#HSEConference2026

Integrated Healthcare Conference

Delivering Integrated Care Together

Clinical Leadership and Governance in Delivering Patient Care

Liffey B, Convention Centre Dublin

3 September, 14:20 – 15:45

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Welcome and Introduction

Dr Colm Henry
Chief Clinical Officer

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Urology Modernised Care Pathways

Eamonn Rogers
Co-Lead, National Clinical Programme in Surgery

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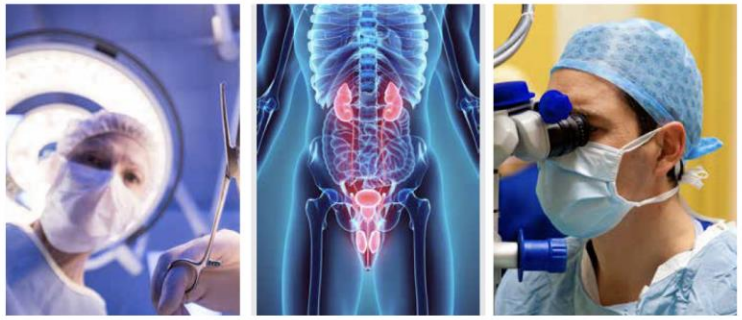
Model of Care in Urology

RCSI SURGICAL AFFAIRS

NCPS NATIONAL CLINICAL PROGRAMME IN SURGERY



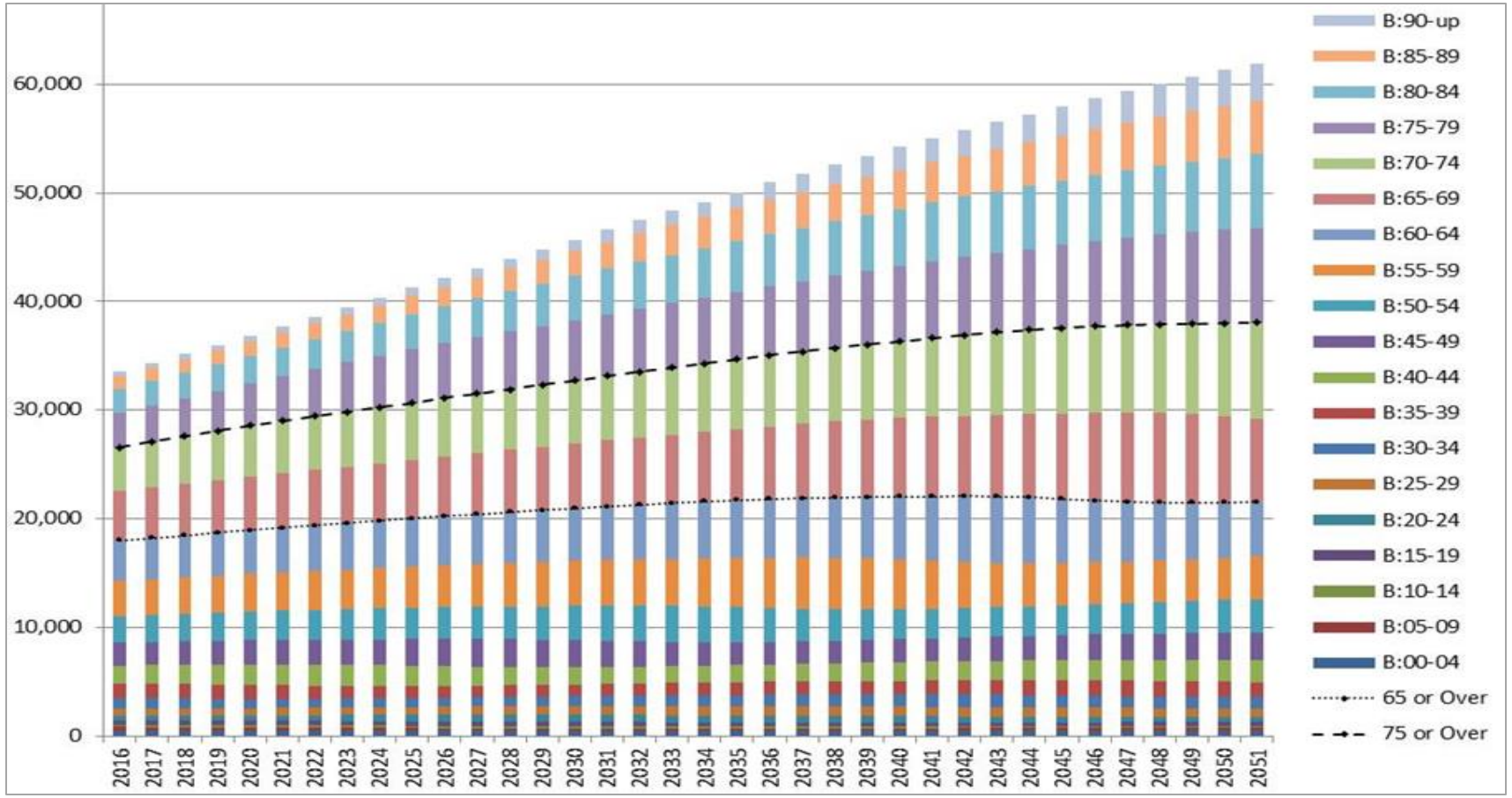
Urology
A model of care for Ireland

Sláintecare.
Right Care. Right Place. Right Time.

Rialtas na hÉireann
Government of Ireland

Demographics

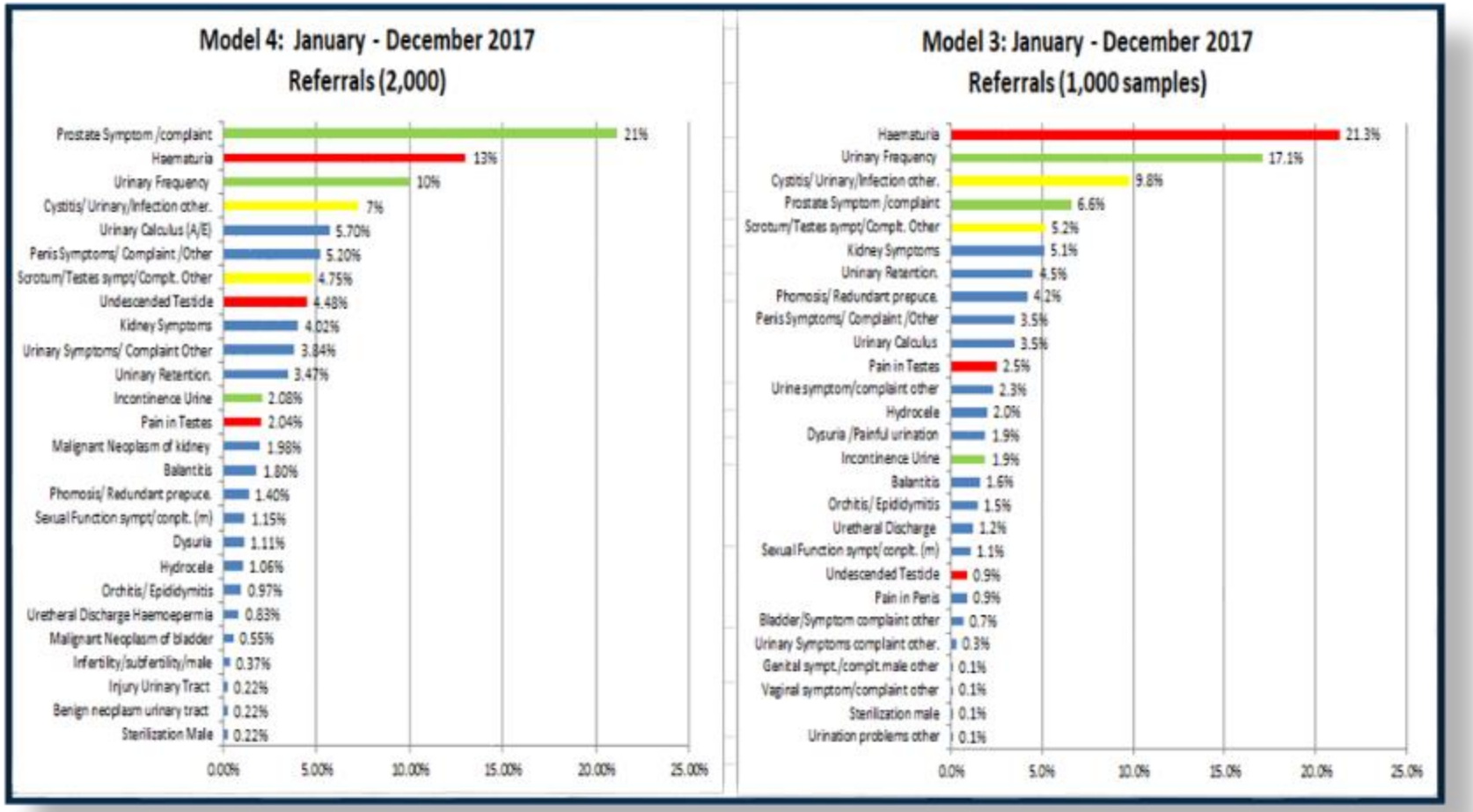
Combined	2016	2021	2026	2031	2036	2041	2046	2051
Discharges	33477	37703	42132	46573	50918	54997	58685	61888



Central statistics office(CSO) projections for urology elective, emergency and day case patients

Evidence

Prevalence of Urology Outpatient Symptoms



Clinical Review (Vetting) of the Waiting List

Assign a **"treatment outcome" plan** to each patient referral/condition indicating:

a) Patient referred for appropriate diagnostics e.g. ultrasound and then seen in **“one stop clinic”**
b) Patient referred to same day **"see and treat"**
c) Patient referred to **Advanced Nurse Practitioner (ANP) / Clinical Nurse Specialist / Continence Advisor**
d) Patient care plan to continue in Primary Care: **Shared Care initiative**
e) Patient referred to Outpatient consultation
f) Location: Model 2-3 Hospitals/Community

Access to the Urology Haematuria Pathway

• 3+ separate visits to the Acute Hospital OP Urology service

Current

Patient journey without the pathway

GP → Urology OP Appointment with Consultant → Radiology → Endoscopy → Diagnostic results +/- further treatment

Person develops haematuria

Modernised Care Pathway

Care Pathway from GP to rapid access service

GP → Rapid Access Haematuria Service

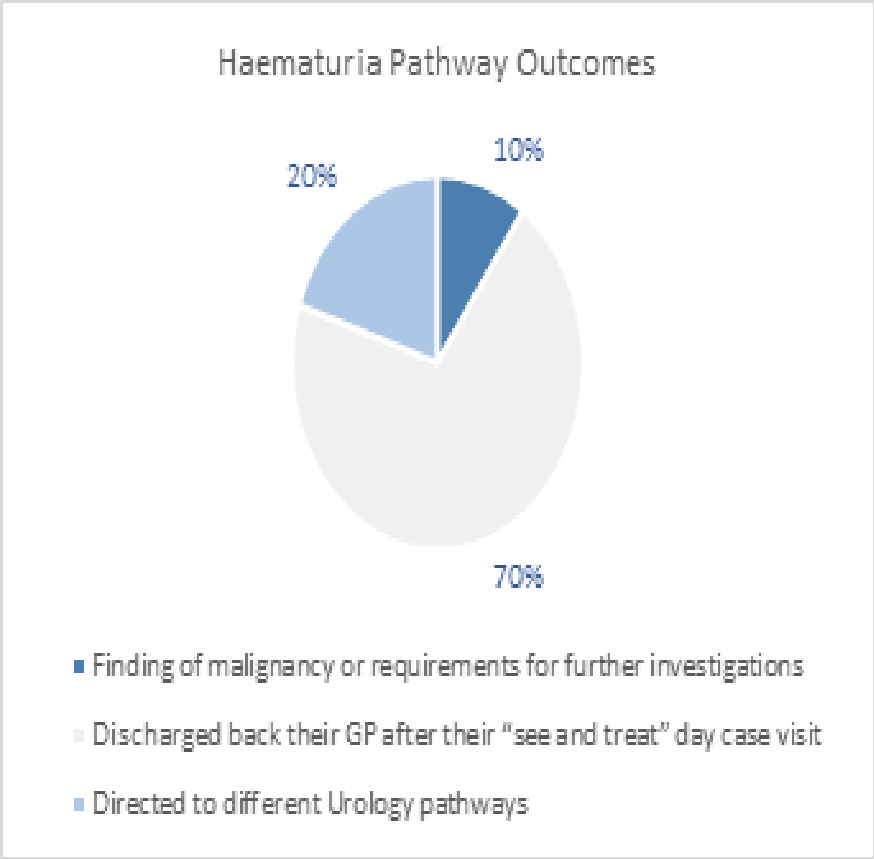
- ANP and consultant- led service,
- One-stop access to urology MDT
- Rapid access haematuria diagnostics
- Rapid commencement of appropriate treatment

→ Assessment and care planning with Urology multidisciplinary team

1 Visit to RAHS in majority of cases

70% Visited just once saving 3 other visits

Haematuria: See and Treat Model



- HAEMATURIA PATHWAY IMPLEMENTATION IN SAOLTA (OUTCOMES DATA, DECEMBER 2019)
- All consultants are referring Haematuria (Band 1, and some Band 2) patients to Roscommon University Hospital.
- 672 Haematuria referrals referred to Roscommon Hospital (Model 2) for “see & treat” service.
- 419 patients treated through the Haematuria pathway “see & treat” service in Roscommon Hospital.
- These patients had no requirement to attend an outpatient appointment and were directed to “see and treat” day case in the first instance.
- Average wait time from triage to attendance of 25 days which is within the clinically recommended wait time of 28 days.
- 70% of 419 patients (293) visited once saving 3 other visits per person = 879 visits saved

Cost Benefit of Clinical Validation in Saolta

- **Saved 827 (18%) OP appointments-** by triaging direct to daycase/RUH/Paeds **potential cost saving of €99,240 (assuming €120 per OP appoint.)**

