate relationships in all clinical professions should remain in place but be set down in written form, so that each group has an accurate record of its education, training and research relationships. After the formation of the hospital groups, changes to current undergraduate arrangements should only happen on the basis of discussion and agreement.

5.20 Voluntary Hospice Group

Generally hospices are separate to the acute hospitals. Although most consultants in palliative care medicine hold joint appointments between acute hospitals and hospices, opinion is divided as to the extent to which services ought to be integrated with the acute hospital sector. A substantial proportion of hospice service is directed towards the care of the dying patient and their family in the community and in the local hospice. A clear view was articulated, based on their experiences over the past few years, that the hospice service ought to be funded through an acute hospital directorate rather than a community services directorate. The Voluntary Hospice Group indicated that they require more time to consider the options that arise from the formation of hospital groups. Determination of the strategic direction of the hospice movement is outside the scope of this project.

6. The Formation of Hospital Groups

6.1 General Principles

The overall aim is to create viable and sustainable groups, capable of meeting the acute hospital needs of the population of Ireland. It is clear from patterns of usage analysis that the vast majority of acute hospital care is provided locally. The groups will adhere to the principles of the national clinical care programmes and *The Framework for Development - Securing the Future of Smaller Hospitals*, thus enhancing local care. Hospital groups will facilitate co-operation and synergy to achieve efficiencies nationally, for example, in procurement, materials management, ICT. The group management framework is designed to afford maximum flexibility for groups to rationalise and reconfigure services as they require.

Each group will have varying model, size and specialty hospitals to maximise the range of services available to populations. As a general principle, specialist hospitals should be members of hospital groups capable of providing a network of clinical support including 24/7 general medical and surgical cover. Particular referral arrangements will be needed to ensure access to national specialist facilities, by way of intergroup working. Most of these are already in place and will be continued. Particular arrangements will also be needed within and across Dublin hospital groups to ensure that appropriate specialist rosters and cross-cover arrangements are facilitated, for instance, in areas such as Vascular Surgery and Urology.

6.2 Key Enablers

6.2.1 Common Identity

The creation of a new identity for hospital groups is critical to their future success. The adoption of a hospital group name will reflect the realignment of hospitals. Ultimately hospital group names will be associated in the public mind with an improved quality service.

6.2.2 Common Business Platform

In order to manage its resources (inputs) and to evaluate the desired outputs (both clinical and corporate), each hospital group will need to ensure that it is capturing and sharing information to a common standard. This will require the use of common corporate business platforms which may be technological (in the form of a shared information system) or procedural (adopting common measures and key performance indicators). Sharing such information will allow the group to be managed as a whole and to measure progress being made in the transition to trusts. Having such common business processes will also facilitate the rationalisation of support functions such as HR and procurement and help target resources to the clinical services.

6.2.3 Community Hospitals

There was a view in many hospitals, large and small, that community hospitals (Model 1 hospitals in the terminology of the Acute Medical Programme) have a key role to play in the further development of local care and that under current governance arrangements this is not being fully realised. The community hospital is a resource for acute hospitals, for GPs and for the local community. Shared clinical governance is already in place in many such institutions and permanent staff within them are generally either directly employed by the HSE or a HSE funded agency. Current utilisation of this resource needs to be enhanced and should be discussed by hospital group management and their local GPs on a case-by-case basis.

6.2.4 Education, Training, Research, Innovation and Medical Manpower

Each hospital group requires a university relationship, with at least a medical school and a nursing school, responsible for leading the group's teaching and training activities, clinical research and innovation. This is necessary to optimise synergy between academic medical function and clinical and service management. All existing and new undergraduate teaching arrangements should be supported by MoUs.

Training posts should be attached to the group, rather than to individual hospitals, and all existing hospital capacity must be utilised. This will help to secure the future Non-Consultant Hospital Doctors (NCHD) and consultant staffing of smaller hospitals, necessary to deliver and develop their clinical services. Similar arrangements should be undertaken in respect of nursing / midwifery / other health care professions, as appropriate. Each Hospital Group must also engage in provision of continuous educational and professional development for their clinical staff. Finally, recognising the closer links to be developed with primary and community care, continuous educational and professional development should continue to be given to nursing / midwifery / other healthcare professionals who work outside of the acute hospital setting. Arrangements for their teaching and supervision should be compatible with the requirements of the relevant multidisciplinary education (undergraduate and postgraduate), training and regulatory bodies. Groups should forge international linkages and twinning arrangements with hospitals and health systems abroad in order to foster a culture of learning and international referencing. This should include the provision of international training opportunities and experiential exchange opportunities for staff (see also 8.2.5).

6.2.5 ICT Systems

The need for modern ICT systems in hospital management is well recognised but requires major investment that is not currently available. Each hospital group should develop a strategic investment plan for systems development that might be part funded by efficiencies in new processes and work practices. Introduction of good IT systems will in turn provide scope for further efficiencies. There have been promising beginnings such as the National Integrated Medical Imaging System (NIMIS) but much more is

required. One of the challenges facing group leadership will be the current use of different systems in different hospitals within the one group. This is a long term issue but one that can be speeded up by creating the right incentives.

All ICT hospital systems must adhere to necessary standards guided by the recent HIQA information system standards, so as to best enable exchanges of structured operational and management information within and between groups, the rest of the health system and internationally, supporting the use of nationally standardised medical charts (ideally paperless) and the development of electronic patient records. Hospital systems should include facilities that fully enable the implementation and, as far as is feasible, incorporate the guidance and protocols of the clinical programmes with easy access to the relevant research databases.

6.2.6 Transport and Retrieval

Transport and retrieval systems (see also section 5.2 and 5.10) will be critical to the successful functioning of hospital groups. The Transport Medicine Programme brings together the Clinical Programmes of Critical Care, Anaesthesia, Emergency Medicine, Acute Medicine, Acute Surgery, Paediatrics, Obstetrics and Neonatology, along with Nursing and Midwifery, and the National Ambulance Service (NAS) under a single programme structure.

The primary goal is to establish a comprehensive Retrieval-Transfer system that:
1. is integrated with and supports the integration of Model 2, 3 and 4 Hospitals
2. is integrated with the National Ambulance Service (NAS), and
3. maximises Air Corps and Coastguard helicopter utilisation for appropriate Retrievals-Transfers within existing service level agreements

A safe and effective national Retrieval/Transfer system is a key enabler for the successful implementation of Hospital Reconfiguration, the Clinical Programmes, the Small Hospitals Framework, and Hospital Groups.

Consensus has been reached on a service model that:
- encompasses Adult, Paediatric and Neonatal Retrieval-Transfer
- provides bi-directional inter-facility transport for patients with needs ranging from Intermediate Care to Critical Care
- prioritises clinically urgent e.g. STEMI, stroke, expanding extradural as well as non-clinically (system) urgent patients e.g. CABG bed becomes available, post PCI patient repatriation
- is supported by nationally agreed policy and standardised procedures ranging from high level governance, to detailed equipment and medication lists.

6.3 Criteria for assigning hospitals to groups

In proposing a small number of relatively large hospital groups the Strategic Board sought to ensure that as many of the following criteria as possible were met:

1. Align hospitals, in broadly contiguous geographical areas, into groups to meet the acute hospital care requirements of the population.

2. Create hospital groups which are consistent with existing acute hospital care pathways for the population with an emphasis on maximising care available locally.

3. Combine varying model, size and specialty hospitals to maximise the range of services available to populations. Each group must have at least one major university teaching hospital, a National Cancer Control Programme (NCCP) centre and a maternity service. The selected combinations should allow for the centralisation of complex care which has volume sensitive outcomes to larger centres, while maximising the use of smaller hospitals consistent with *The Framework for Development - Securing the Future of Smaller Hospitals* (Department of Health, 2013).

4. Ensure groups form single cohesive entities that together provide an overall hospital system which is in optimal balance. The necessary rebalancing, rationalisation and reorganisation of services, particularly in the Dublin area, between and within groups will begin with the establishment of hospital groups but must be enabled to continue through the process of transitioning into hospital trusts.

5. Ensure a population base and infrastructure to maintain the viability of each group in relation to other groups.

6. Create hospital groups large enough to gain efficiency from common business processes.

7. Enable groups to co-operate with each other in an environment of managed competition. This should incentivise excellence whilst maintaining the utmost synergy and integration between each group and the rest of the health system nationally.

8. Create hospital groups with robust academic linkages. Academic linkages are essential to integrate teaching, training, research and innovation in the acute hospital system. This synergy will maximise the economic potential for the wider community and optimise synergy between academic medical function, clinical leadership and service management.

9. Attract and retain sustainable numbers of high quality consultants, trainees and post–graduates across the full range of healthcare specialties and professions, across all hospitals in a group and across all groups.

10. Maximise cross-border health service arrangements in the best interests of patients.

11. Deliver internationally comparable quality care for patients, regardless of where they live.

12. The recommended groups should be broadly comparable to facilitate competition under UHI and to ensure that no group is disadvantaged in the recruitment of clinical staff.

6.3.1 Commentary

Two hospital groups had already been created before this project was established. It was not within the project's scope to dismantle those groups, but it was permissible to consider their enlargement. In determining the number and composition of hospital groups there is an estimated minimum population base of 350,000 people. Each group has a range of hospitals, capable of providing general medical acute care, day surgery and elective inpatient surgery. Each group has at least one Model 4 hospital (as understood within the Acute Medical Programme), which has a 24/7 ED and a Level three Critical Care facility. Each group has at least one NCCP Cancer Centre and a maternity service. Each group is linked to a primary academic partner and has multidisciplinary education and training capacity.

It is envisaged that within new hospital groups, consultants will work in specialist and subspecialist teams that provide outreach services sometimes to widely dispersed rural communities. Each team will be responsible to the relevant CD for the provision of services to the whole group. This is essential if equity of patient access is to be meaningful.

It is recognised that the National Paediatric Hospital (NPH) will be outside these groups with governance and management structures reflecting its national role. It is noted that the NPH will provide secondary and tertiary paediatric care to the greater Dublin area and tertiary care to the national population.

National specialty services will have to be delivered in a systematic and coherent manner cognisant of government policy. These services will be provided across hospital groups.

6.3.2 Potential of Hospital Groups to Facilitate Required Service Change in the Dublin Area

The need to address the fragmentation of acute service provision, particularly in the greater Dublin area, has been acknowledged in previous national and regional reports over many years. There is potential to achieve a better service configuration in key areas such as 24/7 emergency services, trauma services, obstetrics and gynaecology and scheduled and unscheduled orthopaedic services across the city, in order to provide the optimum services required to best meet the needs of the population in the most effective and efficient way.

As recommended in the 2012 HIQA *Tallaght Hospital Investigation Report*, a comprehensive analysis, rationalisation and re-organisation of the distribution and provision of the types, number and operational times of specific types of hospital services in the Dublin area must be undertaken by the Department of Health and the HSE.

The introduction of hospital groups can facilitate the implementation of service changes within each group and across the groups in relation to national and sub–specialist services. The establishment of hospital groups in Dublin must facilitate the priority focus on the rationalisation of services within and across the groups. Progress in this area must be achieved in advance of any consideration of advancement to trust status.

In all instances the recommendations followed careful consideration of the merits and costs attached to continuing existing arrangements vis à vis changing what are, in effect, partially implemented network arrangements.

6.3.3 Ensuring Equitable Resource Allocation between Hospitals in Groups
Guiding Principles:

1. The hospital group must be responsive, with no right to refusal by the Model 4 hospital of appropriate patients from outlying hospitals.
2. Management and governance arrangements for hospital groups must provide sufficient input from the Model 2 and Model 3 hospitals.
3. Hospital groups should prioritise appropriate scarce resources into Model 2 and Model 3 hospitals to ensure continued delivery of services; there is a concern that this has not happened heretofore with some of the clinical programmes, where larger tertiary sites are prioritised over smaller regional services with long waiting lists, so that the available consultant recruitment pool is diluted/eliminated.
4. Funding models must incentivise the group/trust to ensure that the appropriate services are provided in Model 2 and Model 3 hospitals and not involve new cross-charging arrangements within and between groups.
5. Existing established patient pathways outside the group should not be damaged by new hospital groupings.
6. Clear policies must exist to protect the allocation of professional staff, such as NCHDs, to ensure that smaller hospitals are not disadvantaged within a group/trust.

Design Features to Mitigate Serious Risks for the Smaller Hospital in Groups

The following are suggested design features that could be incorporated into the design of hospital groups and trusts:

Governance: When seeking board members, consideration should be given to the competency required, the alignment with voluntary boards (if relevant) and the geographical spread of the population.

Business Plan / MoU: A Business Plan / MoU should be put in place within the group, to ensure that there is clarity on the services that each hospital will provide.

Funding Model: The tertiary centre cannot implement a charging model to other centres, either inside or outside the group, where such an arrangement is not already in place. This is essential as existing pathways could then cease without capacity in the main tertiary centre of any proposed group.

Medical Staffing: Priority must be given to the provision of NCHDs for core specialities in Model 2 and 3 hospitals. Otherwise there is a real risk that NCHDs will be preferentially recruited to the Model 4 hospitals.

Capital Investment: Consideration should be given to targeted capital investment that will incentivise service developments focused on new models of hospital care beyond the tertiary centres.

6.3.4 Implementation and Evaluation

It is expected that when hospital groups are established and up and running (Phase 2), a national steering group will be required to monitor and drive implementation. This group will consider changes required in the light of experience. This steering group will also identify any requirements for the establishment of hospital trusts on a legislative basis.

6.4 Recommendations for Hospital Groups

6.4	**RECOMMENDATIONS FOR HOSPITAL GROUPS**
i	Each hospital group must agree a new name by which it will be known.
ii	The CEO and interim group board will act to deliver safe, equitable access to high quality care for the population they are employed to serve. It will support the key roles of Model 2 and Model 3 hospitals, as defined by the *Report of the National Acute Medicine Programme* (HSE 2010) within the policy framework set by government, particularly respecting the principles of *The Framework for Development - Securing the Future of Smaller Hospitals* and recognising the geographic distribution of services for local communities. This is aimed at ensuring high-quality, safe care and treatment, delivered as close to the patient's home as practicable with more complex care delivered in larger hospitals as required for optimal safety and quality outcomes for patients and families. (See section 6.3.3)
iii	The CEO of the hospital group will, within one year of appointment, present a strategic plan to the board for service configuration and integration consistent with national objectives for the delivery of patient services. The role of each hospital must be outlined under this plan in line with national policy including *The Framework for Development - Securing the Future of Smaller Hospitals* and National Clinical Programmes of Care.
iv	The HSE or its successors must ensure appropriate co-operation and balance between hospital groups and other elements of the health and personal social services system nationally.
v	Hospital groups may acquire or where necessary, purchase services from other groups.
vi	All staff, clinical and non-clinical, should be appointed to groups with maximum flexibility in deployment; a key instrument to maximise effectiveness in service provision.
vii	Joint liaison structures with primary and community care practitioners should be established to ensure that community hospitals operate to their full potential as key linking institutions between hospital and community care. Each hospital group must consider the inclusion of community hospitals in their group.
viii	The Strategic Board and Project Team consider that the effectiveness of each hospital group must be evaluated in advance of statutory trust formation.
ix	Existing cross-border service level arrangements should be enhanced, initially by way of well-targeted commissioning contracts, with the potential to develop formal cross-border hospital networks.

x	Each hospital group has a primary academic partner. This relationship must be of sufficient depth to ensure the capability of the hospital group to deliver the healthcare teaching, training, and research and innovation agenda in a joined up way. This should not prevent groups from providing clinical educational services to other third level institutions.
xi	**It is recommended that there should be six hospital groups in Ireland.** Groups will be of varying sizes with a geographic or functional connection, large enough to operate efficiently and provide a reasonable range of services, and small enough to be effectively managed in order to deliver safe high-quality patient services.

6.5 Recommended Composition of Hospital Groups

This report recommends the six hospital groups option outlined below for the following reasons:

- The six hospital groups are of sufficient scale, number of hospitals and range of services, to be able to deliver meaningful reform prior to the creation of independent hospital trusts.

- Each group has a strong tertiary capacity, maximising the range of tertiary services for the population within each group and minimising intergroup referrals.

- There is the optimum alignment of existing relationships and between hospitals with academic partners, thus creating the grounds for the rapid establishment of groups.

- Groups are of an appropriate size for good governance and effective management.

- Each group has to address a common range of challenges in relation to building corporate and clinical governance, addressing rural/urban issues of equity and access, meeting the clinical staffing needs of smaller hospitals and linking with a primary academic partner.

- Each group has broadly coherent geographic boundaries building on patient flows and referral patterns commensurate with key established relationships.

6.5	RECOMMENDED COMPOSITION OF HOSPITAL GROUPS
i	**Dublin North East:** Beaumont Hospital; Our Lady of Lourdes Hospital, Drogheda; Connolly Hospital; Cavan General Hospital; Rotunda Hospital; Louth County Hospital; Monaghan Hospital.
ii	**Dublin Midlands:** St James's Hospital; The Adelaide & Meath Hospital, Dublin, including the National Children's Hospital; Midlands Regional Hospital,Tullamore; Naas General Hospital; Midlands Regional Hospital at Portlaoise; the Coombe Women and Infant University Hospital.
iii	**Dublin East:** Mater Misericordiae University Hospital; St Vincent's University Hospital; Midland Regional Hospital at Mullingar; St Luke's General Hospital, Kilkenny; Wexford General Hospital; National Maternity Hospital; Our Lady's General Hospital, Navan; St Columcille's Hospital; St Michael's Hospital Dun Laoghaire; Cappagh National Orthopaedic Hospital; Royal Victoria Eye and Ear Hospital.

iv	**South/South West:** Cork University Hospital/CUMH; Waterford Regional Hospital; Kerry General Hospital; Mercy University Hospital, South Tipperary General Hospital; South Infirmary Victoria University Hospital; Bantry General Hospital; Mallow General Hospital, Lourdes Orthopaedic Hospital, Kilcreene.
v	**West/North West**: University Hospital Galway and Merlin Park University Hospital; Sligo Regional Hospital; Letterkenny General Hospital; Mayo General Hospital; Portiuncula Hospital; Roscommon County Hospital.
vi	**Midwest:** Mid-Western Regional Hospital, Limerick; Ennis General Hospital; Nenagh General Hospital; St John's Hospital, Mid-Western Regional Maternity Hospital; Mid-Western Regional Orthopaedic Hospital.
	Note; *The acute paediatric services in Dublin – Our Lady's Children's Hospital, Crumlin, Children's University Hospital, Temple Street and the paediatric service in AMNCH – should also function as a single cohesive entity with appropriate governance arrangements (in line with hospital group proposals).*

HEALTH DUBLIN NORTH EAST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Beaumont Hospital	238270	2954	21890	46121		49337	NCCP
Our Lady of Lourdes Drogheda	113384	1495	20138	7422	3808	53817	
Connolly Hospital	85220	1054	10455	9893		31922	
Cavan General Hospital	67153	743	14674	9075	2054	27099	
Rotunda Hospital	44979	739	17030	3645	9319		
Louth County Hospital	20701	278	437	8065			
Monaghan Hospital	12110	168		4881			
	581817	7431	84624	89102	15181	162175	
28% Dublin, Cavan, Monaghan, Louth, Meath, Estimated Population, 800,000							

- This group contains the following hospitals: Beaumont Hospital, Our Lady of Lourdes Hospital Drogheda, Connolly Hospital Blanchardstown, Cavan General Hospital, Rotunda Hospital, Louth County Hospital and Monaghan Hospital.
- There is an NCCP centre at Beaumont Hospital.
- There are maternity hospitals/units at the Rotunda Hospital in Dublin, Drogheda and Cavan.
- The primary academic partner is the Royal College of Surgeons in Ireland (RCSI).

Commentary

Beaumont and Connolly Hospitals have undertaken considerable preparatory work with this group's primary academic partner, RCSI, to develop a strategic alliance. This preparatory work will serve the new hospital group well.

The Rotunda Hospital will provide leadership in maternity services (obstetrics, midwifery and neonatology) and gynaecology services to all of north Dublin and the northeast. This will require the continuation of strong clinical links with the Mater Misericordiae University Hospital with which it will continue to have joint consultant appointments. The Rotunda hospital will be the only hospital in North Dublin to retain their current paediatric services. This proposal brings many of the hospitals between Dublin and the border into one group. Services for the region should develop cognisant of cross-border linkages and retain the potential to develop formal cross border hospital networks.

HEALTH DUBLIN MIDLANDS						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
St. James's Hospital	317095	3503	25153	93552		45760	NCCP
AMNCH - Tallaght	178027	2544	18731	30288		72995	
MRH Tullamore	81453	945	9546	16769		28047	
Naas General Hospital	56474	670	8999	4821		24494	
Coombe Women & Infant Hospital	46932	725	19453	20354	8749		
MRH Portlaoise	44922	591	13792	5000	2261	41019	
	724903	8978	95674	170784	11010	212315	
35% Dublin, Laois, Offaly, Kildare, Estimated Population, 800,000						

- This group contains the following hospitals: St James's Hospital; The Adelaide & Meath Hospital, Dublin, including the National Children's Hospital (AMNCH); Midland Regional Hospital Tullamore; Naas General Hospital; Coombe Women & Infant University Hospital and the Midland Regional Hospital at Portlaoise.
- There is a National Cancer Control Programme (NCCP) centre at St James's Hospital.
- There are maternity hospitals/units at the Coombe Women & Infant Hospital and at the Midland Regional Hospital at Portlaoise.
- The primary academic partner is Trinity College Dublin (TCD).

Commentary

This grouping is at an advanced state of readiness. St James's Hospital and AMNCH - Tallaght, in conjunction with the Coombe Hospital, have undertaken considerable preparatory work with this group's primary academic partner TCD, to develop a strategic alliance. This preparatory work will serve the new hospital group well.

This group includes the largest hospital in the country and serves a large population base. It has recently been announced that the National Paediatric Hospital (NPH also now known as the New Children's Hospital) is to be located at the St James's campus. Despite the NPH having a separate governance structure, and the fact that the existing Dublin paediatric hospitals will operate as a separate group, this will have significant positive effects for the hospital group. Two hospitals from the Midlands are included in this group. Hospitals in the group have established clinical links with shared clinical appointments and established referral patterns between many of the hospitals. They also share a common population referral base in southwest Dublin and the Midlands.

