Appendix H: Long Listed Options

Introduction

- The following pages represent the initial options that were assessed by the KPMG team. These options were evaluated against the agreed criteria and short listed to five man options which were extensively consulted on with several hundred stakeholders during a series of workshops in Dublin.

- The section begins with an outline of the approach that we took to options development and the issues we considered. After this we profile each of the long listed options.

- A fundamental premise for all the long listed options we considered was the need to place woman and infant at the centre of the decision making process with a strong emphasis on primary and community care support they could access, in addition to modernised secondary care services.

Service configuration – Approach to defining the recommended service configuration

International health economy (where appropriate)	Option	KPMG view	Short List
Birmingham Women's Hospital in the UK is co-located on the site of an adult hospital, University Hospital Birmingham	• Three hospitals co-locate with an Acute Adult hospital • Three hospitals have full range of obstetric and gynaecology services	• This option would provide the benefits associated with co-location whilst maintaining choice of hospital for women needing to access tertiary level of care. An option that should be considered	✓
A combination of Birmingham Women's Hospital in the UK and Royal Hospital for Women (RHW) in New south Wales, Australia. RHW centralises gynaecology, paediatric and adolescent gynaecology, maternal fetal medicine, new born intensive care and reproductive medicine. It is a dedicated centre of excellence providing sub speciality expertise	• Three hospitals co-locate with an Acute Adult Hospital • Each hospital has either Fetal Medicine, IVF/Fertility/gynaeoncology as centralised service in Dublin	• Benefits of co-location and sub specialisation. As the Hanley Report demonstrates, outcomes are improved for the low volume, high complex cases when they are centralised	✓
Principle of co-location/tri-location embedded at many UK hospitals	• Two hospitals co-locate with an Acute Adult Hospital • One hospital tri-locates with paediatric hospital and has all fetal medicine • All gynaecology is transferred into Acute Adult Hospital, with services being centralised	• Tri-location offers benefits to mother and infant. Whilst not all pregnancies involve sick mothers and babies, where this is the case tri-location offers the best model of care. Moving Gynaecology into the adult hospital will improve integration with other specialities such as general surgery and urology. All units having fetal medicine will ensure that women have access to intervention and provide continuity of care for those who do not require the highly complex fetal intervention which will be located on the site of the Level 4 paediatric unit	✓

International health economy	Option	KPMG view	Short List
London has more than 4 providers in one city	• Increase the number of providers to four • Three of the hospitals have obstetrics and routine gynaecology services and either Fetal Medicine, IVF/Fertility/gynaeoncology • Fourth hospital has low risk obstetrics and ambulatory gynaecology	• Increasing the number of units to four will reduce the number of births in each of the units and provide low risk women additional choice for birth	✓
	• Two hospitals • One providing full range of obstetric services, IVF/Fertility and Fetal Medicine • One providing medium/low risk obstetrics and all gynaecology services	• Two hospitals would provide economies of scale and allow one unit to become experts in high risk and the other an expert in low risk births. This would effectively stream the two groups of patients away from each other, and operational policy could be designed to meet the different needs of the patient. The risk to this model would be when the low risk turned to high risk and the potential deskilling of staff in high risk units. This option is worth exploring in more depth before a decision is made in whether it is desirable for the GDA	✓
Liverpool Women's Hospital is a standalone hospital, but delivery has outreach services into the community and has Midwife Led Units	• Status quo with performance improvement	• This is not a viable option, as this would not facilitate co-location, (a principle which we consider essential)	✗
Dublin configuration unique and therefore no international example	• Status quo with performance improvement but rebuild hospitals	• Not viable as this would not facilitate co-location as a principle which we will consider essential	✗

International health economy	Option	KPMG view	Short List
London has more than 4 providers in one city	• Increase the number of providers to four • Three of the hospitals have obstetrics and routine gynaecology services and either IVF/Fertility, Foetal medicine or gynaecology • Fourth hospital has high risk obstetrics, fetal medicine and is tri-located with an acute adult hospital and paediatric hospital	• This would involve the creation of a high risk unit on the site of the paediatric hospital. In order for a unit to have economies of scale in terms of staffing and to ensure staff remain skilled in low risk activity in a larger unit, a minimum of 6,000 births would be needed on the site. Building a fourth unit would also endorse a hospitalised model which would negatively impact on the philosophy of the model of care putting the woman at the centre and for care to be delivered in the community	✗
Mount Sinai Hospitals Toronto, Nottingham University Hospital, McGill University Health Centre Montreal, all operate on a split site basis. A single governance structure, but with multiple sites	• One hospital, three sites	• The concept of the three working together as a network would assist the variation in activity at the different sites However, one hospital over three sites would be difficult to manage, as the three sites would be co-located with adult hospitals which would make it a complex model to manage	✗
Keandagn Kerbau maternity Hospital (KKMH) in Singapore became the regional tertiary referral centre in obstetrics and gynaecology, following the transfer of services from two other hospitals at its peak it delivered 39,83 babies in a year in the 1960's, this has since declined but still provides a model for a large single hospital	• One super hospital	• One large hospital would not be a viable option. Whilst it would provide economies of scale we do not believe that it will provide personal care. It will also enforce the idea of a centralised hospital service which would undermine our philosophy of care	✗

International Health Economy	Option	KPMG view	Short List
London has more than 4 providers in one city	• Increase providers on outskirts of Dublin and maintain three hospitals within Dublin	• Additional hospitals on the outskirts of Dublin would again promote the centralised hospital model. Hospitals on the outskirts such as Naas, Loughlinstown and Blanchardstown do not have the services that would maximise the benefits of co-location	✗
Singapore has numerous private providers from which women can choose to have their babies	• Increase the number of private sector providers and maintain three hospitals in Dublin	• Private hospitals are dependant on market demand; even though up to 50% of women have private insurance, there is no guarantee that they would attend private hospitals if they were to increase in number. If private hospitals open and draw activity from the public hospitals it will reduce pressure on the public system but it cannot be an engineered process	✗
In the Netherlands low risk women have care delivered in the community by the GP or midwife and not the hospital	• Hub and spoke model with the hospitals being the main providers of community care	• A substantial investment is required in primary and community care alongside the investment in maternity hospitals. There should be clear links between hospital-based and community care, however the hospitals are not equipped to take full responsibility	✗

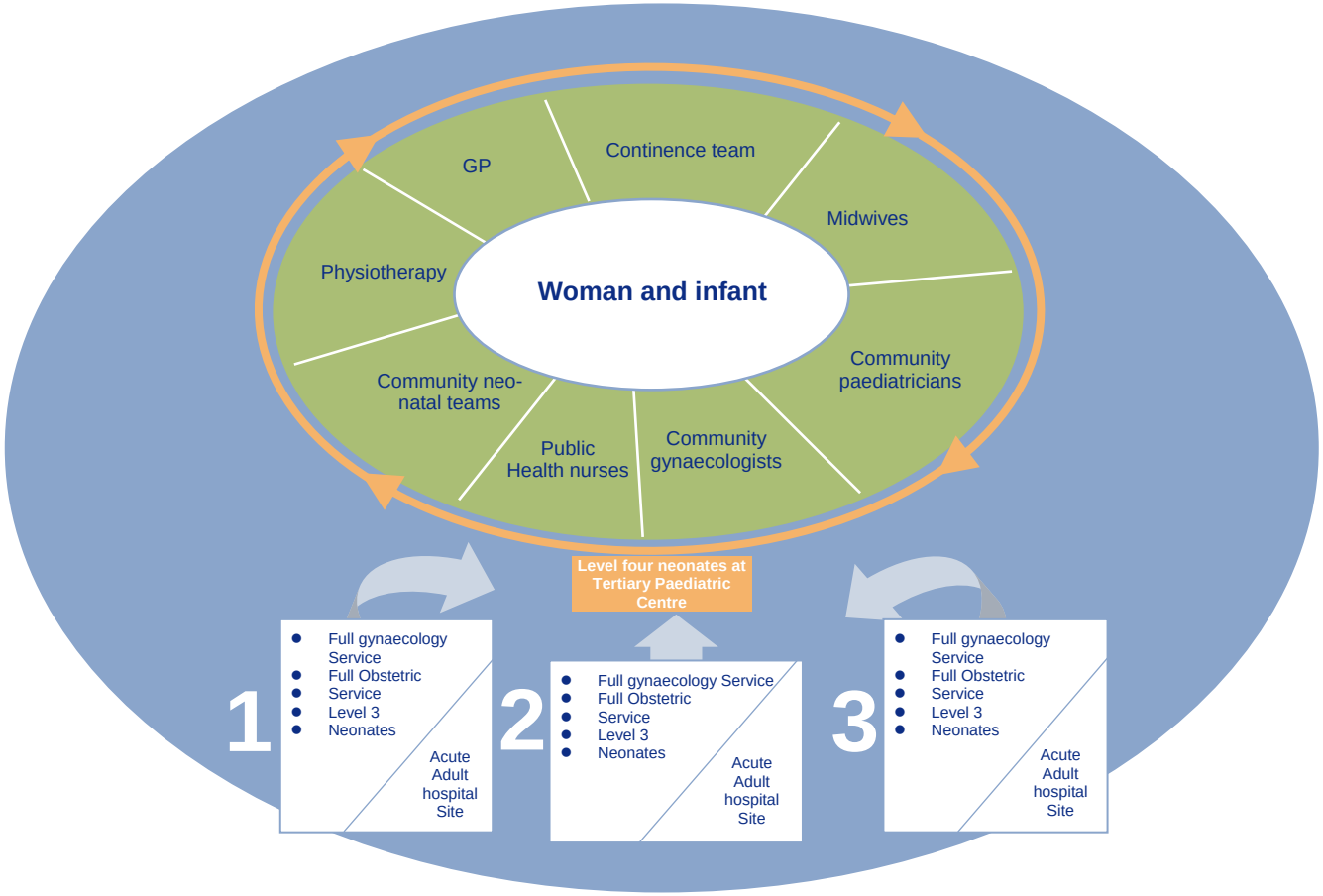
Option	Safety	Women and infant centred care	Equity	Access	Accountability	Value for money	Training and research	Workforce
Two hospitals co-locate with an acute adult hospital. One hospital tri-locates with neonatal medicine and has fetal intervention. All gynaeoncology is transferred into an acute adult hospital with services being centralised	• Two large hospitals would offer increased safety if co-located. There would be opportunity to increase labour ward cover with greater number of consultants on the one site which would improve outcomes for women • This option provides enhanced safety and quality of care for babies requiring Level 4 neonatal care as they do not require to be transferred in this model	• Sub specialisation will require women to go to specific units rather than choose the centre for complex care	• Transfer of babies in utero identified as requiring Level 4 NICU will reduce the need for babies to be transferred and other babies to be separated if surgery is requires	• Access to an integrated maternity and gynaecology service will be impeded if the gynaecologist are employed by a different hospital. Many women require the input of both obstetric and gynaecology services	• No issues	• Sub specialisation will be better value for money, but the split of gynaecology from obstetrics will require additional obstetrician and gynaecologists	• Will provide improved opportunities for sub speciality training programmes	• The fourth NICU will be on the site of a Level 3 NICU, staff can therefore be on call for both, thus reducing need for double rotas
Three hospitals co-locate with	• Co-location will ensure that the	• Women still have the opportunity,	• Equity of access would	• Allows women from across	• No issues	• The duplication of expertise	• There would be the dilution of	• It would enable each