Access to the LUTS Care Pathway

Access to the LUTS Care Pathway

Current

Patient journey without the pathway

GP

- Current max wait time of XX

Urology OP Appointment with Consultant Urologist

Challenges

- Significant wait times due to low priority of many LUTS referrals
- Delayed treatment due to absence of streaming of referrals
- Significant impact on patients' quality of life, with significant discomfort and often withdrawal from social activities

Integrated

The Health service user develops a urological issue

Care Pathway from GP to Integrated urology service

GP

Immediate commencement of care

Moderate patients who do not respond to GP led conservative management (6 week wait time)

ANP-Led Urology Clinic

- ANP will assess and organise same day diagnostics
- AND Consultant advice available virtually
- Pts with severe symptoms will be seen by consultant

Severe

Urology OP Appointment with consultant urologist

Severe

> 28 days commencement of care

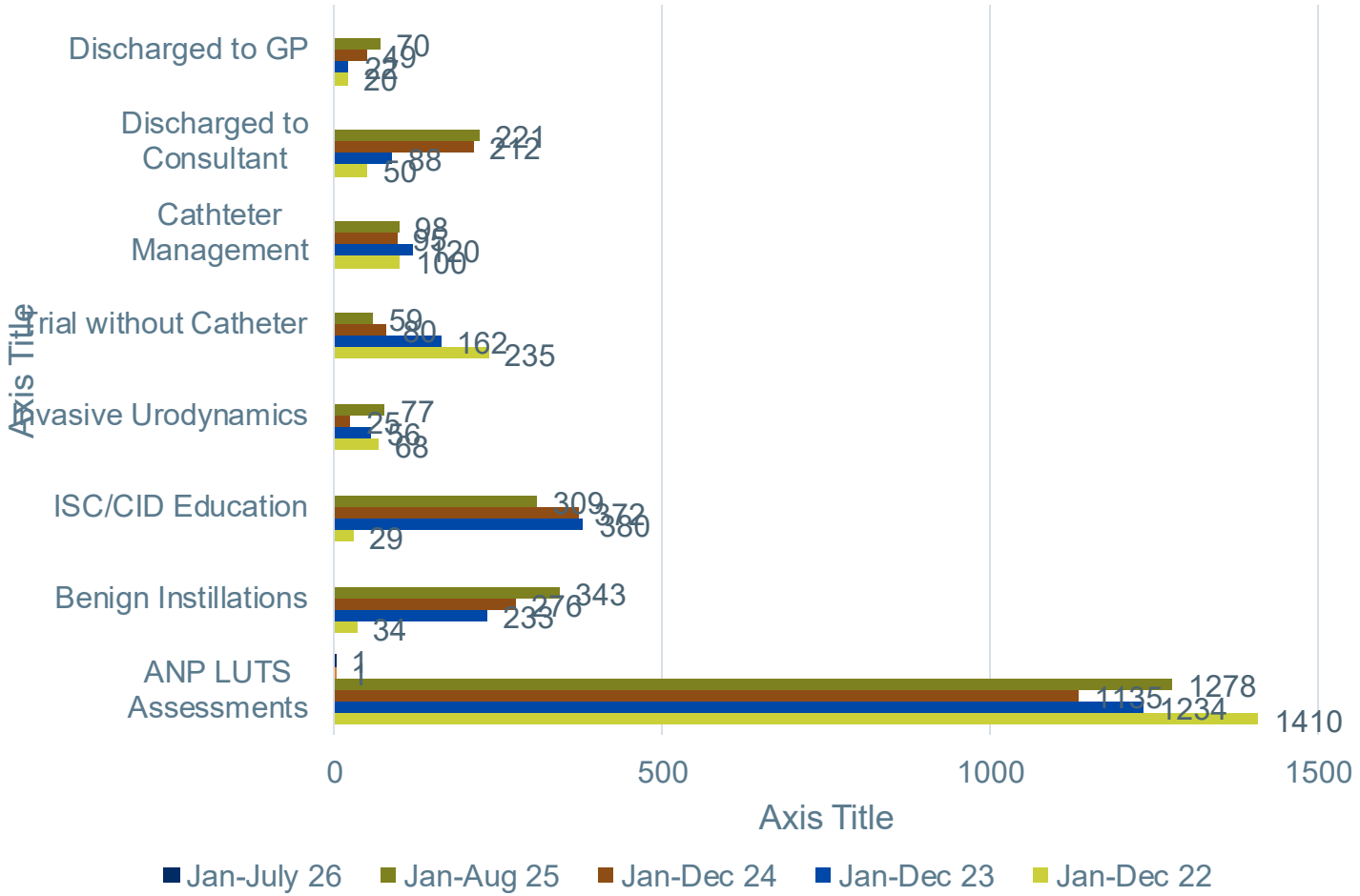
Benefits

- Management closer to home with timely access
- GPs are supported and enabled to manage patients with mild and moderate symptoms
- Significant improvements to quality of life
- Evidence provided in Urology Model of care evidence shows a reduction of 17-20% of outpatient visits where LUTs pathway has been implemented

LUTS and Incontinence Assessments

- Focused Urological/LUTS assessment- frequency, Reduced urinary stream, urgency, Nocturia, urinary incontinence etc.
- Pharmacological review(Prescribed, Over the counter, herbal)
- Allergies/Sensitivities
- Bladder diary
- PROMS: IPSS questionnaire, ICIQ-OAB, ICIQ-MLUTS, ICIQ-FLUTS
- Non-invasive Urodynamics(Flow Study) plus post void residual
- Bloods-SMAC & PSA
- Examination: DRE, Abdominal exam, CNS
- Fluid management-Bladder irritants, Bladder friendly fluids
- Social/Lifestyle circumstances-weight/smoking/alcohol/occupation
- Family history
- Further investigations: Flexi cysto, Invasive urodynamics, radiological imaging

LUTS and Incontinence Assessments



Economic Burden of Incontinence

- Across all EU countries, the estimated economic burden of UI was €69.1 billion in 2023.

- The economic analysis presented in this report estimates the economic burden of UI could increase by 25% if no action is taken, to €86.7 billion in 2030, as patients live longer.

Burden of Incontinence

- Physical
- Psychological
- Environmental
- Social
- Financial

Access to the Urology Continence Care Pathway

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Current

- 2+ separate visits to the Acute Hospital OP with Gynae/Urology
- Significant Gynae/ Urology wait times due to low clinical priority of continence issues

Patient journey without the pathway

GP

Urology/ Gynaecology OP Appointment with Consultant

Follow up appointment +/- diagnostics and inpatient stays

The Health service user develops a urological issue

Challenges

- Significant impact on patients quality of life
- Generate a significant spend on continence wear
- High ED attendance rate for elderly population due to complications arising from serious continence issues
- For women there is an emphasis on surgical management rather than rehabilitation
- Significant waitlist generated due to low priority of continence issues

Integrated

Care Pathway from GP to Integrated continence service

GP

Integrated Community Continence Service

- CNS and physio led service, fast support/ access to gynae/urology MDT as required
- Nurse advisor clinic
- Virtual advice
- See, treat and refer if appropriate

Urology OP Appointment with consultant urologist

It is estimated that 10%-15% of patients on Urology waiting lists present with continence concerns.
The majority of these can be managed conservatively in the community

Benefits

- Significant improvements to quality of life for a range of patient groups including women post childbirth, persons with disabilities and older persons
- A reduction in the use of continence wear and the associated efficiencies
- Management close to home with access in a timely manner
- Community based acute supported multidisciplinary model of service delivery
- Reduction in urology/ gynae wait lists

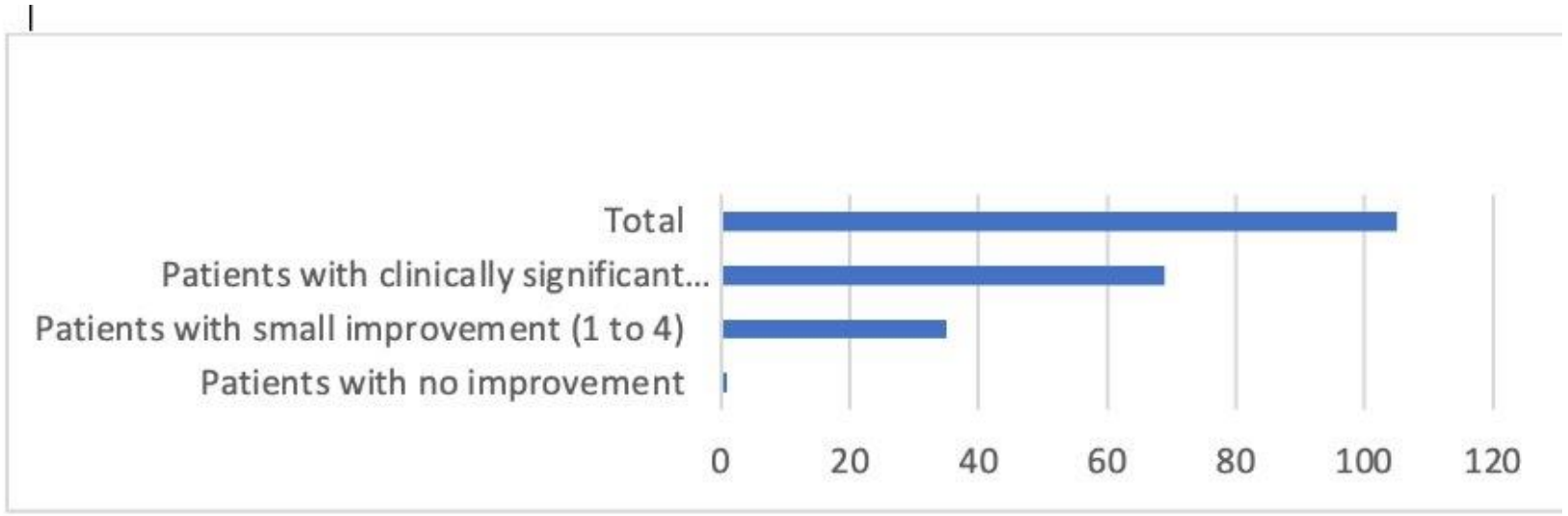
Urology Continence Pathway Activity

Year	Total Removals	Total New (not removals)	Total New (Removed and Not)	Total Review	Total Activity (Total new removed and not +Total review)
2024	406	906	1312	3961	5273
2025	705	1555	2260	9519	11,779
2026 Jan-July incl.	379	1050	1429	5391	6820

ICCSC Patient ICIQ scores - Sligo

January 2025 - present

Patients with no improvement	**1**
Patients with small improvement (1 to 4)	35
Patients with clinically significant improvement (5 and above)	69
Total	105



Patient Feedback

empowered to return to intermittent catherisation

cope with my condition

excellent at putting me at ease in a situation I would normally be very stressed in

encouraged me to understand my own health

more confidence about managing my problem

empathy

was understanding to my needs and informative when I asked questions and also to my wife who was with me for my treatments

Very professional and prompt to consult with further treatment options. Overall, each visit was equally as professional and efficient

I am autistic and find it hard to understand things at times so told my nurse Geraldine who made sure I understood everything from start to finish

Very professional and prompt to consult with further treatment options. Overall, each visit

Patient Feedback

- ***'I feel I have my life back, I can walk 10km without any issue'***
- ***'I finally felt I had been heard'***
- ***'I never thought I could travel again without anxiety, now I can plan trips'***

Reduction of Waiting Times

Modernised Care Pathway significantly reducing wait times for Urology Patients

Posted: December 5, 2024

Using Population Health Data to Inform Service Planning and Meet Changing Population Needs:

The National Maternity Population Health Profile

A joint initiative between National Health Service Improvement, Public Health and the National Women and Infants Health Programme

Dr Ellen Cosgrave

Consultant in Public Health Medicine,
Health Service Improvement

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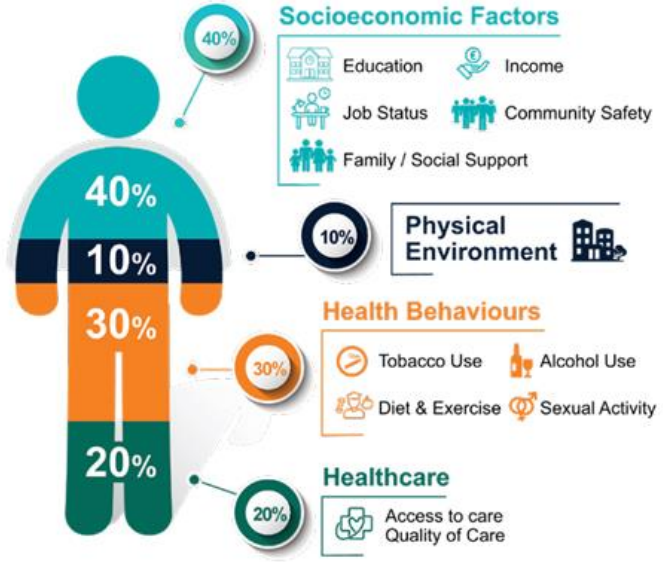
Presentation Overview

- **Population Based Planning and Integrated Care**
- **Overview of the National Maternity Population Health Profile**
- **Profile Impact and Implications**

Why Population Health Matters

- Ireland's population is changing
  - Population ageing
  - Demographic diversity
- Rising chronic disease and service pressures
- Wider determinants shape health
- Persistent socioeconomic and health inequalities
- **Health service planning needs to understand population need and inequalities**



Source: Health Service Executive (2025). *Public Health Strategy 2025-2030.*

Population Health and Integrated Care

"An integrated care system puts the person at the centre of system design and delivery… It also **ensures population health intelligence is a key determinant of design and decision-making**."

Source: Houses of the Oireachtas Committee on the Future of Healthcare (2017). *Sláintecare Report*.

Planning Services Based on Population Needs

Population Based Planning (PBP): A Population Based Approach to Service Planning

"PBP enables decision-makers at different levels to make **decisions that are equitable and orientated to the needs of the population**."