HEALTH DUBLIN EAST						
	Approved Budget	**WTE**	**Inpatient**	**Day Cases**	**Births**	**ED Attendance**	**NCCP Centre**
Mater Misericordiae University Hospital	213608	2597	16802	39006		48348	NCCP
St. Vincent's University Hospital	203622	2377	14631	52395		40106	NCCP
MRH Mullingar	58035	750	19365	7397	2782	31339	
St. Luke's Hospital, Kilkenny	56639	825	13905	11968	2042	31065	
Wexford General Hospital	49047	802	16544	8791	2232	34212	
National Maternity Hospital	44482	725	17779	3080	9459		
Our Lady's General Hospital, Navan	40514	440	4651	4953			
St. Columcille's Hospital	37538	446	3726	2495		19874	
St. Michaels Hospital, Dún Laoghaire	26285	391	2579	5803		13704	
Cappagh National Orthopaedic Hospital	25428	301	2195	9041			
Royal Victoria Eye and Ear	20865	268	2415	7251			
	776063	**9922**	**114592**	**152180**	**16515**	**218648**	

37% Dublin, Longford, Westmeath, Kilkenny, Carlow, Wexford, Wicklow, Estimated Population 1,000,000

- This group contains the following hospitals: Mater Misericordiae University Hospital; St Vincent's University Hospital; Midland Regional Hospital, Mullingar; St Luke's Hospital, Carlow/Kilkenny; Wexford General Hospital; the National Maternity Hospital; Our Lady's General Hospital, Navan; St. Columcille's Hospital, St. Michaels Hospital, Dún Laoghaire, Cappagh National Orthopaedic Hospital and the Royal Victoria Eye and Ear Hospital.
- There are National Cancer Control Programme (NCCP) centres at St Vincent's University Hospital and the Mater Misericordiae University Hospital.
- There are maternity hospitals/units at the National Maternity Hospital Dublin, the Midland Regional Hospital Mullingar, Wexford General Hospital and St Luke's Hospital, Carlow/Kilkenny.
- The primary academic partner is University College Dublin (UCD).

Commentary

This will be the largest of the hospital groups. The Mater Misericordiae University Hospital and St Vincent's University Hospital have undertaken considerable preparatory work with this group's primary academic partner, UCD, to develop a strategic alliance. This preparatory work will serve the new hospital group well.

The Mater Misericordiae University Hospital will continue to have strong links with the Rotunda Hospital and to have joint consultant appointments.

The group includes one hospital from the Midlands, the Regional Hospital, Mullingar, and one hospital from the northeast, Our Lady's General Hospital, Navan.

This group includes two hospitals from the southeast; St Luke's Hospital Kilkenny and Wexford General Hospital. There is an absence of a consensus/shared vision amongst all the hospitals in the current southeast hospital network. The patterns of hospital usage for the catchment population of St Luke's Hospital Kilkenny and Wexford General Hospital indicate a strong utilisation of services in Dublin; for instance 10% of the acute hospital discharges for the population of County Wexford are from St Vincent's University Hospital.

Wexford General Hospital, because of its geographic location, similar to Kerry and Letterkenny General Hospitals, should retain its full range of Emergency Department (ED), medical, surgical, maternity and paediatric services.

HEALTH SOUTH / SOUTH WEST							
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Cork University Hospital	264081	3223	29472	54437		56709	NCCP
Waterford Regional Hospital	141673	1720	22925	20350	2439	49984	NCCP
Kerry General Hospital	71097	964	14083	10361	1753	30290	
Mercy University Hospital	55978	923	9374	18945		26634	
South Tipperary General Hospital	46445	708	12882	7138	1247	28668	
SIVUH	43663	704	7898	16193		18336	
Bantry General Hospital	17574	234	1889	1725			
Mallow General Hospital	16524	238	3887	2728			
CUMH	-	-	14067	5362	8784		
Lourdes Orthopaedic Hospital, Kilcreene	-	70	845	919			
	657035	8784	117322	138158	14223	210621	
Cork, Kerry, South Tipperary, Waterford, estimated population 850,000							

- This group contains the following hospitals: Cork University Hospital, incorporating Cork University Maternity Hospital; Waterford Regional Hospital; Kerry General Hospital; Mercy University Hospital; South Tipperary General Hospital; South Infirmary Victoria University Hospital; Mallow General Hospital and Lourdes Orthopaedic Hospital, Kilcreene.
- There are NCCP centres at Cork University Hospital and Waterford Regional Hospital.
- There are maternity hospitals/units at Cork University Maternity Hospital, Waterford Regional Hospital, Kerry General Hospital and South Tipperary General Hospital.
- The primary academic partner is University College Cork (UCC).

Commentary

Hospital reconfiguration is at an advanced stage in the south western part of this group, and the implementation of the *Reconfiguration of Acute Hospital Services, Cork & Kerry Region; a Roadmap to develop an integrated university hospital network* (2010) will continue under the group structure. However, there is an absence of a consensus/shared vision amongst all the hospitals in the current southeast hospital network.

Waterford Regional Hospital (WRH) will continue to be an NCCP centre, retaining its current population referral base for cancer patients. Joint consultant appointments, such as general surgery shared with Wexford, across the groups will continue to support the specialist cancer services it provides.

Waterford Regional Hospital will continue to be the hub for the South East renal services which include a centre of haemodialysis, renal home therapies (peritoneal dialysis/home haemodialysis) and renal transplant follow up.

Waterford Regional Hospital will continue to be a regional trauma centre, including ED, Ear, Nose and Throat (ENT) and Ophthalmology. To ensure WRH continues to provide the full range of elective and trauma orthopaedics services, Lourdes Orthopaedic Hospital, Kilcreene will be managed from WRH within the new South/South West group structure. (It is currently managed by St Luke's Hospital, Carlow/ Kilkenny.)

Waterford Regional Hospital will continue to provide invasive cardiology services for the South East population. Working in collaboration with the cardiology service in Cork the current service should be extended with new joint appointments of cardiologists.

As part of the review of the transitional hospital groups the Health South/South West should be able to demonstrate that at least one regional subspecialty will be based at WRH.

Kerry General Hospital, because of its geographic location, similar to Letterkenny and Wexford General Hospitals, should retain its full range of ED, medical, surgical, maternity and paediatric services.

HEALTH WEST/NORTH WEST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
UHG/Merlin Park	251624	3086	35179	66102	3428	59349	NCCP
Sligo Regional Hospital	98011	1354	15924	26467	1582	31622	
Letterkenny General Hospital,	97007	1370	20927	17586	2003	32100	
Mayo General Hospital, Castlebar	76293	979	16594	16258	1835	32762	
Portiuncula Hospital, Ballinasloe	41095	657	11022	8046	2148	19366	
Roscommon County Hospital	18914	284	3565	3789		6722	
	582944	7730	103211	138248	10996	181921	
Donegal, Sligo, Leitrim, Mayo, Roscommon, Galway, Estimated Population, 700,000						

- This group contains the following hospitals: University Hospital Galway/Merlin Park, Sligo Regional Hospital, Letterkenny General Hospital, Mayo General Hospital, Portiuncula Hospital, and Roscommon County Hospital
- There is an NCCP centre at University Hospital Galway
- There are maternity hospitals/units at Galway, Portiuncula, Letterkenny, Mayo, and Sligo.
- The primary academic partner is National University of Ireland, Galway (NUIG).

Commentary

This group was partially pre-determined by the appointment of a CEO to the Galway Roscommon group and the appointment of a chair to the interim board for the group. This group will serve the western seaboard, stretching from Galway to Donegal, a geographically dispersed and relatively sparsely populated region.

In recognition of the geography of the region, Sligo and Letterkenny General Hospitals will be managed as a distinct unit within the West/North West. The precise management arrangements will be determined and agreed by the interim board of the group. The synergistic service model developed between Sligo and Letterkenny hospitals should be retained.

Letterkenny Hospital, because of its geographic location, similar to Kerry and Wexford General Hospitals,

should retain its full range of ED, medical, surgical, maternity and paediatric services.

Services for the region should develop cognisant of cross-border linkages and retain the potential to develop formal cross-border hospital networks.

There are plans to locate a rehabilitation centre at Roscommon County Hospital as part of the National Clinical Programme for Rehabilitation.

HEALTH MIDWEST						
Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
MWRH Limerick 138059	1826	25053	20401		57916	NCCP
Ennis General Hospital; 19653	231	3607	2825		13399	
Nenagh General Hospital 17976	232	2687	4888		9556	
St. John's Hospital, Limerick 17626	279	3892	7754		15492	
MWR Maternity Hospital 15705	298	8331		5167		
MWR Orthopaedic Hospital 9824	163	1801	2780			
218843	**3029**	**45371**	**38648**	**5167**	**96363**	
Limerick, Clare, North Tipp, Estimated Population 400,000						

- This group contains the following hospitals: Mid-Western Regional Hospital, Limerick; Ennis General Hospital; Nenagh General Hospital; St John's Hospital, Limerick; Mid-Western Regional Maternity Hospital; Mid-Western Regional Orthopaedic Hospital.
- There is an NCCP centre at the MWRH, Limerick
- There is a maternity hospital in Limerick.
- The primary academic partner is the University of Limerick (UL).

Commentary

This group was partially pre-determined by the appointment of a CEO to the Mid-Western group and the appointment of a chair to the interim board for the group. It has the smallest natural population base. It has a limited range of tertiary referral specialties. However, it has the advantage of being very cohesive and there is the potential to develop a strong shared regional identity with its partner University of Limerick. It also has the advantage that hospital reconfiguration is at an advanced stage with the centralisation of cancer services and all emergency surgery at the Mid-Western Regional Hospital, Limerick.

This group should develop structured collaborations with Health West/North West and Health South/South West in order to provide a full range of services, including many specialist services, for the people of the Midwest. The success of these, and any similar arrangements in other regions, can be evaluated as part of

the national evaluation process preparatory to the establishment of Hospital Trusts.

6.6 Hospital Activity Analysis

Data analysis illustrating hospital activity can be seen in Appendix 4.

7. A Governance Framework for Hospital Groups

This section deals with the application of the *HIQA Tallaght Hospital Investigation Report* to the governance of hospital groups.

7.1 Corporate Governance

Corporate governance comprises the systems and procedures by which enterprises are directed and managed. State bodies must serve the interests of the taxpayer, pursue value for money in their endeavours, manage risk appropriately and act transparently as public entities. Governance and management are separate but complementary functions. Management is responsible for running the organisation. Governance ensures that it is being run well and in the right direction. Management is the responsibility of the Chief Executive Officer and the management team. Governance is the responsibility of the Chairperson and members of the board.

7.2 The Role of the Interim Group Board

The *HIQA Tallaght Hospital Investigation Report* sets out clearly the role and function of a hospital board within currently accepted principles of corporate governance.

> "The focus of a hospital board must be setting the strategic direction, establishing effective corporate and clinical governance arrangements, assuring itself, by holding the executives to account, that the hospital is being well run and providing good quality and safe care as part of a national health system within the allocated resources. (Tricker, 2009)

The board's task is to direct the hospital, not manage it, and to do this through four main elements:
1. strategic planning
2. policy making
3. supervision and challenge of executive management, and
4. accountability to stakeholders.

The governing boards of service providers should "set the tone from the top and play a pivotal role in leading and building a culture that puts quality and safety at the centre of the delivery of care." (HIQA, 2012)

The role of an interim hospital group board in shaping the tone and culture of the group is very important and should include, in addition to the quality and safety of patient care, an embracing of change, international connectedness and a striving for excellence through measurement against the best comparators in all areas of the care they deliver. Individually, few Irish hospitals can hold their

own against the best international hospital systems but, working together as larger groups, there is no reason not to aspire to favourable comparison with suitable international comparators.

Strategic planning and policy making are the means by which the board moves the group forward. It will only be successful at group level if it is rooted in a knowledge of performance at every level of the organisation and every clinical site within the group.

Challenge to management and accountability to stakeholders are about ensuring the group moves forward in a manner that is safe, efficient and compliant with best practice. As a public body in receipt of public funds, each group must have:

> *"internal codes of governance in place, including an adequate system of internal controls, to ensure compliance with laws and regulations. The service provider is required to use the Code of Practice for the Governance of State Bodies[13] as a guide for drawing up such codes of governance. In addition, these service providers must have in place governance arrangements with defined management processes, organisational roles, responsibilities and reporting relationships, which support the provision of safe and high quality services. The board should hold the chief executive and the executive management team, who are responsible for managing the hospital, to account through a clearly defined scheme of delegation of accountabilities. Boards need to be confident by seeking and receiving assurances from the executives, through a process of constructive challenge, that the arrangements, systems, processes and people that they have in place are operating in a way that it is safe, effective, managing risks for service users and achieving the articulated objectives of the hospital [groups] within the available resources."*
>
> (HIQA, 2012)

Where hospital groups include smaller hospitals within their remit, the board must implement *The Framework for Development - Securing the Future of Smaller Hospitals*, seeking to ensure that smaller hospitals are fully networked to the larger centres with respect to patient safety, clinical protocols, inter-hospital transport, professional training and corporate governance. The same approach should be taken to a specialist hospital that may find itself within a group of general hospitals.

7.3 Structure and Composition of Interim Group Boards

The Tallaght Hospital Investigation Report takes the view that boards should be competency based rather than representative of sectional interests. This issue is likely to be considered fully in the

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13 Department of Finance. Code of practice for governance of state Bodies. Dublin: Department of Finance; 2001

preparation of hospital trust legislation. In the transition phase, where boards are advisory rather than statutory, the HIQA recommendation and competency framework should be followed.

HIQA has made 29 different recommendations on board governance. The establishment of hospital groups provides a unique opportunity to put all but those referring specifically to AMNCH - Tallaght into practice.

Recommendation 5 states that:

> *"The chairpersons of all hospital boards (in the first instance) in receipt of State funds should be line managed by a nationally designated post-holder for the purpose of holding the chairperson and the board accountable for the provision of well governed and effectively managed services and in relation to the appointment, performance and termination of the chief executive (this post-holder may be, for example, the Director General of the new HSE structure, or equivalent)."*

(HIQA, 2012)

HIQA is clear that employees of the group should not be voting members of the board. In this respect, members of the management team should be **in attendance** but non-voting.

7.4 Handling Conflicts of Interest at Board Level

HIQA is also clear in its approach to potential conflicts of interest:

> *"17. There should be a register of interests in place in relation to individuals with potential and/or actual conflicts of interest, in accordance with the requirements of the Ethics in Public Office Act (1995) that includes board members and employees of the hospital and those with other relevant conflicts of interest. This should be subject to no less than annual review by the chairperson and chief executive.*
>
> *18. There should be an effective process in place for board members to declare potential and/or actual conflicts of interest whilst conducting board business that would allow the chairperson and board secretary to consider for themselves if there were agenda items that might possibly present a conflict of interest for any member of the board. All potential and/or actual conflicts that arise and decisions in relation to them should be documented."*

(HIQA, 2012)

In Ireland, populating a small number of hospital group boards with informed persons having the required range of knowledge, skills and attitudes, who reside within reasonable distance of the chosen location(s) for board meetings so that they can attend regularly, will inevitably lead to situations where conflicts of interest can occur. In this respect, recommendations 17 and 18 above should be rigorously applied.

7.5 The Relationship between Existing Voluntary Hospital Boards and Interim Group Boards

Most new hospital groups will include one or more voluntary hospitals with pre-existing boards. Some will be established by charter and others already operate under the Companies Act. Hospital groups must be sensitive to the position of voluntary boards and aware of their legal rights and obligations. Each group, cognisant of the Minister's intention to provide a non-executive challenge for group management by means of an interim group board, and sensitive to the existing status of voluntary boards, should consider the most appropriate form for this non-executive challenge, given its own particular circumstances. The critical issue is to find a solution that delivers effective governance based on the four elements in 7.2 above and is fully supported by any pre-existing governance structures. Common membership should be considered as a way of securing this support.

7.6 Recommendations on Governance

7.6	RECOMMENDATIONS FOR THE GOVERNANCE OF THE TRANSITIONAL HOSPITAL GROUPS
i	Each hospital group will be established on an administrative basis. These arrangements are transitional and will need to be formally evaluated in light of the emerging UHI model before the establishment of independent hospital trusts.
ii	Hospital groups can utilise an Academic Healthcare Centre (AHC) model to provide overarching governance structures for the relationship between hospitals within a group and their relationship to their primary academic partner. Within the AHC model, any proposed over-arching board must meet the criteria outlined in the recommendations below for interim group boards.
iii	There is a legitimate concern that emphasis on the Academic Healthcare Centre agenda may not fully recognise the urgent need for the reorganisation of acute hospital service provision. Therefore, hospital groups must demonstrate a capacity to respond effectively to national imperatives on service reorganisation within and between groups.
iv	Each hospital group will establish an interim group board to which the management team reports. Ideally, this board should have a minimum of six and maximum of nine members.
v	In a hospital group where there are pre-existing voluntary boards with statutory authority, it is critical that these boards fully support the decisions of the interim group board during the transition phase. Common membership should be considered as a way of securing this support.
vi	The primary function of the interim group board is to oversee the delivery of high quality, safe patient care to meet the needs of the population it is appointed to serve.
vii	Pending the enactment of legislation establishing independent hospital trusts, the interim group board will provide regular reports through the CEO/Chair, to the Director General of the HSE/Director of Acute Hospitals or the equivalent in any successor to the HSE.
viii	The Chair of the interim group board will be appointed by the Minister.
ix	The Chair will nominate the interim group board membership for ministerial appointment.
x	The role of the Chair and CEO will not be combined.

xi	The interim group board will comprise the necessary skills, competencies and experience which will enable them to make a contribution to the performance of the hospital group. Membership must ensure demonstrable expertise including but not limited to at least the following domains: Clinical; Business; Social; Legal; Medical Academic; Patient Advocacy. (HIQA, 2012)
xii	Each hospital group will agree an annual business plan / memorandum of understanding (MoU) with the Director General of the HSE/Director of Acute Hospitals or the equivalent in any successor to the HSE. The business plan / MoU will outline the national strategies to be incorporated in delivering on its commitments and specify within clearly defined budget and employment ceilings which services will be funded, and where those services will be provided within the hospital group. It will state the performance and outcome targets to be met within a defined timeframe and what nationally agreed measures will be used in order to monitor performance.
xiii	The interim group board will develop a Quality Improvement Framework to monitor the delivery of high-quality, safe patient care at all levels and on all sites across the group. Hospital groups will be required to comply with clearly articulated national performance requirements in relation to issues such as quality, access, and financial management.
xiv	Governance training will be offered to members of the interim group board early in the first term of their appointment.
xv	Board members must exercise their responsibilities in a professional and independent manner. Individual members, when carrying out their duties, must not act as representatives for different constituencies.
xvi	Interim group board must proceed towards full implementation of the governance recommendations in the *HIQA Tallaght Hospital Investigation Report* (HIQA, 2012) and other recommendations as contained in but not limited to the Ethics in Public Office Act (1995).
xvii	Evaluation of board performance should be the responsibility of the Chair of the board and carried out according to evolving best practice.
xviii	The CEO and Executive Management Team of the hospital group will attend board meetings, but will not be members of the group board.
xix	Hospital groups will adhere to the terms of Business Plan/MoU (for the group) or contracts for the provision of services set out for them by the HSE or its successors as a component of the national service plan agreed with the Minister. These Business Plans/MoUs and/or contracts must give maximum flexibility to the hospital group whilst ensuring all necessary synergy and linkages required for the overall national health plan to be implemented.

xx	The HSE or its successor will ensure the accountability of hospital groups by auditing service delivery against the Business Plan/MoU and/or other contracts or modifications thereto under the existing legal framework. Such auditing by the HSE or its successor will be done in a way that maintains the group's flexibility and independence in deciding the most effective means of delivery.
xxi	The interim group board will appoint sub-committees to oversee specific functions, as outlined in the *HIQA Tallaght Hospital Investigation Report*. (HIQA, 2012)
xxii	Where a hospital group has one or more pre-existing hospital boards, the hospitals in the group must work, through voluntary delegation of powers and common membership, to reach a position where the interim group board is the effective decision-making body for all hospitals in the group.

8. A Management Framework for Hospital Groups

8.1 The Management Team

The Tallaght Hospital Investigation Report sets out the role of the senior management team as follows:

> *"An effective executive management team ensures that a hospital fulfils its operational functions aligned to their strategic direction by planning, controlling and organising the service to achieve its outcome in the short, medium and long term. In order to achieve this, it is necessary that there is an effective and competent chief executive, and executive management team, to lead, manage and integrate the inter-dependencies between the organisational arrangements and clinical services in order to deliver high quality, safe and reliable patient care."*

(HIQA, 2012)

It stresses the necessity of recruiting capable leaders and senior managers of healthcare organisations, and supporting them to do their jobs once appointed:

> *"From a national perspective, it is imperative 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, with a strong culture of openness, learning and continuous improvement. The chief executive, executive directors and other senior managers, should be recruited and appointed with these competencies and effectively supported, developed and performance managed to ensure that they are capable of delivering in this role as both individuals and as members of a high performing management team."*

(HIQA, 2012)

There must be a clear leadership team to manage the group. The leadership team will comprise six individuals who will be party to all the major management decisions of the group. These will be the Chief Executive Officer, the Chief Clinical Director, the Chief Nursing Officer, the Chief Academic Officer, the Chief Finance Officer and the Chief Operations Officer. Their role should be in strategic corporate management with detailed operational management delegated to others. Their priority should be the creation of a viable and vibrant hospital group. The group will comprise a number of separate hospital sites, each with its own management reporting in to the group CEO. The resources allocated to hospital management will be a matter for each group to decide but should be

proportionate to the size and complexity and geographic location of each site.

The group CEO is required to operate "within a clearly defined budget and employment ceiling."[14] Funding for the group management team should come from a pooling of resources within the group leading to greater administrative efficiencies. Other administrative functions such as human resources, communications, buildings and estates, procurement, ICT, finance and patient relations should be consolidated over time to group functions with a site presence where necessary.

8.1.1 The Group Chief Executive Officer (CEO)

During the administrative phase, hospital groups will be led by a group Chief Executive Officer (CEO) who, under current legislation, will be legally accountable to the Director General of the HSE/Director of Acute Hospitals or equivalent. Powers are delegated by the CEO so all personnel in the group are ultimately accountable, and report to, that officer and s/he reports on an administrative basis, fully and frequently, to the Chair of the interim group board. The ultimate goal should be for the trust CEO to be accountable to the Chair of the hospital trust board, and for the hospital trust board to become accountable to the state for all the services and assets of the trust. These arrangements will need to be addressed in primary legislation for hospital trusts. The *HIQA Tallaght Hospital Investigation Report* provides a clear framework that applies equally to the chief executive of a single hospital or a hospital group:

> *"The organisation should have formalised governance arrangements with clear lines of delegated accountability and responsibility at chief executive, executive director, healthcare professional, managerial and other staff levels, thereby ensuring that everyone is aware of their respective role and responsibilities.*

> *All boards should establish a clear scheme of delegation of accountability and responsibility to the chief executive and, through the chief executive, to other designated executive directors.*

> *All chief executives must have annually agreed objectives with the chairperson and the board, that accurately reflect the realm of their accountability, responsibility and authority and be subject to effective performance management and development reviews to assess their performance. Where there are issues of poor performance, the chief executive should be supported and developed and where these issues persist, action should be taken accordingly within an established process. The same process should exist for the setting of objectives and*

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14   Section 10 letter from the Minister for Health to the Chairman of the HSE dated 28th March 2012

performance management and development of executive directors by the chief executive and similarly, through an established process of delegation throughout the organisation."

(HIQA, 2012)

8.1.2 The Chief Clinical Director (CCD) and the CD team

The transitional hospital group will have a Chief Clinical Director (CCD) who carries overall responsibility for delivery of all clinical services within the group. The CCD carries overall clinical responsibility for the delivery of national clinical care programmes within the group. Individual CDs for Medicine, Perioperative, Diagnostics and Women and Children should report into the CCD. In this respect, the Chief Clinical Director post is analogous to the National Lead CD Acute Care post being promulgated by the HSE and will have a similar range of duties within each group. However, the title of Chief CD is proposed here because it identifies the post more closely with the Senior Management Team of the group.