Option	Safety	Women and infant centred care	Equity	Access	Accountability	Value for money	Training and research	Workforce
an acute adult hospital. All three have the full range of obstetric and gynaeoncology services	full spectrum of services are available to women in the case of complex obstetric and gynaecology cases and in critical or emergency situations	as they do in the current model to choose from a number of providers for all aspects of their obstetric and maternity care. If the Level 4 NICU remains on a different site therefore the mothers and babies would need to be separated	be assured	the GDA to access services in different geographical areas i.e. complex uro-gynaecology would be available at all three and women wouldn't need to travel		across the three centres would not offer value for money	expertise of specialist services are provided over three sites	organisation to provide the full spectrum of training it would however require double neonatology on-calls
Three hospitals co-locate with an acute adult hospital. Each hospital has either fetal medicine, IVF/Fertility or gynaeoncology as a centralised service in Dublin	• Provides the clinical benefit to maternal outcomes for mothers but babies requiring Level 4 NICU would need to be moved	• Would restrict the number of choices available to women for sub speciality care	• Would not provide equitable access to sub speciality services across the GDA as only one of the units would have any one of the sub speciality services	• Access would be fair	• No issues	• Centralisation of sub speciality services would provide better value for money as specialist staff would not be deployed in different centres	• Centralisation of sub speciality services would allow the individual centres to develop as centres of excellence	• Would attract staff they would be working in centres of excellence for the centres particularly sub speciality
Increase the number of providers to four and three of the hospitals have obstetrics and routine gynaecology	• The three obstetric units will have the benefit of co-location. The low risk unit would need robust transfer	• The provision of a fourth low risk unit allows women with high risk pregnancies to choose an alternative to the typically high risk	• As there would only be one low risk unit it would provide an equitable choice for women, as geographically	• There would be reduced access to obstetricians and other professionals in the case of obstetric	• There would be issues over who was alternatively accountable for women in a low risk unit, especially if	• Low risk units need to be fully utilised to ensure the utilisation of resources	• If training was undertaken at the fourth unit, then steps would need to be taken to ensure that it incorporated a	• Provide midwives with the opportunity to practice independently

Option	Safety	Women and infant centred care	Equity	Access	Accountability	Value for money	Training and research	Workforce
services and either IVF/Fertility, fetal medicine or gynaeoncology	guidelines to ensure safety of mothers who move from low to high risk	obstetric led maternity units	it would not be an option for some women in the GDA • Babies requiring NICU would need to be transferred	emergencies for women opting to deliver in the low risk unit. Women in the other three obstetrics nits may not be able to access the same level of midwifery care	there were no consultants presence		full and appropriate programme	
Two hospitals, one providing a full range of obstetrics services, IVF/Fertility and fetal medicine. The other provides medium to low risk obstetrics and routine gynaecology	• Two hospitals would benefit from co-location. The larger number of consultants on site would facilitate the move to 24 hour consultant cover	• Would reduce choice for women not only from a sub speciality perspective but also for mainstream services. It is also felt that two large hospitals are likely to decrease to personal approach	• A reduction in the number of units may damage equity of services	• By centralising services into two sites services will be centralised into two geographical areas which will decrease the access that already exists for women	• Two large hospitals with sub specialisation will create economies of scale	• There would be some efficiency gains by reducing the number of providers, however stand alone units in the UK are becoming difficult to justify financially	• Provide opportunities for training and research, large volumes of activity will facilitate research	• Two units would be extremely busy and staff would not benefit from quiet times that occur in the three units due to concentration of activity

Option 1 - All co-locate with acute adult hospital

All maintain full range of obstetric and gynaecology services

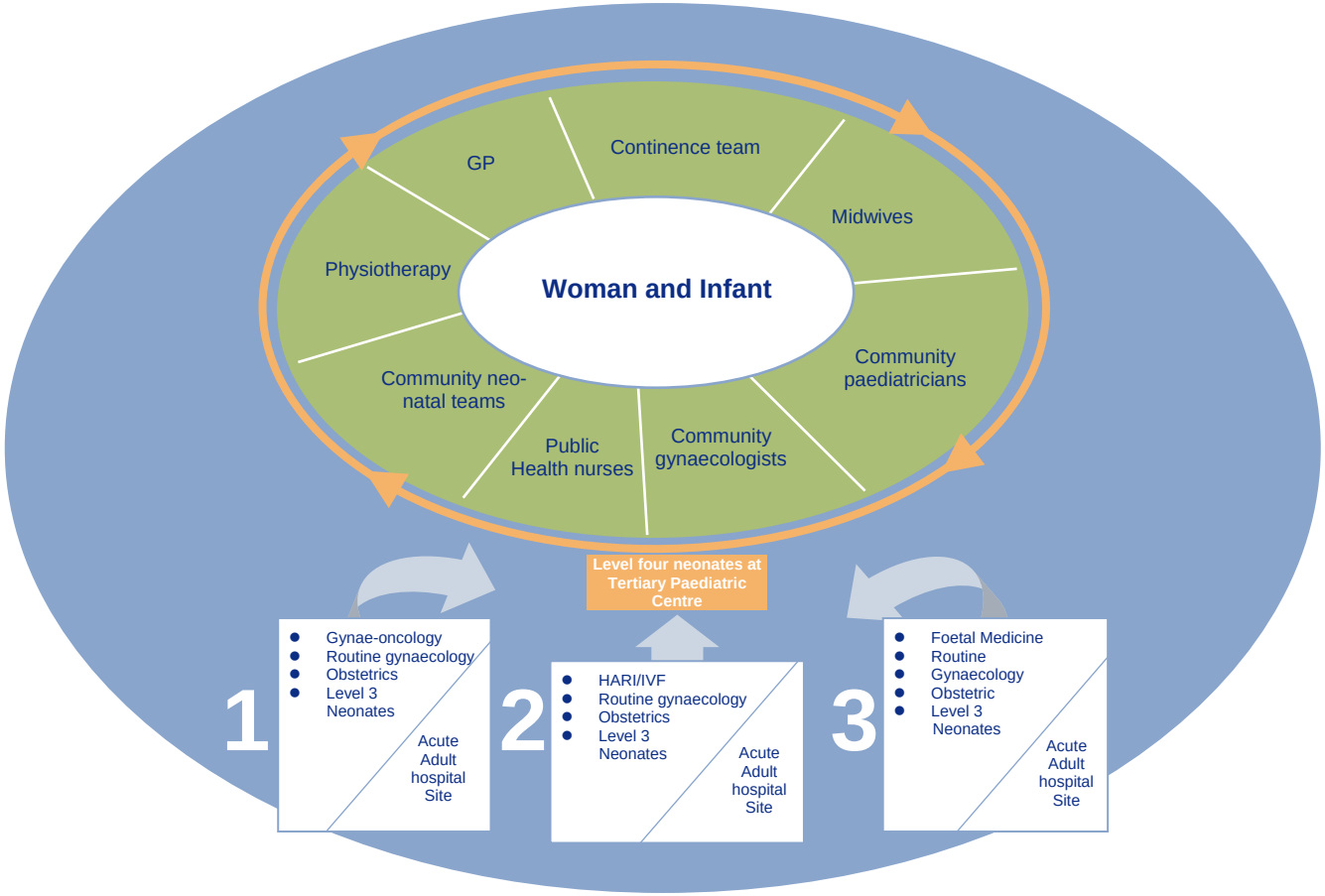


Key features of this option:

- All three hospitals co-locate to an acute adult hospital site
- All three continue to provide the full complement of obstetric and gynaecology services that they offer at present
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for their care. Neonatologists and neonatal nurses at the 3 Women's hospitals would do sessions at the level 4 unit to maintain skills

Option 2 - All co-locate with acute adult hospital

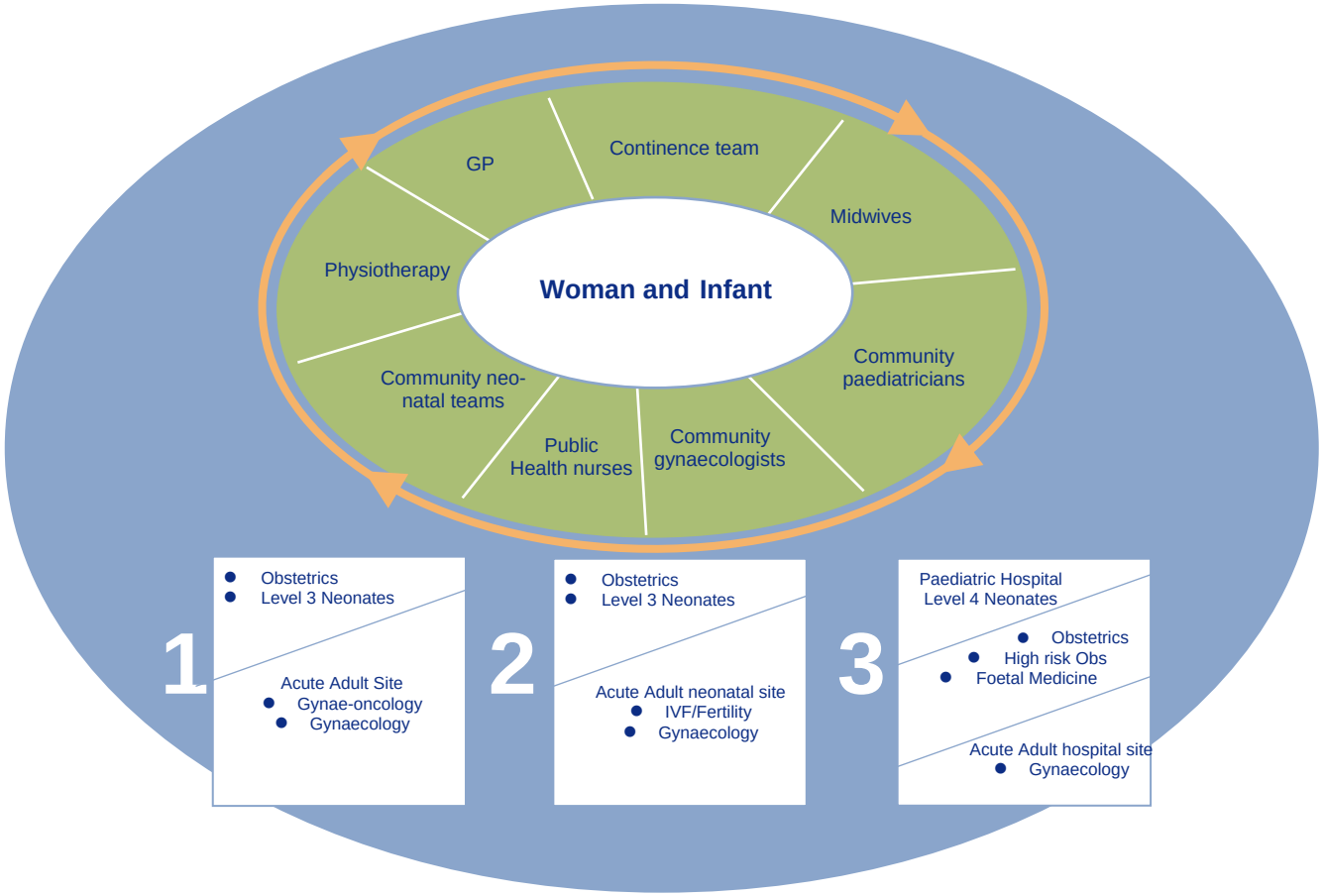
Centralisation of specialist services in obstetrics and gynaecology