PBP Decision Support Hub: Approach to Health Profiles

Sources: Government of Ireland (2023). *Organisational Reform: HSE Health Regions Implementation Plan*; Health Service Executive (2025). *HSE Corporate Plan 2025-2027;* Health Service Executive, Population Based Planning Programme (2025). *A Strategic Framework for Population Based Planning within Health Regions in Ireland*, V1.0; Health Service Executive, Population Based Planning Programme (2026). *Internal SharePoint Resource*.

Population Based Planning for Maternity Services

CHANGING CONTEXT

Maternity services are facing increasing complexity and demand

Since the 2016 National Maternity Strategy, services have reported increasing clinical complexity and growing service pressures, despite a decline in births.

EVIDENCE GAP

A national picture of changing population need was missing

There was a need for a national evidence base describing who is using maternity services, how the population is changing, and what this means for future need.

PLANNING RESPONSE

The National Maternity Population Health Profile was developed to address this gap

National Health Service Improvement, Public Health, and the National Women and Infants Health Programme worked together to develop Ireland's first national maternity population health profile.

PURPOSE

The aim is to support better planning

The profile applies a population health approach to identify changing needs, support equitable and evidence informed service planning, and inform the next maternity strategy.

Source: Department of Health (2016), *National Maternity Strategy 2016-2026.*

How We Developed the National Maternity Profile

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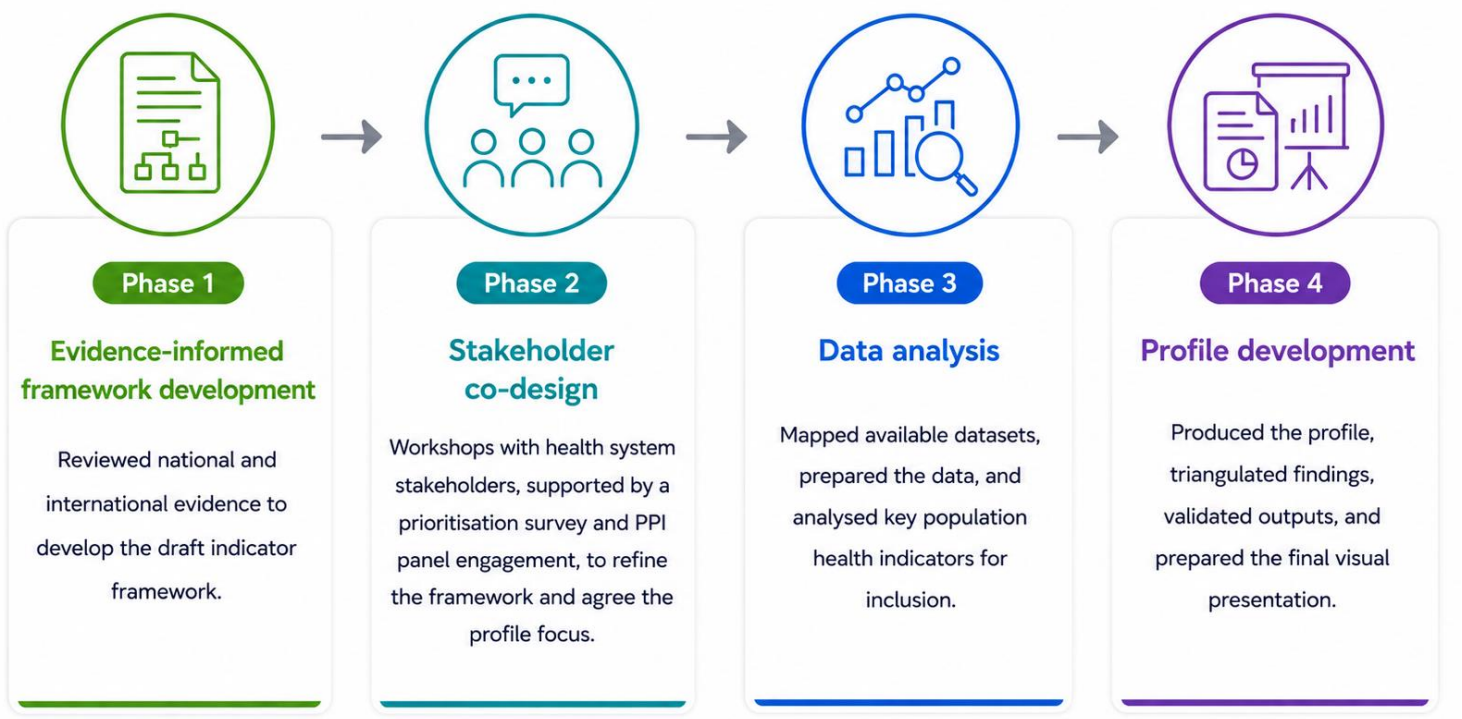
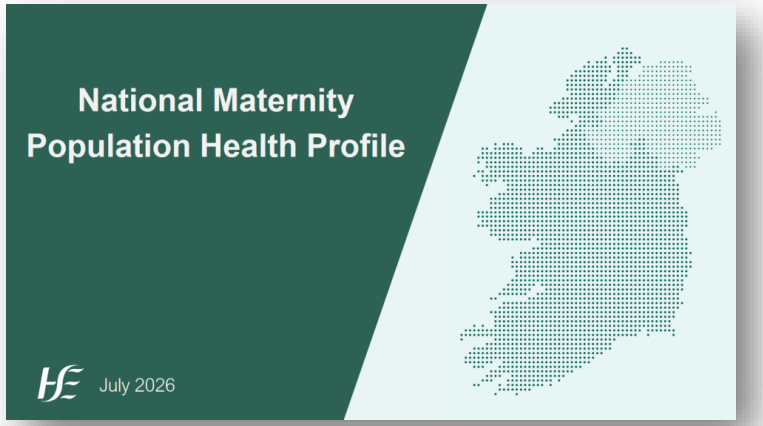
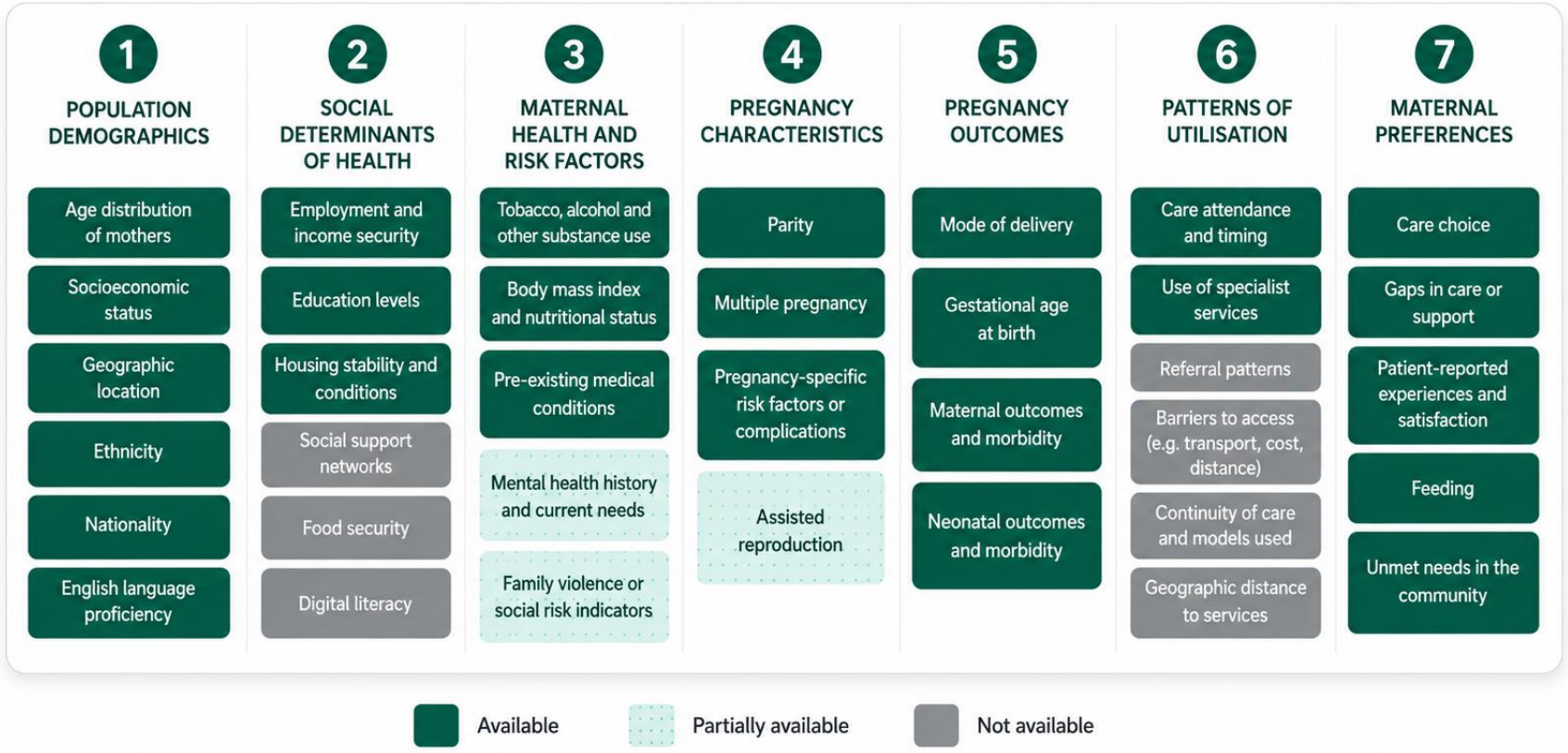




Population Health Indicator Framework



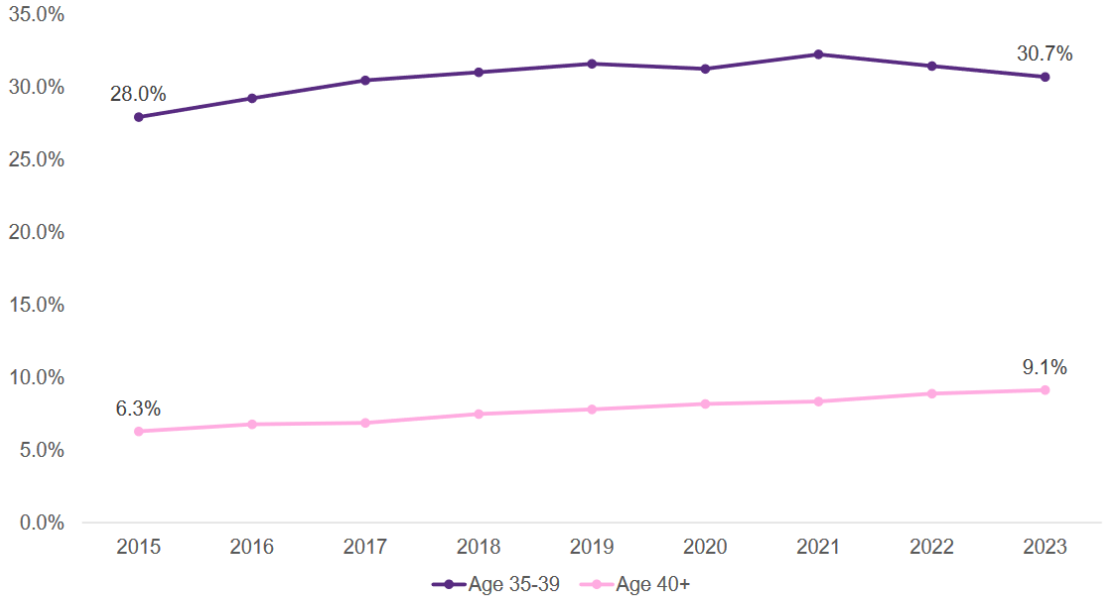
Measuring what Matters

- Co-designed with service providers and women
- 7 domains
- 84 population health indicators
- Multiple national datasets
- Data spans 2014-2025

Key Profile Finding 1:

The Maternity Population is Changing

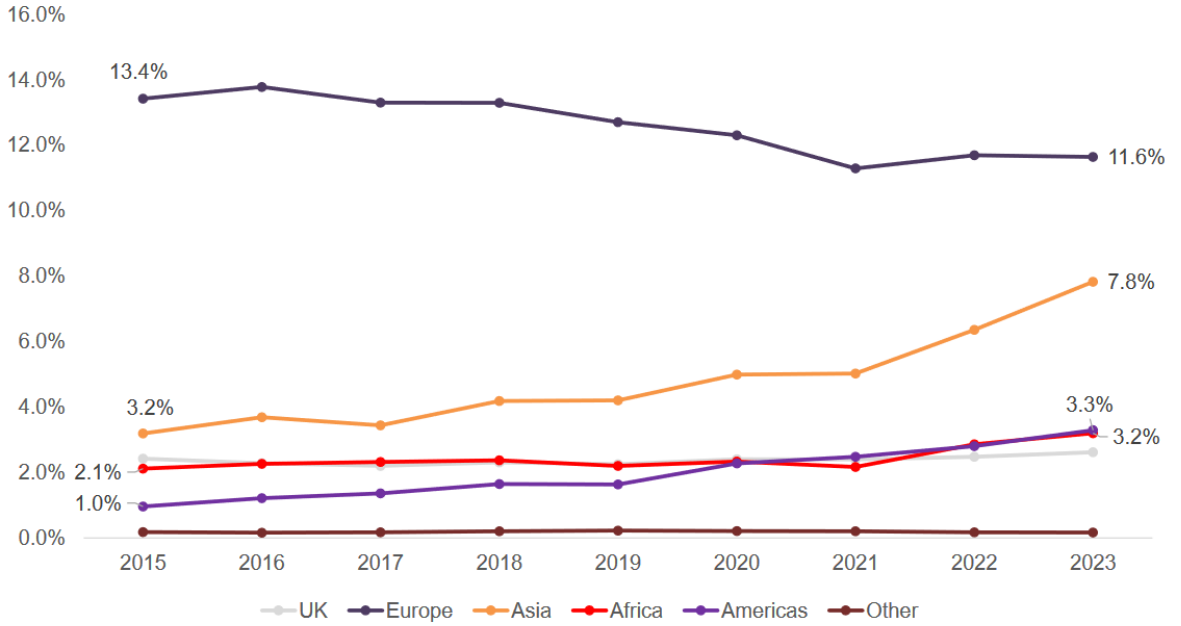
Pregnancies in Women Aged 35 Years and Over