Mindful of the long tradition of clinical direction of maternity hospitals in Ireland, if a hospital group includes a specialist maternity hospital, the CD for Women and Children should be nominated by this hospital according to its own procedures in the transition phase. If a group includes, in addition, a significant capability in paediatric medicine, it may be considered appropriate to appoint an additional CD for children, making five in all. These arrangements should be reviewed nationally, prior to the introduction of legislation on hospital trusts.

Some hospitals have site specific CDs who currently work in close collaboration with their general managers and provide valuable clinical input to the operational management of the hospital. During the transition phase it may be appropriate to continue this arrangement on those sites that are large enough and/or geographically distant enough from the centre to make it difficult for the group CD team to provide the required level of clinical oversight on a day-to-day basis.

8.1.3 The Chief Academic Officer (CAO)

Responsibility for the education, research and innovation functions of the hospital group should be delegated to the CAO. The CAO should develop structured relationships (teaching agreements and MoUs) with all the linked academic institutions and with international organisations such as overseas universities and health service systems. The CAO should be responsible on behalf of the group for approval of all research and for all 'start-ups' and clinical trials on the group's clinical sites. The appointment of a CAO will bring the academic function to top table decision making. The CAO should have a senior executive role in both the hospital group and primary academic partner

institution. The CAO should act as the link person for each hospital group with the proposed new National Director for Health Service Research.

8.1.4 The Chief Director of Nursing (CDN)

The transitional hospital group will have a Chief Director of Nursing who carries overall responsibility for nursing and midwifery care in the group and reports to the group CEO. Individual hospital site Directors of Nursing will report to the CDN, who will work closely with the CCD and the CD team to ensure nursing resources are fully aligned to the delivery of clinical services in the group.

8.1.5 The Chief Finance Officer (CFO)

The transitional hospital group will have a Chief Finance Officer who should, in collaboration with the CEO, devise a system of financial organisation and control for the group. During the transition phase, site-specific finance heads should report to the CFO.

8.1.6 The Chief Operations Officer (COO)

The transitional hospital group will have a Chief Operations Officer who will be responsible to the CEO for the co-ordination and direction of the day-to-day operations of the group with respect to all logistical and support functions.

8.1.7 Recruitment of the Management Team

The Hospital Group Team: The recruitment of the best possible candidates to positions in the senior leadership team is of critical importance to the success of hospital groups during the transition phase. The recruitment and appointment process for members of the management team needs to be transparent if it is to attract a top field of candidates. The CEO, CFO, CDN and COO posts should be filled by way of expressions of interest from staff in publicly funded health agencies. The Public Appointment Service will recruit the Chief CD from within the Consultant Medical Staff in the group and in accordance with Section 62 of the Health Act 1953. Invitations for expressions of interest should be accompanied by a detailed statement of duties and responsibilities, together with a statement of required qualifications and experience for each post appropriate to the level of performance expected. The Chief Academic Officer should be appointed by open competition after agreement on the shared role between the hospital group and the primary academic partner.

In advertising and considering appointments to the posts outlined, Hospital Groups are expected to comply with relevant legislation, including Public Service Management (Recruitment and Appointments) Act 2004. Employment Equity Acts 1998 and 2004, Disability Act 2005, Official Languages Act 2003, Data Protection Acts 1988 and 2003, Freedom of Information Acts 1997 and

2003, as applicable. In addition, standards and procedures for appointment of persons to the transitional management team of each Hospital Group are expected to reflected those standards and procedures used by Commission of Public Service Appointments (examples of which may be found in the following codes of practice);

- Code of Practice for the Employment with Persons with Disabilities
- Code of Practice: Appointment to Positions in the Civil Service and Public Service
- Code of Practice: Emergency Short Term Appointments to positions in the Health Service Executive
- Code of Practice: Appointment of Persons with Disabilities to positions in the Civil Service and Certain Public Bodies
- Code of Practice: Atypical Appointments to Positions in the Civil Service and Certain Public Bodies

The Hospital Trust Team: The appointment of the transitional hospital group management team should not compromise the eventual appointment of the full executive team through an externally validated, open, competitive process.

8.2 Functions of Management

8.2.1 The Role of the Transitional Hospital Group Management Team

A key role of the management team is to prepare the group for successful transition to trust status when the necessary legislation and administrative arrangements are in place. Group management teams will need guidance on intermediate objectives. These objectives should be based on key performance indicators for clinical care set by the national clinical programmes and key corporate objectives based on the principles that will underpin the hospital trust legislation. Guidance should be provided by a national steering body set up to support the establishment and evaluation of hospital groups.

Leadership of the group is not the same as leadership of the largest hospital in the group; there needs to be a clear differentiation between the two roles. Group leadership should focus on maximising appropriate and safe clinical activity in all the group's clinical sites within a robust clinical governance framework.

8.2.2 The Group Business Plan / Memorandum of Understanding (MoU)

The CEO will be responsible for signing off the annual Business Plan/MoU of the group, for negotiating sub components of the group Business Plan/MoU to be delivered by each hospital and for monitoring and assuring its fulfilment.

8.2.3 The Size and Scope of Individual Management Teams

The CEO and the leadership team should look closely at the individual management needs of each site and devise an appropriate model. Early work should target the sharing of corporate functions such as HR and ICT and the rationalisation of support activities to achieve maximum cost savings. Achieving common corporate business platforms will allow group activity to be measured uniformly and facilitate decision-making across the group.

8.2.4 The Position of the Voluntary Hospitals

Voluntary hospitals, given their current independent legal status, should retain their own management teams who will be responsible to the group leadership team for delivery of their element of the group Business Plan/MoU. However, as the group management team begins to deliver group corporate functions, it should be possible for voluntary hospital group members to begin to reform their management teams within an overall agreed framework for the group.

8.2.5 An International 'Buddy'

An international 'buddy' can help attitudinal change and promote a more open culture. Each group must identify a leading international medical institution of international repute to provide on-going expertise, support, organisational mentoring and advice to the group.

8.3 Recommendations for Key Leadership Posts within the Management Team of the Hospital Groups

8.3	Leadership Posts within the Transitional Management Team
i	The consolidated management team of transitional hospital groups must comprise at least the following key posts: Chief Executive Officer, Chief Clinical Director, Chief Academic Officer, Chief Director of Nursing, Chief Finance Officer and Chief Operations Officer.
ii	The Chief Executive Officer will provide leadership for the hospital group and prepare it for trust status. S/he will lead group formation on the basis of an agreed strategic vision and will direct the corporate activity of the whole group. S/he will be appointed by way of expressions of interest from staff in publicly funded health agencies.
iii	The Public Appointments Service (PAS) will recruit for appointment for the Hospital Groups, the Chief Clinical Director, from within the consultant medical staff in the group, and in accordance with Section 62 of the Health Act 1953.
iv	The Chief Academic Officer's remit will be education, research and innovation in the group. The CAO should have a senior executive role in both the hospital group and the primary academic partner institution. The Chief Academic Officer will be appointed by open competition.
v	The Chief Director of Nursing will be appointed by way of expressions of interest from staff in publicly funded health agencies.
vi	The Chief Finance Officer will be appointed by way of expressions of interest from staff in publicly funded health agencies.
vii	The Chief Operations Officer will be appointed by way of expressions of interest from staff in publicly funded health agencies.
viii	Each group must identify a leading international hospital of international repute with the experience and expertise to provide on-going support, organisational mentoring and advice to the group.
ix	The establishment of hospital groups must be achieved within the existing framework of public service human resources and pay policy. To this end the formation of the transitional management teams must fully utilise all the management potential as it exists in the wider public health service.
x	Advertising and recruitment of leadership posts within the transitional management team will comply with all relevant legislation and codes of practice (see section 8.1.7)

8.4 Recommendations on Key Management Functions of Hospital Groups

8.4	Recommendations on Key Management Functions of Hospital Groups
i	Hospital groups will be led by a group Chief Executive Officer (CEO) who, under current legislation, will be legally accountable to the Director General of the HSE/Director of Acute Hospitals or equivalent. Powers are delegated by the CEO so all personnel in the group are ultimately accountable, and report to, that officer and s/he reports on an administrative basis, fully and frequently, to the Chair of the interim group board.
ii	The requirement for individual hospital management teams will be determined by the size of the hospital and the range of services provided at each site. For instance, it is envisaged that large Model 4 hospitals would have their own management teams, while Model 2 hospitals may be under the direct management of a Model 4 hospital.
iii	The key role of the management team is to deliver high-quality, safe patient care to meet the needs of the population it is appointed to serve. They will prepare the group for trust status. Early work will target the sharing of common corporate business platforms such as Human Resources (HR) and Information Communication Technology (ICT) and the rationalisation of support activities to achieve maximum cost savings. Achieving common corporate business platforms will reduce duplication and minimise bureaucracy. The hospital groups will also be required to comply with evolving policies on shared services in the public services in areas such as procurement, payroll and recruitment.
iv	Where hospitals have been governed under different arrangements (HSE or voluntary joint board hospitals) in the transition phase, the hospital managers within the group will continue to manage their own hospitals but they will be accountable to the CEO of their hospital group either directly (HSE hospitals) or via their board (voluntary/joint board hospitals).

9. Preparing for Future Hospital Trusts

9.1 Review of Transitional Hospital Groups

Most of this report has been about putting in place as soon as possible hospital groups on an administrative basis. As stated in Future Health '*These arrangements will be transitional and will be formally reviewed in 2014 in the light of the emerging UHI model*'. Throughout the report the transitional nature of these arrangements has been stressed. They are stepping-stones to the total reorganisation of acute hospital services in Ireland into a small number of competing hospital trusts. The nature of this competition is still a matter of discussion and debate - the term 'managed competition' is probably more appropriate because there are large areas where co-operation will yield better patient care. These trusts in turn will facilitate the introduction of UHI that will radically change the provision of healthcare in Ireland.

As part of the review of hospital groups in 2014 progress made by the hospital group in advancing the appropriate configuration of services within the group needs to be considered. Progress in implementing the high level service objectives and requirements for overall national hospital service reorganisation, as set out by the Department of Health, must be demonstrated. Individual hospital groups can only develop into trusts once it is proven by the group that it is viable and capable of providing the relevant services to its population. The concept of a trust being formed by more than one group, or by a revised grouping of hospitals, should also be considered.

10. Appointment of the CEO to Hospital Trusts

10.1 Recommendations on Recruitment and Role of the CEO of a Hospital Trust

Hospital trusts will operate in a different landscape from hospital groups and will require new leadership. An enlightened hospital group leadership team will identify talent and provide opportunities for developing it so that, when hospital trusts become a reality, there will be people to lead and work them. The key management position in the trust will be the Chief Executive Officer. This may be a manager or a clinician by background but it will be a leader by disposition and ambition. It is vital that each trust fills this post with the best talent available nationally and internationally. Looking forward to that time, it is appropriate to detail what the recruitment process for the trust CEO should be. This is a vital sign that the future is not simply a reworking of the past. The public and the staff of the hospital system need to have confidence that real change is happening. The following recommendations set out a framework that is open, transparent, internationally valid and will assure the public and staff that hospital trusts represent a new beginning.

10.1a	Recruitment of the CEO of a Hospital Trust
i	Under the auspices of the Public Appointments Service (PAS), there will be an open international competition for the post of CEO.
ii	The process will involve the establishment of a search and selection committee to recruit nationally and internationally. The committee will include: two nominees by the Minister for Health, one to be an international expert in health service leadership/management; two nominees by the primary academic partner, one to be international; and two nominees by the board of the hospital trust. The search and selection committee will be chaired by the chairman of the board of the hospital trust. This selection process will be designed and will operate in accordance with all relevant legislation and codes of practice (see section 8.1.7)
iii	The CEO will be appointed for a period of five years, renewable only on the basis of a performance review by the board.

The role of the CEO of a hospital trust will be established in legislation. However, as this will be the key leadership role in each trust, the Strategic Board believes the following elements will need to be considered when addressing this role definitively.

	10.1b Role of the CEO Of A Hospital Trust
i	The CEO will be empowered to lead the group and manage its resources, assets and staffing levels (including recruitment), cognisant of Government policy.
ii	The CEO will be responsible for adhering to national and EU public procurement/competitive tendering requirements and will also play a full part in relevant national procurement and materials management initiatives.
iii	The CEO will ensure that site-specific services will be merged in order to reduce duplication of personnel: among them Finance, ICT, Risk Management, HR and non-pay costs, including advertising and training.
iv	The CEO will ensure maximum sharing of information, within existing legal frameworks, with ICT systems communicating within and between groups and with other health and personal social services, in particular primary care, and other public services, to enable maximum health benefits to be attained.
v	The CEO will be responsible for managing risk across the hospital group. The hospital group will develop a risk management framework and monitor its effectiveness. Risk management will be a standing item on each board's agenda.
vi	In order to ensure compliance with best practice, government policy, regulatory and statutory requirements, a robust and transparent audit process must be put in place. This will be an essential duty of the CEO.
vii	Any significant capital spending or service development must be supported by a business case to the Department of Health and Director General/Director of Acute Hospitals of the HSE or its equivalent. Transparency and equity must be evidenced in the approval and allocation of new services both to and within hospital groups.
viii	The CEO will develop a quality and safety framework to monitor quality and patient safety in accordance with published guidelines and national policy.
ix	Professional Codes of Conduct, Ethics in Public Office, disclosure obligations etc. must be complied with in order to avoid conflicts of interest.

11. Concluding Remarks

The formation of six hospital groups is the initial step in the creation of statutory hospital trusts, and thus in the implementation of a key pillar of government policy on transforming the Irish health service.

All who work in the Irish health service are aware of the challenges we face. We can only meet them successfully if we act together in a co-ordinated and planned way. In the future hospitals will be different from how they are now. The link with an academic partner will assist hospital groups to envision and appraise that future and work towards it in a proactive way. We have to move on to shape that future and we have to start now.

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Appendix 1 – Alternative Options Considered

Up to now hospitals were established to meet the health care needs of local communities in Ireland. Multiple management, governance and funding models have evolved over time, resulting in the *ad hoc* development of both hospitals and their services. Activity within this valuable resource must be coordinated and rationalised to meet current and future health care needs of our society.

There are 49 acute hospitals in Ireland. They are not evenly distributed around the country. For instance, there is a concentration of model four with relatively few model three and model two hospitals in Dublin. Additionally, there is not an even distribution of specialty services between hospitals, with evidence of both duplication and fragmentation of tertiary care. Consequently there isn't a single grouping model for the country which would perfectly align acute hospitals.

Nevertheless, there are a number of ways in which the 49 acute hospitals in Ireland could be arranged into a small number of groups. The possible composition of hospital groups was extensively explored by the Project Team, the Strategic Board, and in discussions with hospitals. As few as four and as many as eight groups were considered. Much of the consideration focused on assessing the benefits and disadvantages of various options. The following appraisal details the activity levels and the pros and cons of three out of many options considered by the Project Team and Strategic Board.
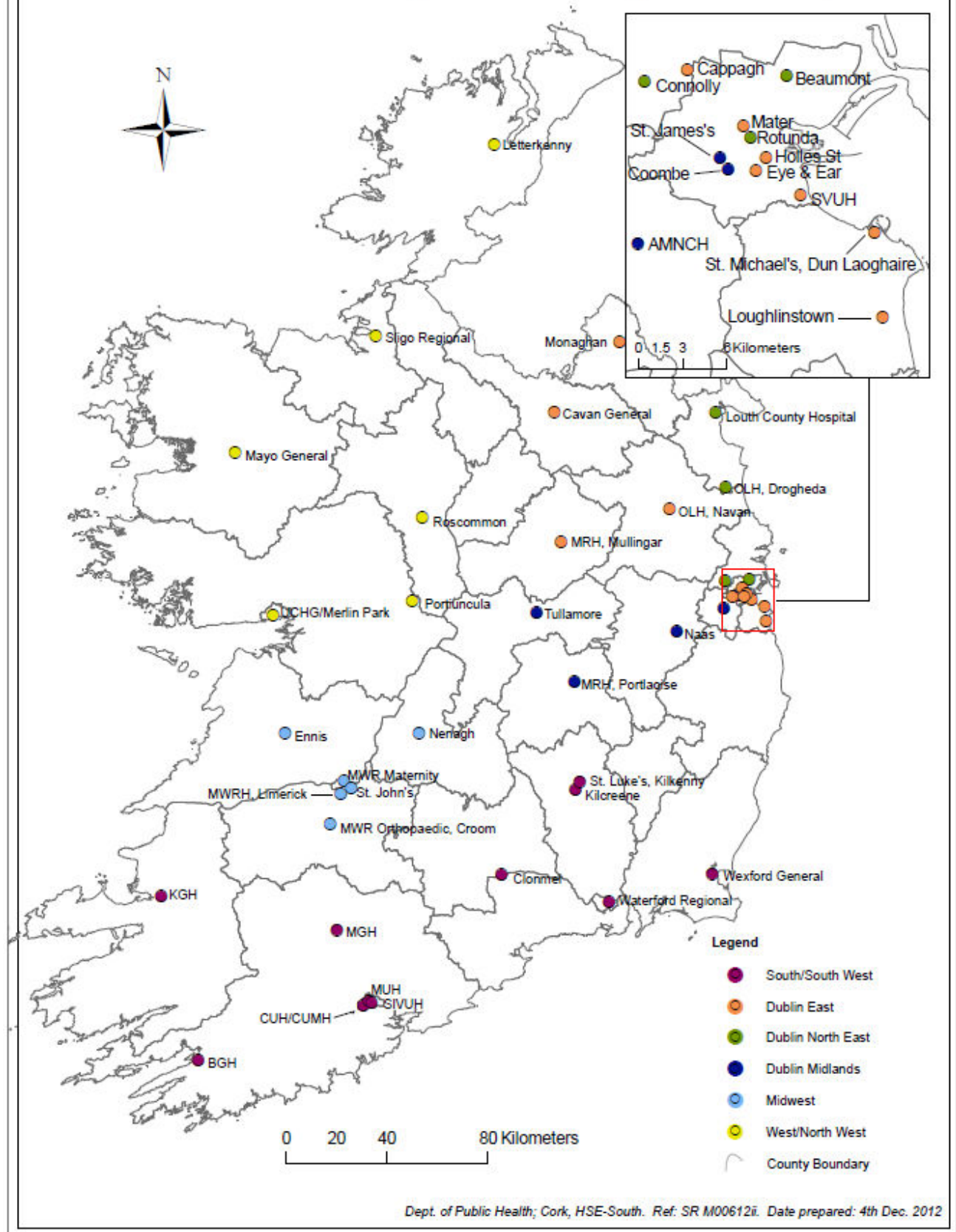
The recommended option is presented in the body of the report (section 6) and is not included here.

A1: Six Group Option with the South of the country in a single group

A six group option which would retain the current configuration in the South, the recently established hospital group in the Midwest, extend the recently established Galway Mayo group to include the North West and divide the remainder of the country into three Dublin associated groups was given very careful consideration by the Strategic Board. Though not the recommended grouping, it provided the best alternative.

	RECOMMENDED COMPOSITION OF HOSPITAL GROUPS
i	**Dublin North East:** Beaumont Hospital; Our Lady of Lourdes Hospital Drogheda; Connolly Hospital; Rotunda Hospital; Louth County Hospital.
ii	**Dublin Midlands:** St. James's Hospital; The Adelaide & Meath Hospital, Dublin including the National Children's Hospital; Midlands Regional Hospital, Tullamore; Naas General Hospital; the Coombe Women's and Infant's University Hospital; Midlands Regional Hospital, Portlaoise.
iii	**Dublin East:** Mater Misericordiae University Hospital; St. Vincent's University Hospital; Cavan General Hospital; Midland Regional Hospital at Mullingar; National Maternity Hospital; Our Lady's Hospital, Navan; St. Columcille's Hospital; St. Michaels Hospital Dun Laoghaire; Cappagh National Orthopaedic Hospital; Royal Victoria Eye and Ear Hospital; Monaghan Hospital.
iv	**South:** Cork University Hospital/CUMH; Waterford Regional Hospital; Kerry General Hospital; St. Luke's General Hospital, Kilkenny; Mercy University Hospital; Wexford General Hospital; South Tipperary General Hospital; South Infirmary Victoria University Hospital; Bantry General Hospital; Mallow General Hospital; Lourdes Orthopaedic Hospital, Kilcreene.
v	**West/North West**: University Hospital Galway and Merlin Park University Hospital; Sligo Regional Hospital; Letterkenny General Hospital; Mayo General Hospital; Portiuncula Hospital; Roscommon County Hospital.
vi	**Midwest:** Mid-Western Regional Hospital, Limerick; Ennis General Hospital; Nenagh General Hospital; St. John's Hospital; Mid-Western Regional Maternity Hospital; Mid-Western Regional Orthopaedic Hospital.
	Note; The acute paediatric services in Dublin – Our Lady's Children's Hospital, Crumlin, Children's University Hospital, Temple Street and the paediatric service in AMNCH – should also function as a single cohesive entity with appropriate governance arrangements (in line with hospital group proposals).

A1: Six Group Option with the South of the Country in a Single Group

Inset (Dublin area):
- Cappagh
- Connolly
- Beaumont
- Mater
- Rotunda
- St. James's
- Holles St
- Coombe
- Eye & Ear
- SVUH
- AMNCH
- St. Michael's, Dun Laoghaire
- Loughlinstown
- 0 1.5 3 6 Kilometers

Main map labels:
- Letterkenny
- Sligo Regional
- Monaghan
- Cavan General
- Louth County Hospital
- Mayo General
- OLH, Drogheda
- Roscommon
- OLH, Navan
- MRH, Mullingar
- Portiuncula
- Tullamore
- UCHG/Merlin Park
- Naas
- MRH, Portlaoise
- Ennis
- Nenagh
- MWR Maternity
- MWRH, Limerick — St. John's
- St. Luke's, Kilkenny Kilcreene
- MWR Orthopaedic, Croom
- Clonmel
- Wexford General
- KGH
- Waterford Regional
- MGH
- MUH
- SIVUH
- CUH/CUMH
- BGH

Legend

- South/South West
- Dublin East
- Dublin North East
- Dublin Midlands
- Midwest
- West/North West
- County Boundary

0 20 40 80 Kilometers

Dept. of Public Health; Cork, HSE-South. Ref: SR M00612ii. Date prepared: 4th Dec. 2012

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HEALTH DUBLIN NORTHEAST							
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Beaumont Hospital	238270	2954	21890	46121		49337	NCCP
Our Lady of Lourdes Drogheda	113384	1495	20138	7422	3808	53817	
Connolly Hospital	85220	1054	10455	9893		31922	
Rotunda Hospital	44979	739	17030	3645	9319		
Louth County Hospital, Dundalk	20701	278	437	8065			
	502554	**6520**	**69950**	**75146**	**13127**	**135076**	
Academic Partner: Royal College of Surgeons in Ireland (RCSI)							

- This group contains the following hospitals: Beaumont Hospital; Our Lady of Lourdes Hospital Drogheda; Connolly Hospital, Blanchardstown; Rotunda Hospital; Louth General Hospital, Dundalk.
- There is an NCCP centre at Beaumont Hospital.
- There are maternity hospitals/units at the Rotunda Hospital in Dublin and in Drogheda.
- The primary academic partner is the Royal College of Surgeons in Ireland (RCSI).