Key features of this option:

- All three hospitals co-locate to an acute adult hospital site
- Each of the hospitals would provide routine gynaecology services including ambulatory gynaecology services; and obstetric cases not requiring fetal medicine
- Each hospital will have either Gynae-oncology, IVF/Fertility or foetal medicine
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for their care. Neonatologists and neonatal nurses at the 3 Women's hospitals would do sessions at the level 4 unit to maintain skills

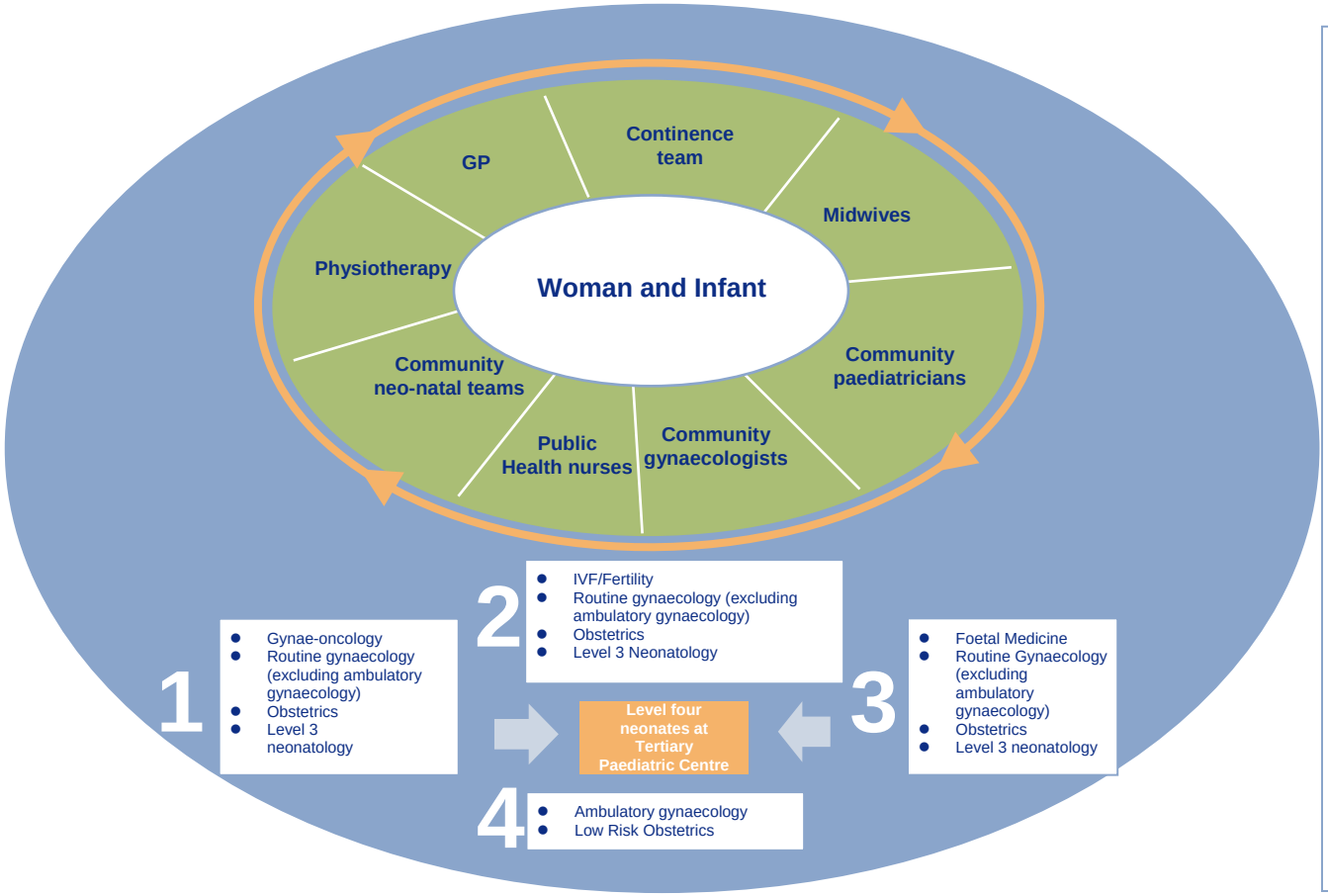
Option 3 - Two co-locate with acute adult hospital, one tri-locates with adult hospital and paediatric hospital. Centralisation of specialist services in obstetrics, gynaecology transferred to acute adult hospital



Key features of this option:

- All three hospitals co-locate to an acute adult hospital site
- All gynaecology activity would take place in the co-located adult hospital. This would include all gynaecology sub-specialities
- All three hospitals will continue to provide obstetric services
- One of the three hospitals will have all the high risk obstetrics and be tri-located with an adult and paediatric site
- The tri-located site will have foetal medicine and level 4 neonatology
- Babies requiring Level 4 neonatology services from the other two hospitals will be transferred to the Paediatric tertiary centre for their care. Neonatologists and neonatal nurses at the 2 hospitals will undertake level 3 neonatology and would do sessions at the level 4 unit to maintain their skills and experience

Option 4 - Increase the number of providers to four



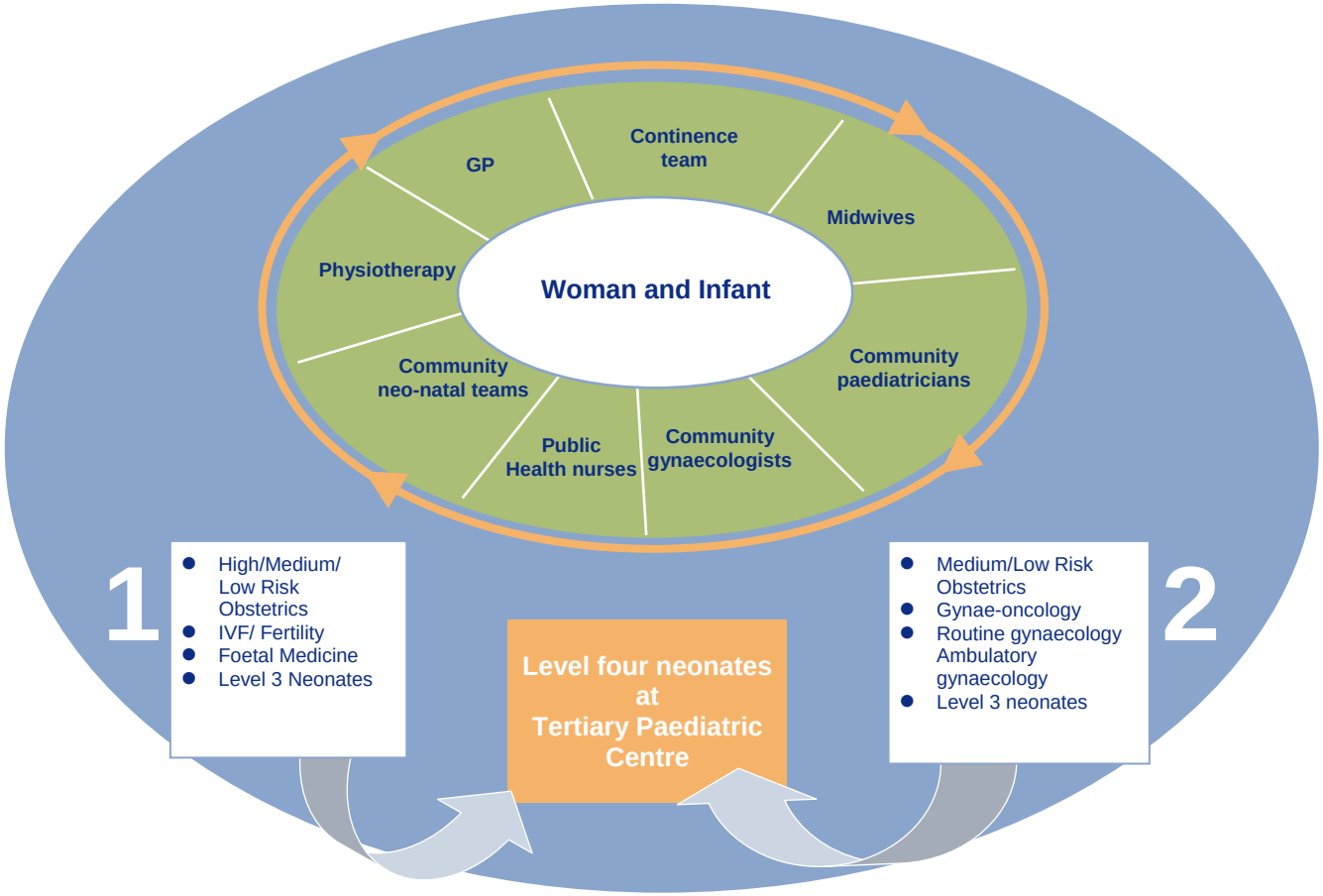
Key features of this mode:

- Three of the hospitals would provide routine gynaecology services and obstetric services for high and low risk women. This would be supported with a Level 3 neonatal service
- The fourth provider would provide ambulatory gynaecology services and a low risk obstetric service that would provide women wanting a midwifery led service a unit in which babies could be delivered
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for their care. Neonatologists and neonatal nurses at the 3 Women's hospitals providing neonatal services would do sessions at the level 4 unit to maintain skills

Variations on Option

- Three/four hospitals co-locate to an acute adult hospital site
- 1 tri-location with tertiary paediatric centre

Option 5 - Centralise services down to two hospitals



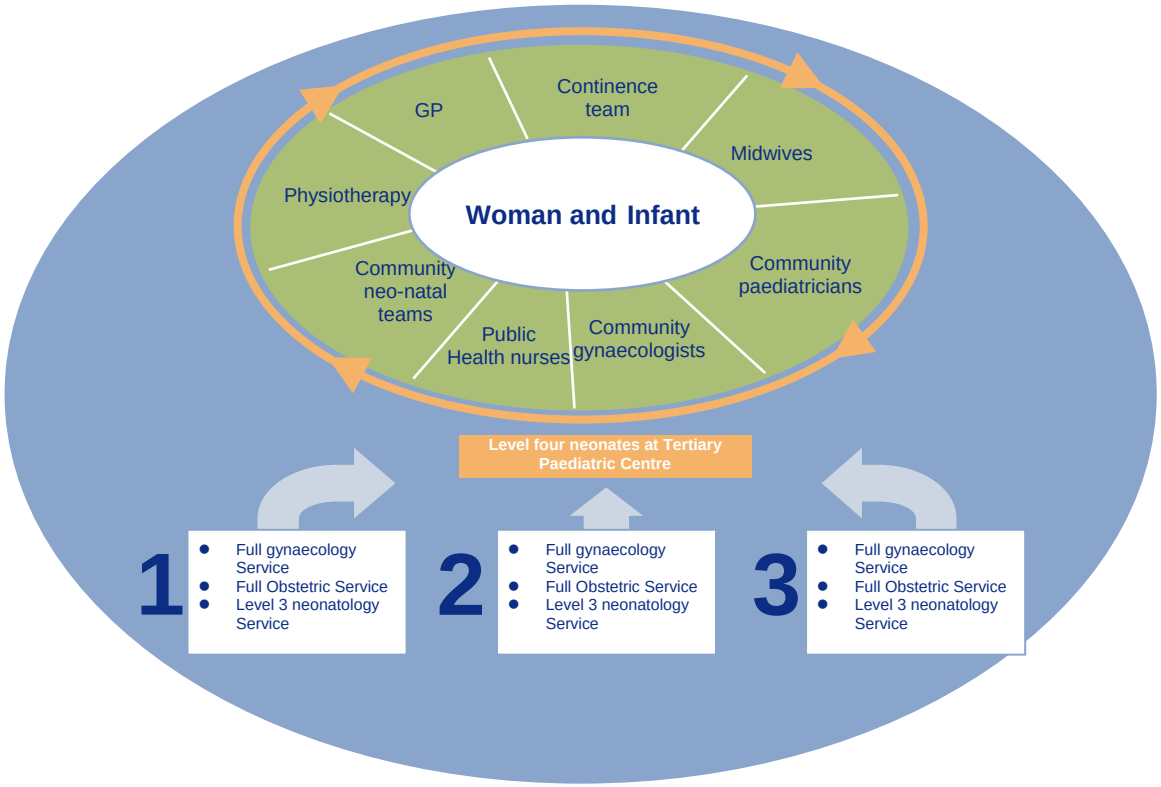
Key features of this model:

- A decrease to 2 providers would be supported by delivery of care in the community by primary care teams and new ways of working in the hospital
- One hospital would do high/medium/low obstetrics, IVF/Fertility, fetal medicine and have level 3 neonatology
- Both sites would do obstetrics, with one leading on high risk obstetrics and fetal medicine
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for care. Neonatologists and neonatal nurses at the 2 Women's hospitals would do sessions at the level 4 unit to maintain skills

Variations on Option

- One/two sites co-locate to an acute adult hospital site
- One site tri-locate with adult and paediatric services

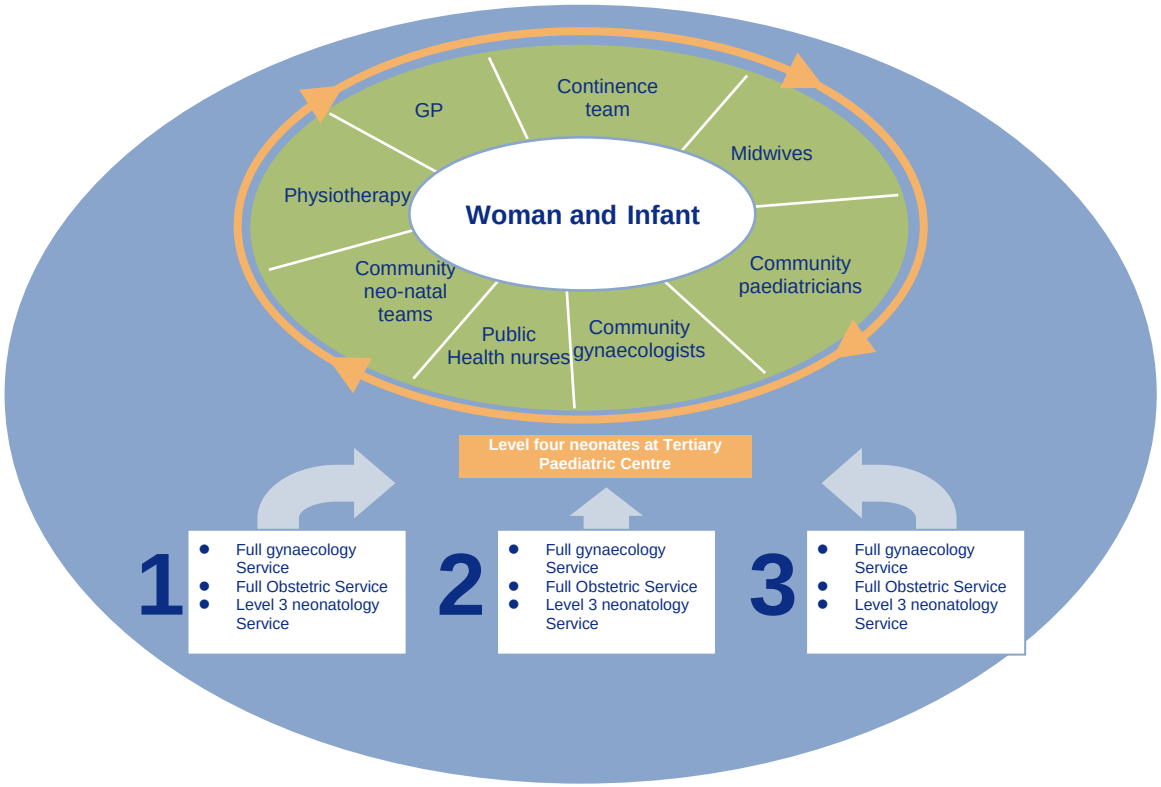
Option 6 - Status quo with performance improvement



Key features of option:

- Status quo with performance improvement to increase choice for women and reduce pressure on infrastructure
- All three hospitals maintain stand alone status and continue to work with the acute adult hospitals with whom they have relationships
- All three hospitals continue to provide the full compliment of obstetric and gynaecology services that they offer at present

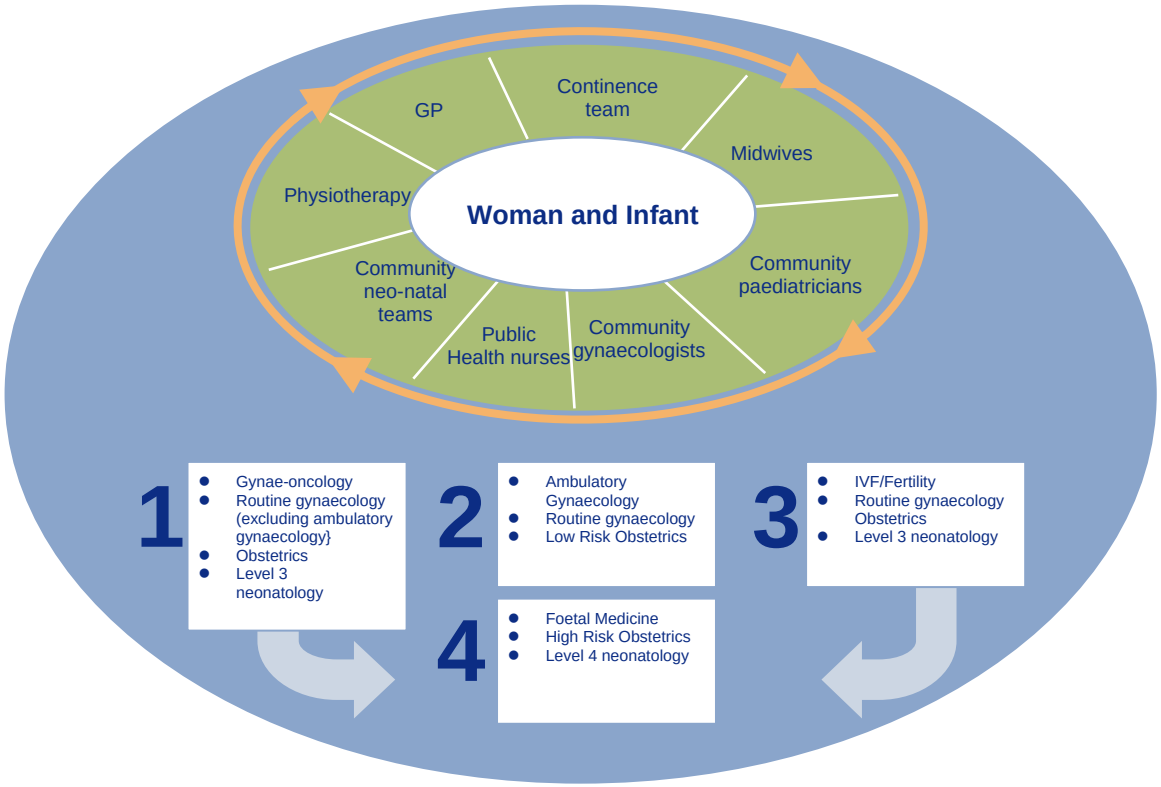
Option 7 - Rebuild on current sites



Key features of option:

- Status quo but in new buildings on current sites. Performance improvement to increase choice for women and reduce pressure on infrastructure
- All three hospitals maintain stand alone status and continue to work with the acute adult hospitals with whom they have relationships
- All three continue to provide the full compliment of obstetric and gynaecology services that they offer at present
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for their care. Neonatologists and neonatal nurses at the 3 Women's hospitals would do sessions at the level 4 unit to maintain skills

Option 8 - Increase the number of providers to four centralise high risk obstetrics and Level 4 neonatology on one site



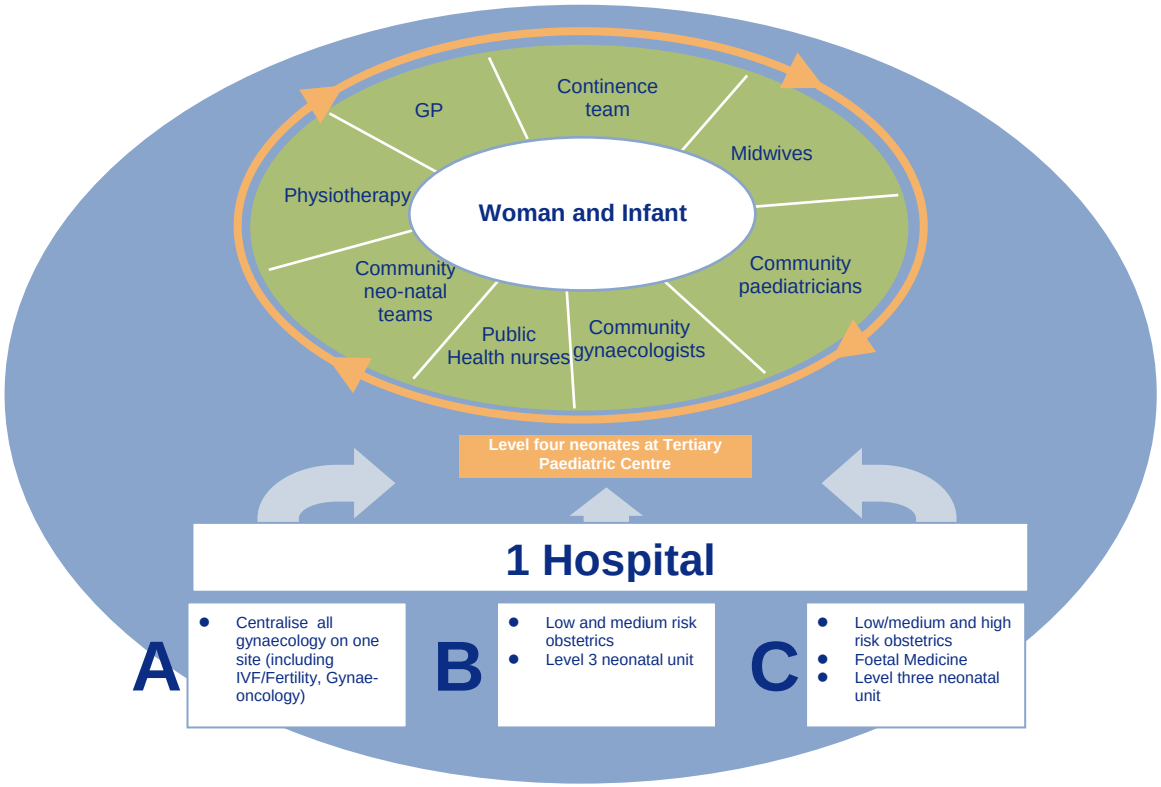
Key features of this option:

- Two of the hospitals would provide routine gynaecology services and obstetric services for medium and low risk women. These would be supported with level 3 neonatology services
- Each hospital will have either Gynae-oncology, IVF/Fertility or foetal medicine
- One of the hospitals would provide ambulatory and routine gynaecology services. They would also provide a low risk obstetric service that would provide women wanting a midwifery led service a unit in which that care could be delivered
- One unit would have high risk obstetrics, fetal medicine and level 4 neonatology

Variations on Option

- Two/three hospitals co-locate to an acute adult hospital site
- One tri-locate with adult and paediatric services

Option 9 - Merge three hospitals into one with three sites



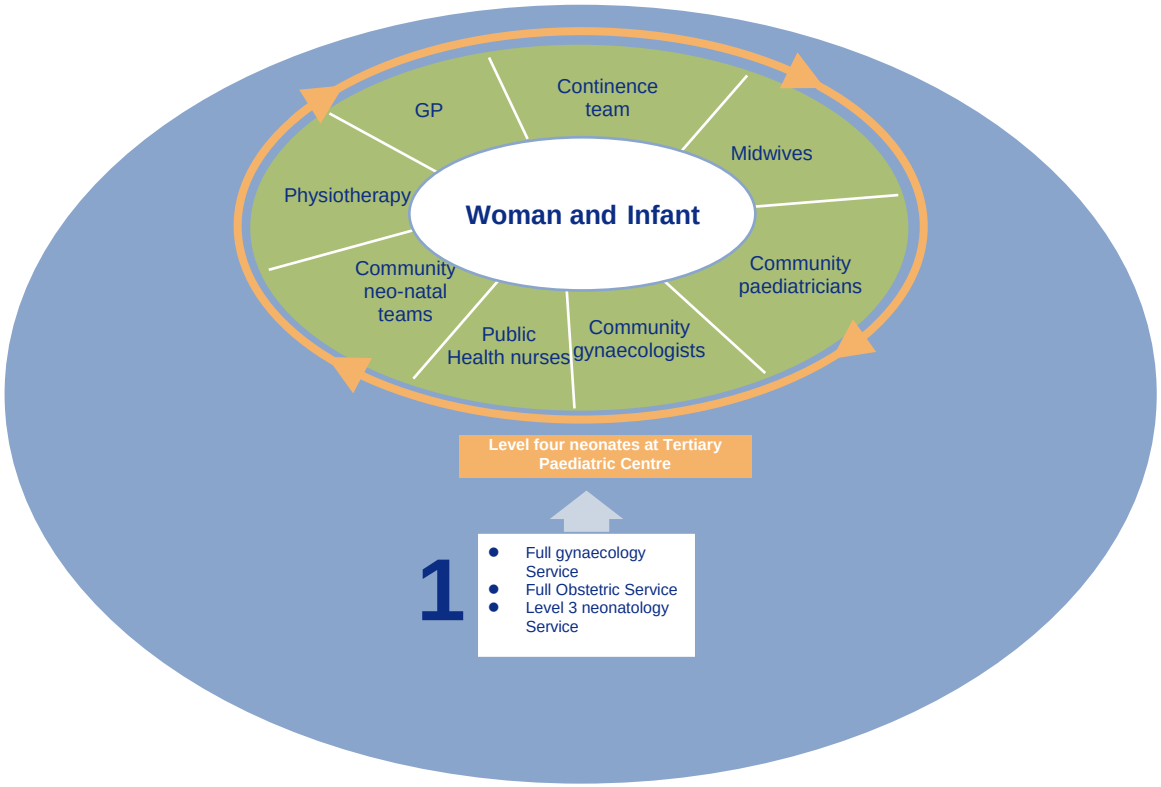
Key features of this option:

- One hospital, split over three sites
- Each site would have either Gynae-oncology, IVF/Fertility or fetal medicine services
- One site would do all gynaecology activity
- Two sites would do obstetrics, with one leading on high risk obstetrics and foetal medicine
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for their care. Neonatologists and neonatal nurses at the Women's hospitals would do sessions at the level 4 unit to maintain skills

Variations on Option

- Two/three sites co-locate to an acute adult hospital site
- One site tri-locate with adult and paediatric services

Option 10 - Centralise into one super hospital



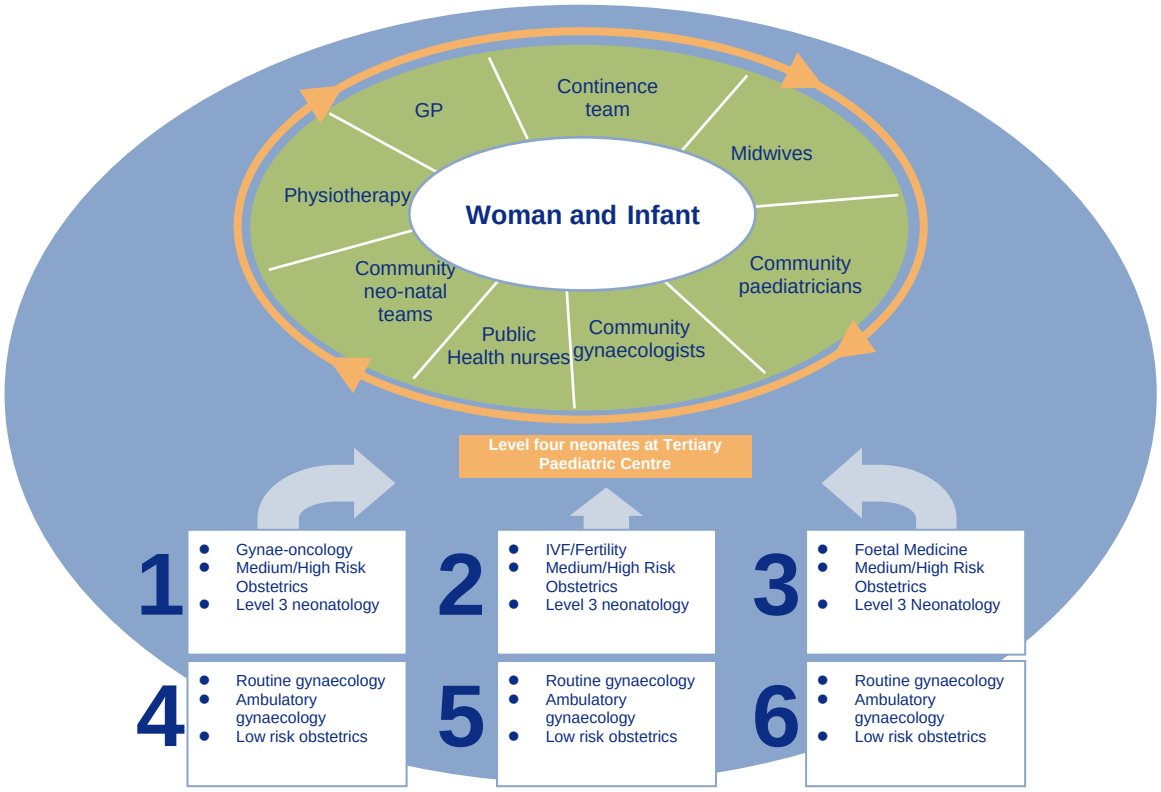
Key features of this option

- A decrease to 1 provider would be supported by delivery of care in the community by primary care teams and new ways of working in the hospital
- The hospital would provide a full complement of obstetric and gynaecology services
- Three delivery suites
- high risk
- medium risk (low risk requiring epidurals, instrumental delivery}
- low risk
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for care. Neonatologists and neonatal nurses at the Women's hospitals would do sessions at the level 4 unit to maintain skills