Measure 1: Percentage of maternities to women aged 35-39 years, by calendar year
Measure 2: Percentage of maternities to women aged 40 years and over, by calendar year

Source: National Perinatal Reporting System (NPRS), N=530744

Nationality - Country of Birth



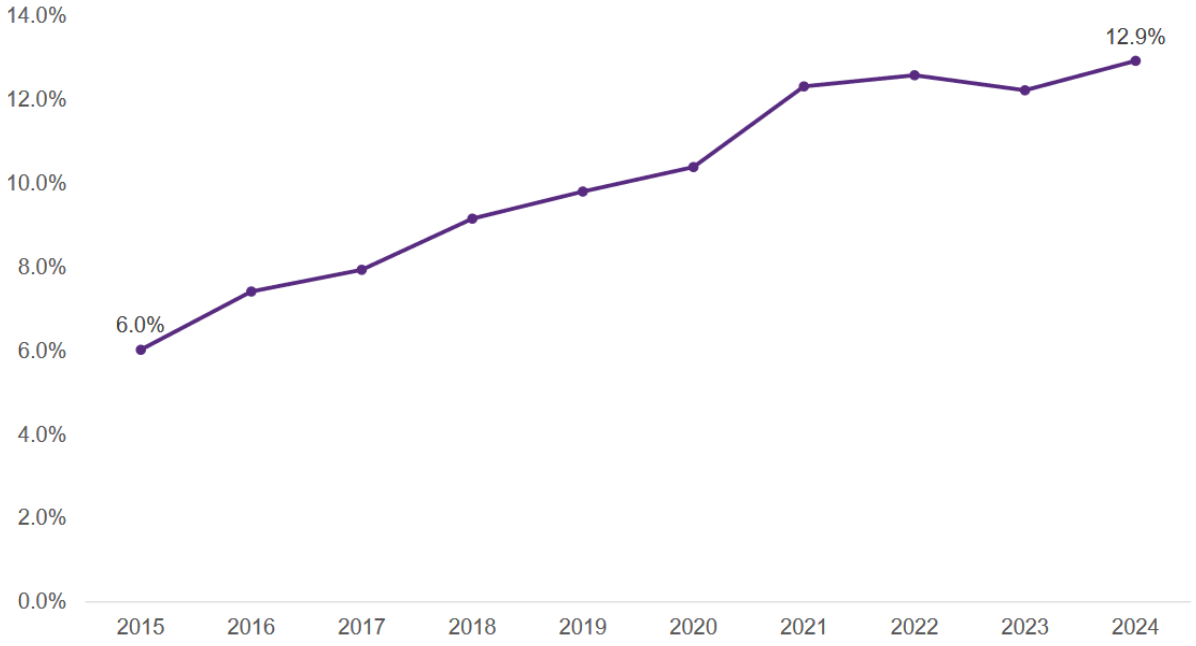
Measure: Percentage distribution of maternities by maternal country of birth, by calendar year

Source: National Perinatal Reporting System (NPRS), N=527856

Key Profile Finding 2:

Clinical Complexity is Increasing, Care Demand is Shifting

Gestational Diabetes



Measure: Percentage of delivery discharge episodes with a diagnosis of gestational diabetes, by calendar year

Source: Hospital Inpatient Enquiry System (HIPE), N=577445 (delivery episodes only)

Admission Type

Measure: Percentage distribution of types of maternity admissions, by calendar year

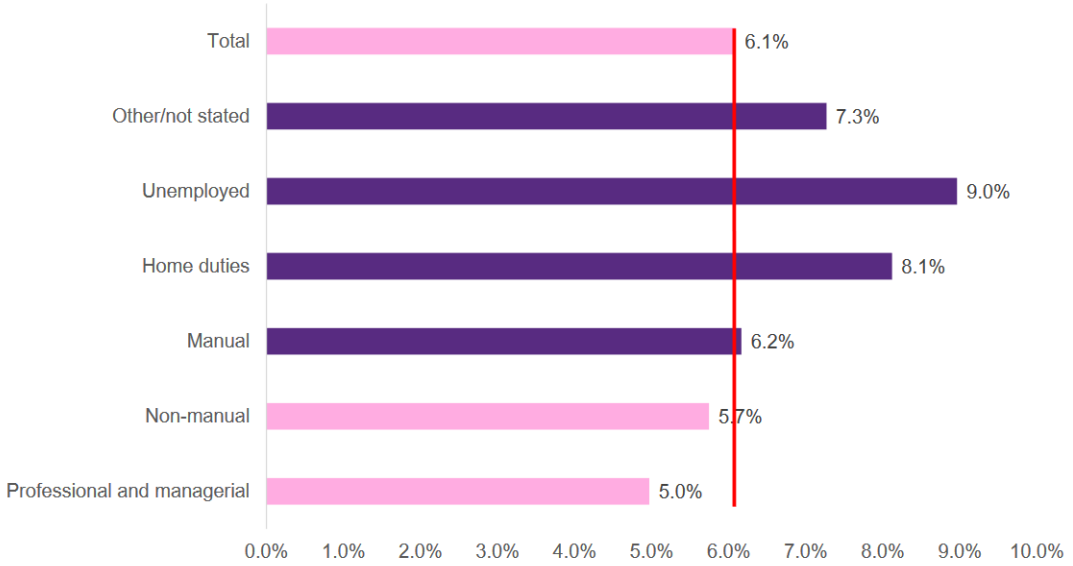
Source: Hospital Inpatient Enquiry System (HIPE), N=1282922

Key Profile Finding 3:

Outcomes are Not Evenly Distributed Across the Population

INDICATOR	DIFFERENCES OBSERVED
Preterm Birth	Higher among **younger** and **older** women, women born **outside Ireland** and women from **lower socioeconomic groups**
Perinatal Mortality	Higher among **younger** and **older** women, women born **outside Ireland** and women from **lower socioeconomic groups**
Low Birth Weight	Higher among **younger** and **older** women, women born **outside Ireland** and women from **lower socioeconomic groups**
Unbooked Pregnancy	More common among women born **outside Ireland**
Maternal ICU Admission	More common among women **aged ≥40 years**

Low Birth Weight by Occupation

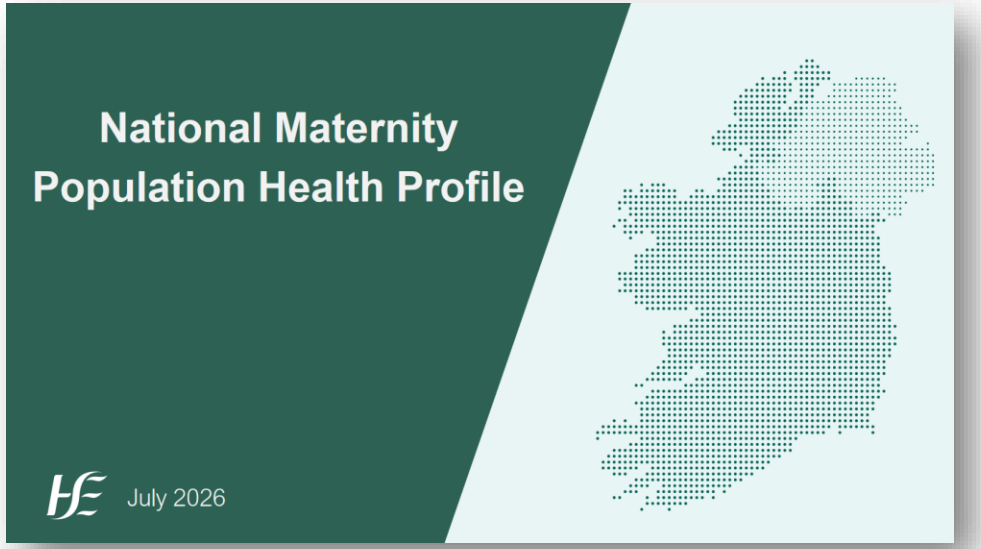


Measure: Percentage of births with low birth weight, by maternal occupation (2015-2023)

Source: National Perinatal Reporting System (NPRS), N=540780, $p < 0.001$

Impact of the National Maternity Profile

- Brought together demographic, health, and service data to build a **national picture of maternity population health**
- Created a **shared understanding of changing population needs**, differences in outcomes, service pressures, data gaps and **priorities for improvement**
- **Enabled performance data to be put into context**
- **Strengthened partnerships** between Public Health and the National Women and Infants Health Programme
- **Findings translated into action and are informing:**
  1. **National Service Plan** 2027
  2. Successor **National Maternity Strategy**



Lessons for Other Services Across Health Regions

The **Maternity Profile demonstrates an approach to population health profiling at national level**. Similar approaches have been applied within other specialties and at regional level, **using the level of geographic detail required for the decisions being made**.

1 Start with the decisions the profile needs to inform

Define the purpose, audience, decision pathways and entry points.

Link to planning cycles from the outset.

2 Co-design the indicator framework

Involve clinicians, planners, public health, service users and other partners in deciding what matters.

3 Look beyond activity to population need

Consider need, wider determinants, access, outcomes and care preferences.

4 Create a shared evidence base across services

Build shared understanding of population need and priorities across services.

5 Make variation and equity visible

Identify variation in need, access and outcomes, and put performance data in context.

6 Design the profile for action

Combine profile findings with community and service insight to inform decision-making and improvement.

How Population Based Planning Supports Clinical Leadership

The Maternity Profile provided a starting point for Population Based Planning in maternity services. Its value was realised when it was used to inform priorities and decision-making. **Clinical leadership is essential to translate profile data into action for service improvement.**

01

Enables leaders to understand how population needs are changing.

02

Highlights variation in outcomes, unmet need and service gaps and where improvement is most needed.

03

Provides population context to interpret system performance data.

04

Supports transparent and equitable decisions informed by need and inequalities.

05

Informs workforce, capacity and care models based on need and complexity rather than activity alone.

06

Supports more anticipatory, integrated and equitable care.

Potential Impact of Population Based Approaches to Support Integrated Care and Improve Outcomes

Benefits of Population Based Planning Approach

- **Uses data to align services and resources with need**, unmet need and inequalities
- **Considers wider determinants** of health and opportunities for **prevention**
- Incorporates **community voice**
- Creates **shared understanding of need**, supporting joint planning and integrated care

International Examples of Impact

The Netherlands

- Regional health profiles *(regiobeeld)* embedded within the Dutch approach to regional planning, informing cross-sectoral regional plans *(regioplan)*.
- **Impact:** Population health data informs regional plans, driving cross-sector collaboration to address local health priorities.

Jönköping Region, Sweden

- Population data used to inform planning, alongside coordinated care approaches across organisations, bringing health and social care together around what matters to the person.
- **Impact:** Fewer hospital admissions and readmissions, shorter rehabilitation stays and improved patient experience were observed.

Sources: Government of the Netherlands (2022). *Integraal Zorgakkoord*; RIVM (2026). *Regional health at a glance: A regional information platform for integrated health care reform in the Netherlands*. Alderwick (2015). *Population Health Systems: Going Beyond Integrated Care*; Gray (2016). *Sweden's Esther Model, Commonwealth Fund*.

Conclusion: Planning Around Population Need

Population Based Planning designs services around the needs of populations. Integrated care designs care around the needs of individuals. **Improving population health and reducing health inequalities requires both approaches working together within one system.**

Acknowledgements

Core Team	Jennifer Martin, Davinia O'Donnell, Kilian McGrane, Cliona Murphy
Contributors	Aparna Keegan, Mary Browne, Stephen Barrett, Siobhan Reynolds, Irene Gorman, Emma Kearney, Julianne Harte, Angela Dunne, Aideen Quigley, Leán McMahon, Ríona Cotter, Claire Plunkett
Data Provision and Support	Teams in the Healthcare Pricing Office (HPO), the Central Statistics Office (CSO), the National Maternity Experience Programme (NMES), Health Information and Quality Authority (HIQA) and The Coombe Hospital for data provision and support, in particular Sinéad O'Hara, Izabela Sikora and Karen Kearns (HPO), Bernie Casey, Sheelagh Bonham and Tomás Kelly (CSO), Conor Foley (NMES), Amy O'Higgins (The Coombe Hospital), and colleagues in the National Perinatal Epidemiology Centre (NPEC)
Stakeholder Engagement	Participants and facilitators of the stakeholder engagement workshops and members of the National Women and Infants Health Programme Public and Patient Involvement Panel for their insights and perspectives which helped shape the final profile

The Role of the Clinical Director

Prof. Pat Nash

Regional Clinical Director and Consultant Cardiologist,
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The Role of the Clinical Director

Effective Clinical Leadership – Cornerstone of Safe, high-quality healthcare

- Clinical Director - Medical lead – part of a wider Clinical Leadership Team
  - bridges the gap between frontline clinical practice and organisational decision-making.

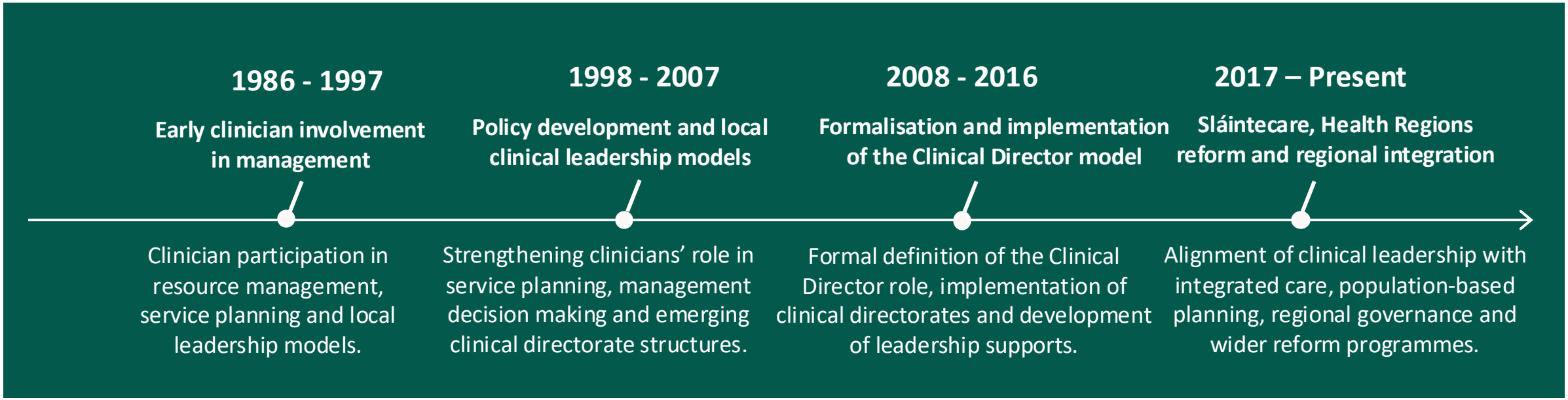
Combines:

- Professional Clinical Credibility
- Managerial Accountability

Responsible:

- Leadership, management, quality and strategic development of a defined clinical service, directorate, hospital, region…..