Commentary

Beaumont and Connolly Hospitals have undertaken considerable preparatory work with this group's primary academic partner, RCSI, to develop a strategic alliance. This preparatory work would serve the new hospital group well.

The Rotunda Hospital would provide leadership in maternity services (obstetrics, midwifery and neonatology) and gynaecology services to all of north Dublin and the northeast (Drogheda/Cavan). This would require the continuation of strong clinical links with the Mater Hospital with which it would continue to have joint consultant appointments. Of note, the Rotunda Hospital will be the only hospital in north Dublin to retain its current paediatric services.

This proposal divides the hospitals between Dublin and the border into two groups. However, services for the region should develop cognisant of cross-border linkages and retain the potential to develop formal cross border hospital networks.

HEALTH DUBLIN MIDLANDS							
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
St. James's Hospital	317095	3503	25153	93552		45760	NCCP
AMNCH - Tallaght	178027	2544	18731	30288		72995	
MRH Tullamore	81453	945	9546	16769		28047	
Naas General Hospital	56474	670	8999	4821		24494	
Coombe Women's Hospital	46932	725	19453	20354	8749		
MRH Portlaoise	44922	591	13792	5000	2261	41019	
	724903	**8978**	**95674**	**170784**	**11010**	**212315**	
Academic Partner: Trinity College Dublin (TCD)							

- This group contains the following hospitals: St James's Hospital; The Adelaide & Meath Hospital, Dublin including the National Children's Hospital; Midland Regional Hospital Tullamore; Naas General Hospital; the Coombe Women & Infant University Hospital; the Midland Regional Hospital Portlaoise.

- There is an NCCP centre at St James's Hospital.

- There are maternity hospitals/units at the Coombe Women & Infant Hospital and at the Midland Regional Hospital Portlaoise.

- The primary academic partner is Trinity College Dublin (TCD).

Commentary

This grouping is at an advanced state of readiness. St James's Hospital and AMNCH – Tallaght (in conjunction with the Coombe Hospital) have undertaken considerable preparatory work with this group's primary academic partner, TCD, to develop a strategic alliance. This preparatory work would serve the new hospital group well.

This group contains the largest hospital in the country and serves a large population base. It has recently been announced that the National Paediatric Hospital (NPH also known now as the New Children's hospital) is to be located at the St James's campus. Despite the NPH having a separate governance structure and the existing Dublin paediatric hospitals forming a separate group, this will have significant positive knock on effects for this hospital group. Two hospitals from the Midlands are included in the group. Hospitals in the group have established clinical links with shared clinical appointments and established referral patterns between many of the hospitals. They also share a common population referral base in southwest Dublin and the Midlands.

HEALTH DUBLIN EAST							
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Mater Misericordiae Hospital	213608	2597	16802	39006		48348	NCCP
St. Vincents Hospital Elm Park	203622	2377	14631	52395		40106	NCCP
Cavan General Hospital	67153	743	14674	9075	2054	27099	
MRH Mullingar	58035	750	19365	7397	2782	31339	
National Maternity Hospital	44482	725	17779	3080	9459		
Our Lady's General Hospital, Navan	40514	440	4651	4953			
St. Columcille's Hospital	37538	446	3726	2495		19874	
St. Michaels Hospital Dún Laoghaire	26285	391	2579	5803		13704	
Cappagh Orthopaedic	25428	301	2195	9041			
Royal Victoria Eye and Ear Hospital	20865	268	2415	7251			
Monaghan Hospital	12110	168		4881			
	749640	**9206**	**98817**	**145377**	**14295**	**180470**	
Academic Partner: University College Dublin (UCD)							

- This group contains the following hospitals: Mater Misericordiae Hospital; St Vincent's University Hospital; Cavan General Hospital; Midland Regional Hospital Mullingar; the National Maternity Hospital; Our Lady's General Hospital Navan; St Columcille's Hospital; St Michael's Hospital Dún Laoghaire; Cappagh National Orthopaedic Hospital; the Royal Victoria Eye and Ear Hospital and Monaghan Hospital.

- There are NCCP centres at St Vincent's University Hospital and the Mater Misericordiae University Hospital.

- There are maternity hospitals/units at the National Maternity Hospital Dublin and the Midland Regional Hospital Mullingar.

- The primary academic partner is University College Dublin (UCD).

Commentary

The Mater Misericordiae University Hospital and St Vincent's University Hospital have undertaken considerable preparatory work with this group's primary academic partner, UCD, to develop a strategic alliance. This preparatory work would serve the new hospital group well.

The Mater would retain current links with the Cavan and Monaghan hospitals within the group. The Mater would also maintain its strong links with the Rotunda Hospital with which it would continue to

have joint consultant appointments. The Rotunda Hospital clinical network would continue to provide maternity and gynaecology services in Cavan General Hospital.

The referral base of the National Maternity Hospital is sub-optimal in this group; cross-group tertiary referral arrangements with southeast hospitals would have to be considered under this arrangement.

	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
HEALTH SOUTH							
Cork University Hospital	264081	3223	29472	54437		56709	NCCP
Waterford Regional Hospital	141673	1720	22925	20350	2439	49984	NCCP
Kerry General Hospital	71097	964	14083	10361	1753	30290	
St. Luke's Hospital, Kilkenny	56639	825	13905	11968	2042	31065	
Mercy Hospital, Cork	55978	923	9374	18945		26634	
Wexford General Hospital	49047	802	16544	8791	2232	34212	
South Tipperary General Hospital	46445	708	12882	7138	1247	28668	
SIVUH	43663	704	7898	16193		18336	
Bantry General Hospital	17574	234	1889	1725			
Mallow General Hospital	16524	238	3887	2728			
CUMH			14067	5362	8784		
Lourdes Orthopaedic Hospital, Kilcreene		70	845	919			
	762721	**10411**	**147771**	**158917**	**18497**	**275898**	
Academic Partner: University College Cork (UCC)							

- This group contains the following hospitals: Cork University Hospital (incorporating Cork University Maternity Hospital); Waterford Regional Hospital; Kerry General Hospital; St Luke's Hospital Kilkenny; Mercy University Hospital; Wexford General Hospital; South Tipperary General Hospital; South Infirmary Victoria University Hospital; Bantry General Hospital; Mallow General Hospital and Lourdes Orthopaedic Hospital, Kilcreene.

- There are NCCP centres at Cork University Hospital and Waterford Regional Hospital.

- There are maternity hospitals/units at Cork University Maternity Hospital, Waterford Regional Hospital, Kerry General Hospital, St Luke's Hospital Kilkenny, Wexford General Hospital and South Tipperary General Hospital.

- The primary academic partner is University College Cork (UCC).

Commentary

Hospital reconfiguration is at an advanced state in the south western part of this group, and the implementation of the Roadmap for Acute Hospital Services in Cork and Kerry will continue under the group structure.

There is an absence of consensus/ shared vision amongst the hospitals in the South East. Therefore, the transitional group management team and the interim board would need to ensure that the service synergies between the hospitals of the southeast are optimised. They would also need to ensure that the relationship between the hospitals of the southeast are characterised by trust, transparency and

equity.

Kerry General Hospital and Wexford General Hospital, because of their geographic location, (similar to Letterkenny) should retain their full range of ED, medical, surgical, maternity and paediatric services.

HEALTH WEST /NORTH WEST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
UCHG /Merlin Park	251624	3086	35179	66102	3428	59349	NCCP
Sligo General Hospital	98011	1354	15924	26467	1582	31622	
Letterkenny General Hospital	97007	1370	20927	17586	2003	32100	
Mayo General Hospital, Castlebar	76293	979	16594	16258	1835	32762	
Portiuncula Hospital, Ballinasloe	41095	657	11022	8046	2148	19366	
Roscommon County Hospital	18914	284	3565	3789		6722	
	582944	**7730**	**103211**	**138248**	**10996**	**181921**	
Academic Partner: National University of Ireland, Galway (NUIG)						

- This group contains the following hospitals: University Hospital Galway/Merlin Park; Sligo Regional Hospital; Letterkenny General Hospital; Mayo General Hospital; Portiuncula Hospital and Roscommon County Hospital.
- There is an NCCP centre at University Hospital Galway.
- There are maternity hospitals/units at Galway, Portiuncula, Letterkenny, Mayo and Sligo.
- The primary academic partner is National University of Ireland, Galway (NUIG).

Commentary

This group is partially pre-determined by the appointment of a CEO to the Galway Roscommon group and the appointment of a chair to the interim board for the group. This group would serve the western seaboard, stretching from Galway to Donegal, a geographically dispersed and relatively sparsely populated region. In recognition of the geographic remoteness challenges Sligo and Letterkenny General Hospitals, while part of the group, would be managed as a single unit within that group. The synergistic service model developed between Sligo and Letterkenny hospitals should be retained.

Letterkenny Hospital, because of its geographic location, (similar to Kerry and Wexford) should retain its full range of ED, medical, surgical, maternity and paediatric services.

Services for the region should develop cognisant of cross-border linkages and retain the potential to develop formal cross border hospital networks.

There are plans to locate a rehabilitation centre at Roscommon County Hospital as part of the National Clinical Programme for Rehabilitation.

HEALTH MIDWEST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
MWRH - Dooradoyle	138059	1826	25053	20401		57916	NCCP
Ennis General Hospital	19653	231	3607	2825		13399	
Nenagh General Hospital	17976	232	2687	4888		9556	
St. John's Hospital, Limerick	17626	279	3892	7754		15492	
Regional Maternity Hospital Limerick	15705	298	8331		5167		
Mid Western Regional Orthopaedic Hospital	9824	163	1801	2780			
	218843	**3029**	**45371**	**38648**	**5167**	**96363**	
Academic Partner: University of Limerick (UL)						

- This group contains the following hospitals: Mid-Western Regional Hospital, Limerick; Ennis General Hospital; Nenagh General Hospital; St. John's Hospital, Limerick; Mid-Western Regional Maternity Hospital; Mid-Western Regional Orthopaedic Hospital.

- There is an NCCP centre at the MWRH, Limerick

- There is a maternity hospital in Limerick.

- The primary academic partner is the University of Limerick (UL).

Commentary

This group is partially pre-determined by the appointment of a CEO to the Mid-Western group and the appointment of a chair to the interim board for the group. It has the smallest natural population base. It has a limited range of tertiary referral specialties. However, it has the advantage of being very cohesive and there is the potential to develop a strong shared regional identity with its academic partner, the University of Limerick. It also has the advantage that hospital reconfiguration is at an advanced stage with the centralisation of cancer services and all emergency surgery at MWRH, Limerick.

This group should develop structured collaborations with Health West/North West and Health South/South West in order to provide a full range of services, including many specialist services, for the people of the midwest. The success of these, and any similar arrangements in other regions, can be evaluated as part of the national evaluation process preparatory to the establishment of Hospital Trusts.

Overall features of the six group model outlined above

- This option provides a mix of model two or three and four hospitals in each group except for Health Midwest which doesn't have a model three hospital.

- Each of the four groups has at least one NCCP centre, while two of them have two centres.

- The number of maternity services in each group ranges from one to six, with one major Dublin maternity hospital in each of the Dublin groups.

- Each group currently has a number of 24-hour ED services.

- The groups are of variable size with variable budgets.

- In most instances, existing clinical networks would be enhanced, e.g. Mater Misericordiae/Cavan Monaghan care pathways, but in some established links would be disrupted, e.g. Midland Regional Hospital Group.

Discussion

The main advantage of this option is that the hospitals in the South East, which are currently linked for specialist services such as Cancer and Trauma Orthopaedics, remain together, while grouping them with the South would provide many of the tertiary services currently not available in the South East.

Patterns of hospital usage for the population of the southeast indicate that while, as is the case for all regions, the bulk of care is delivered at the local hospital, there is also a heavy reliance on Cork and Dublin hospitals. There are complex patterns of patient flow from the South East hospitals. Nine percent of South Tipperary residents and 10% of Waterford residents have hospital discharges from Cork. In contrast, Carlow residents have 53% of their hospital care delivered by St Luke's Hospital Kilkenny, 11% by Waterford Regional Hospital and most of the remainder by Dublin hospitals. 10% of hospital discharges for the residents of Wexford are from St Vincent's University Hospital Dublin. There is an absence of a consensus/ shared vision amongst the hospitals in the South East.

Health South would be the only group in the country to mirror the current HSE Regional configuration. There is a risk that because of the geographical spread of this group, the fact that it has always been managed as two separate networks and the tendency to refer outside the South East region, that the transition to trust status would be challenging for this group.

Because of the geographical distribution of the Health South and Health West / North West groups, distinct management units would be envisaged for the former South East and North West (Sligo/Letterkenny) Health Board areas. Precise management arrangements would be determined and agreed by the interim board of the group. However, a large unit within a group, as would be the case in

Health South under this option, has the potential to weaken group cohesion.

This option would leave the Midwest hospitals together as a group building on their existing network arrangements.

This option would also impact on the configuration and catchment of Dublin hospitals. The main advantage for the Dublin hospitals in this option is that they are grouped according to existing clinical practice and strategic alliances that link St James's Hospital and AMNCH - Tallaght hospital with other midland hospitals that share a common population referral base. It also builds on the existing alliance between the Mater Misericordiae University Hospital and St Vincent's University Hospital. The Mater Misericordiae University Hospital would retain its existing clinical links with Cavan and Monaghan hospitals while forging further links with Mullingar. It would require a cross group maternity service network between Rotunda, Drogheda and Cavan to avoid disruption to the existing maternity service network between these three maternity service providers. Under other options considered, the Cavan and Monaghan hospitals would link to the other North Dublin/North East hospitals, a more cohesive arrangement for that region.

A2: Four Group Option with two groups in Dublin

1. Health South
2. Health West/ North West
3. Health Dublin/ Midlands
4. Health Dublin /Northeast

Features

- The groupings provide a mix of model two, three and four hospitals in each group.
- Each of the four groups has two NCCP centres.
- There are between three and six maternity services in each group.
- Each group currently has a number of 24-hour ED services.
- The groups would be of similar size, with comparable budgets.
- Each of the groups have established clinical care networks within them.

Discussion

This ambitious option has the benefit of creating a small number of hospital groups with significant scale in budget, staffing and the range of specialties available within each group. Creating two groups in Dublin could facilitate the significant rationalisation of services required in the city. The configuration wouldn't differ significantly from the current HSE Regions and established clinical networks would remain largely intact.

However, the hospitals within the existing regions although managed under single Regional Director of Operations (RDO) are not managed as a single hospital network. For instance HSE South contains hospital networks based on the older Health Board structure and within those networks, hospitals have individual management teams. Were the Strategic Board to recommend a four group option to truly function as a group, radical changes to existing relationships between hospitals would be required.

Because of the geographical spread of some of the groups, e.g. Health South and Health West North West, distinct management units would be necessary for the former South East and North West health board hospitals. The precise management arrangements of these units would be determined and agreed by the interim board of the group.

It was the view of the Strategic Board that based on both Irish and international experience of implementing hospital groups, it could take up to a decade for some of these groups to function effectively.

HEALTH SOUTH						
	Approved				ED	
	Budget	WTE	Inpatient	Day Cases	Births	Attendance	NCCP Centre
Cork University Hospital	264081	3223	29472	54437		56709	NCCP
Waterford Regional Hospital	141673	1720	22925	20350	2439	49984	NCCP
Kerry General Hospital	71097	964	14083	10361	1753	30290	
St. Luke's Hospital, Kilkenny	56639	825	13905	11968	2042	31065	
Mercy Hospital, Cork	55978	923	9374	18945		26634	
Wexford General Hospital	49047	802	16544	8791	2232	34212	
Sth Tipperary General Hospital	46445	708	12882	7138	1247	28668	
SIVUH	43663	704	7898	16193		18336	
Bantry General Hospital	17574	234	1889	1725			
Mallow General Hospital	16524	238	3887	2728			
CUMH			14067	5362	8784		
Orthopaedic Hospital, Kilcreene		70	845	919			
	762721	**10411**	**147771**	**158917**	**18497**	**275898**	
Academic Partner: University College Cork (UCC)							

HEALTH WEST /NORTH WEST						
	Approved				ED	
	Budget	WTE	Inpatient	Day Cases	Births	Attendance	NCCP Centre
UCHG /Merlin Park	251624	3086	35179	66102	3428	59349	NCCP
MWRH - Dooradoyle	138059	1826	25053	20401		57916	NCCP
Sligo General Hospital	98011	1354	15924	26467	1582	31622	
Letterkenny General Hospital ,	97007	1370	20927	17586	2003	32100	
Mayo General Hospital, Castlebar	76293	979	16594	16258	1835	32762	
Portiuncula Hospital, Ballinasloe	41095	657	11022	8046	2148	19366	
Ennis General Hospital	19653	231	3607	2825		13399	
Roscommon County Hospital	18914	284	3565	3789		6722	
Nenagh General Hospital	17976	232	2687	4888		9556	
St. John's Hospital, Limerick	17626	279	3892	7754		15492	
Regional Maternity Limerick	15705	298	8331		5167		
Regional Orthopaedic - Croom	9824	163	1801	2780			
	801787	**10759**	**148582**	**176896**	**16163**	**278284**	
Academic Partner 1: National University of Ireland, Galway (NUIG)							
Academic Partner 2: University of Limerick (UL)							

HEALTH DUBLIN NORTHEAST						
	Approved				ED	
	Budget	WTE	Inpatient	Day Cases	Births	Attendance	NCCP Centre
Beaumont Hospital	238270	2954	21890	46121		49337	NCCP
Mater Misericordiae Hospital	213608	2597	16802	39006		48348	NCCP
Our Lady of Lourdes Drogheda	113384	1495	20138	7422	3808	53817	
Connolly Hospital	85220	1054	10455	9893		31922	
Cavan General Hospital	67153	743	14674	9075	2054	27099	
Rotunda Hospital	44979	739	17030	3645	9319		
Our Lady's General Hosp, Navan	40514	440	4651	4953			
Cappagh Orthopaedic	25428	301	2195	9041			
Louth County Hospital, Dundalk	20701	278	437	8065			
Monaghan Hospital	12110	168		4881			
	861367	**10769**	**108272**	**142102**	**15181**	**210523**	
Academic Partner 1: Royal College of Surgeons in Ireland (RCSI)							
Academic Partner 2: University College Dublin (UCD)							

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HEALTH DUBLIN MIDLANDS						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
St. James's Hospital	317095	3503	25153	93552		45760	NCCP
St. Vincents Hospital Elm Park	203622	2377	14631	52395		40106	NCCP
AMNCH - Tallaght	178027	2544	18731	30288		72995	
MRH Tullamore	81453	945	9546	16769		28047	
MRH Mullingar	58035	750	19365	7397	2782	31339	
Naas General Hospital	56474	670	8999	4821		24494	
Coombe Women's Hospital	46932	725	19453	20354	8749		
MRH Portlaoise	44922	591	13792	5000	2261	41019	
National Maternity Hospital	44482	725	17779	3080	9459		
St. Columcille's Hospital	37538	446	3726	2495		19874	
St. Michaels Hospital DLaoire	26285	391	2579	5803		13704	
Royal Victoria Eye and Ear	20865	268	2415	7251			
	1115730	**13935**	**156169**	**249205**	**23251**	**317338**	
Academic Partner 1: Trinity College Dublin (TCD)						
Academic Partner 2: University College Dublin (UCD)						

A3. Eight Group Option with Four Groups in Dublin

An eight hospital group option, four of which would be in the greater Dublin area was considered:

1. Health Dublin/Midlands
2. Health Dublin East
3. Health Dublin/North East (Louth/Meath)
4. Health Dublin/North East (Cavan/Monaghan)
5. Health West/North West
6. Health Mid West
7. Health South West
8. Health South East

Features
- All groupings have a range of different model hospitals.
- Each of the groups contains one NCCP centre.
- The number of maternity services in each group ranges from one to five, but one of the Dublin groupings, Health Dublin North East (Louth/Meath), does not have a Dublin maternity hospital.
- Each group has a number of 24-hour ED services.
- The groups are of variable size with variable budgets.
- Existing clinical networks would be largely unchanged.

Discussion

An eight hospital group option, four of which would be in the greater Dublin area, would result in groups with closer geographical linkages and would not require significant changes to existing relationships between hospitals. However, this option would largely maintain the status quo and not support the necessary service reform. It was considered that four groups in Dublin would limit the potential to address the specialist service fragmentation and service duplication across the group. Other disadvantages, given the relatively small scale of some of these groups, include the restricted budget and the restricted range of specialties that would be available in certain groups; neither would it address current recruitment and attrition difficulties. The Rotunda Maternity Hospital is in the Dublin North East (Cavan Monaghan) group, but it would also have to provide obstetrics and gynaecology referral services to the other Dublin North East group (Louth Meath).

It was the view of the Strategic Board that eight hospital groups are too many for a country the size of Ireland.

