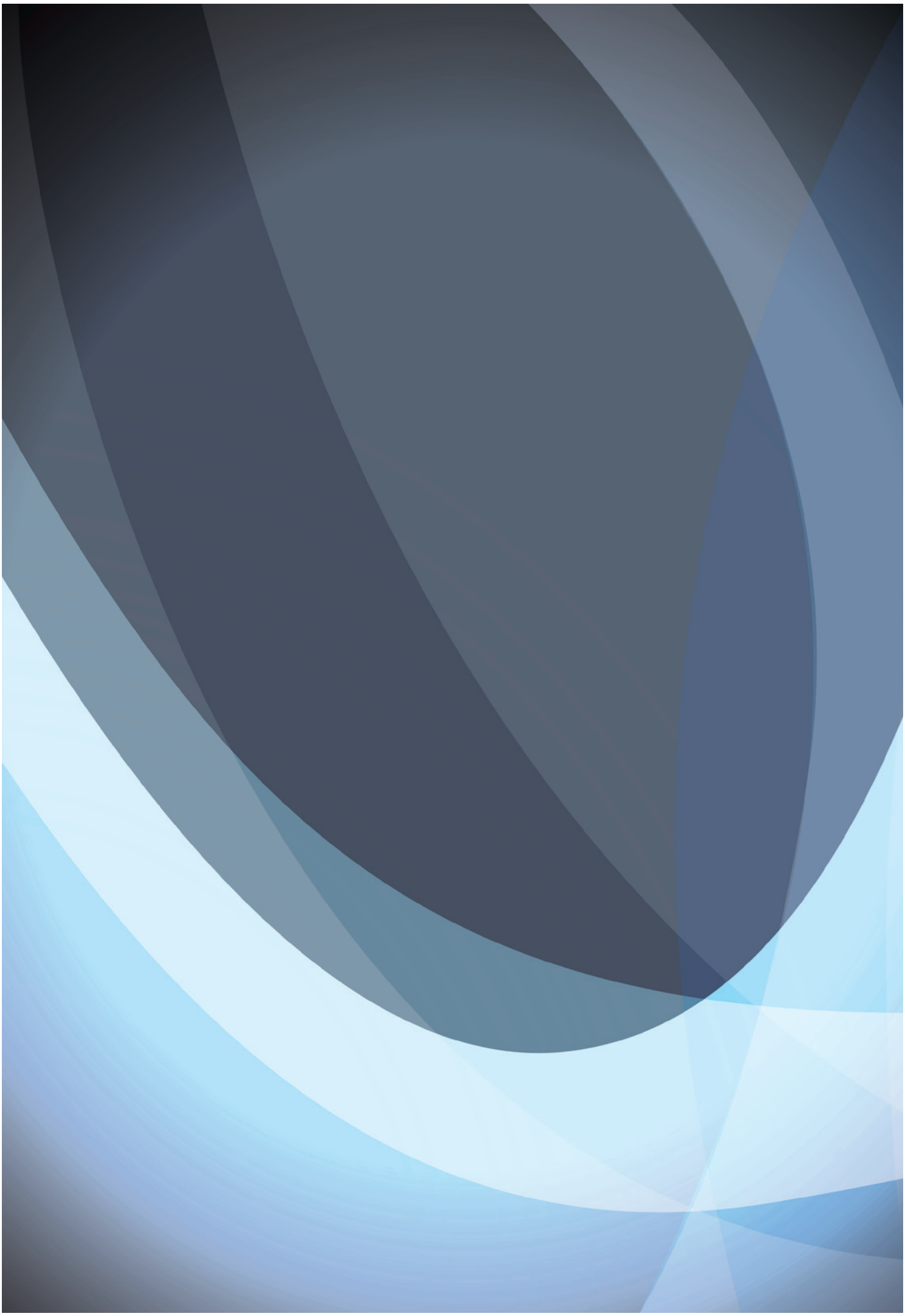
Frequently Asked Questions

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

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

February 2013



What is in the report on the establishment of hospital groups?

The report on the Establishment of Hospital Groups as a Transition to Independent Hospital Trusts contains recommendations to the Minister for Health Dr James Reilly T.D. on merging the acute hospitals in Ireland into groups.

How was the report produced?

The report was produced by a panel of national and international experts. It was informed by consultation, including face-to-face meetings with; management and senior clinicians from hospitals, health agencies and clinical programmes, patient advocates and others, as well as data analysis.