Historical Overview



HIQA CHI HSE Recommendations

Recommendation 5-HSE:

As part of the HSE current reform of clinical governance arrangements in the establishment of the new Regional Health Areas, the HSE should review the effectiveness of the clinical directorate model, with a focus on the role of the clinical director to ensure that:

The role is assigned the appropriate level of responsibility and accountability to enable the clinical director to drive high quality, safe and effective care
The role is assigned the appropriate level of authority to effect required change, in particular when things go wrong

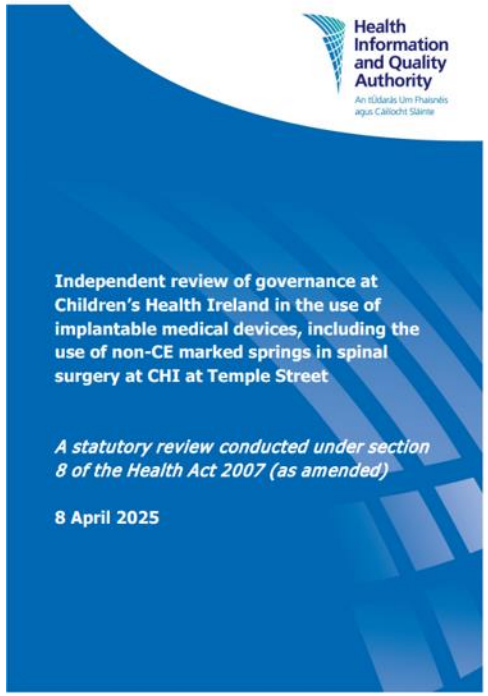
The scope of the role is clearly defined with clear and realistic responsibilities, in particular when services span across multiple hospital sites.

There is clear guidance and supports in place for clinical directors to carry out their day-to-day functions including performance review, supervisory support and management as well as, business and administrative support functions enabling access to and use of information.

Arrangements to facilitate close working with other senior executives and the wider hospital consultant body should form a key focus for ongoing enhancement of the role.

Such a role should take on board the learnings from this report and have regard to international best practice.

Recommendation 6-HSE:
The HSE much recognise, develop and formalise the role of clinical speciality leads so that each position holder has both clarity in what is expected of them in fulfilling the position and formal authority for leadership within each speciality, supporting and reporting to the Clinical Director.



Our Approach

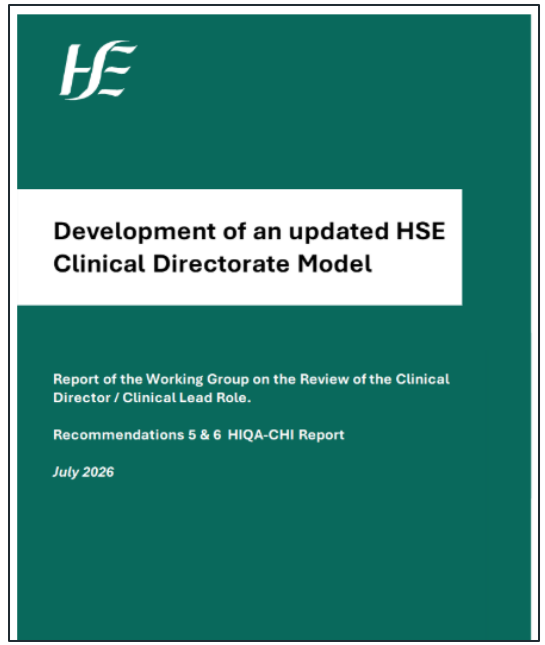
Establish a National Working Group

Review Current State

Examine international best practice

Engage key stakeholders

Co-design future model



Current Clinical Directorate Models

- Well established across Ireland
  - Significant variation exists in leadership structures, authority, resources and governance arrangements.
  - Resulting in a **lack of national consistency**.
- Recruitment and retention are affected by unclear role expectations, limited support, leadership burden and concerns regarding indemnity for executive clinical decisions.

Variance in Titles and Roles

- Regional Clinical Directors
- Executive Medical Directors in Model Four voluntary hospitals
- Executive Clinical Directors in Mental Health Services
- Clinical Directors
- Associate Clinical Directors
- Clinical Department or Speciality Leads

Current Clinical Directors

Clinical Leadership Role	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
RCD	1	2	1	1	1	1
CD (acute services)	28	22	10	21	8	7
Associate CD	9	0	0	0	3	25
CD (Mental Health)	8	7	8	8	2	4
Executive CD (Mental Health)	3	2	2	2	1	4
Total CDs	**49**	**33**	**21**	**32**	**15**	**41**

July 2025

National Clinical Director Survey

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KEY FINDINGS

50% Rate the current model as having **average** effectiveness.

40% Reported **authority** to implement agreed changes.

17% Reported access to **timely and relevant performance data.**

12% Reported influence over **funding/resource allocation.**

WHERE CLINICAL DIRECTORS ARE STRONGEST VS. WHERE THEY ARE CONSTRAINED

STRONGEST AREAS

83% Influence over quality and patient safety initiatives

80% Involved in service planning

58% Involved in workforce planning

KEY CONSTRAINTS IDENTIFIED

- Variable authority
- Inconsistent access to information
- Limited influence over resources
- Inadequate organisational support

SURVEY PROFILE

60 respondents

29% response rate

68% worked in Model 3 or Model 4 acute hospitals

Governance - “Why would you do that job?”

“All the Responsibility without the Authority”

Responsibility

- What is expected of you – what is yours to do/manage?

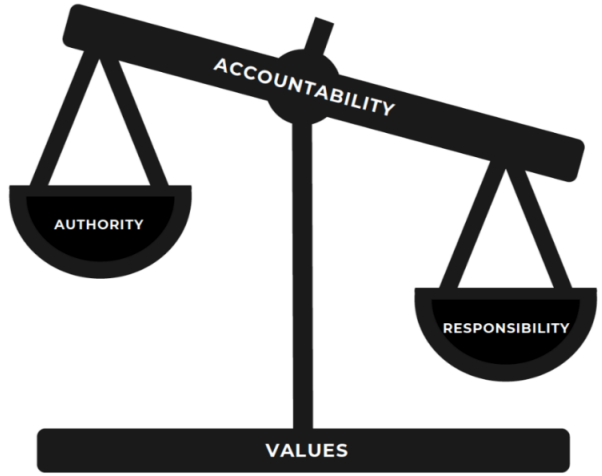
Accountability

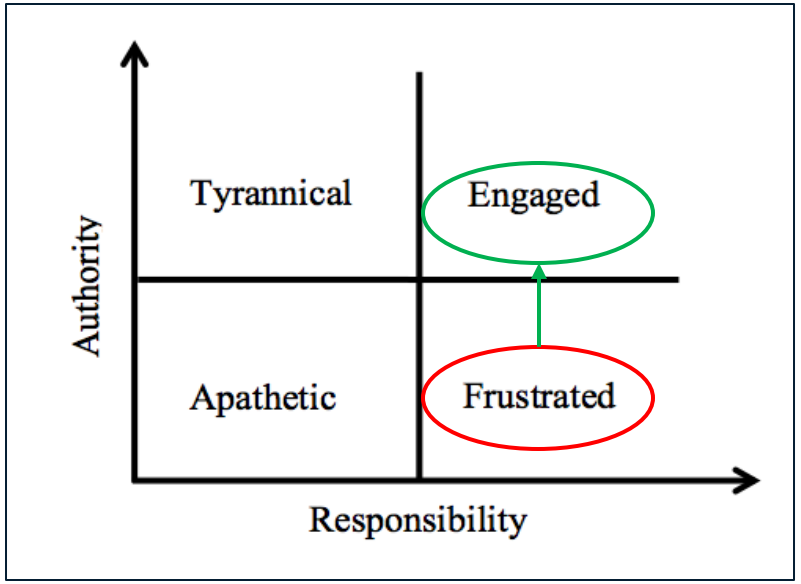
- What you are expected to answer for?

Authority

- Delegated power to decide and act

Delegated authority is essential if one is to be accountable for their areas of responsibility

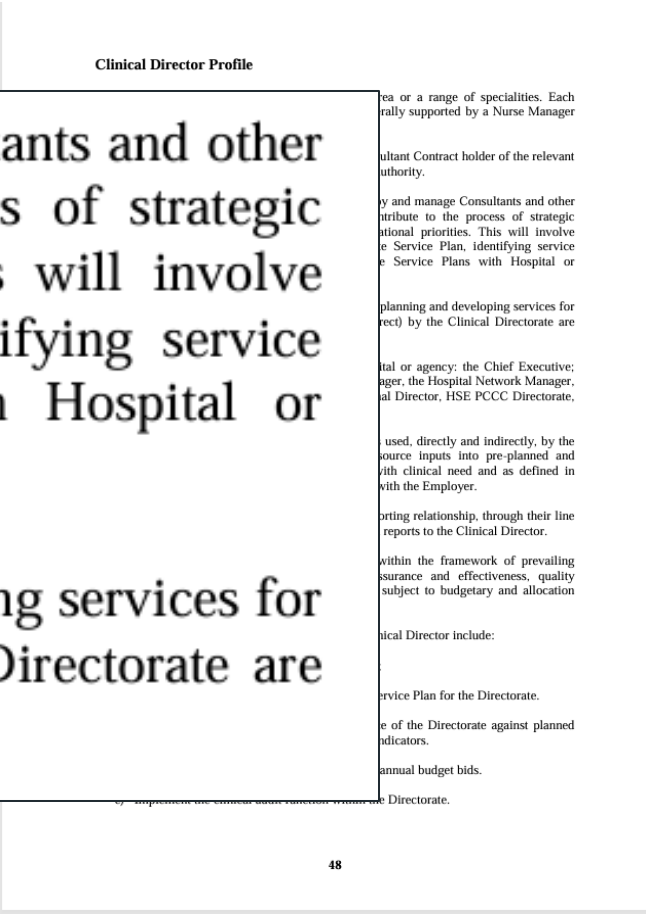




Consultant's Contract 2008

3) The primary role of a Clinical Director is to deploy and manage Consultants and other resources, plan how services are delivered, contribute to the process of strategic planning and influence and respond to organisational priorities. This will involve responsibility for agreeing an annual Directorate Service Plan, identifying service development priorities and aligning Directorate Service Plans with Hospital or Network Plans.

4) Executive power, authority and accountability for planning and developing services for and managing available resources (direct or indirect) by the Clinical Directorate are delegated from the Employer.


Clinical Director Profile

ea or a range of specialities. Each
rally supported by a Nurse Manager

ultant Contract holder of the relevant
uthority.

y and manage Consultants and other
ntribute to the process of strategic
ational priorities. This will involve
e Service Plan, identifying service
e Service Plans with Hospital or

planning and developing services for
rect) by the Clinical Directorate are

tal or agency: the Chief Executive;
ager, the Hospital Network Manager,
al Director, HSE PCCC Directorate,

used, directly and indirectly, by the
ource inputs into pre-planned and
ith clinical need and as defined in
with the Employer.

orting relationship, through their line
reports to the Clinical Director.

within the framework of prevailing
ssurance and effectiveness, quality
subject to budgetary and allocation

ical Director include:

rvice Plan for the Directorate.

e of the Directorate against planned
dicators.

annual budget bids.

e Directorate.

48

Recurring Issues from Stakeholder Engagement

1. Substantial variation in role titles, remit and organisational structures;
2. Insufficient alignment between responsibility, accountability and delegated authority;
3. Inconsistent contractual, working-time and remuneration arrangements;
4. Variable access to information, management expertise and administrative support;
5. Poorly defined relationships between departmental, directorate, hospital, IHA and regional leadership roles;
6. Limited integration of clinical governance across acute, community and mental health services;
7. Uncertainty regarding indemnity, education, appointment and performance-review arrangements.