HEALTH DUBLIN MIDLANDS						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
St. James's Hospital	317095	3503	25153	93552		45760	NCCP
AMNCH - Tallaght	178027	2544	18731	30288		72995	
MRH Tullamore	81453	945	9546	16769		28047	
MRH Mullingar	58035	750	19365	7397	2782	31339	
Naas General Hospital	56474	670	8999	4821		24494	
Coombe Women's Hospital	46932	725	19453	20354	8749		
MRH Portlaoise	44922	591	13792	5000	2261	41019	
	782938	**9728**	**115039**	**178181**	**13792**	**243654**	
Academic Partner: Trinity College Dublin (TCD)						

HEALTH DUBLIN EAST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
St. Vincents Hospital Elm Park	203622	2377	14631	52395		40106	NCCP
National Maternity Hospital	44482	725	17779	3080	9459		
St. Columcille's Hospital	37538	446	3726	2495		19874	
St. Michaels Hospital DLaoire	26285	391	2579	5803		13704	
Royal Victoria Eye and Ear	20865	268	2415	7251			
	332792	**4207**	**41130**	**71024**	**9459**	**73684**	
Academic Partner: University College Dublin (UCD)						

HEALTH DUBLIN NORTH EAST (LOUTH/MEATH)						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Beaumont Hospital	238270	2954	21890	46121		49337	NCCP
Our Lady of Lourdes Drogheda	113384	1495	20138	7422	3808	53817	
Connolly Hospital	85220	1054	10455	9893		31922	
Our Lady's General Hosp, Navan	40514	440	4651	4953			
Louth County Hospital, Dundalk	20701	278	437	8065			
	498089	**6221**	**57571**	**76454**	**3808**	**135076**	
Academic Partner: Royal College of Surgeons in Ireland (RCSI)						

HEALTH DUBLIN NORTH EAST (CAVAN/MONAGHAN)						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Mater Misericordiae Hospital	213608	2597	16802	39006		48348	NCCP
Cavan General Hospital	67153	743	14674	9075	2054	27099	
Rotunda Hospital	44979	739	17030	3645	9319		
Cappagh Orthopaedic	25428	301	2195	9041			
Monaghan Hospital	12110	168		4881			
	363278	**4548**	**50701**	**65648**	**11373**	**75447**	
Academic Partner: University College Dublin (UCD)						

HEALTH SOUTH WEST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Cork University Hospital	264081	3223	29472	54437		56709	NCCP
Kerry General Hospital	71097	964	14083	10361	1753	30290	
Mercy Hospital, Cork	55978	923	9374	18945		26634	
SIVUH	43663	704	7898	16193		18336	
Bantry General Hospital	17574	234	1889	1725			
Mallow General Hospital	16524	238	3887	2728			
CUMH			14067	5362	8784		
	468917	**6286**	**80670**	**109751**	**10537**	**131969**	
Academic Partner: University College Cork (UCC)						

HEALTH WEST /NORTH WEST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
UCHG /Merlin Park	251624	3086	35179	66102	3428	59349	NCCP
Sligo General Hospital	98011	1354	15924	26467	1582	31622	
Letterkenny General Hospital ,	97007	1370	20927	17586	2003	32100	
Mayo General Hospital, Castlebar	76293	979	16594	16258	1835	32762	
Portiuncula Hospital, Ballinasloe	41095	657	11022	8046	2148	19366	
Roscommon County Hospital	18914	284	3565	3789		6722	
	582944	**7730**	**103211**	**138248**	**10996**	**181921**	
Academic Partner: National University of Ireland, Galway (NUIG)						

HEALTH MIDWEST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
MWRH - Dooradoyle	138059	1826	25053	20401		57916	NCCP
Ennis General Hospital	19653	231	3607	2825		13399	
Nenagh General Hospital	17976	232	2687	4888		9556	
St. John's Hospital, Limerick	17626	279	3892	7754		15492	
Regional Maternity Limerick	15705	298	8331		5167		
Regional Orthopaedic - Croom	9824	163	1801	2780			
	218843	**3029**	**45371**	**38648**	**5167**	**96363**	
Academic Partner: University of Limerick (UL)						

HEALTH SOUTH EAST						
	Approved Budget	WTE	Inpatient	Day Cases	Births	ED Attendance	NCCP Centre
Waterford Regional Hospital	141673	1720	22925	20350	2439	49984	NCCP
St. Luke's Hospital, Kilkenny	56639	825	13905	11968	2042	31065	
Wexford General Hospital	49047	802	16544	8791	2232	34212	
Sth Tipperary General Hospital	46445	708	12882	7138	1247	28668	
Orthopaedic Hospital, Kilcreene		70	845	919			
	293804	**4125**	**67101**	**49166**	**7960**	**143929**	
Academic Partner: Royal College of Surgeons (RCSI)						

Appendix 2 – Minister's Section 10 Letter

An Roinn Sláinte
DEPARTMENT OF HEALTH

Oifig an Aire
Office of the Minister

28 March 2012

Mr Michael Scanlan
Chairman
Health Service Executive

Dear Chairman

I am writing to you in accordance with section 10 of the Health Act 2004 to provide the Health Service Executive with a policy direction in relation to the development of new management arrangements for public hospitals which are designed to support the move to universal hospital care.

As you are aware, the Programme for Government says that public hospitals will become independent not-for-profit trusts with managers accountable to their boards.

This is part of the Government's wider reform programme which reflects the overriding objective of improving services to those who use our services, as well as helping those working in the service to deliver better services and demonstrating to taxpayers that they are getting value from the health service.

Clearly, primary legislation will be required in due course to give full effect to the foregoing but I am satisfied that it would be better, and should be possible, to implement many of the required changes on an administrative basis. Such an approach will facilitate earlier implementation of the policy goals and help to ensure the legislation can be drafted in a way which takes full account of the practical experience gained in the meantime and incorporates whatever decisions are required as we deal with various issues which will inevitably arise during the implementation process.

I am keen that transitional arrangements be developed as a matter of urgency which would enable me to finalise proposals for Government in relation to the creation of further hospital groups and the establishment of new governance arrangements for these groups.

Accordingly, I want the HSE to work with my Department to prepare proposals for:

(i)   the creation of hospital groups as quickly as possible this year on an administrative basis (i.e. ahead of the establishment of hospital trusts) with a single consolidated management team with responsibility for performance and outcomes within a clearly defined budget and employment ceiling for each hospital group;

Othar

Patient Safety

(ii)   the establishment of executive teams for each group with the autonomy to reconfigure services across the group subject to an agreed policy framework and approval process; and

(iii)   the creation on an administrative basis of "boards" for each hospital group with suitable individuals being selected through an appropriate process for appointment as non-executive members of these "boards".

I intend to await receipt of the forthcoming HIQA report on Tallaght Hospital before making final decisions on some issues but my view at this stage is that:

(a)   there is a need to identify suitable hospital groups very quickly on the clear understanding that the groupings and their governance arrangements will be reviewed prior to 2015 to ensure an appropriate environment for the introduction of UHI;

(b)   arrangements should be developed for appointing suitable people to the key leadership positions such as group CEO, chief financial officer, clinical director, director of nursing and chief operating officer;

(c)   an annual budget and employment ceiling should be developed for each group along with arrangements which would give the executive team the authority to deploy and re-deploy staff (including consultants) across the group (where a group involves a HSE and a voluntary hospital, the aim would be to use the service level agreement provision to give the larger hospital the authority to manage the entire group).

(d)   it should be made clear to the staff concerned that the policy does not involve any change in their existing public service employment status or in their core terms and conditions, although it will require the type of changes in reporting relationships, work practices, etc. that are provided for in the Public Service Agreement and that health service staff have already been delivering across the country;

(e)   the executive team/board should have autonomy to reconfigure services across the group subject to compliance with an agreed policy framework and process; the policy framework would incorporate the criteria described in the draft Framework for Smaller Hospitals (safety, quality, cost and sustainability of medical staffing/EWTD compliance) as well as access standards and targets set by the Minister; and

(f)   arrangements should be made to create, in advance of legislation, some form of "non-executive challenge" for HSE hospitals, i.e. akin to a voluntary hospital board.

The proposals for hospital groups should be consistent with the 2012 budget and employment targets as approved by Government in the Revised Estimates Volume and the Health Expenditure and Numbers Ceilings for 2013 - 2014 in the published

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Comprehensive Expenditure Report 2012 -2014 and any related decisions by Government.

I intend to revert to my colleagues in Government to agree the arrangements for, and make up of, hospital groups where they are not already in existence. Preliminary work in this regard is already underway within the Special Delivery Unit. The process will include an appropriate consultation element.

It is my intention to publish soon the Framework for Smaller Hospitals which has been developed by the HSE and the Department. It will also be necessary to develop an appropriate process dealing with the implementation by hospital groups of this Framework and other service changes.

Work is also underway within the Department on preparing legislation to abolish the Board of the HSE and replace it with a Directorate comprising a Director General and a number of Directors, one of whom will be a National Director for Hospitals. I envisage that the hospital group CEOs will report to this National Director pending the enactment of legislation establishing independent hospital trusts.

I want to make it clear that hospital groups, and in due course hospital trusts, will be required to comply with clearly articulated national performance requirements in relation to issues such as quality, access and financial management. The new structures are designed to strengthen, not undermine, existing financial control systems by, for example, having clearer accountability at hospital group level about budgets, employment ceilings, etc. and strengthening local financial control capabilities (as the HSE are already taking steps to do in the case of the mid-west hospital group). The hospital groups will also be required to comply with and use existing and future shared services in areas such as procurement, payroll and recruitment.
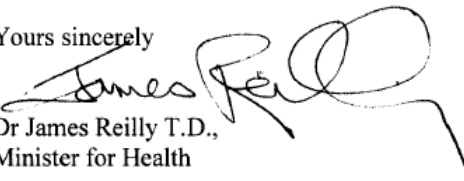
As you know, I wrote to your predecessor on 9 December 2011 about the new management arrangements for groups of hospitals in the west and mid-west and I am pleased that two experienced managers have already taken on the role of group CEO for each of these hospital groups. In light of the fact that these hospital groups have already been established and given the service delivery and financial performance challenges facing those hospital groups, it is essential that the changes outlined above for the generality of public hospitals should, in the case of hospital groups already established, move ahead urgently and the Government is fully in agreement on this approach."

Clearly, there is a considerable amount of work to be done to develop the various different elements of the new arrangements, e.g. in relation to budgets, employment ceilings and governance. I want the HSE to work closely with the Department to develop proposals for my approval, and ultimately that of Government, covering all aspects of the new policy.

I would ask that the Board provide me with a report by the end of April 2012 under section 10(2) of the 2004 Act as to the steps being taken to (i) implement these important policies in the west and mid-west groups and (ii) ensure viable proposals to

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implement these policies in the case of other hospitals across the country can be put to Government.

Yours sincerely

Dr James Reilly T.D.,
Minister for Health

Appendix 3 – Members of Strategic Board & Project Team

<u>Membership of the Strategic Board</u>

Prof. John R. Higgins (Chair)	Professor of Obstetrics and Gynaecology, Cork University Maternity Hospital Head of College of Medicine & Health, University College Cork, Ireland
Mr. Charlie Hardy	Principal Officer, Department of Health, Dublin, Ireland
Prof. Paul K. Whelton	Previously CEO Loyola University Health System, Chicago, Illinois, USA
Mr. Michael J. Dowling	President & CEO, North Shore LIJ Health System, New York, USA.
Prof. Dr. Eduard. C. Klasen	Previously Member of the Executive Board and Dean, Leiden University Medical Centre, The Netherlands
Ms. Katie Burke	Senior Manager, Centre for Effective Services, Dublin, Ireland
Mr. Mike Farrar	CEO of NHS Confederation, London, UK
Prof. Eilis McGovern	Director of Medical Training, HSE – Dublin, Ireland *(Strategic Board member from August 2012 to October 2012)*

Membership of the Project Team

Ms Margo Topham (Project Lead)

Manager, Planning, Development & Strategy Department**,** South Infirmary-Victoria University Hospital.
(Project Team Lead from June 2012 to December 2012)

Dr Orla Healy

Specialist in Public Health Medicine, HSE
(Project Team Lead from January 2013)

Mr Michael Hanna

Senior Health Education Officer (retired).

Ms Kathryn Neville

College Manager, College of Medicine and Health, University College Cork

Mr Charlie Hardy

Principal Officer, Department of Health
(Replaced Ms Ryan on Project Team from July 2012)

Ms Miriam Joyce

Assistant Principal Officer, Special Delivery Unit

Ms Fionnuala Duffy

Special Delivery Unit, Department of Health.

Ms Simonetta Ryan

Principal Officer, Department of Health.
(Project Team member from June 2012 to July 2012)

Appendix 4 – Summary Data Analysis (2011)

Two sets of graphs are presented: the first suite of "hospital" graphs demonstrate the county of residence of patients discharged from each publically funded hospital in the country in 2011. The second set of "county" graphs, demonstrate patterns of publically funded hospital usage for each county in 2011. The analysis includes the full range of inpatient (overnight emergency and elective) day-case, maternity, newborn and paediatric activity for the year. It does not include emergency department or outpatient activity. It is evident from the analysis that local populations tend to use their local hospital. The distribution of hospital usage tends to be more dispersed in areas not served by a local hospital, e.g. Carlow, and counties closer to Dublin, e.g. Kildare and Wicklow.

It should be noted that this is an analysis of the number of discharges and not of numbers of patients. An individual patient may have multiple hospital discharges in a single year, particularly if the patient attends the hospital for treatments such are haemodialysis or chemotherapy. Finally, while the analysis includes private patients in publically funded hospital, it does not include private hospitals.

Hospital Discharges, Area of Residence, 2011 by Hospital

Health Dublin North East
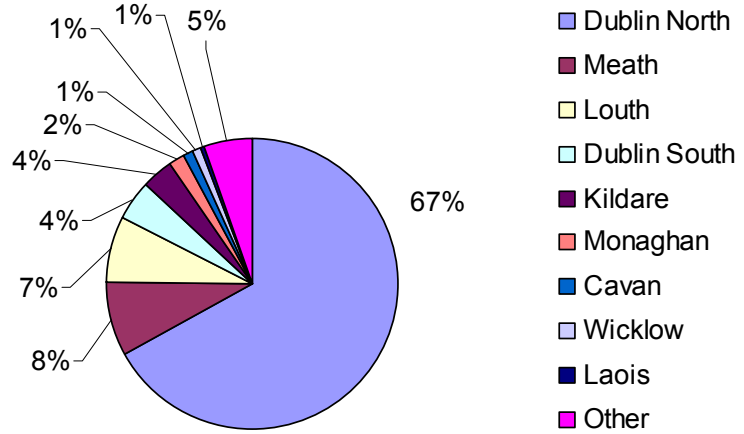
Beaumont Hospital

Legend:
- Dublin North
- Meath
- Louth
- Dublin South
- Kildare
- Monaghan
- Cavan
- Wicklow
- Laois
- Other

67%, 8%, 7%, 4%, 4%, 2%, 1%, 1%, 1%, 5%

Our Lady of Lourdes Hospital, Drogheda

Legend:
- Louth
- Meath
- Monaghan
- Dublin North
- Cavan
- Other

57%, 26%, 8%, 5%, 3%, 1%

Connolly Hospital Blanchardstown

Legend:
- Dublin North
- Meath
- Kildare
- Dublin South
- Other

51%, 21%, 15%, 9%, 4%
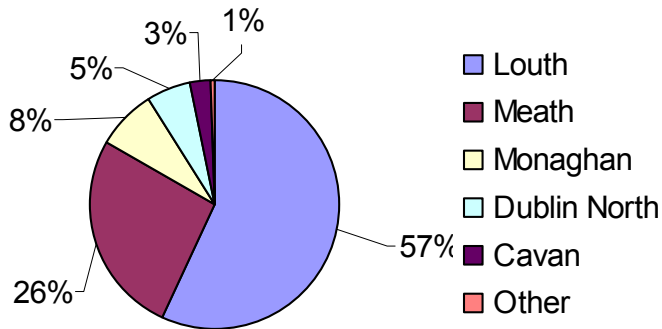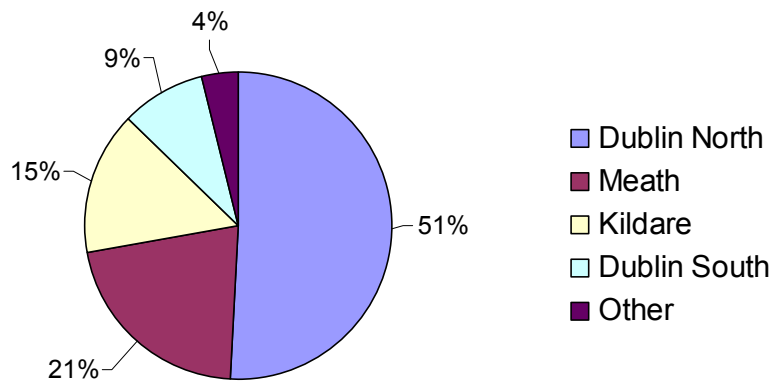
Health Dublin North East *(cont'd...)*

Cavan General Hospital
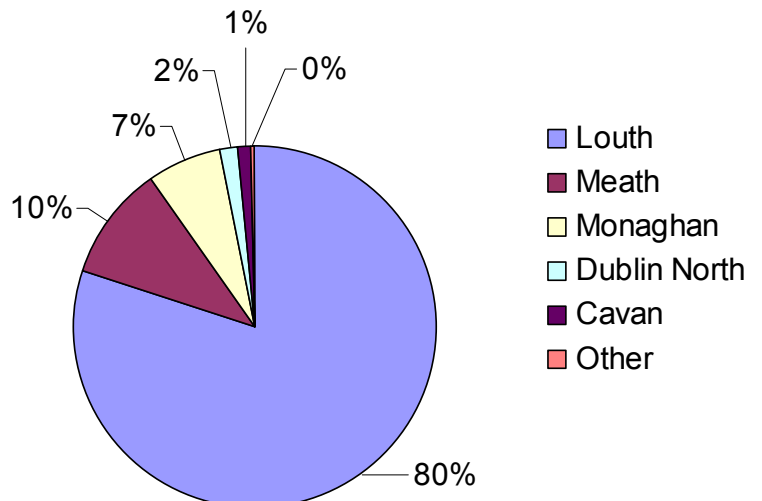
■	Cavan
■	Monaghan
□	Meath
□	Longford
■	Leitrim
■	Westmeath
■	Other

1%
1%
2%
4%
6%
27%
59%

Rotunda Hospital

■	Dublin
■	Meath
□	Kildare
□	Wicklow
■	Other

1% 4%
4%
9%
82%

Louth County Hospital

■	Louth
■	Meath
□	Monaghan
□	Dublin North
■	Cavan
■	Other

1%
0%
2%
7%
10%
80%

Monaghan Hospital

■	Monaghan
■	Cavan
□	Meath
□	Louth
■	Longford
■	Leitrim
■	Other

Health Dublin Midlands

St James's Hospital

Legend:
- Dublin South
- Dublin North
- Kildare
- Laois
- Meath
- Westmeath
- Wicklow
- Offaly
- Kilkenny
- Carlow
- Louth
- Donegal
- Wexford
- Longford
- Cavan
- Other

Values: 60%, 8%, 7%, 2%, 2%, 2%, 2%, 2%, 2%, 2%, 1%, 1%, 1%, 1%, 1%, 6%

The Adelaide & Meath Hospital, Dublin incorporating the National Children's Hospital, Tallaght

Legend:
- Dublin South
- Kildare
- Wicklow
- Dublin North
- Carlow
- Laois
- Meath
- Westmeath
- Offaly
- Longford
- Wexford
- Other

Values: 62%, 17%, 7%, 2%, 2%, 2%, 1%, 1%, 1%, 1%, 1%, 3%

Midlands Regional Hospital - Tullamore

Legend:
- Offaly
- Westmeath
- Laois
- Longford
- Tipperary North
- Kildare
- Roscommon
- Meath
- Other

Values: 40%, 27%, 19%, 5%, 3%, 3%, 1%, 1%, 1%

Naas General Hospital

- Kildare
- Wicklow
- Dublin South
- Carlow
- Laois
- Rest

2%
1%
1%
1%
9%
86%

Midlands Regional Hospital - Portlaoise

- Laois
- Kildare
- Offaly
- Tipperary North
- Carlow
- Other

2%
1%
4%
5%
20%
68%

The Coombe Women and Infant University Hospital

- Dublin
- Kildare
- Meath
- Wicklow
- Carlow
- Laois
- Other

1%
1%
4%
3%
4%
20%
67%

Health Dublin East

Mater Misericordiae University Hospital

Legend:
- Dublin North
- Meath
- Louth
- Dublin South
- Cavan
- Kildare
- Monaghan
- Westmeath
- Carlow
- Donegal
- Other

67%, 8%, 5%, 4%, 3%, 2%, 2%, 1%, 1%, 1%, 6%

St Vincent's University Hospital

Legend:
- Dublin South
- Wicklow
- Wexford
- Dublin North
- Kildare
- Laois
- Carlow
- Meath
- Westmeath
- Other

56%, 22%, 5%, 5%, 3%, 1%, 1%, 1%, 1%, 5%

Midland Regional Hospital - Mullingar

Legend:
- Westmeath
- Longford
- Offaly
- Meath
- Kildare
- Roscommon
- Leitrim
- Other

51%, 25%, 11%, 8%, 2%, 1%, 1%, 1%

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St Luke's General Hospital - Kilkenny

Kilkenny — 53%
Carlow — 39%
Tipperary North — 3%
Laois — 1%
Kildare — 1%
Wexford — 1%
Waterford — 1%
Wicklow — 0%
Other — 1%

Wexford General Hospital

Wexford — 95%
Wicklow — 3%
Carlow — 1%
Dublin South — 0%
Waterford — 0%
Rest — 1%

National Maternity Hospital

Dublin — 71%
Wicklow — 15%
Kildare — 6%
Meath — 4%
Wexford — 1%
Other — 3%

Health Dublin East *(cont'd...)*

Our Lady's Hospital Navan
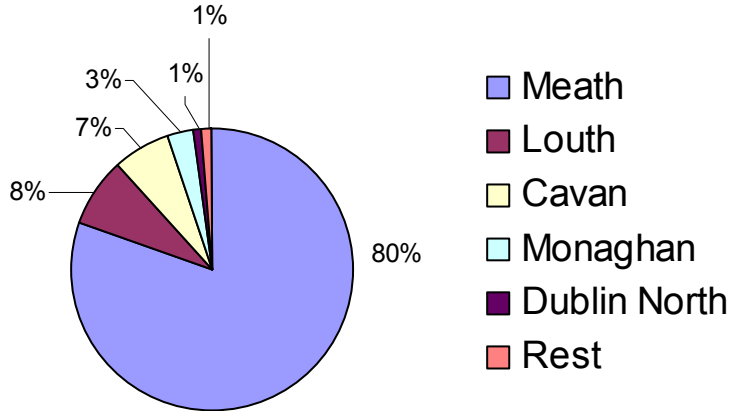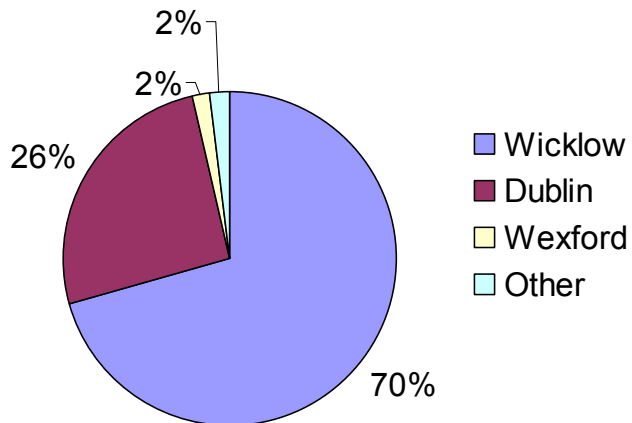
1%
1%
3%
7%
8%
80%

- Meath
- Louth
- Cavan
- Monaghan
- Dublin North
- Rest

St. Columcille's Hospital

2%
2%
26%
70%

- Wicklow
- Dublin
- Wexford
- Other

St. Michael's Hospital, Dun Laoghaire

0%
0%
0%
1%
4%
1%
26%
68%

- Dublin
- Wicklow
- Wexford
- Carlow
- Kildare
- Meath
- Kilkenny
- Other

Cappagh National Orthopaedic Hospital

Legend:
- Dublin
- Meath
- Wicklow
- Kildare
- Louth
- Wexford
- Donegal
- Tipperary
- Cavan
- Monaghan
- Carlow
- Laois
- Westmeath
- Other