Why is it necessary to change how our hospitals work?

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 an ageing population, increased public expectations and inequalities in access to care. The changing nature of healthcare - new technologies and clinical specialisation and greater financial and regulatory pressures from national and international bodies - add further challenges.

The traditional practice of providing as many services as possible in every hospital is neither sustainable nor safe. Experience in Ireland and beyond teaches us that a co-ordinated system of care is better for patients than a more sporadic approach.

The Irish healthcare system is being reformed to meet these challenges. Primary and community delivered care are 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. 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. All of these changes seek to enhance and facilitate the Government's health reform agenda.

Why are acute hospitals being merged into groups?

We have a large number and range of acute hospitals in Ireland, each held in high esteem and used mainly by local people for the vast majority 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 modern high-quality, safe healthcare requires increasing levels of co-operation and overarching systems of clinical governance and communication. Furthermore, patients and the public expect that the level of care they receive is standardised to the greatest degree from Malin Head to Mizen Head.

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. It 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.

Individually few Irish hospitals can hold their own against the best international hospital systems. But working together in larger groups they can aspire to favourable comparison with the best in the world.

What benefits will there be in creating acute hospital groups?

Hospitals working in isolation with separate management, governance and budget structures compete with one another for patients and funding. These hospitals often provide the same services within small geographical areas which is a wasteful use of resources. By working in groups, hospitals will balance the services provided between the hospitals in each group based on the needs of their population. Complex services will be concentrated at particular hospitals to ensure that the clinicians treat high numbers of patients with complex needs thus optimising their skills in these areas. This will ensure that patients get the best care available from highly skilled, specialist clinicians. Staff will work across a group rather than in individual hospitals which will reduce duplication in areas such as human resources and finance services. When groups are established, services can be exchanged between sites maintaining activity in smaller hospitals but allowing them to provide a type of care that is safe and appropriate.

What will this mean for me, as a patient?

You will not notice an immediate change. When grouped, the hospitals will work together to provide acute care for patients in their area rather than competing with each other for resources and funding and duplicating services. The amount of care delivered locally will be maximised. However, the aim is to give the best quality care in the most appropriate setting which may, of course, necessitate treatment in different locations, as groups develop.

You will not be restricted in the choice of hospital group, though over time the range of services in individual hospitals may change to maximise group effectiveness. All but very specialist services, e.g. Neurosurgery, will be provided by each hospital group. However, you as a patient will not be restricted in your choice of group. Your GP may refer you to the hospital/hospital group of choice outside your local area if you so wish.

Why is this important for people who work in hospitals?

We are facing considerable difficulties in maintaining the large number of rotas for all specialities across all acute hospitals. Ongoing problems with recruitment and retention of staff will challenge the quality of care required in the 21st century. Recruitment and retention will be greatly facilitated by larger rotas providing standardised care and training.

External pressures such as the imperative to implement the European Working Time Directive means that there are many hospitals working in isolation with unsustainable rotas in contravention of EU directives. Nine years after the Directive, Ireland is still not compliant and cannot hope to be without the formation of hospital groups.

The way our clinicians are expected to work has changed radically and will continue to change. All staff, including doctors, are expected to work in teams rather than in isolation. This results in higher quality, standardised and easily auditable clinical care, all of which is good for patients.

Where groups have been established, patients and staff have found a greater certainty in accessing and providing services.

How do these changes relate to Universal Health Insurance (UHI)?

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

Once implemented UHI will provide:

- Better patient safety
- Better patient care; and
- Better value for money.

A new financing system, Money Follows the Patient (MFTP), will be introduced. 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 staff to work more effectively.

What are the characteristics of the recommended groupings?

The recommended groupings are predicated on the following characteristics:

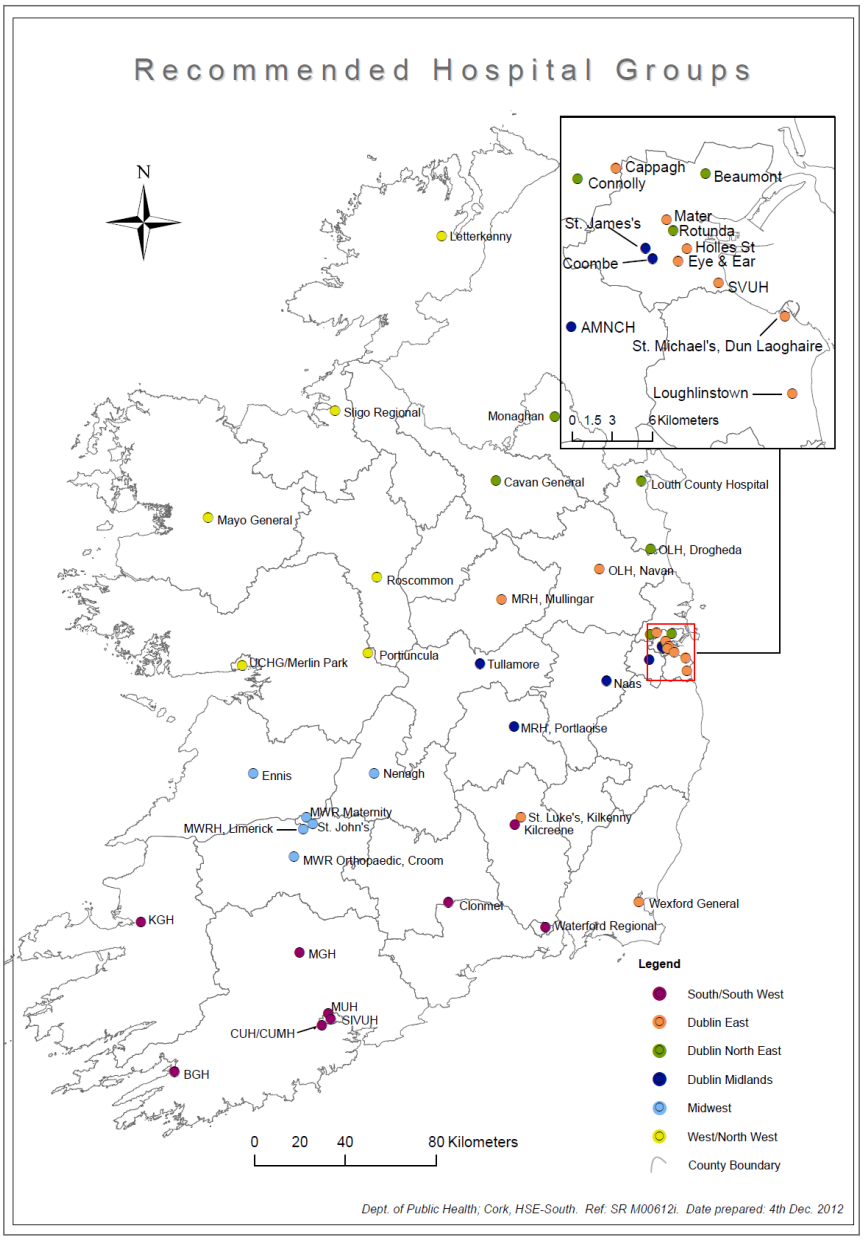
- Each hospital group is of sufficient scale, numbers of hospitals and range of services to be able to deliver meaningful reform prior to the creation of independent hospital trusts.
- Each group includes at least one major teaching hospital that usually has a full range of services such as an emergency department, surgery, general medicine, paediatrics, obstetrics and gynaecology. This will maximise the range of services available to the population within each group and minimise the need to refer patients between the hospital groups.
- The hospitals in each group have a link with an existing academic partner, which means the groups can be established quickly.
- 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 more closely with the primary academic partner.

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

Note: The Midwest was already formed into a hospital group and we did not apply any change to this group. Similarly, the West has the 'Galway/Roscommon Hospital Group' in situ and this has been used as the basis for the formation of the West/Northwest Group.

What is the recommended composition of the acute hospitals groups?

Six hospital groups are recommended, they are as follows:



Dublin North East: Beaumont Hospital; Our Lady of Lourdes Hospital, Drogheda; Connolly Hospital; Cavan General Hospital; Rotunda Hospital; Louth County Hospital; Monaghan Hospital.

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 & Infant University Hospital.

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 Hospital, Navan; St Columcille's Hospital; St Michael's Hospital, Dun Laoghaire; Cappagh National Orthopaedic Hospital; Royal Victoria Eye and Ear Hospital.

South/South West: Cork University Hospital/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, Kilcreene Orthopaedic Hospital.

West/North West: University Hospital Galway and Merlin Park University Hospital; Sligo Regional Hospital; Letterkenny Regional Hospital; Mayo General Hospital; Portiuncula Hospital; Roscommon County Hospital.