Variations on Option

- Co-locate with acute adult site
- Tri-locate with tertiary paediatric site

Option 11 - Increase number of providers outside Dublin



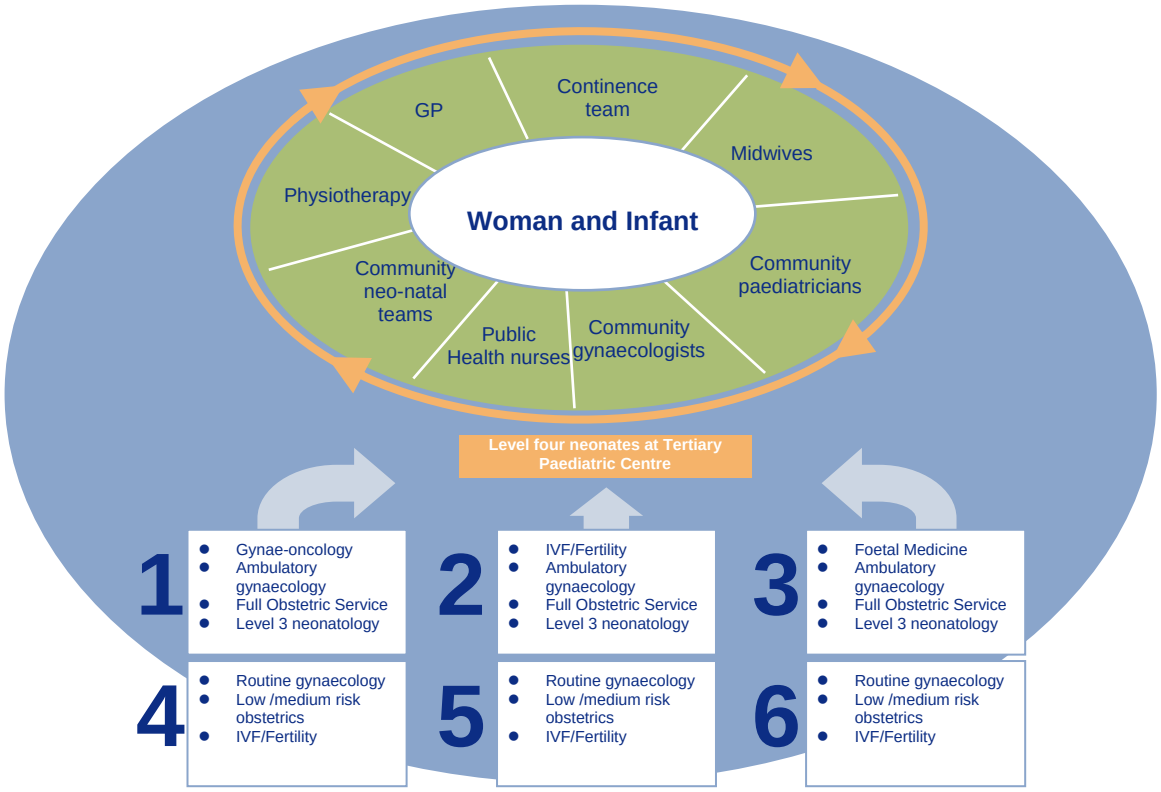
Key features of this option

- An increase to 6 or more secondary care providers would be supported by delivery of care in the community by primary care teams and new ways of working in the hospital
- Gynae-oncology, IVF/Fertility and foetal medicine will be centralised into one hospital
- Low risk obstetrics, routine gynaecology and ambulatory gynaecology would be done in hospitals outside of Dublin
- The hospitals in Dublin would focus on medium to high risk obstetrics and specialist services
- Consultant staff could have sessions in the hospitals outside of Dublin. Midwifery staff would rotate to maintain skills
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for care. Neonatologists and neonatal nurses at the 3 Women's hospitals would do sessions at the level 4 unit to maintain skills

Variations on Option

- Dublin hospitals are co-located with acute adult hospitals
- One of the Dublin hospitals tri-locate with tertiary paediatric provider
- Hospitals outside of Dublin are co-located with general hospitals
- Hospitals outside of Dublin are units within general hospitals

Option 12 - Increase of plurality in private sector



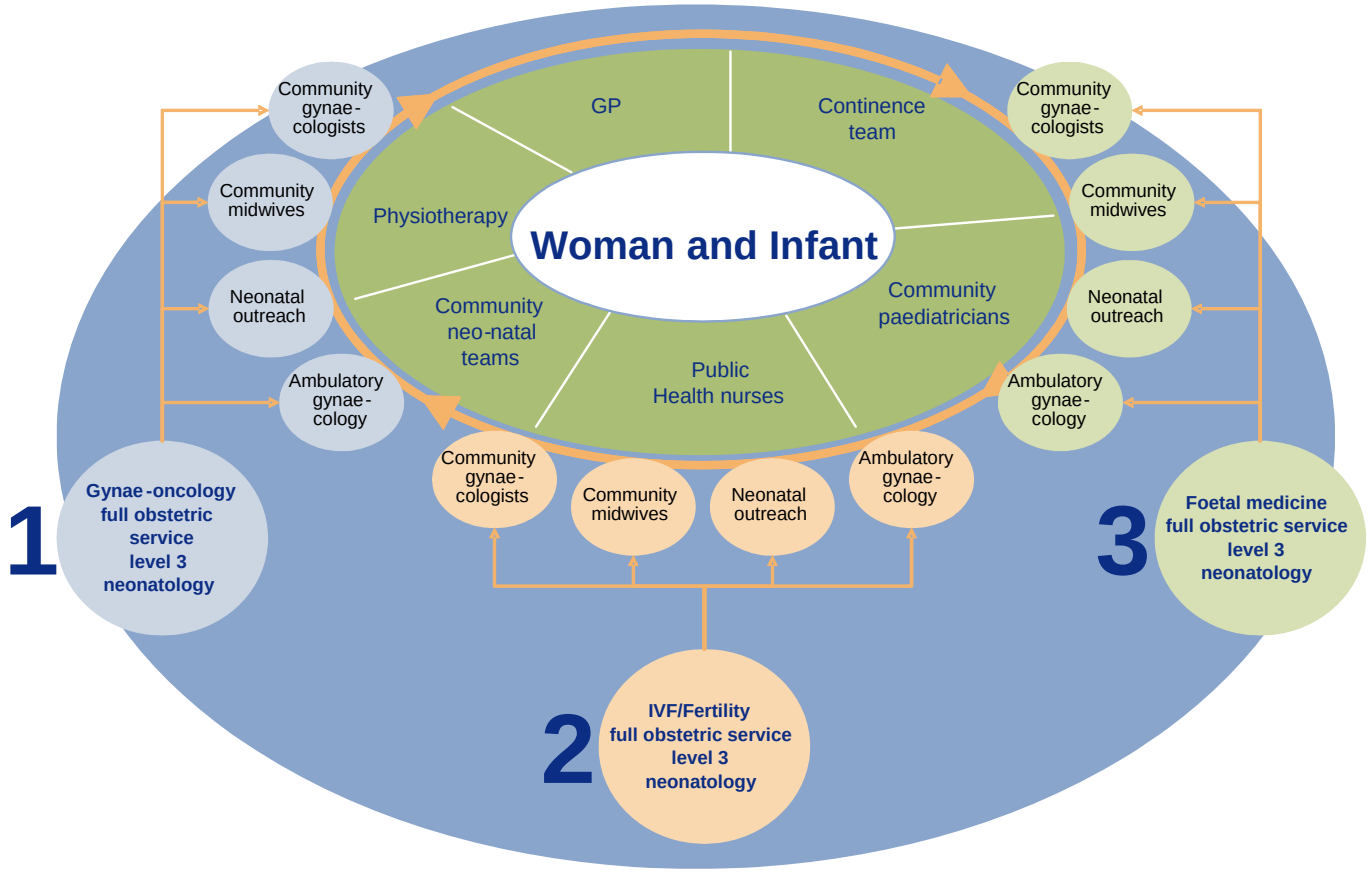
Key features of this option

- An increase in private providers would be supported by delivery of care in the community by primary care teams and new ways of working in the hospital
- Private hospitals would provide low/medium risk obstetrics, routine gynaecology procedures and IVF/Fertility services
- The women's hospitals would continue to provide a full range of services with gynae-oncology, IVF/Fertility and foetal medicine centralised into one of the hospitals
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for care. Neonatologists and neonatal nurses at the 3 Women's hospitals would do sessions at the level 4 unit to maintain skills

Variations on Option

- Private hospitals are co-located with acute adult hospitals
- Private hospitals are co-located with women's hospitals
- 1 or more Women's hospitals, private hospital and acute adult hospital located on one site

Option 13 - Three networked/franchised hospitals providing community model



Key features of this option:

- Hospitals provide primary care services through franchised community providers
- Staff providing the services in the community are employed by the hospitals and work within the same governance structures as hospital staff
- The three hospitals will each have a full obstetric service, level 3 neonatology
- Each hospital will have either Gynae -oncology, IVF/Fertility or fetal medicine
- Babies requiring Level 4 neonatology services are transferred to the Paediatric tertiary centre for care. Neonatologists and neonatal nurses at the 3 Women 's hospitals would do sessions at the level 4 unit to maintain skills

Variations on option

- One/two sites co -locate to an acute adult hospital site
- One site tri -locate with adult and paediatric services
- Primary care services are provided on site of hospitals outside of Dublin

Appendix I: Bibliography/References

Outlined below is a list of the references that have contributed to our work. A full list of references on the international literature review is separately set out in Appendix G on page 79.