Key Messaged from International Review

1	Clearly defined roles, responsibilities and delegated authority
2	Competency-based recruitment, development and appraisal
3	Protected time for leadership responsibilities
4	Strong governance substructures and distributed leadership arrangements
5	Access to business, HR and data support.
6	Clear accountability for quality, safety and performance outcomes

Key Themes – International Evidence Review

Leadership and Governance – Role of the CD

- Senior member of the organisation's management team
- Provide medical and clinical leadership in the relevant department, directorate, hospital, region.
- Collaborative Multidisciplinary team based approach

- Provide assurance to the management team on the quality and safety of clinical services within their remit

- Establish and maintain robust clinical governance structures and escalation frameworks

- Focus on service development and integration consistent with Slaintecare priorities

Clinical Governance, Quality, Risk and Patient Safety

- Accountable for the governance of all clinical activities within the department, directorate, hospital, service, region..
- Identify, manage and escalate clinical risks
- Structure approach to incident and adverse event management and review
- Ensure quality improvement processes in place
- Empowered to take action to protect patient safety
- Structured quality assurance processes in place with a culture of openness and focus on continuous improvement
- Monitor key quality indicators and safety metrics and take corrective action when necessary

Line Management of Medical Workforce

- Line management for consultants and NCHDs across the department, directorate, hospital, region etc
- Responsible for workforce planning, recruitment, appraisal etc
- Oversee consultant workplan development and alignment with POCC23 obligations with HSE and Dept of Health priorities
- Address performance concerns in a timely and fair manner in accordance with organisational priorities

Planning and Performance

- Contribute expert clinical insight to organisational planning, decision making and strategic development

- Lead development and implementation of department/directorate service plans aligned with the organisational strategy and population needs

- Ensure delivery of performance targets across access, quality, activity, productivity and financial stewardship
  - Monitor performance data, identify trends and implement improvement measures

- Work collaboratively with executive leadership, finance, HR, nursing and HSCP colleagues to ensure services are sustainable, efficient and responsive

Role of the Clinical Department Lead

- Move away from representative departmental lead - appointed by colleagues
- Executive appointed role with delegated responsibility, accountability and authority for an individual department
  - Reporting to a Clinical Director (over a Directorate/Division)
- Lead a departmental multi-disciplinary team
  - Supported by the Directorate team (manager, finance, HR etc)

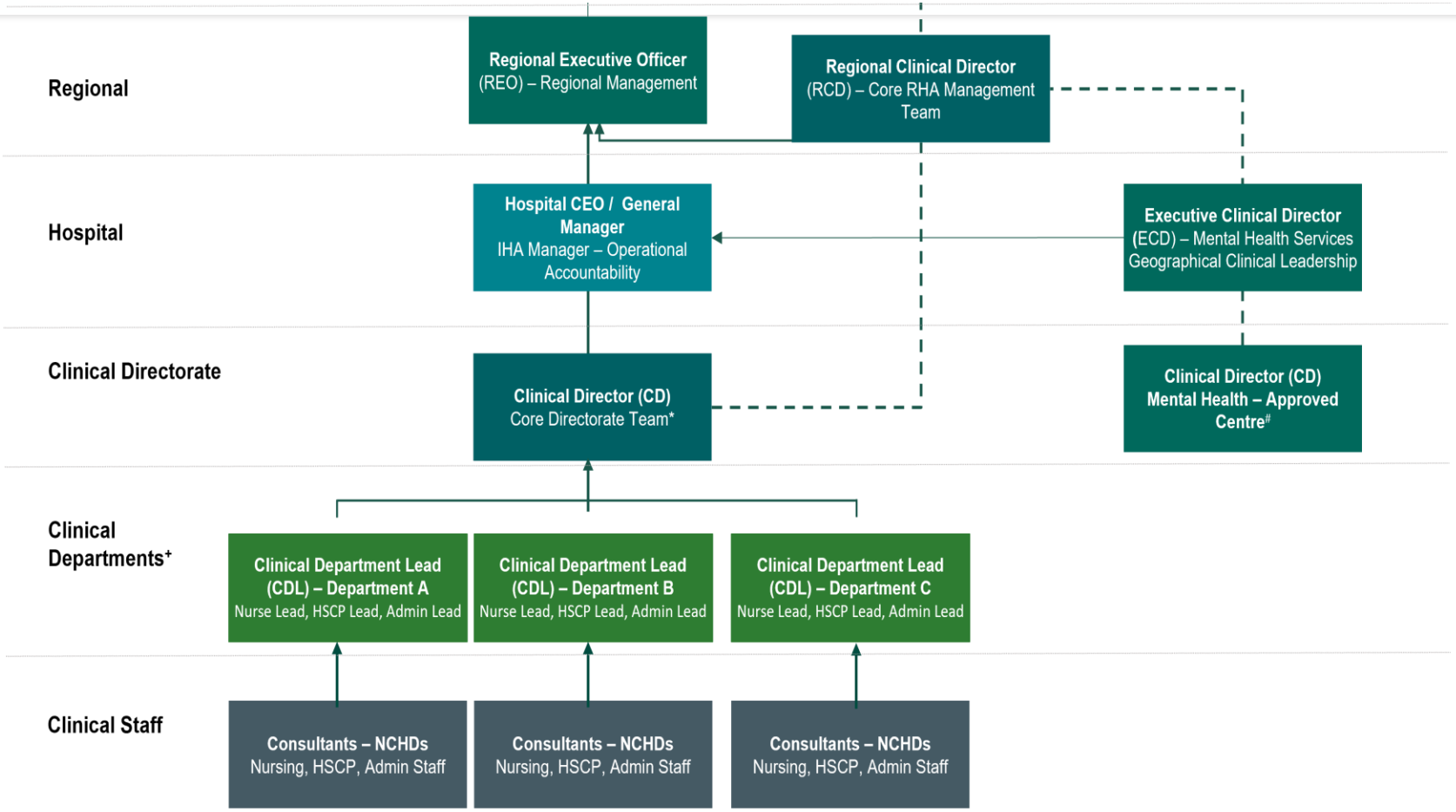
Same functions as Clinical Director at a Departmental Level

1. Leadership and Governance
2. Clinical governance, Quality and Patient Safety
3. Line Management of Departmental workforce
4. Departmental planning and performance

Key Issues and Challenges

1. No national baseline exists for clinical leadership roles:
2. Misalignment between responsibility, accountability and authority
3. A critical governance gap exists below Clinical Director level
4. Clinical governance structures are highly variable
5. Regional clinical governance arrangements remain unclear
6. Networks of Care are not formally supported by clinical governance arrangements
7. Clinical leadership across care pathways is fragmented
8. General practice is not fully integrated into clinical governance structures
9. Governance processes are not standardised nationally
10. Clinical leaders do not consistently receive the supports required to succeed:
11. Indemnity arrangements create uncertainty for clinicians in leadership roles
12. The clinical leadership pipeline is underdeveloped

Proposed Clinical Governance Structures



+Three clinical departments shown for illustration. Actual number and configuration of departments will vary by directorate size and complexity, agreed with RCD.
The Mental Health CD pathway right (right) reflects the distinct statutory framework under the Mental Health Act 2001. The CDL model applies in both acute and mental health settings.
* Core Directorate Team: CD, Nurse Manager, HSCP Lead, Business Manager, Business Partners (Finance, HR, BI, ICT)

Authority

- Significant Influential authority currently

- Devolve the authority to be accountable for the areas of responsibility

- Start at the departmental operational unit
  - Clinical Departmental lead
  - Devolved authority for the service
    - Accountable to the clinical Director/Directorate
    - Accountable to hospital/service/IHA manager

- Professional/supportive relationship to the Regional CD

Key Enablers

Core Directorate Team

1. CD/Nursing/HSCP/Manager
2. Business Support function
   a. Project support
   b. Data Analysis
   c. HR/Medical Workforce
   d. Finance
3. Quality and patient Safety support
4. Clerical/Admit
5. Space

1. Delegated Authority
2. Roles ensure integrated approach to patient care with responsibilities across acute and community care
3. Protected Time
4. Performance and Accountability Framework
5. Governance Frameworks and Standardised processes
6. Education, training and mentoring/support

Summary

- Key Leadership role - leading a collaborative multidisciplinary team
- Consistent structures
- Clear definition of Role/Responsibility
- Delegated authority
- Governance structure of Clinical Departmental Leads, reporting to a CD/Directorate to Hospital/IHA manager
- Key enablers for success
- Education and Training

- Report with 14 recommendations is at draft stage

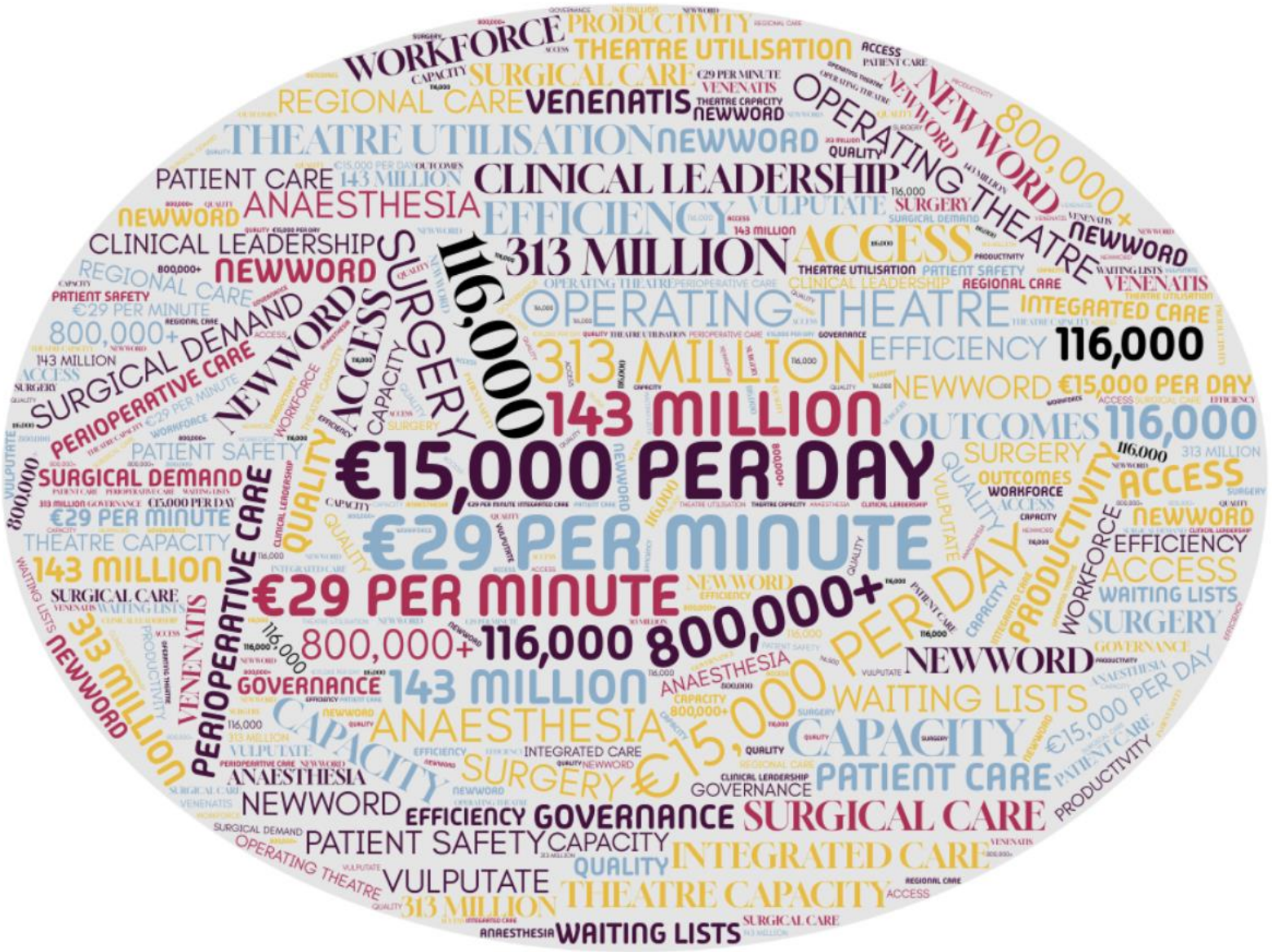
Transforming Theatre: HSE South West

Implementation to Operationalisation

Grace Reidy / Mark Corrigan

Programme Lead / Clinical Lead

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event


WORKFORCE
PRODUCTIVITY
THEATRE UTILISATION
SURGICAL CARE
REGIONAL CARE
VENENATIS
NEWWORD
800,000
OPERATING THEATRE
CLINICAL LEADERSHIP
PATIENT CARE
ANAESTHESIA
EFFICIENCY
VULPUTATE
ACCESS
313 MILLION
116,000
143 MILLION
€15,000 PER DAY
€29 PER MINUTE
OUTCOMES
INTEGRATED CARE
PERIOPERATIVE CARE
SURGICAL DEMAND
PATIENT SAFETY
QUALITY
CAPACITY
GOVERNANCE
WAITING LISTS
PRODUCTIVITY
800,000+
THEATRE CAPACITY

HSE South West

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

HSE South West

Serving Cork and Kerry

740,614
PEOPLE
Population (Census 2022)
14.4% of Ireland's population
Fourth largest of the six HSE health regions

3
HEALTHCARE AREAS
- Cork North & East
- Cork South & West
- Kerry

14
COMMUNITY HEALTHCARE NETWORKS
Serving populations of approximately **35,000** to 72,000 people

20,000+
STAFF
More than 20,000 people working across our health and social care services

33
PRIMARY CARE CENTRES
Supporting primary care and community services across the region

WIDE RANGE OF SERVICES
Acute hospitals, mental health, disability, social care and health & wellbeing

Integration of the former South/South West Hospital Group and Cork Kerry Community Healthcare into a single regional system

OPERATING THEATRE CAPACITY ACROSS THE REGION (TTP 2025)

7	45	52,359	78,238	70%
ACUTE HOSPITALS	THEATRES & PROCEDURE ROOMS	PROCEDURES ANNUALLY (2025)	AVAILABLE THEATRE HOURS (2025)	THEATRE UTILISATION (2025)

Sources: HSE South West Regional Profile (Census 2022) | HSE South West | TTP South West Theatres Report 2025