Values: 58%, 9%, 1%, 1%, 2%, 2%, 2%, 2%, 2%, 3%, 3%, 4%, 4%, 7%
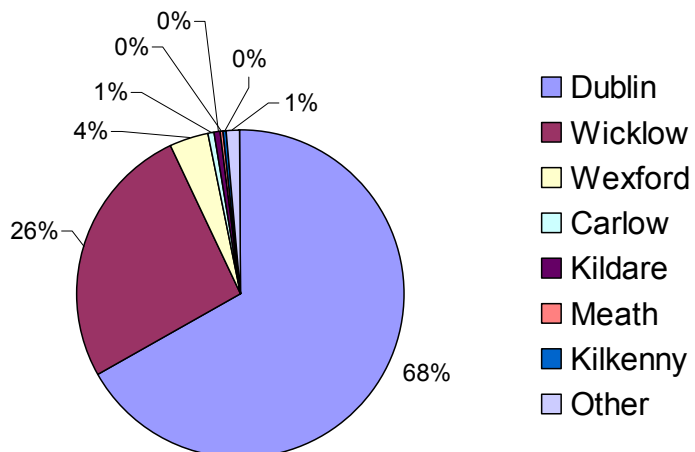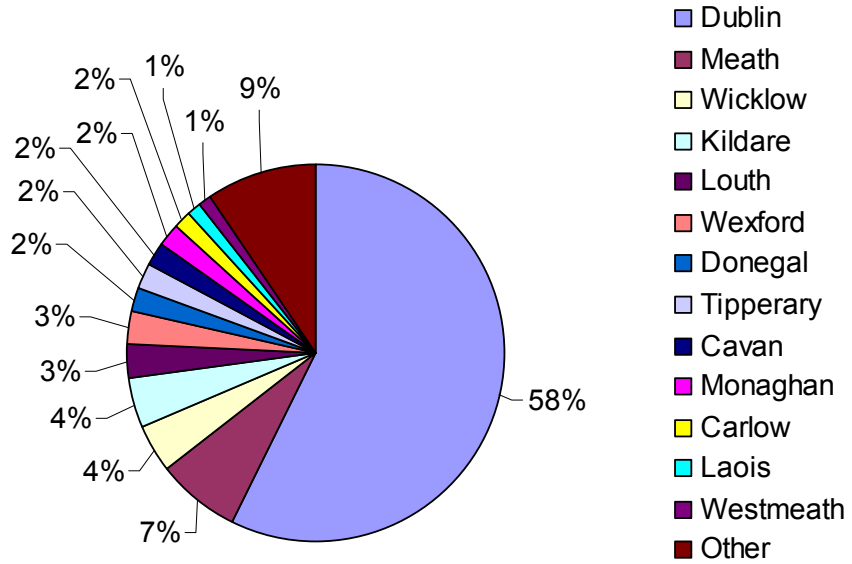
Royal Victoria Eye & Ear Hospital
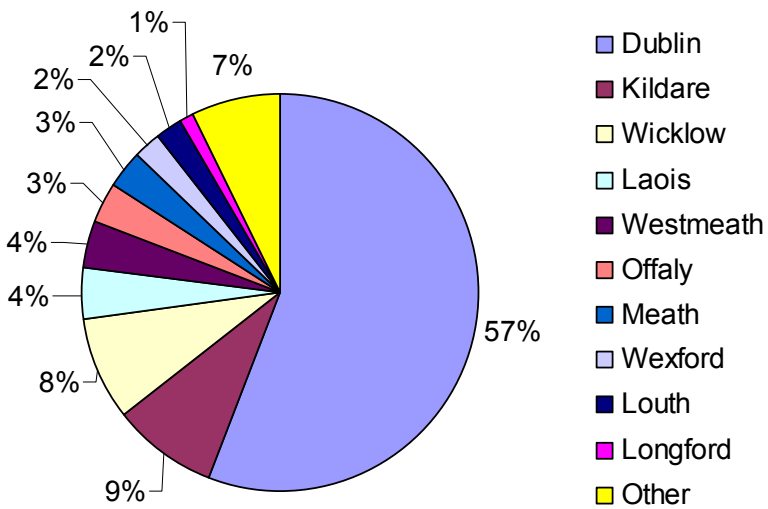
Legend:
- Dublin
- Kildare
- Wicklow
- Laois
- Westmeath
- Offaly
- Meath
- Wexford
- Louth
- Longford
- Other

Values: 57%, 9%, 8%, 7%, 1%, 2%, 2%, 3%, 3%, 4%, 4%

Health South / South West

Cork University Hospital

Legend:
- Cork
- Kerry
- Limerick
- Waterford
- Tipperary South
- Other

2%, 2%, 1%, 2%, 8%, 85%

Waterford Regional Hospital

Legend:
- Waterford
- Wexford
- Kilkenny
- Tipperary South
- Carlow
- Other

4%, 1%, 9%, 11%, 24%, 51%

Kerry General Hospital

Legend:
- Kerry
- Cork
- Limerick
- Other

3%, 2%, 1%, 94%
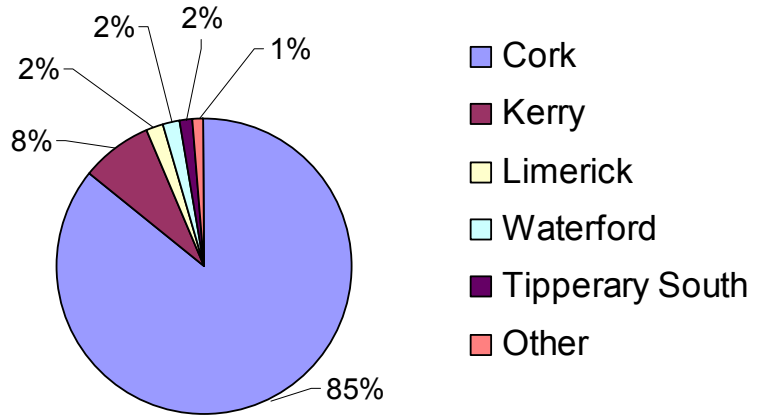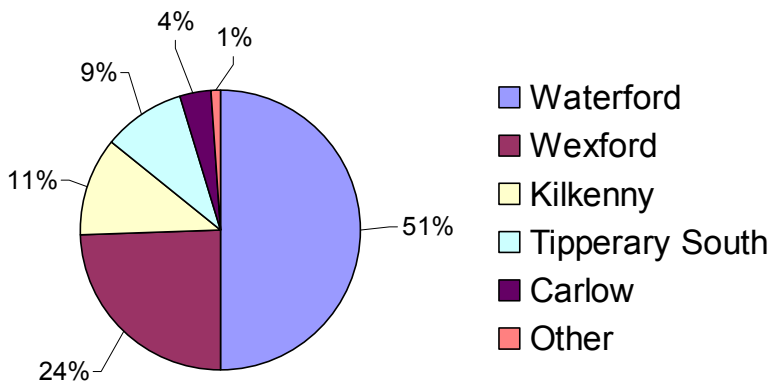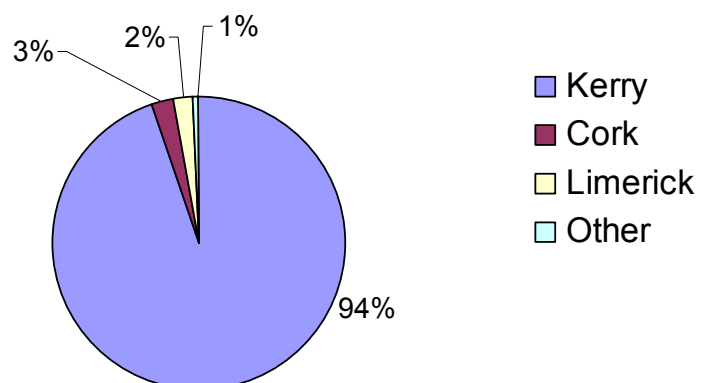
Health South / South West *(cont'd...)*

Mercy University Hospital
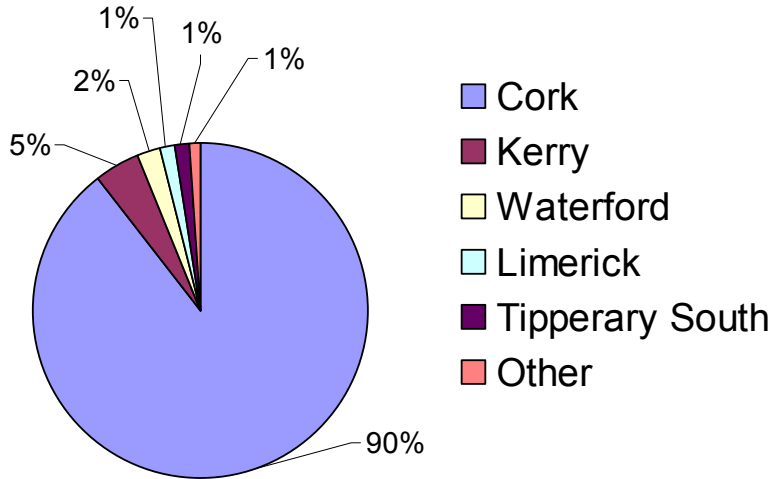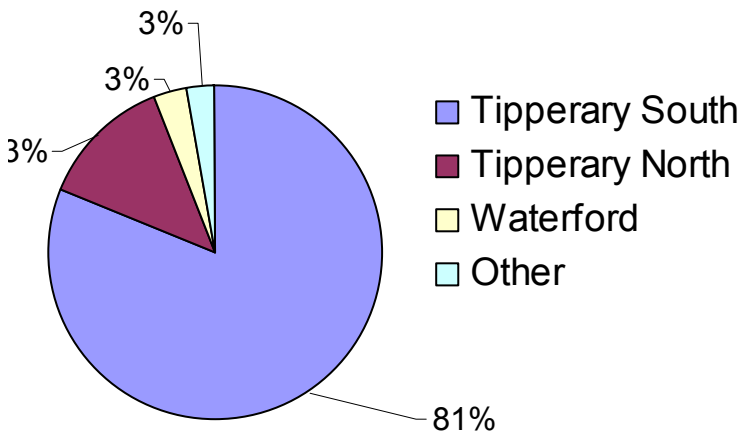
Legend:
- Cork — 90%
- Kerry — 5%
- Waterford — 2%
- Limerick — 1%
- Tipperary South — 1%
- Other — 1%

South Tipperary General Hospital

Legend:
- Tipperary South — 81%
- Tipperary North — 3%
- Waterford — 3%
- Other — 3%

South Infirmary Victoria University Hospital

Legend:
- Cork — 92%
- Kerry — 3%
- Waterford — 2%
- Tipperary South — 1%
- Limerick — 1%
- Other — 1%

Mallow General Hospital

1%
2%
10%
87%

- Cork
- Limerick
- Kerry
- Other

Lourdes Orthopaedic Hospital, Kilcreene

2%
9%
19%
25%
21%
24%

- Waterford
- Tipperary
- Wexford
- Kilkenny
- Carlow
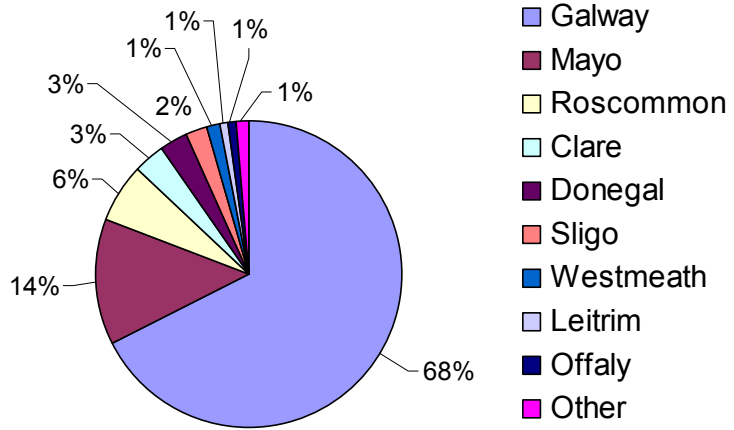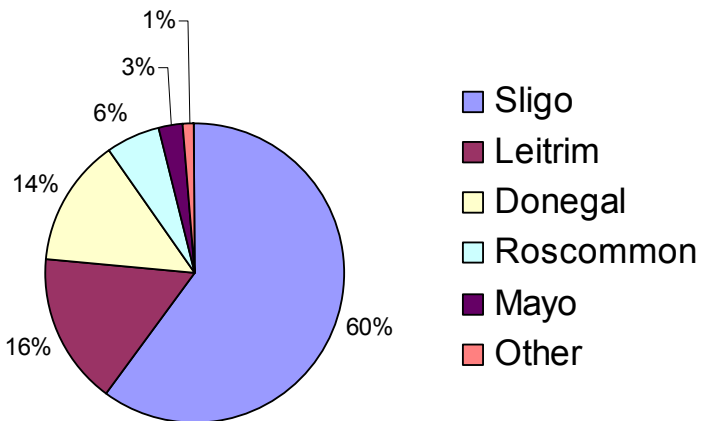- Other
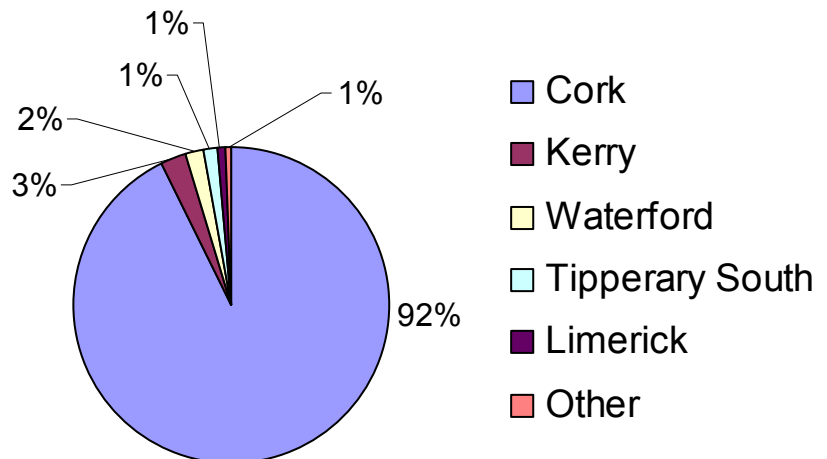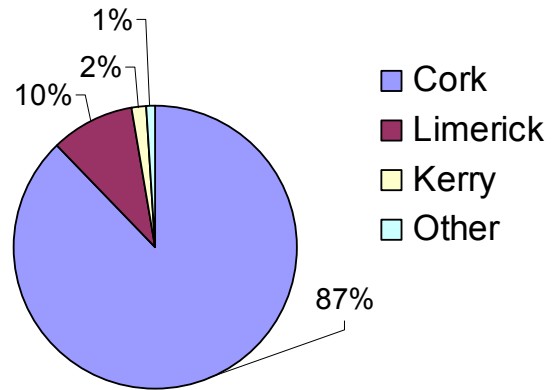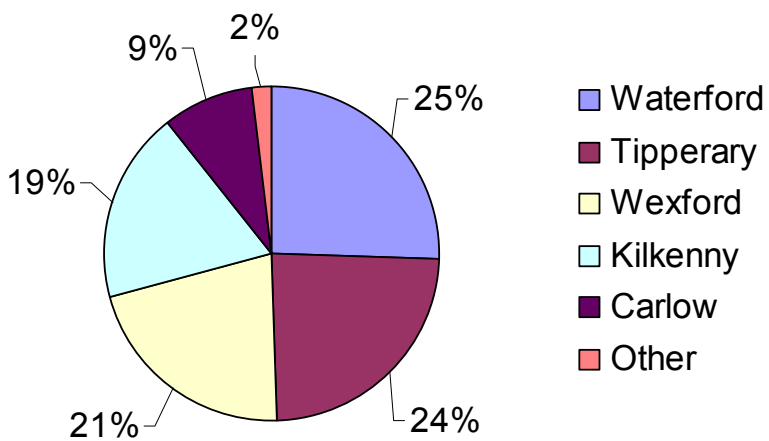
Note: Bantry General Hospital is not included as 2011 HIPE data incomplete and therefore overall figures should be interpreted with caution.

Health West / North West

University Hospital Galway / Merlin Park

Legend:
- Galway
- Mayo
- Roscommon
- Clare
- Donegal
- Sligo
- Westmeath
- Leitrim
- Offaly
- Other

Values: 68%, 14%, 6%, 3%, 3%, 2%, 1%, 1%, 1%, 1%

Sligo Regional General

Legend:
- Sligo
- Leitrim
- Donegal
- Roscommon
- Mayo
- Other

Values: 60%, 16%, 14%, 6%, 3%, 1%

Letterkenny General Hospital

Legend:
- Donegal
- Other

Values: 100%, 0%

Mayo General Hospital

1%
1%
1%
3%

Mayo
Roscommon
Galway
Sligo
Other

94%

Portiuncula Hospital

3%
3%
9%
18%
20%
47%

Galway
Roscommon
Westmeath
Offaly
Tipperary North
Other
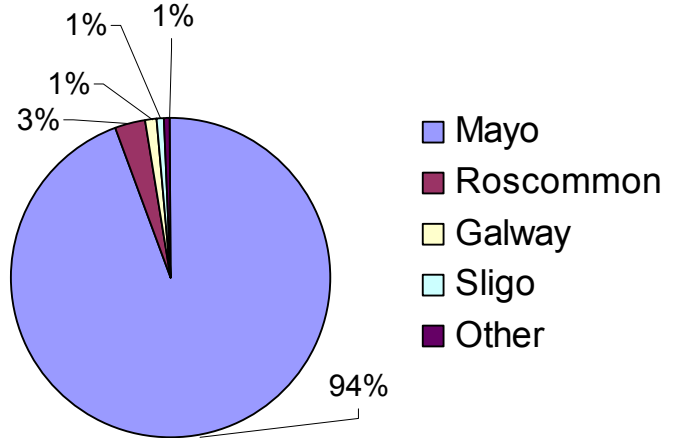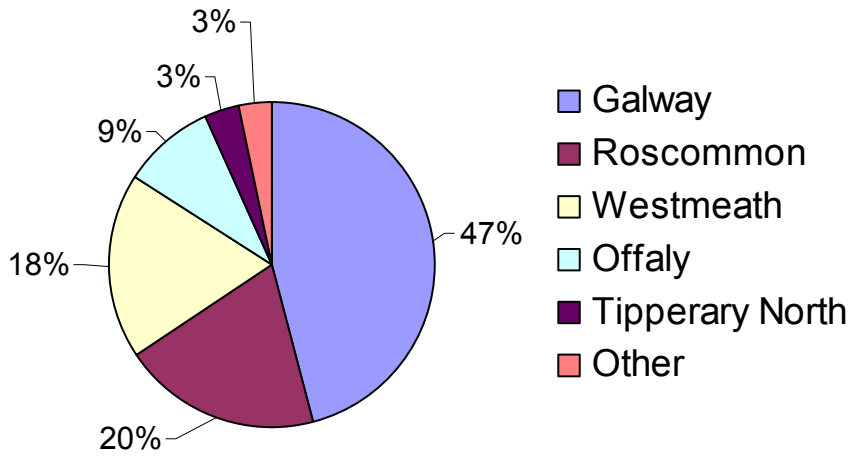
Note: Roscommon County Hospital is not included as 2011 HIPE data incomplete and therefore overall figures should be interpreted with caution.
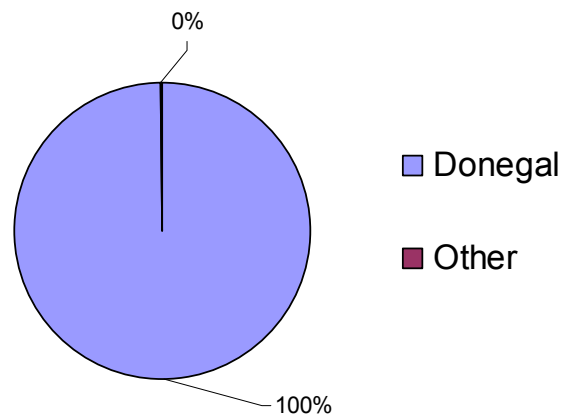
Health Midwest

Mid-Western Regional Hospital, Limerick

- 56%
- 24%
- 15%
- 2%
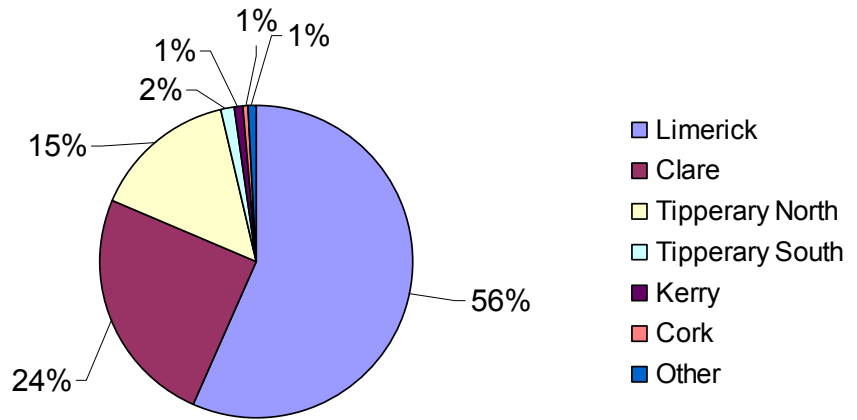- 1%
- 1%
- 1%

Legend:
- Limerick
- Clare
- Tipperary North
- Tipperary South
- Kerry
- Cork
- Other

Ennis General Hospital

- 92%
- 6%
- 1%
- 1%

Legend:
- Clare
- Limerick
- Tipperary North
- Other

Nenagh General Hospital

- 70%
- 19%
- 8%
- 3%

Legend:
- Tipperary North
- Limerick
- Clare
- Other
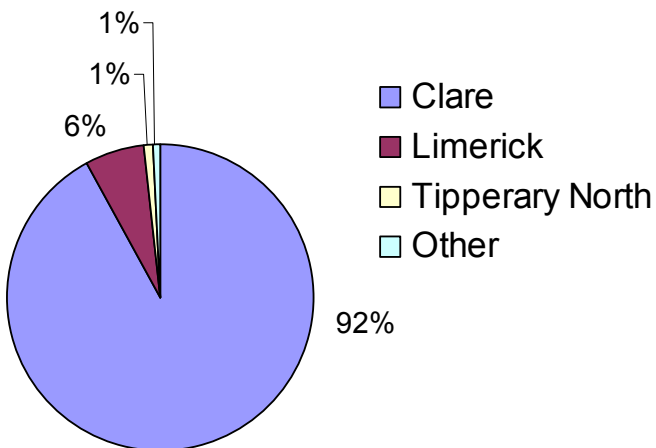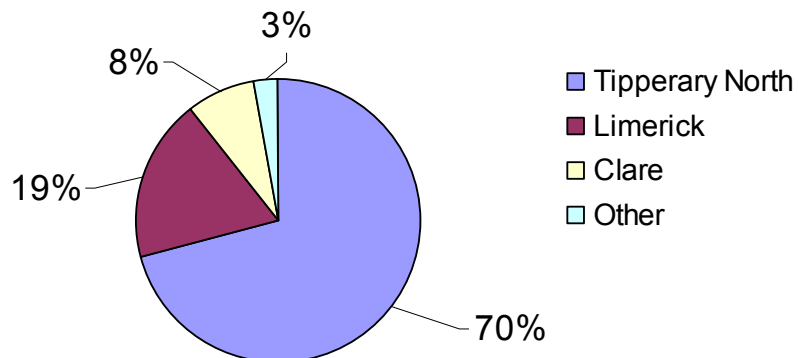
Health Midwest *(cont'd...)*