- Advisory Council: for Science Technology/Innovation (2006) Towards Better Health: Advancing a Step Change in Health Research in Ireland.
- AIHW National Hospital Morbidity Database, Australia's Health 2004, AIHW
- Australian Institute of Health and Welfare,www.aihw.gov.au
- Bissell 2004
- Breaking the silence: a national voice for gynaecological cancers reports, Commonwealth of Australia, 2006
- British Association of Prenatal medicine guidelines (2001)
- Central statistics office (C50)
- Chung JW, Jeong HJ, Joh JH, Park JS, Kim SH (2003)
- Comhairle na nOspideal, (2003), Report of the Committee Reviewing Maternity and Related Services in North Eastern Health Board Area
- Commission on Financial Management and Control Systems in the Health Service (the Brennan Report), January 2003
- Comptroller and Auditor General, Special Report, Health Service Executive, Medical Consultants' Contract, March 2007
- Confidential Enquiry into Maternal and Child Health (2004)
- Coombe Women's Hospital, (2005) Annual Clinical Report
- Crawford SM Brunskill, P (2007) Centralisation of services for the management for the management of ovarian cancer; arguments against, British Journal of Obstetrics and Gynaecology 114, 183-1187
- Davane, (2007) Childbirth policies and practices in Ireland and the journey towards midwifery-led care
- Davane, (2007) Evaluating Maternity Care – A core set of outcome measures
- Dept of Community Health and General Practice, Trinity College, Dublin (2002) People Living in Finglas and their Health, The health needs of people living in Finglas area
- Dept of Community Health and General Practice, Trinity College, Dublin (2002) People Living in Tallaght and their Health, A community based cross-sectional survey
- Dept of Community Health and General Practice, Trinity College, Dublin (2002) People Living in the Dublin Docklands and their Health; The health needs of people living in the Pearse Street area, Ringsend and Irishtown
- Dept. of Health & Children (DOHC) (2001) report of the National Advisory Committee on Palliative care
- Dept. of Health & Children (DOHC) (2003) The Development of Radiation Oncology Services in Ireland

- Dept. of Health & Children (DOHC) (2006) a Strategy for cancer Control in Ireland, National Cancer Forum
- Dept. of Health & Children (DOHC), (2002), The Nursing & Midwifery Resource, Final Report of the Steering Group towards Workforce Planning
- Dept. of Health & Children (DoHC), (2006), The Lourdes Hospital Inquiry (An Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda.) Report of Judge Maureen Harding Clark S.C.
- Devane, D et al (2007) Midwifery 23, 92-101
- Domiciliary Births Group, (2004) Report to the Chief Executive Officers of the Health Boards (PDF)
- Dr Foster
- Eastern Region Health Authority Strategy 2005 -2011 (Eastern Region Health Authority and the Joint Standing Committee)
- Eastern Regional Health Authority, (ERHA) (2004), Report of the Steering Group factors that influence the Recruitment and Retention of Midwives and Nurses in the Dublin Maternity Hospitals
- Elective caesarean sections at maternal request
- European Foundation for the Improvement of Living and Working Conditions, (2006), Fertility and family issues in an enlarged Europe
- Faculty of Family Planning and Reproductive Health Care of the RCOG Updated January 2006
- Fetal Tachyarrhythmia - Part II: Treatment, Indian Pacing and Electrophysiology Journal (ISSN 0972-6292), 4(4): 185-194 (2004) Martijn A. Oudijk, MD, PhD*, Gerard H.A. Visser, MD, PhD* and Erik J. Meijboom, MD, PhD† (*Department of Obstetrics and Gynecology, University Medical Center Utrecht,The Netherlands; †Division of Pediatric Cardiology, Central Hospital University of Vaud, Lausanne, Switzerland)
- Giving Birth in Canada, Providers of Maternity and Infant Care, Canadian Institute for Health Information, 2004
- Health Service Executive (HSE), (2005), Maternity Services in the Eastern Region - A Strategy for the Future 2005-2011
- Health Service Executive (HSE), (2006), Changing Models of Health Service Delivery A Public Health Nursing Service Response Health Service Executive
- Health Service Executive (HSE), (2006), Children's Health First International best practice in tertiary paediatric services: implications for the strategic organisation of tertiary paediatric services in Ireland
- Health Service Executive (HSE),, (2004) Needs Assessment for Women's Health in the Context of Maternity Services in the Eastern Region
- Health Service Executive (HSE)/ Dept. of Health & Children (DOHC), (2006), Report of the Joint Health Service Executive/Dept. of Health & Children Task Group to advise on the National Paediatric Hospital
- Health Service Executive, (2007) Final Draft Short Term Action plan for Maternity Services based on Maternity Services in the Eastern Region – A strategy for the Future 2005-2011 (Unpublished)
- Health Sociology Review Volume 15 Issue 4 Childbirth, Politics & the Culture of Risk Cover October 2006

- HIPE (Hospital Inpatient Enquiry) data collected by HIPE and National Perinatal Reporting System (NPRS) Unit of the Economic and Social Research Institute
- Hong TM, Tseng HS, Lee RC, Wang JH, Chang CY (2004) Unterine artery embolism; an effective treatment for intractable obstetric haemorrhage, Clinical radiology V59 96-107
- HSE Intercultural Health Strategy 2007
- Improving Patient Safety: Risk Management for Maternity and Gynaecology
- Institute of Obstetricians & Gynaecologists (2006) The Future of Maternity & Gynaecology Service in Ireland 2006 -2016, Report from Institute Subgroup.
- Intrapartum Care: Management and Delivery of Care to Women in Labour
- Kennedy, S (2007) Telephone triage in maternity care, RCM Midwives Journal, Volume 10
- M. McCormack, (2007) British Journal of Obstetrics and Gynaecology 114, 118-1190
- Maternity Matters: Choice, access and continuity of care in a safe service, Department of Health, 2007
- Maternity Services in the Eastern Region – A Strategy for the Future 2005-2011 (Eastern Regional Health Authority and the Joint Standing Committee, 2005)
- Maternity services in the NHS, Professor Nick Bosanquet, Jen Ferry, Christoph Lees, Professor Jim Thornton, Reform, 2005
- MIDWIVES, October 2003.
- Models of Maternity Service Provision across NSW, Progressing implementation of the NSW Framework for Maternity Services, NSW Health, April 2003
- Multidisciplinary Collaborative Primary Maternity Care Project – Summary of Current Practice in Europe and Australia: A Descriptive Study, Authors: Kathy Herschderfer and Hanneke Kateman, International Confederation of Midwives (MCPMCP)
- NAO;Dec 11 2007. Caring for Vulnerable Babies: The reorganisation of neonatal services in England
- National Council for the Professional Development of Nursing & Midwifery (2006) Improving the Patient Journey: Understanding Integrated Care Pathways
- Needs Assessment for Woman's Health in the Context of Maternity Services in the Eastern Region 2004 (Eastern Regional Health Authority and the Joint Standing Committee, 2005)
- NHS Institute for Innovation and Implementation Delivering Quality and Value - Success; A self improvement toolkit - focus on normal birth and reducing caesarean section rates
- NICE – Antenatal care guideline
- NICE 2003 Guidelines for the Routine Care for the healthy Women
- NICE 2007, Intrapartum Care; Management and delivery of care to women in labour
- North Eastern Health Board, (2001), Report of the Maternity Services Review Group to the North Eastern Health Board (Kinder Report)
- Northern Sydney central Coast Health, (2007)
- O&G, Vol. 6, No. 3, September 2004, pg 186-189
- OECD Public Management Reviews – Ireland – Toward an integrated public service (2008)
- Olaition, A, McCormack m, Centralisation of services for the management of ovarian cancer; arguments for, British Journal of Obstetrics and Gynaecology 114, 1188-1190
- Olsen and Jewell, 2003
- Paediatrics 2007 815-825

- Paediatrics 2007;120;815-825
- Phibbs, (2007) Level and volume of neonatal intensive care and mortality in very low birth weight infants, New England Journal of medicine 356; 2165-2175
- Primary Health Care in the Netherlands, Ministry of Health, Welfare and Sport.
- Quality and Fairness – A Health System for you.
- Quality Review of Primary Level Maternity Service at Ryde Hospital
- RANCOG - Intrapartum Fetal Surveillance, Clinical Guidelines, 2nd Ed
- RANCOG College Statement - Obstetricians and childbirth: responsibilities: Home Births
- RCOG - Clinical Governance Advice No. 2 Revised October 2005
- RCOG Clinical Standards: Advice on Planning the Service in Obstetrics and Gynaecology, July 2002
- RCOG Towards Safer Childbirth: Minimum Standards for the Organisation of Labour Wards
- RCOG, Dec 2005 The Future of Obstetrics and Gynaecology in Scotland – Service Provision and Workforce Planning
- Recent advances in fetal surgery Raul A. Cortes* and Diana L. Farmer, * Division of Pediatric Surgery, The Fetal Treatment Center, University of California, San Francisco, CA, USA
- Report of a joint Health Service Executive/Department of Health and Children Task Group to advise on the optimal location of the new national paediatric hospital, May 2006
- Report of the Lourdes Hospital Inquiry (Judge Harding Clark, 2006)
- Report on Maternity, Maternal and Newborn Information, 2003 New Zealand Health Information Service, 2006
- Report to Chief Executive Officers of the Health Board – Domiciliary Births Group (Domiciliary Birth Expert Group, 2004)
- Rogowski et al JAMA 2004;291;202-209
- Rotunda Hospital Dublin, (2005) Clinical Report
- Royal College of Obstetricians and Gynaecologists/Royal College of Midwives. Towards Safer Childbirth: Minimum Standards for the Organisation of Labour Wards
- Safer Childbirth – Minimum standards for organisation and delivery of care in labour
- Safety of maternity led services - British medical journal 2005 v1 pg 16
- Saving Mothers Lives 2007
- Schwartz's Principles of Surgery, 8th Ed
- Service Standards for Sexual Health Services
- Short Term Action Plan for Maternity Services in the Eastern Region – A strategy for the future (Joint Standing Committee, 2007)
- Survival Effect of Maximal Cytoreductive Surgery for Advanced Ovarian Carcinoma During the Platinum Era: A Meta-Analysis, By Robert E. Bristow, Rafael S. Tomacruz, Deborah K. Armstrong, Edward L. Trimble, F. J. Montz, Journal of Clinical Oncology, Vol 20, Issue 5 (March), 2002: 1248-1259
- The Effect of Centralization of Primary Surgery on Survival in Ovarian Cancer Patients, Solveig Tingulstad, MD, Finn Egil Skjeldestad, MD, PhD and Bjørn Hagen, MD, PhD, Obstetrics & Gynecology 2003;102:499-505
- The Future of Maternity and Gynaecology Services in Ireland 2006-2011 (Institute of Obstetricians and Gynaecologists, 2006)