OUR REGION

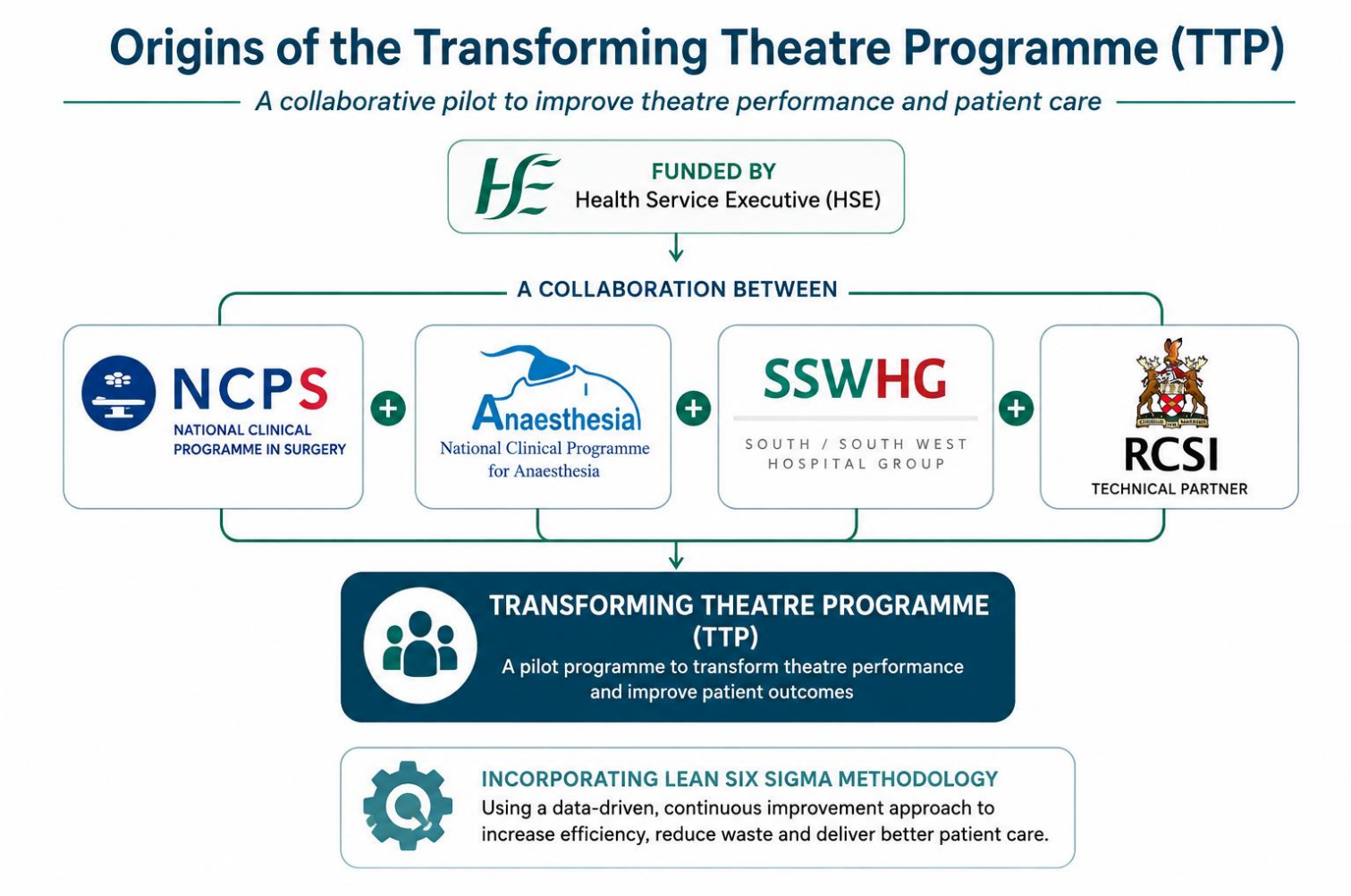
Two counties. One health region.

740,614
PEOPLE
in the South West
(Census 2022)

14.4%
of Ireland's population

Fourth largest
of the six HSE health regions
(Census 2022)

Origins of the Transforming Theatre Programme



Data, Information, Knowledge

Data Alone = Noise

Data + Context = Information

Information + Experience = Knowledge

Timestamps

Anaesthesia Start Time
Time of completion of the Safe Surgery Checklist ***Sign In***

Surgery Start Time
Time procedure starts, after completion of Safe Surgery Checklist ***TIme Out***

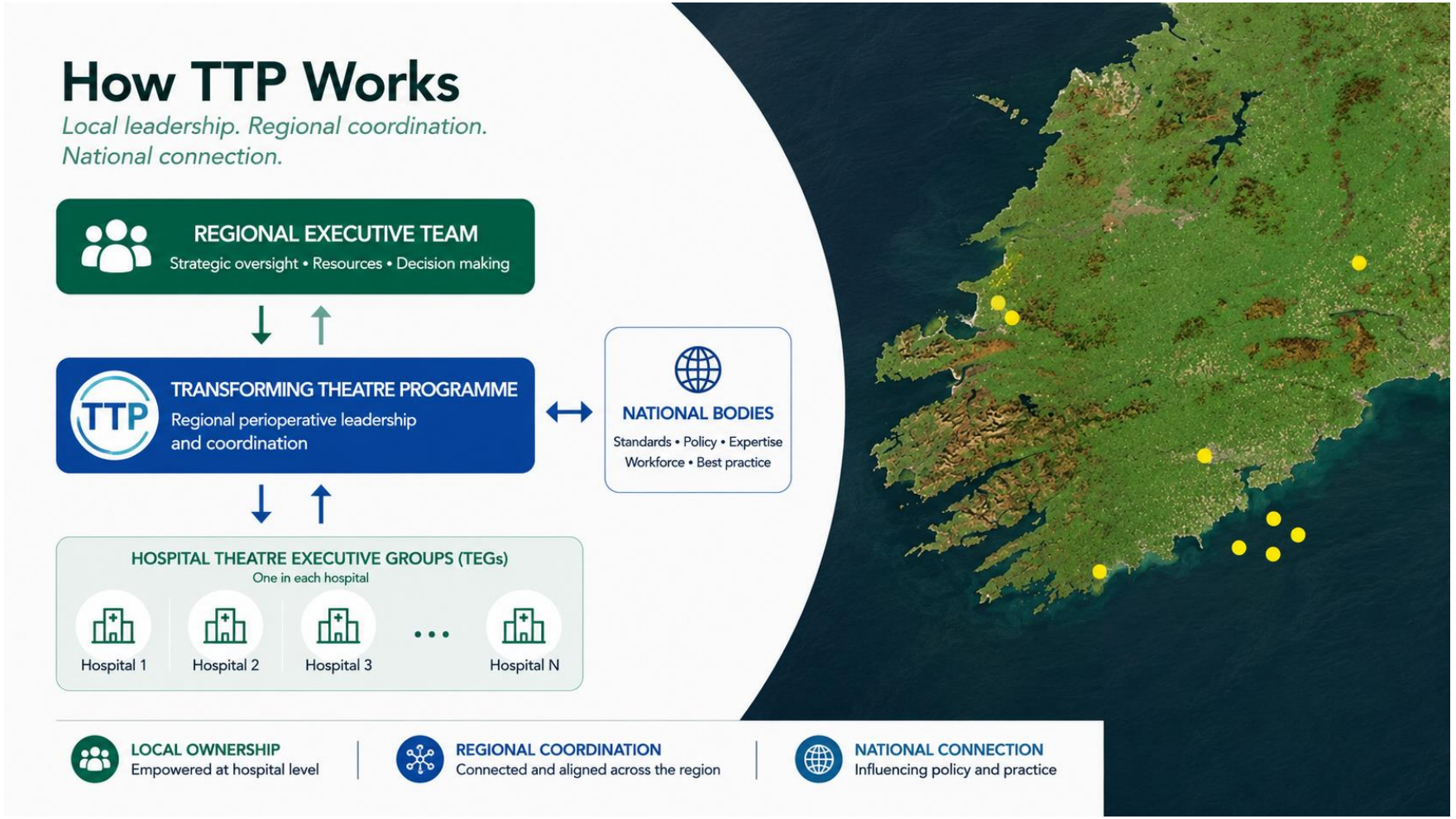
Surgery Finish Time
Time operative site covered, after completion of Safe Surgery Checklist ***Sign Out***

Anaesthesia Finish Time
Time Anaesthetist is satisfied the patient is ready for transfer to recovery

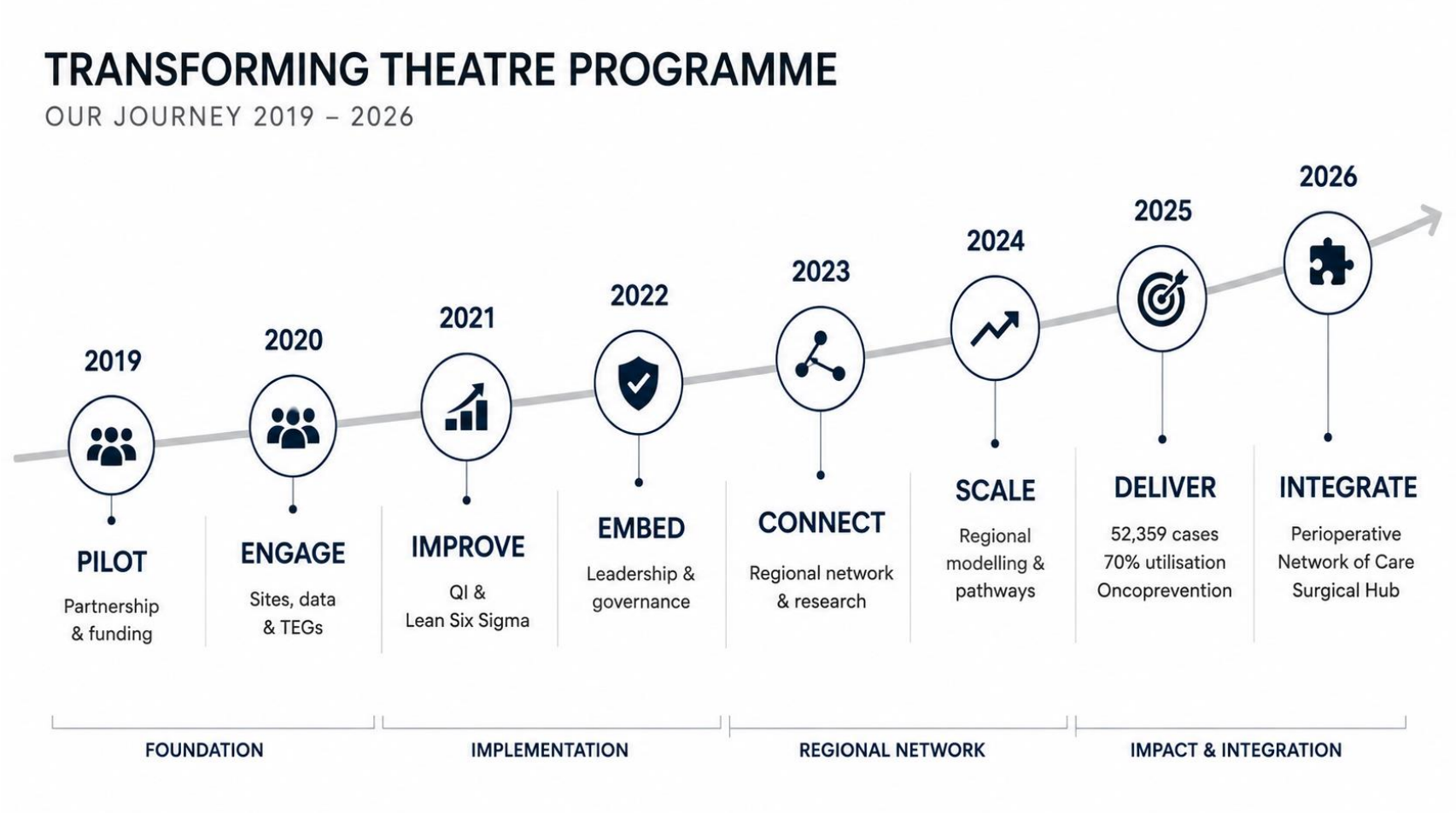
Left Theatre
Time patient is transferred from theatre to the recovery room


The Observer
Johnson's U-turn puts country under tough new lockdown
US campaign heads to a frenzied finish
GOODBYE MR BOND
Hollywood giant Sir Sean Connery dies aged 90
SEE PAGES 2&3 PLUS SPECIAL TRIBUTE PAGES 33-38
SIR SEAN CONNERY
THE MAN WITH A LICENCE TO THRILL
LOCKDOWN 2 TO AVOID DISASTER
PM's last-ditch plea to save NHS and Christmas
The Sunday Telegraph
Four-week lockdown 'to save NHS as millions face return to furlough
THE SUNDAY TIMES
CONNERY
THE MAN BORN TO BE BOND
TRIBUTES AND PICTURES
TRACEY EMIN EXCLUSIVE
HER HAUNTING INTERVIEW
The Mail ON SUNDAY
THE BIDEN FILES
WORLD EXCLUSIVE Astonishing full story of laptop security scandal that'll rock Joe Biden's bid to be US President
SEE PAGES 20-23
Tributes to Sir Sean Connery, dead at 90
FREE PULLOUT
Fears of 'medical disaster' force PM into new lockdown
27-day shutdown as cases hit 1 million
Johnson told virus could break NHS
CORONAVIRUS CRISIS
SHOCKDOWN
Boris's lockdown delay will cost lives, say experts
Shut: Pubs and High St Open: Schools and colleges
Starmer: Public will pay price of PM's failures
Government chaos
Cabinet fury at being kept in dark
MPs vow to rebel in the Commons
Leak probe into Hancock
LOCKDOWN SPARKS TORY CIVIL WAR
EXCLUSIVE