St. John's Hospital - Limerick
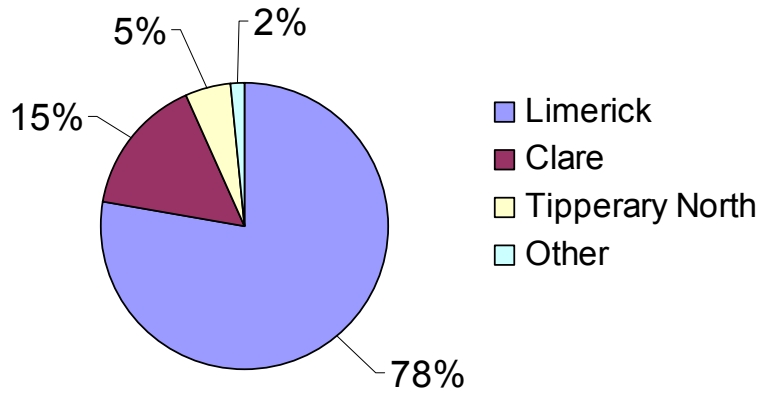
- Limerick — 78%
- Clare — 15%
- Tipperary North — 5%
- Other — 2%

Mid-Western Regional Maternity Hospital

- Limerick — 62%
- Clare — 27%
- Tipperary — 10%
- Cork — 1%
- Other — 0%

Mid Western Regional Orthopaedic Hospital

- Limerick — 58%
- Clare — 22%
- Tipperary — 13%
- Cork — 4%
- Kerry — 2%
- Other — 1%
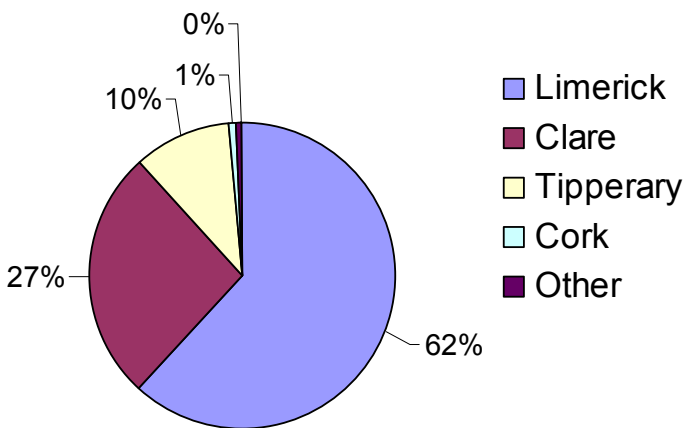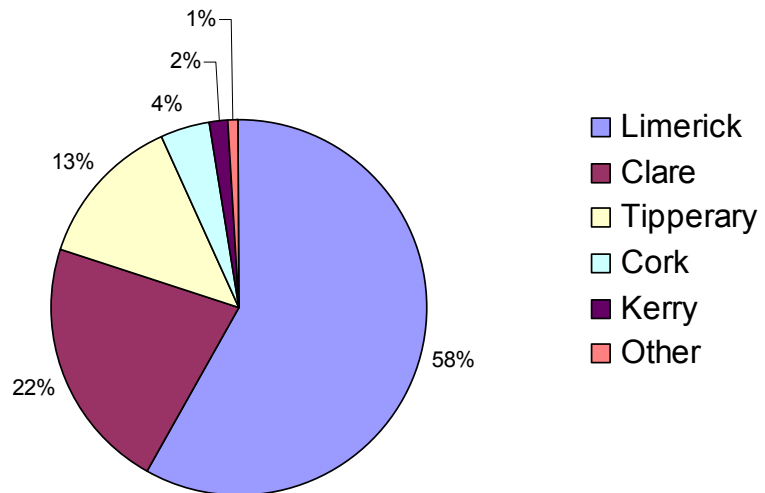
Hospital Discharges, (2011) Area of Residence by County
(in alphabetical order)

Discharges in 2011 by hospital for all ages by county of residence: Carlow
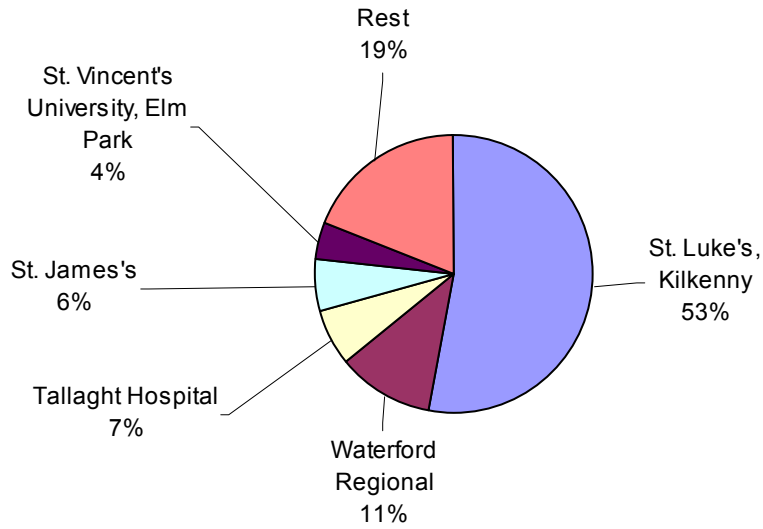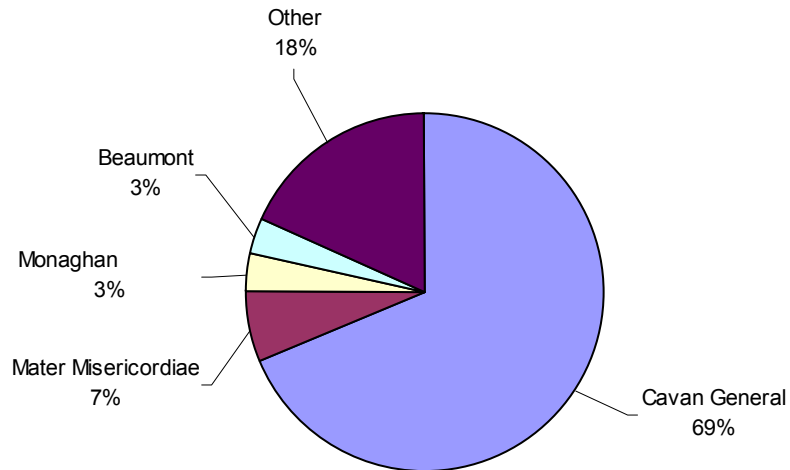
Rest
19%

St. Vincent's University, Elm Park
4%

St. James's
6%

Tallaght Hospital
7%

Waterford Regional
11%

St. Luke's, Kilkenny
53%

Discharges in 2011 by hospital for all ages by county of residence: Cavan

Other
18%

Beaumont
3%

Monaghan
3%

Mater Misericordiae
7%

Cavan General
69%

Discharges in 2011 by hospital for all ages by county of residence: Clare

Nenagh Regional 2%
Other 5%
Croom Orthopaedic 3%
St. John's, Limerick 5%
Limerick Regional 46%
Limerick Regional Maternity 8%
UCH, Galway 11%
Ennis Regional 20%
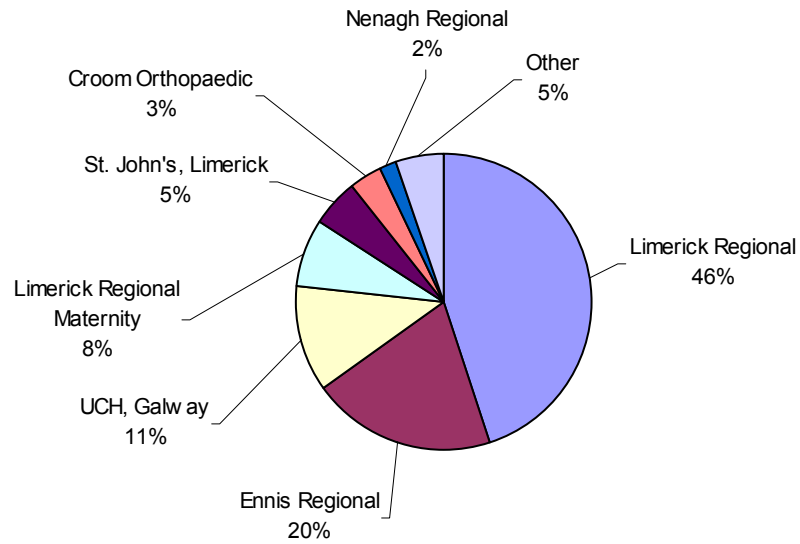
Discharges in 2011 for all ages by county of residence: Cork

St. Mary's Orthopaedic, Cork 2%
Other 3%
Mallow General 3%
South Infirmary - Victoria, Cork 15%
Cork University 61%
Mercy University, Cork 16%
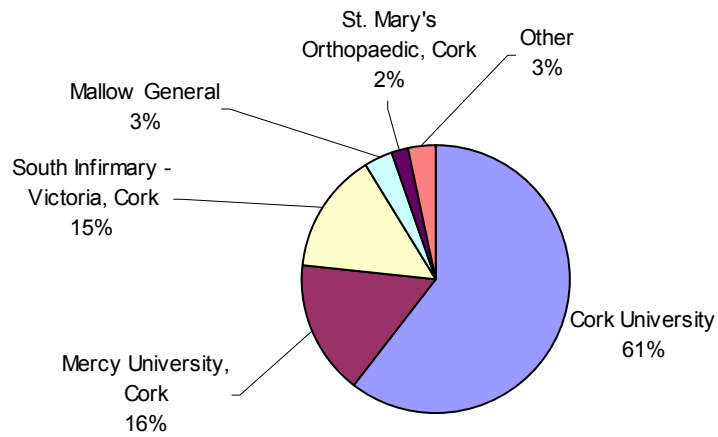
Discharges in 2011 for all ages by hospital by county of residence: Donegal
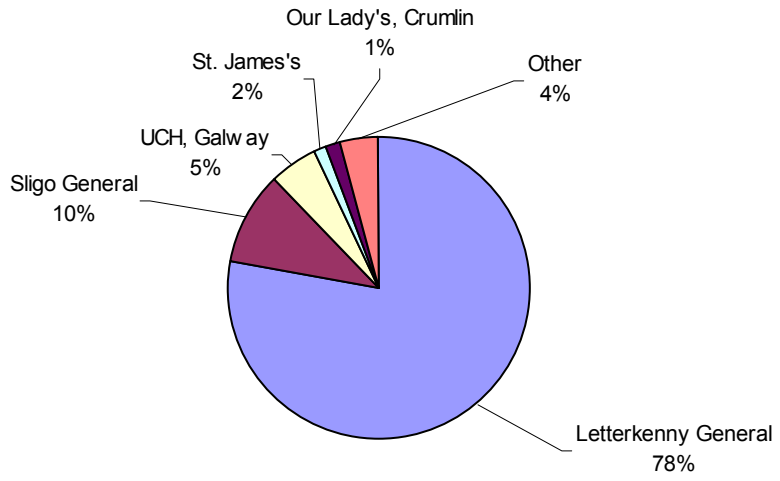
Our Lady's, Crumlin
1%

St. James's
2%

UCH, Galway
5%

Sligo General
10%

Other
4%

Letterkenny General
78%

Discharges in 2011 for all ages by hospital by county of residence: Dublin

Beaumont
16%

Other
29%

St. James's
13%

St. Luke's, Rathgar
6%

Mater Misericordiae
13%

Tallaght Hospital
11%

St. Vincent's
University, Elm Park
12%
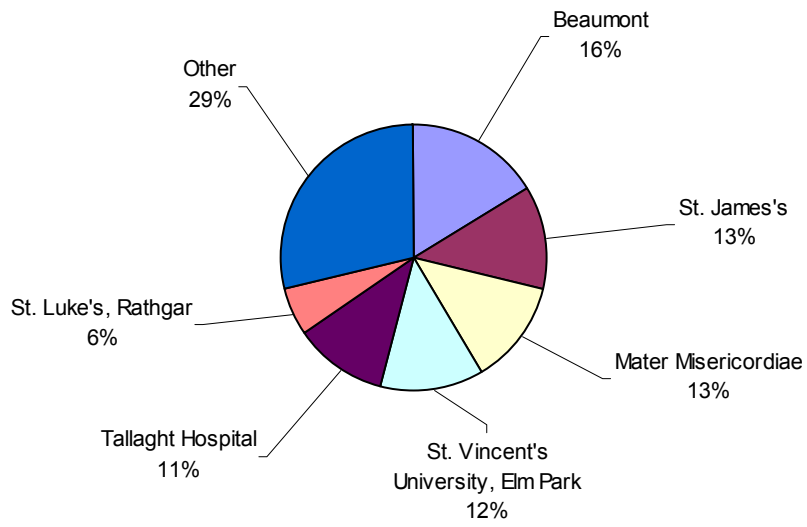
Discharges in 2011 for all ages by hospital by county of residence: Galway
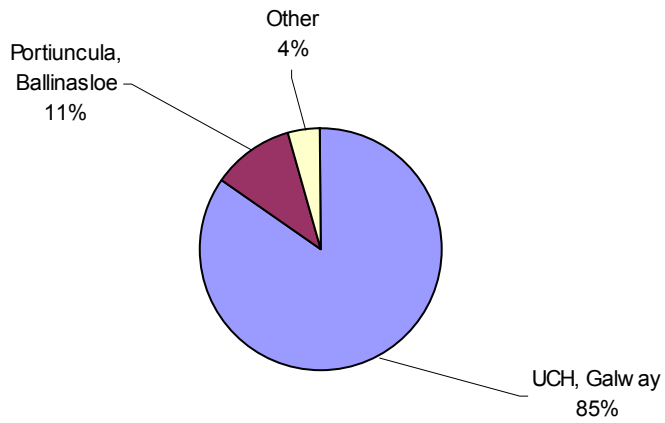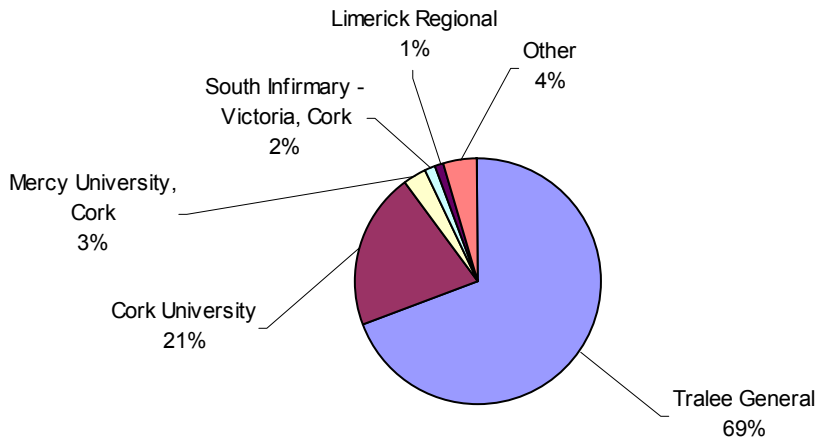
Other
4%

Portiuncula,
Ballinasloe
11%

UCH, Galway
85%

Discharges in 2011 for all ages by hospital by county of residence: Kerry

- Limerick Regional 1%
- South Infirmary - Victoria, Cork 2%
- Mercy University, Cork 3%
- Cork University 21%
- Other 4%
- Tralee General 69%

Discharges in 2011 for all ages by hospital by county of residence: Kildare

- Tullamore Regional 2%
- NMH Holles Street 2%
- St. Vincent's University, Elm Park 4%
- Our Lady's, Crumlin 4%
- Connolly 5%
- Beaumont 5%
- St. Luke's, Rathgar 6%
- Portlaoise Regional 6%
- Mater Misericordiae 3%
- Rotunda 2%
- Royal Victoria Eye & Ear 1%
- Other 4%
- Tallaght Hospital 20%
- Naas General 19%
- St. James's 9%
- Coombe Women's Hospital 8%

Discharges in 2011 for all ages by hospital by county of residence: Kilkenny

Other
13%

St. James's
5%

Waterford Regional
26%

St. Luke's, Kilkenny
56%

Discharges in 2011 for all ages by hospital by county of residence: Laois

St. Vincent's
University, Elm Park
3%

Other
12%

St. Luke's, Rathgar
3%

Tallaght Hospital
4%

St. James's
6%

Portlaoise Regional
44%

Tullamore Regional
28%

Discharges in 2011 for all ages by hospital by county of residence: Leitrim

Other
16%

Cavan General
7%

UCH, Galway
9%

Sligo General
68%

Discharges in 2011 for all ages by hospital by county of residence: Limerick

Nenagh Regional
3%

Other
9%

Cork University
4%

Croom Orthopaedic
5%

Limerick Regional
Maternity
9%

Limerick Regional
55%

St. John's, Limerick
15%
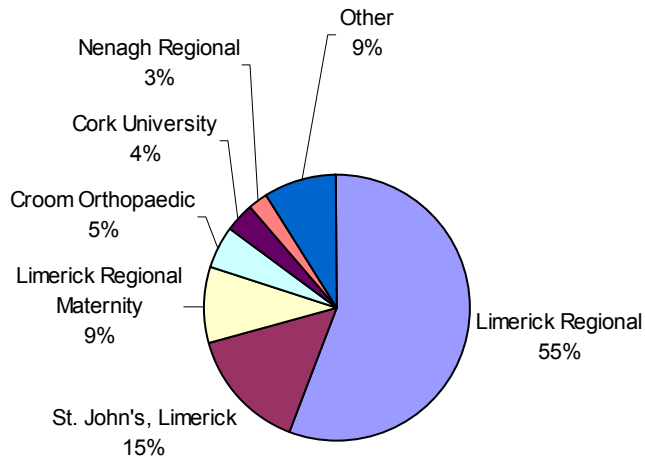
Discharges in 2011 for all ages by hospital by county of residence: Longford
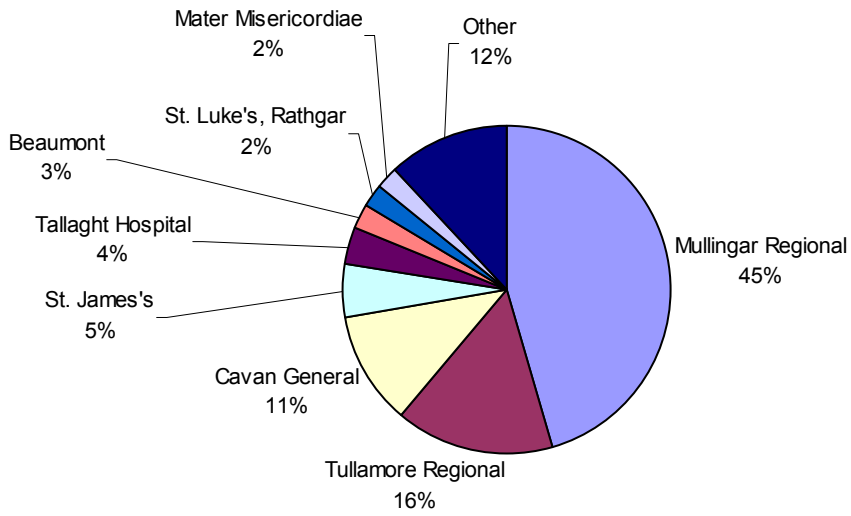
Mater Misericordiae 2%
Other 12%
St. Luke's, Rathgar 2%
Beaumont 3%
Tallaght Hospital 4%
St. James's 5%
Cavan General 11%
Tullamore Regional 16%
Mullingar Regional 45%

Discharges in 2011 for all ages by hospital by county of residence: Louth

Other 15%
Mater Misericordiae 9%
Beaumont 16%
Louth County, Dundalk 17%
Our Lady of Lourdes, Drogheda 43%
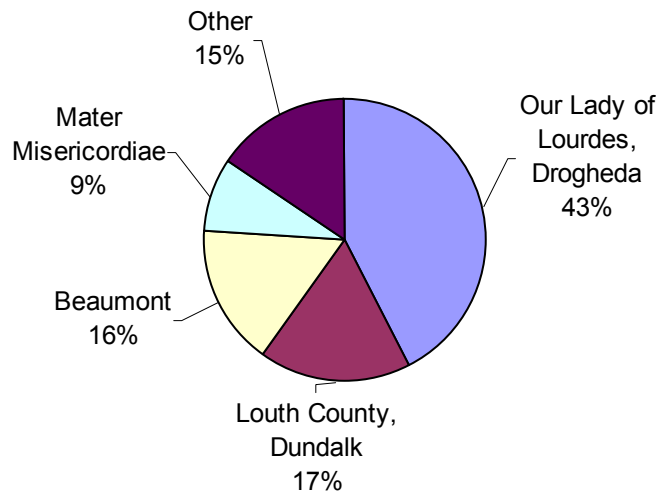
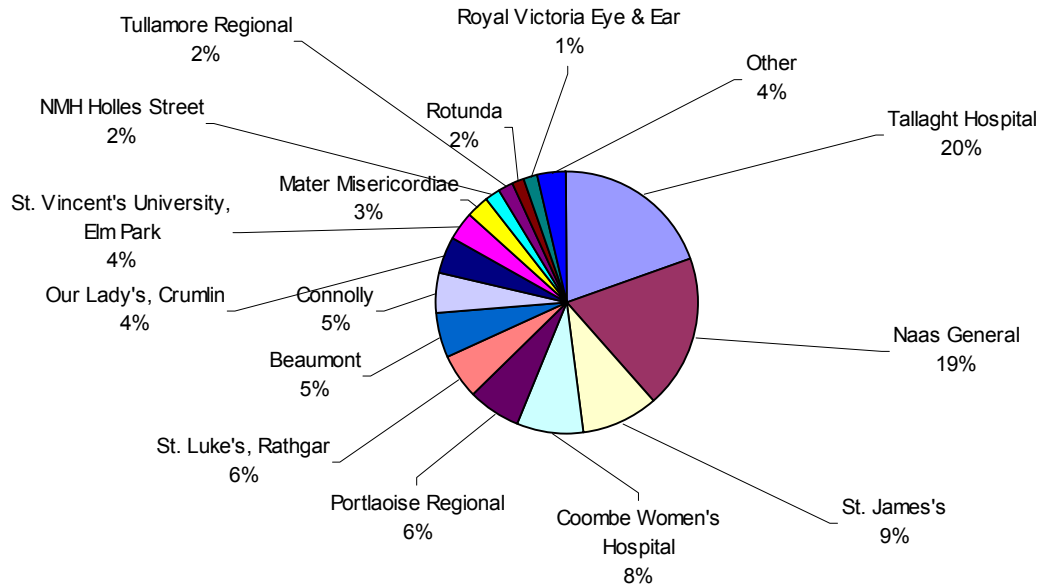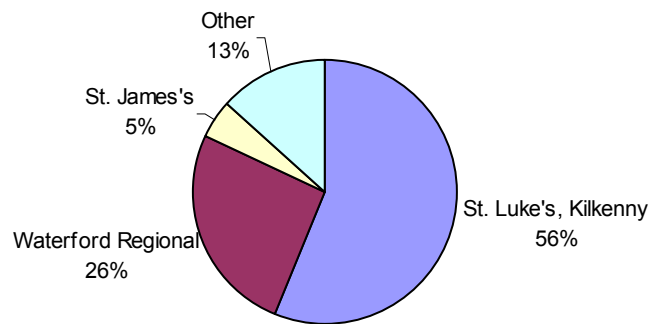**Discharges in 2011 for all ages by hospital by county of residence: Mayo**