Midwest: Mid-Western Regional Hospital, Dooradoyle, Limerick; Ennis General Hospital; Nenagh General Hospital; St John's Hospital; Mid-Western Regional Maternity Hospital; Mid-Western Regional Orthopaedic Hospital.

What were they criteria used to select hospital groups?

Hospital groups were selected to ensure that most of the following criteria were met:

- The hospitals in the group are geographically located to be able to meet the needs of related populations.
- The groups are consistent with existing acute hospital care pathways for the population, with an emphasis on maximising care available locally.
- The groups contain varying models, 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 groups have a population base and infrastructure to maintain the viability of each group in relation to other groups.
- The groups are large enough to gain efficiency from common business processes.
- The groups are capable of competition with each other in an environment of managed competition.
- The groups have robust academic links.
- The groups can attract and retain sustainable numbers of high-quality consultants, trainees and post–graduates across the full range of healthcare specialties and professions.
- The groups can maximise cross-border health service arrangements in the best interests of patients living in the border areas.
- The groups can deliver internationally comparable quality care for patients, regardless of where they live.
- The groups should be broadly comparable to facilitate competition under universal health insurance and to ensure that no group is disadvantaged in the recruitment of clinical staff.

Why are academic partners included in the hospital groups?

Including an academic partner in each hospital group is 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 the academic medical function, clinical leadership and service management. It will further ensure that patients will benefit from the latest clinical expertise and knowledge as it flows from education and research into the hospital system.

Why are voluntary acute hospitals incorporated in the hospital groups?

The hospital groups will include all voluntary and statutory public acute hospitals in Ireland working together in the best interest of the patient. This is vital in order to ensure that all the hospitals in any given area provide the widest and best range of services possible in the most efficient way to meet the needs of the population.

Do primary care services and community hospitals have a role in hospital groups?

Up to 95% of health needs can be met in primary care or local hospitals. Hospital groups will work closely with GPs, community hospital staff and other primary care professionals to provide treatment as close to people's homes as possible and to try and keep people well enough to avoid acute hospital admission.

What if I require a number of different healthcare providers?

Hospital groups will be managed to work closely with colleagues in primary care as well as within and between hospital groups, which means that patient care pathways will be co-ordinated and better managed between acute and community hospitals or other primary care providers such as nursing homes.

Who was involved in the consultation process?

A wide group of interested parties was consulted with by means of face-to-face meetings, questionnaire distribution and receipt of written submissions. This process included management and senior clinicians from the HSE and voluntary acute hospitals, chairs of the acute hospital boards, national HSE directors, regional directors of operations, hospital association bodies, medical schools and post graduate education departments and regulatory bodies. We also invited feedback from hospital partners such as GPs, the Health Information and Quality Authority (HIQA), the National Ambulance Service (NAS), the National Cancer Control Programme (NCCP) and others.

How will the hospital groups be governed?

Each hospital group will be established on an administrative basis during an interim period. During this period legislation will be enacted allowing the hospitals to transition from group status to independent hospital trust status. Each hospital group will establish an interim group board to which the management team reports. 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. The Chair of the interim group board will be appointed by the Minister. The Chair will nominate the interim group board membership for ministerial approval. The interim group board will comprise the necessary skills, competencies and experience to enable them to contribute to and challenge the performance of the hospital group. This experience and expertise will include clinical, business, social, legal, medical academic and patient advocacy.

Who will manage hospital groups?

Hospital groups will be led by a group Chief Executive Officer (CEO) who will be the accounting officer for the group. The CEO is responsible to the interim group board for the safe and efficient management of the group. Powers are delegated by the CEO so that all personnel ultimately report to that officer and s/he reports to the Chair of the interim group board. 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. The 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.

Are these hospital groups permanent?

The groups will be evaluated before becoming independent, not-for-profit trusts, as the Government moves towards introducing the universal health insurance system. Between the establishment of these groups and the introduction of hospital trusts on a statutory basis in 2015, a rigorous evaluation and review of the governance systems and group compositions will be undertaken to ensure that groups meet all the benchmarks set out in the report. Achievement of these benchmarks will be required if a hospital group is to achieve trust status. Revision of hospital group composition will be considered where the above evaluation and review indicates this is needed. Changes in group composition in preparation for trust status, if required, will be brought to Government for consideration.