- The Future Role of the Consultant , Setting standards to improve women's health, A Working Party Report, the Royal College of Obstetricians and Gynaecologists, 2005
- The National Maternity Hospital, Holles Street, (2005) Annual Report
- The Women's Health Council, (2004), Consultation on Maternity Services for Strategy (Unpublished)
- Towards better births – A review of maternity services in England, Healthcare Commission, July 2008
- UK Royal College of Obstetricians and Gynaecologists Guidelines No 8 Revised January 2005
- Victorian Maternity Services Performance Indicators, Complete set for 2005–06, March 2007
- Who should operate on patients with ovarian cancer? An evidence-based review, Kurt Christopher Giede, Katharina Kieser, Jason Dodge and and Barry Rosen University of Toronto, Canada Received 5 June 2005. Gynecologic Oncology, Volume 99, Issue 2, November 2005, Pages 447-461
- "Who Usually Delivers Whom and Where" Report on Models of Antenatal Care, Perinatal Data Collection Unit, Victoria Government, 1999
- Women Health Council Submission
- Women's Health Council, 2004a
- www.comh-n-osp.ie/pdf/maternity.pdf
- www.coombe.ie/intro/repintro.html
- www.cso.ie
- www.dh.gov.uk
- www.dohc.ie/publications
- www.dohc.ie/publications Report of the Expert Working Group on….
- www.dohc.ie/publications/CancerControlStrategy
- www.drfoster.co.uk
- www.erofound.eu/publications
- www.ghc.on.ca
- www.hse.ie/en/Publications New National Children's Health First
- www.hse.ie/en/Publications New National Children's Hospital Report
- www.kkh.com
- www.medicine.tcd.ie/public_health_primary_care/research/reports/finglas
- www.medicine.tcd.ie/public_health_primary_care/research/reports/irishtown
- www.medicine.tcd.ie/public_health_primary_care/research/reports/tallaght
- www.nehb.ie/nehb/publications/reports/Maternity.pdf
- www.nuh.nhs.uk
- www.patient.co.uk
- 80/155/EEC

Appendix J: Original terms of reference

Introduction

The Health Service Executive (HSE) acquired full operational responsibility for the management of the country's health and personal social services on 1 January 2005. The HSE is established as the first body charged with managing the health service as a single national entity.

Our mission is to *'enable people live healthier and more fulfilled lives'* by *'providing easy and equal access to high quality care and services that the public has confidence in and staff are proud to provide'*.

The HSE is the largest purchaser in the state spending in excess of €13 billion annually on a diverse range of goods, services and works projects.

The health services are managed by a number of national directorates/programmes. HSE Procurement is managing the award of the contract on behalf of the Health Service Executive.

Further general information about the HSE is available on the website www.hse.ie

Background & Context

Care surrounding pregnancy and childbirth takes place in circumstances that distinguish it from many other areas of clinical practice. Pregnancy is not an illness and maternity and gynaecology services are available to provide care and support for a predominantly healthy population through a normal health event. The majority of pregnancies end with a healthy mother and baby and without complication. A significant minority of women may be at risk of, or may develop, clinical problems during pregnancy or labour for which additional, more specialist help is required.

An Independent Review of Maternity and Gynaecology Care Services is now required to consider the best configuration of hospital, primary and community maternity and gynaecology services in the Greater Dublin Area that ensures consistency and choice of care to all groups of women.

The three Dublin maternity hospitals, The Rotunda Hospital, National Maternity Hospital and Coombe's Women's Hospital, provide obstetric, gynaecology and neonatology services. All three hospitals act as tertiary referral centres for women and babies in need of specialist treatment.

The three hospitals provide education and training on a national basis in collaboration with the universities and the Royal College of Surgeons. They carry out collaborative research with each other, with other hospitals and with universities and research bodies on a national and international basis.

Local models of maternity and gynaecology care services within Dublin and beyond have evolved in response to a combination of factors related to local circumstances and requirements, the advice of health professionals and both national and international guidance.

The work of obstetricians, midwives, GPs, practice nurses and public health nurses is fundamental to high quality maternity and gynaecology care.

The three Dublin Maternity Hospitals have guided and developed local/regional/national models of maternity and gynaecology care in co-operation with the relevant health authorities.

The voluntary governance and Mastership system has been in existence since the Dublin Maternity Hospitals inception extending 260 years ago. The system has served all three hospitals well and is considered an effective example of clinicians in management working and has proven to be highly effective in terms of both clinical and administrative governance. Each Master as Chief Executive together with his Management team is responsible to his respective Board for the day to day running of the hospital, strategic planning and the formulation of plans/initiatives to maintain and develop a quality driven service for women, babies their partners and families.

Approximately 40% of births nationally per annum take place in the three maternity hospitals in Dublin i.e.:

- Coombe Women's Hospital
- National Maternity Hospital
- The Rotunda Hospital

In addition to the three public maternity hospitals, a private maternity unit in Dublin is based in Mount Carmel Hospital, with delivery of approx 1400 babies per year (6% of births in the Greater Dublin Area).

The Health Services Executive acknowledge the partnership working performed to date with the Maternity Service Providers in working towards developing flexible models for maternity and gynaecology care services.

Neonatal Care Services

The neonatal period is considered the most vulnerable time for babies and is associated with the highest mortality rate. The development of neonatology services is closely liked with maternity services. Higher survival rate of premature babies and babies of low birth rate requiring complex care are placing higher demands on neonatal units. Technology has enabled premature babies to live from a much earlier age (24-26 weeks) and this increases the demand for neonatal care

The growing requirement for neonatal care is placing pressure on service delivery in neonatology and needs to be considered as part of this review.

Development of National Paediatric Hospital

The work of the Joint Task Group in advising on the optimum location of the paediatric hospital concluded that the location of the new national paediatric hospital on the Mater Misericordiae Hospital campus will have significant implications for the development of paediatric, adult and maternity services in Dublin and highlighted the need to begin a process of looking at how maternity services will be developed into the future. In particular the Task Group's analysis of the evidence led the Group to recommend that the site selected for the new national paediatric hospital to also accommodate a full Maternity Hospital.

Following on from the publication of the Joint Task Group Report, a Joint HSE/Department of Health & Children Transition Group has been established to carry out the preparatory work necessary to progress the establishment of the new National Paediatric Hospital. The group will also advance considerations on the tri-location of a Maternity Hospital with the new National Paediatric Hospital. The Transition Group is securing external expert support for certain aspects of its work.

Project Brief

The Health Service Executive wish to invite suitably qualified suppliers to submit a tender to carry out an independent review of the current provision of maternity and gynaecology care services in the Greater Dublin Area. The review will consider the best configuration of hospital, primary and community maternity and gynaecology services.

The consultancy will prepare an **independent report** for the HSE that is robust and that the consultancy will defend and stand over. The report will make recommendations and provide an action plan to facilitate the optimal configuration of primary, community and hospital services for the geographic area and population of the Greater Dublin Area, in making available safe, sustainable, cost effective and high quality maternity and gynaecology care services ensuring consistency of care to all groups of women.

The review will build on the comprehensive work that has already been undertaken whilst focusing on the need to provide effective evidence based care and value for money.

Major Deliverables

The major deliverable in support of the project objective is a detailed **report** that will include the following key components:

- Determine with reference to current National, European and international best practice the optimal configuration of primary, community and hospital services and workforce requirements for the geographic area and population of the Greater Dublin Area that will provide safe, sustainable, cost effective and high quality maternity and gynaecology care services. It must take account of existing and potential best practice models of care and the tertiary role of the Dublin maternity service providers

- Evaluate the benefits and risks associated with current provision of hospital and primary/community maternity and gynaecology care service provision in the Greater Dublin Area;

- Update/revise and evaluate the current capacity, usage and deployment of consultants, midwives, beds, neonatal care, theatres, outreach clinics, home care, emergency facilities, diagnostics, gynaecology and other services provided;
- Evaluate speciality strengths in current maternity and gynaecology service organisations & propose optimal speciality distribution e.g. foetal monitoring, prenatal care, gynaecology cancer;

- Assess the impact of additional emerging clinical trends and technologies;

- Identify the best way to ensure high standard training and educational (undergraduate/ postgraduate) models for the future needs of the health service as well as optimising the capacity for research;

- Advise on the optimal governance arrangements for maternity and gynaecology care services in Dublin.

- Consider the current public and private mix when making recommendations for future model configuration;

- Be cognisant of and make reference to the private sector's current & potential role in the delivery of maternity and gynaecology care services;

- Consider the current and potential contribution of primary & community services to enhancing choice. This includes reviewing the effectiveness and appropriateness of the current GP Mother & Infant Contract in the provision of maternity interdisciplinary primary, community and hospital care through integrated team working;

- Advise on the elements of current hospital maternity and gynaecology care service provision that would be more appropriately provided in other settings i.e. evidence on specific synergies with primary & community care & general acute hospital service providers;

- Take account of current and projected demographic trends and the infrastructure, workforce and capacity deficiencies of the Dublin Hospitals affecting maternity and gynaecology service planning, provision and delivery in the Greater Dublin Area;
- Consider the multinational dimension of maternity and gynaecology care services and the ensuing cultural /language challenges;

- Make recommendations to the HSE, on the all of the above aspects, including short, medium and long term recommendations on the future configuration of maternity and gynaecology care services that support and strengthen universal access; whilst at the same time, finding new ways of providing accessible and appropriate services for women, their partners and babies;

- Provide an Action Plan setting out the next steps to progress implementation of the recommendations.

Project Methodology:

In preparing the report for the Transition Group the consultancy will:

- Ensure that the report is informed by international best practice in the area of development of maternity and gynaecology care services and the Irish national model of paediatric care;

- Review the relevant national reports regarding the development of maternity services as a starting point;

- Consult with relevant stakeholders (e.g. Governing Boards of the three Dublin Maternity Hospitals, obstetricians/gynaecologists, midwives, neonatologists, anaesthetists, General Practitioners, Practice Nurses, Public Health Nurses, Service Users) under the aegis of the project group;

- Ensure that the document produced is informed by the DoHC & HSE maternity, and gynaecology care service provider work undertaken in this area to date;

- Incorporate the appropriate requirement to expand and accommodate future needs;

- Ensure that value for money and efficiency requirements are considered from both capital and revenue perspectives;

This exercise will take account of existing relevant national strategy and health policy documents - such as the Department of Health and Children's, "Quality and Fairness - A Health System for You", "The Primary Care Strategy", "The Health Service Executive Corporate Plan" and Population Health Model of Care.

As stated in Major Deliverables Section, the review will take account of and build on the extensive work already undertaken and relevant to the development of maternity services. The publications are included in Appendix 1.

International Best Practice

The consultancy will need to base the report on international best practice and an understanding of latest thinking and current trends in relation to maternity and gynaecology care services and the application of this to the proposed service configuration for Dublin services.

It is essential that the information provided in the report is backed up with evidence of international appropriate best practice and that the conclusions and recommendations are fully supported by such references.

In submitting tender documents, consultancies must clearly outline to the HSE the range and scope of international expertise that they plan to utilise in meeting the project objectives. In addition, the consultancies will need to identify to the HSE international clinical leaders in obstetric, neonatal, gynaecology and midwifery practice who will be deployed in this project.