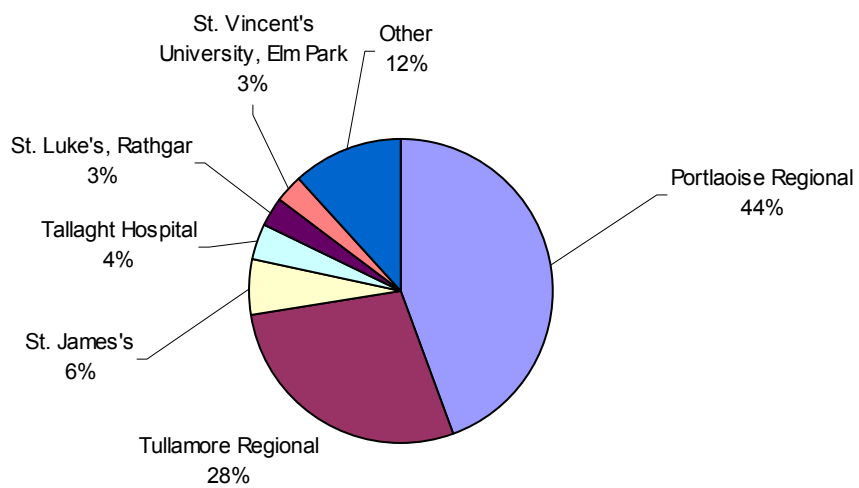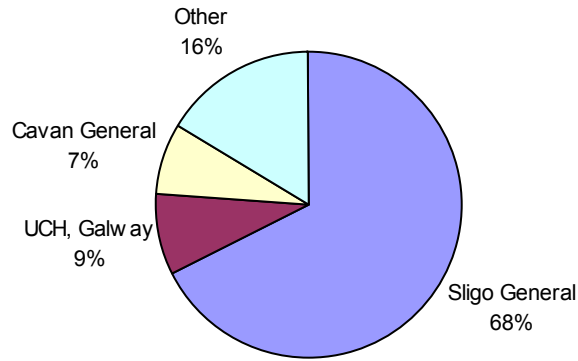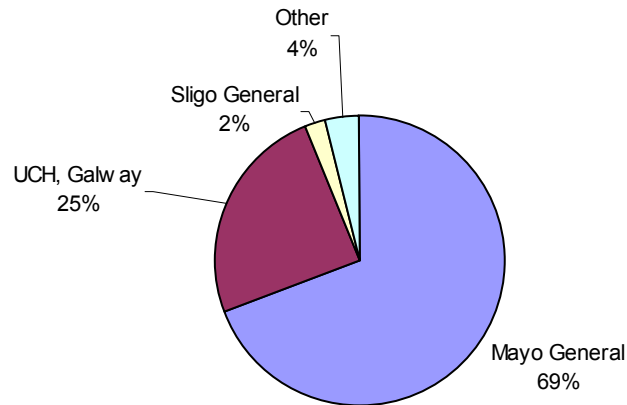**Discharges in 2011 for all ages by hospital by county of residence: Meath**
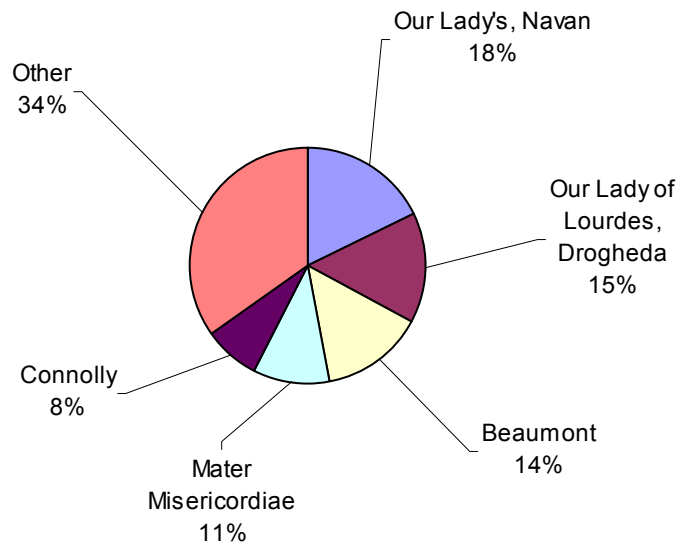
Discharges in 2011 for all ages by hospital by county of residence: Monaghan

Other
15%

Mater Misericordiae
6%

Beaumont
8%

Our Lady of
Lourdes, Drogheda
11%

Cavan General
43%

Monaghan
17%
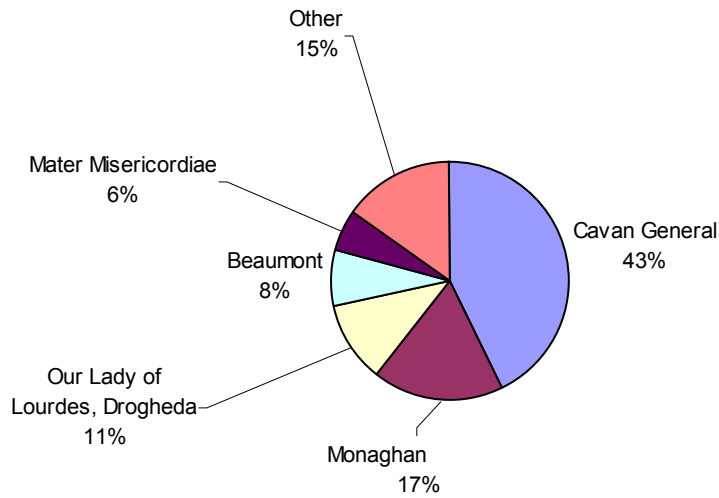
Discharges in 2011 for all ages by hospital by area of residence: Offaly

Other
18%

Portlaoise Regional
3%

St. James's
5%

Portiuncula,
Ballinasloe
6%

Tullamore Regional
57%

Mullingar Regional
11%
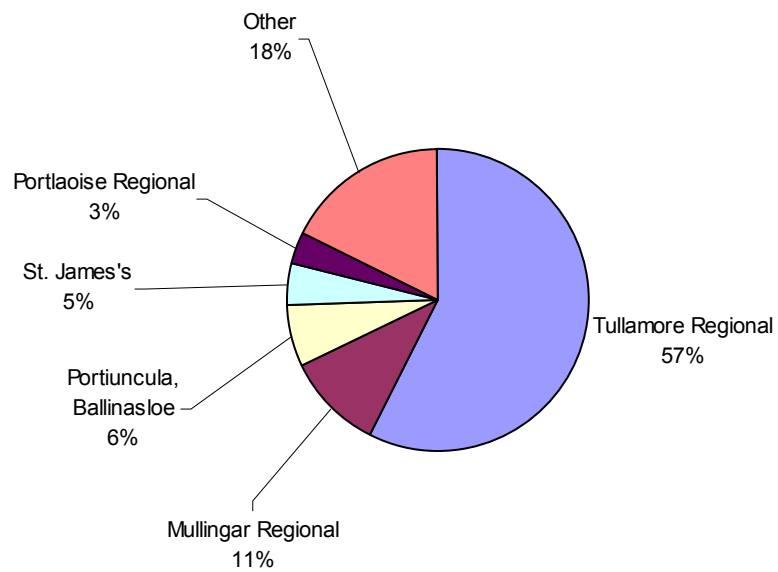
Discharges in 2011 for all ages by hospital by county of residence: Roscommon
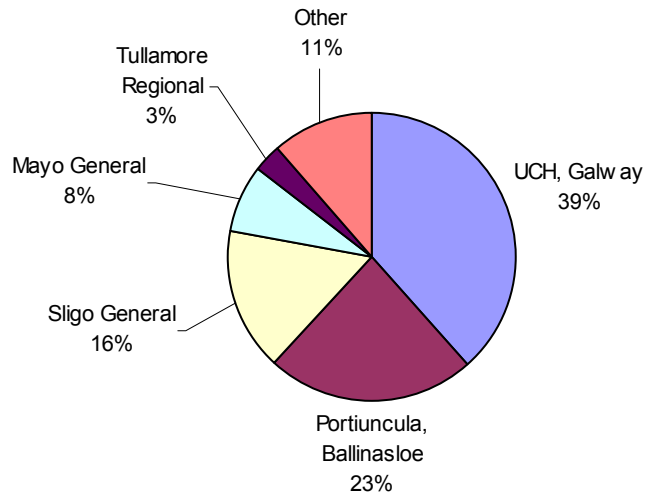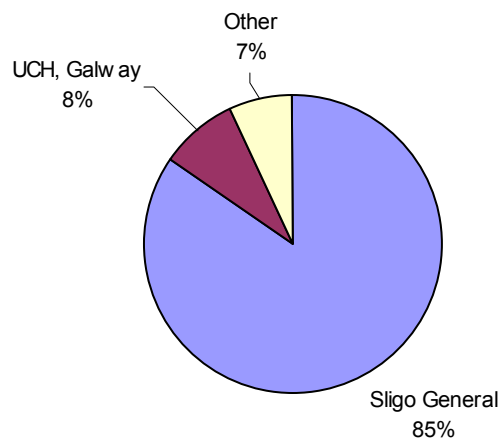
Other
11%

Tullamore
Regional
3%

Mayo General
8%

Sligo General
16%

Portiuncula,
Ballinasloe
23%

UCH, Galway
39%

Discharges in 2011 for all ages by hospital by county of residence: Sligo

Other
7%

UCH, Galway
8%

Sligo General
85%

Discharges in 2011 for all ages by hospital by county of residence: Tipp South

Other 6%
SIVUH 1%
MUH 1%
Kilcreene 1%
Crumlin 2%
LRH 3%
CUH 6%
WRH 19%
Clonmel 61%

Discharges in 2011 for all ages by hospital by county of residence: Tipp North

UCHG 2%
St. James's 2%
St. John's, Limerick 2%
Croom Orthopaedic 2%
Portiuncula 3%
Kilkenny 3%
Portlaoise Regional 3%
Limerick Mat 3%
Tullamore 5%
Clonmel 11%
St. Vincent's 2%
CUH 1%
Other 8%
MWRH 31%
Nenagh 22%
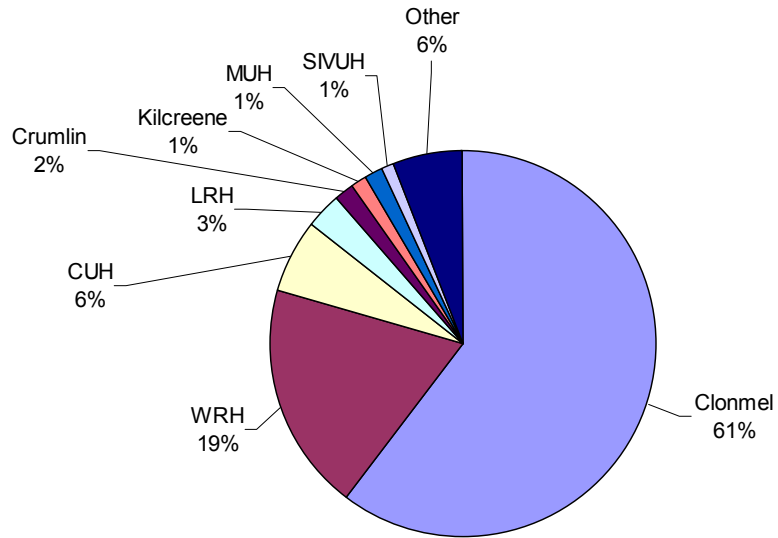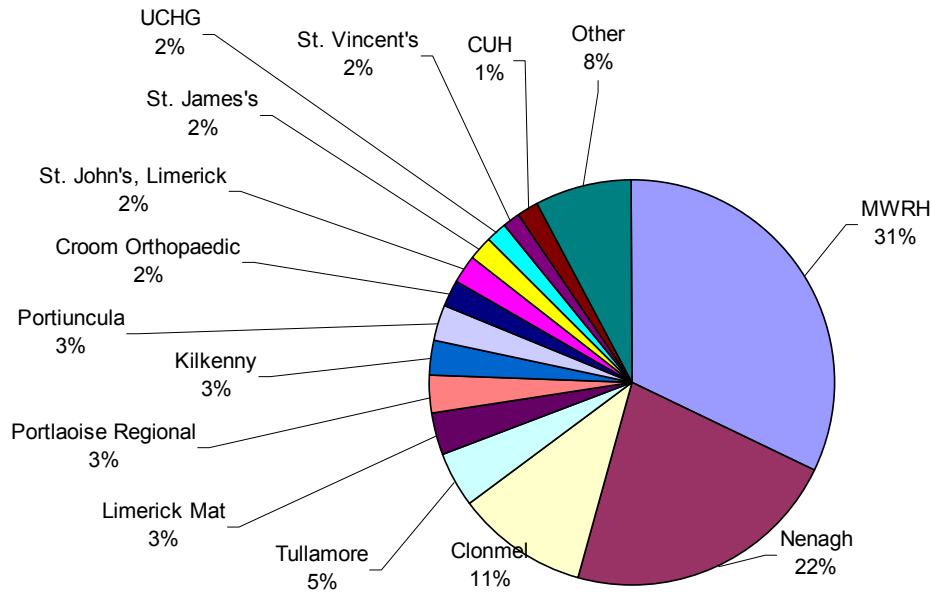
Discharges in 2011 for all ages by hospital by county of residence: Waterford

Other
13%

Cork University
6%

Waterford
Regional
81%
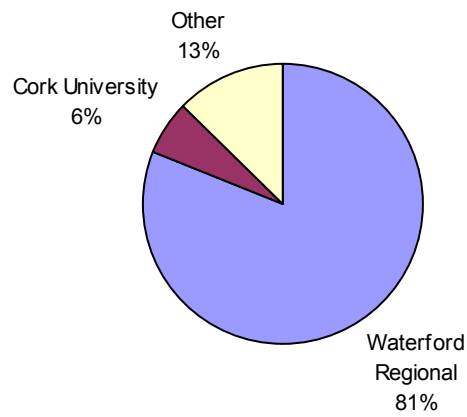
Discharges in 2011 for all ages by hospital by county of residence: Westmeath
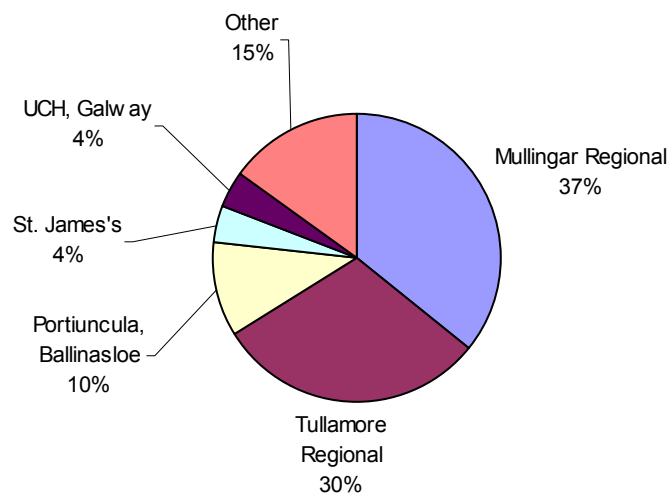
Other
15%

UCH, Galw ay
4%

St. James's
4%

Portiuncula,
Ballinasloe
10%

Mullingar Regional
37%

Tullamore
Regional
30%

Discharges in 2011 for all ages by hospital by county of residence: Wexford

- Other 14%
- St. Vincent's University 10%
- Wexford 45%
- Waterford 31%
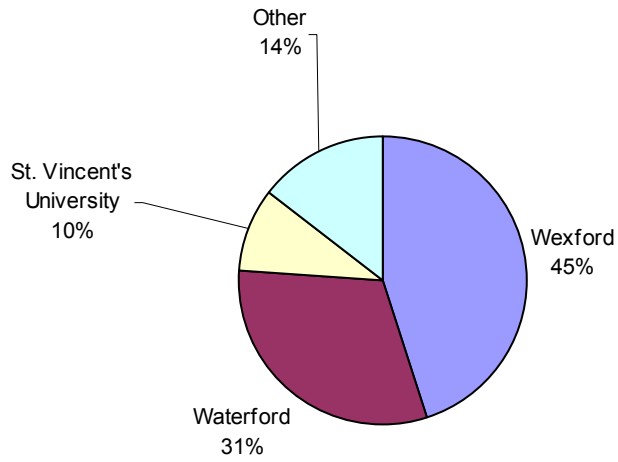
Discharges in 2011 for all ages by hospital by county of residence: Wicklow

- Other 11%
- Naas General 3%
- St. James's 3%
- Our Lady's, Crumlin 3%
- St. Michael's, Dun Laoghaire 5%
- St. Luke's, Rathgar 7%
- NMH Holles Street 8%
- St. Columcilles 10%
- St. Vincent's University, Elm Park 39%
- Tallaght Hospital 11%
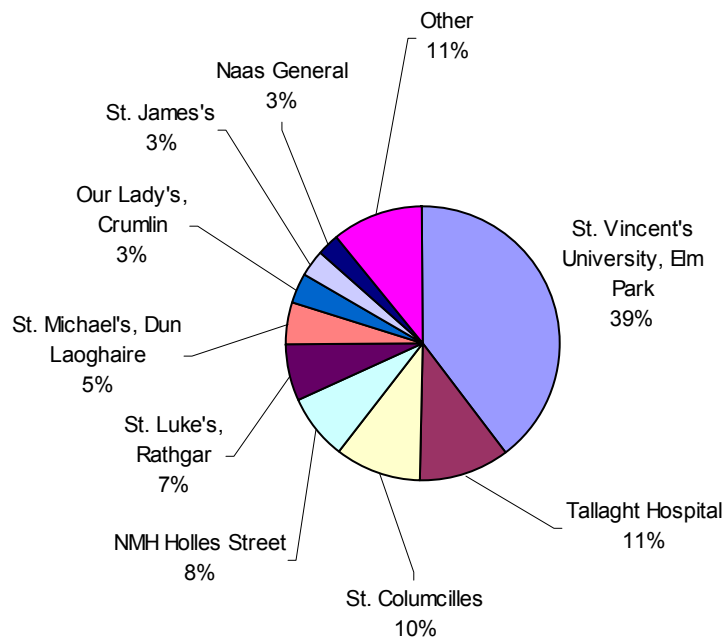
PROJECT PLAN FOR THE ESTABLISHMENT OF HOSPITAL GROUPS; HOSPITAL QUESTIONNAIRE

SECTION A: GENERAL HOSPITAL DESCRIPTION

1. Name and address of hospital:

2.   Voluntary hospital   ☐   HSE hospital   ☐

3. Please insert total bed numbers per specialty.

Specialty	Total Number of Beds
Total Medicine	
Total Surgery	
Total Paediatric	
Obstetrics	
Gynaecology	
Child Psychiatry	
Acute Psychiatry	
Long-stay Geriatric	
ICU	
CCU	
A&E observation beds	
AMU / MAU	
Unallocated	
Others: *(please specify)*	
Total	

4. Please list the specialties provided in your hospital; specify level of care for each specialty i.e. secondary, tertiary quaternary referral centre.

Specialty	Secondary Referral	Tertiary Referral	Quaternary Referral

5. Please outline the number of staff currently employed at your hospital (WTE on payroll).

	WTE
Consultant	
Specialist Registrar	
Registrar	
SHO	
Intern	
Nursing	
Health and Social Care Professionals	
Management/Administration	
General Support Staff	
Other Patient and Client Care	
TOTAL WTE	

SECTION B: MANAGEMENT AND GOVERNANCE

6. Please provide an organogram to describe current <u>MANAGEMENT</u> structure (to include Clinical Directorate arrangements, Executive Management Board (EMB), Senior Management Team etc.)

7. Please list existing committees (e.g. Clinical Governance, Risk Management etc.); please specify reporting arrangements to EMB, Board of Management etc.

8. Please provide an organogram to describe current <u>GOVERNANCE</u> structure.

9. Please provide details of board membership.

Name	Area of Expertise	Term of Office	Means of Appointment [1]

[1]_Specify whether appointed/ elected/ co-opted or otherwise, and by whom_

SECTION C: ALIGNMENT TO OTHER HOSPITALS

10. Is your hospital a member of a hospital group?

Yes ☐   **No** ☐

If yes, please list the hospitals in the group.

11. Do you have referral arrangements with other hospitals?

Yes ☐   **No** ☐

If yes, please outline the referral arrangements; for instance if your hospital is a designated cancer centre, which un-designated hospitals <u>do you receive referrals from?</u> If your hospital is not a designated cancer centre, specify <u>the hospitals to which you refer</u>?

Hospital	Specialty	Referral Arrangement *(specify to and from)*

12. Do you have joint consultant appointments with other hospitals?

Yes ☐   No ☐

If yes, please outline the distribution of service between associate hospitals/services. *
*Please see sample given below in grey shading.

Consultant/ Specialty	1^0Hospital/Service/ Academic	No of Hours 1^0 Institution	1st Associate Institution	No of Hours 1st Associate Institution	2nd Associate Institution	No of Hours at 2nd Associate Institution
Breast Surgery	SIVUH	10	CUH	10	UCC	5

13. Do you have formal cross-cover arrangements with another hospital?

Yes ☐   No ☐

If yes, please describe those arrangements.

Hospital	Cross-Cover Description

14. Do you participate in on-call rotas with other hospitals?

Yes ☐   No ☐

Specialty	Participating Hospitals	Frequency

15. Does your hospital have a proposal for strategic and/or operational alliance with other hospitals?

Yes ☐   No ☐

If yes, please describe the proposed alliances and append any agreed documentation in support of the alliance.

SECTION D: ACADEMIC ALLIANCES

16. Is your hospital aligned to a university/other third level institution?

Yes   ☐   **No**   ☐

If yes, please list universities/other third level institutions.

17. Does your hospital have joint appointments with a university/ third level institution for any of the health professions?

Yes   ☐   **No**   ☐

If yes, please specify.

Academic Institution	Clinical Profession/Specialty	Appointment Grade [2]

[2] *For example, Professor/ Adjunct Professor/ Senior Lecturer/ Lecturer/ Clinical Tutor*

18. Do you have undergraduate/postgraduate teaching /placement arrangements with a university/other third level institution?

Yes   ☐   **No**   ☐

If yes, please specify.

Academic Institution	Clinical Profession/Specialty	Programme Specify undergraduate/ postgraduate

Date of Completion	
Completed By	
Contact Details	

Should you require any clarification in relation to this form, please contact Margo Topham; email topham.margo@sivuh.ie or telephone 021 4926267.

Thank you for your assistance.

The Establishment of Hospital Groups as a
Transition to Independent Hospital Trusts