How TTP works

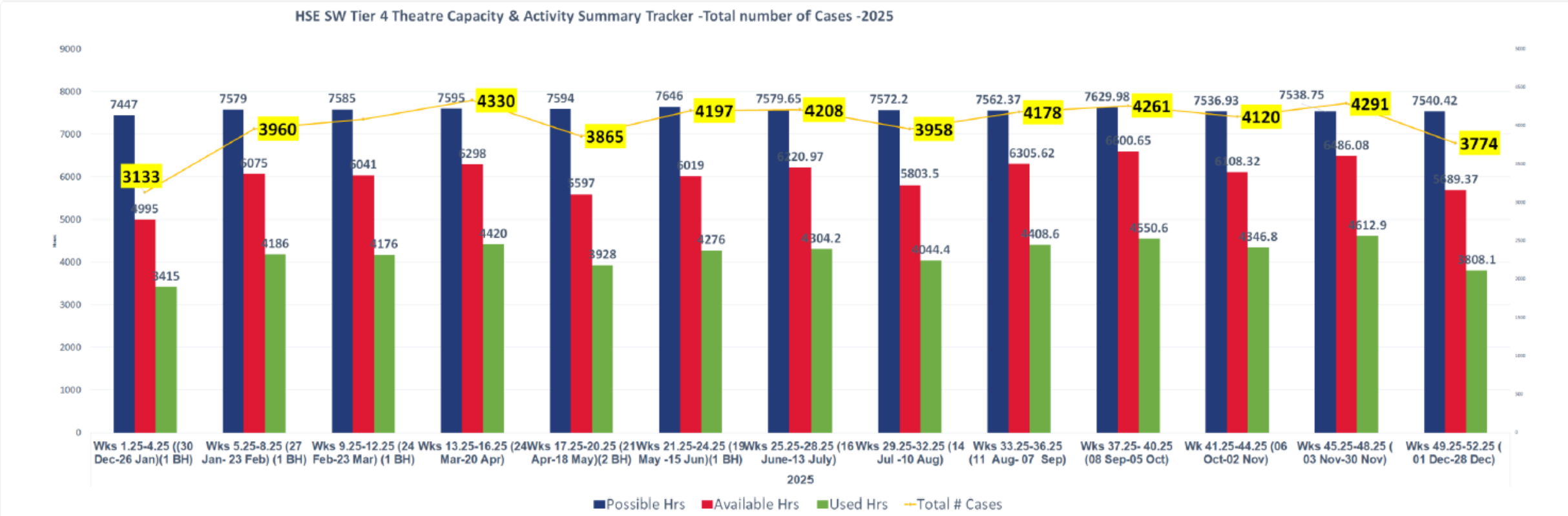


Transforming Theatre Programme



What the data looks like

SW Tier 4 Data 2025



45 Rooms included

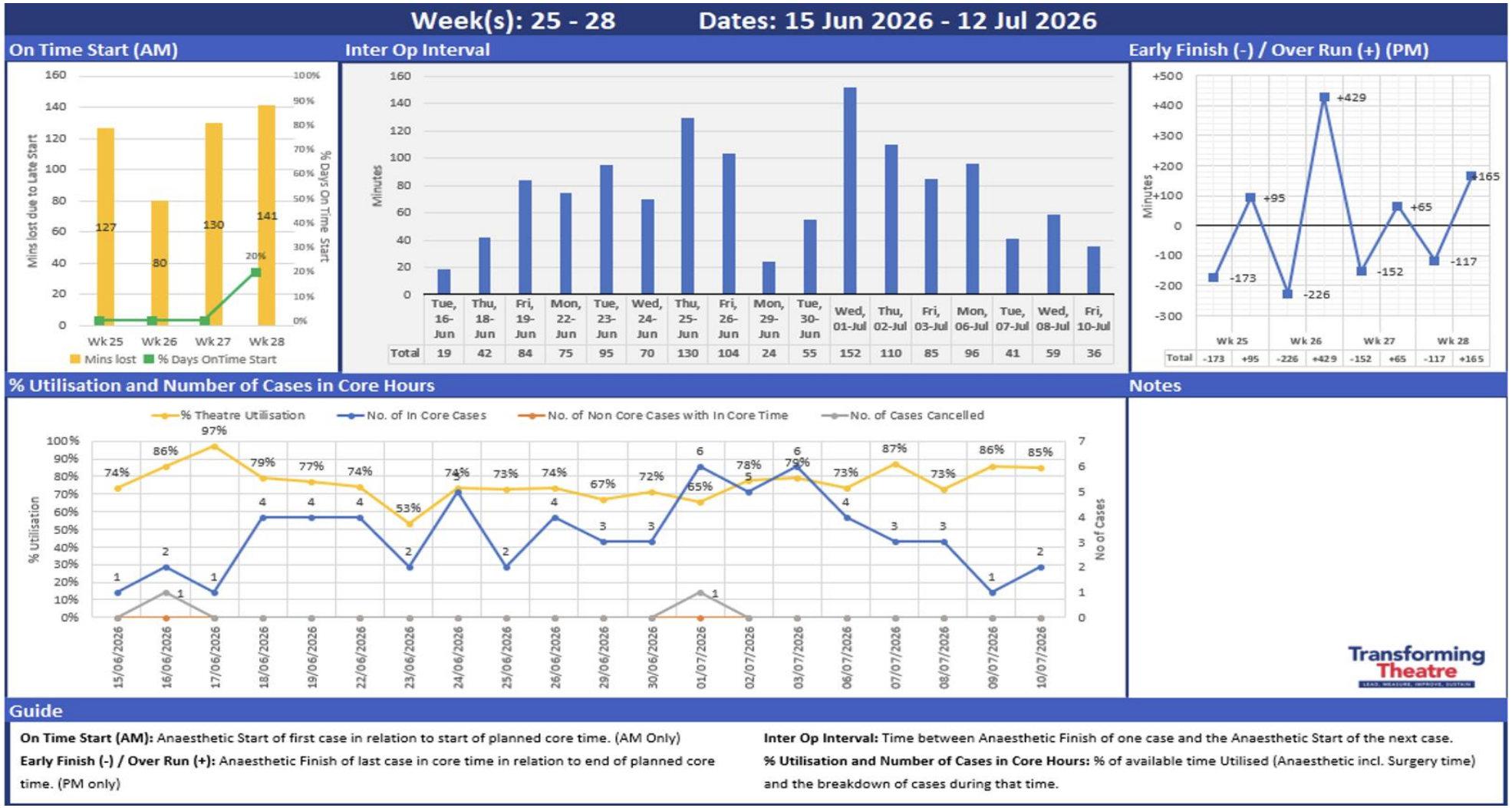
What the data looks like

SW Tier 4 Data 2024 v 2025

HSE South West Region 2024 v 2025 (7 Hospitals,45 rooms)			
	13 Time buckets 2024	13 Time buckets 2025	
Possible hours	98073	98405	↑
Available hours	76810	78238	↑
Used hours	52597	54476	↑
Average % Utilisation	68%	70%	↑
Average % of Possible Time available for use	78%	80%	↑
Total number of cases (Core & Non Core)	49253	52359	↑6.3%

What the data looks like

Tier 1 Data 2024 vs 2025



What the data looks like

Typical Theatre Activity Gantt Chart

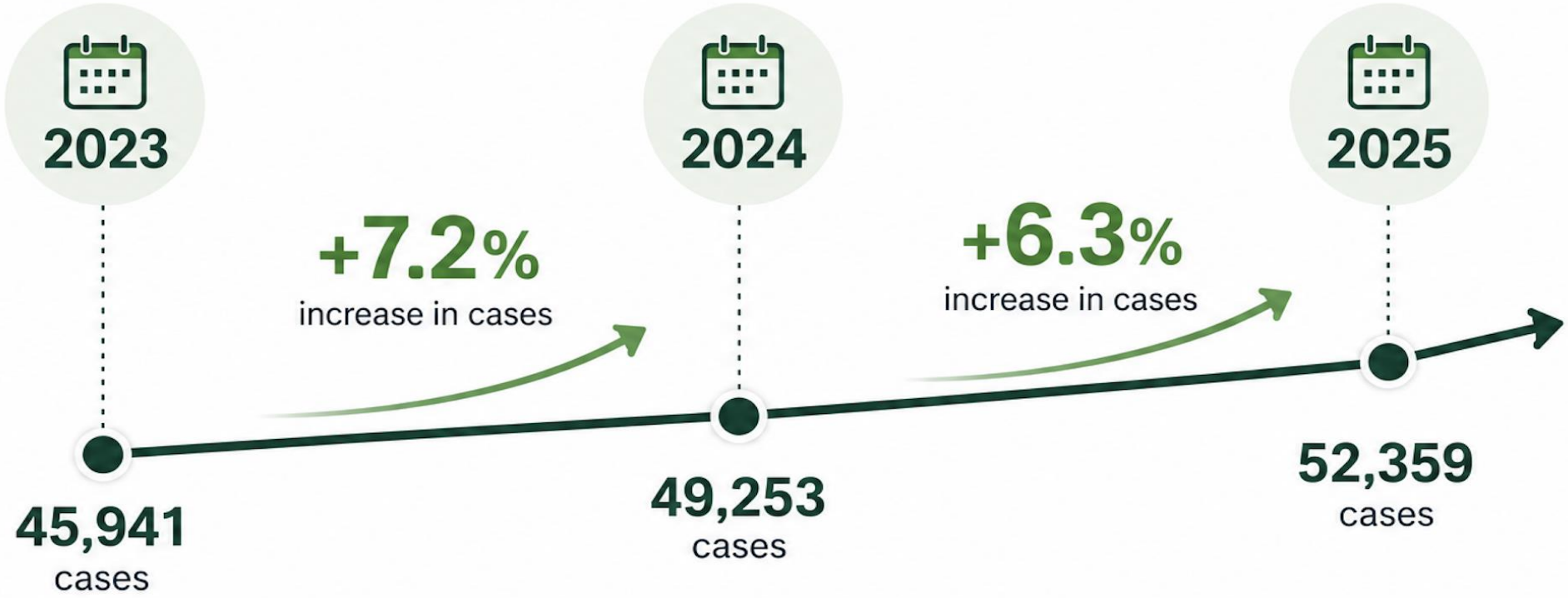
ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

Theatre Utilisation

Surgery Start Date	Theatre	% Utilisation
Mon, Jun 15, 2026	21	74%
Tue, Jun 16, 2026	21	86%
Wed, Jun 17, 2026	21	97%
Thu, Jun 18, 2026	21	79%
Fri, Jun 19, 2026	21	77%
Mon, Jun 22, 2026	21	74%
Tue, Jun 23, 2026	21	53%
Wed, Jun 24, 2026	21	74%
Thu, Jun 25, 2026	21	73%
Fri, Jun 26, 2026	21	74%
Mon, Jun 29, 2026	21	67%
Tue, Jun 30, 2026	21	72%
Wed, Jul 01, 2026	21	65%
Thu, Jul 02, 2026	21	78%
Fri, Jul 03, 2026	21	79%
Sun, Jul 05, 2026	21	0%
Mon, Jul 06, 2026	21	73%
Tue, Jul 07, 2026	21	87%
Wed, Jul 08, 2026	21	73%
Thu, Jul 09, 2026	21	86%
Fri, Jul 10, 2026	21	85%
Sat, Jul 11, 2026	21	0%
Sun, Jul 12, 2026	21	0%

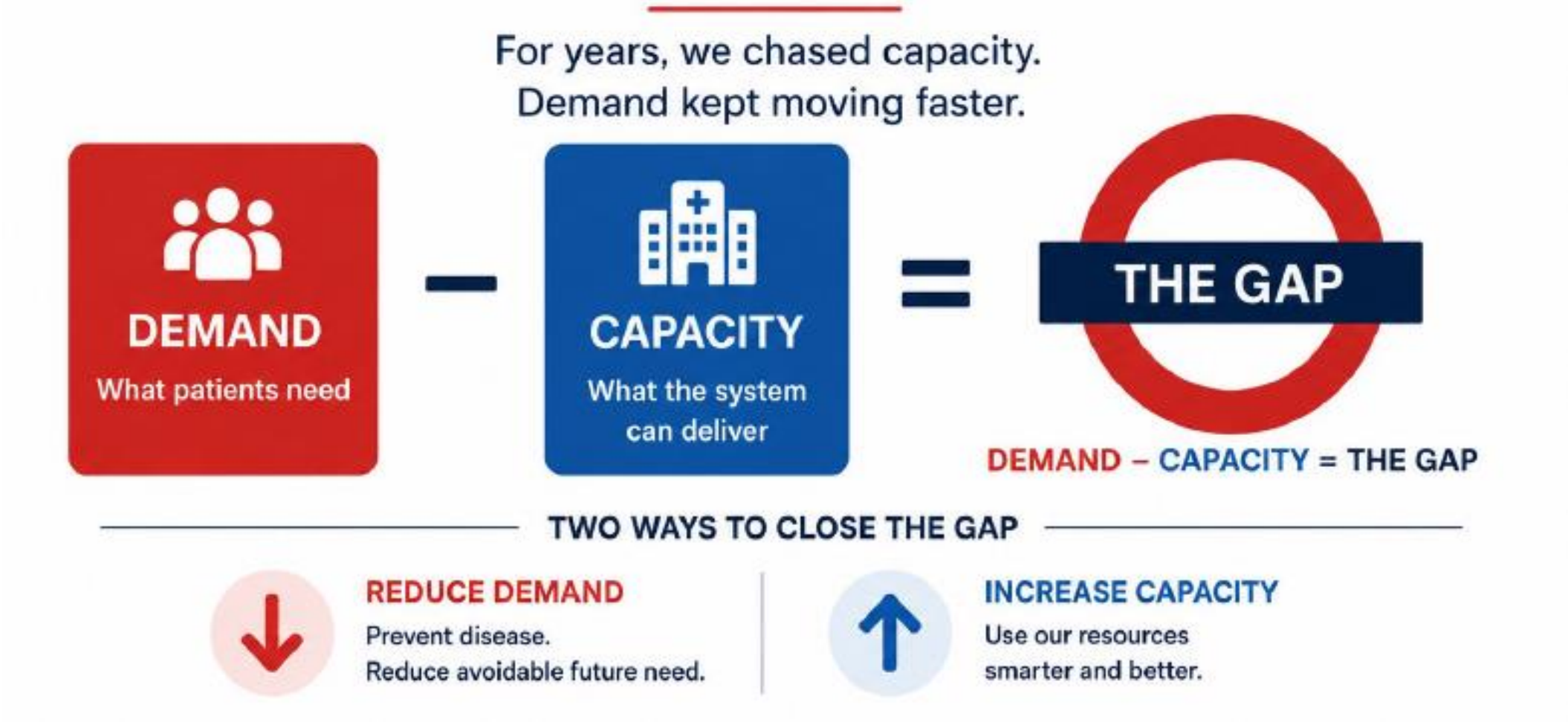
What the data looks like

Sustained Growth in Surgical Activity



From 45,941 cases in 2023 to 52,359 cases in 2025 –
an overall increase of 14.0% over two years.

Mind the Gap


For years, we chased capacity.
Demand kept moving faster.
DEMAND
What patients need
CAPACITY
What the system can deliver
THE GAP
DEMAND – CAPACITY = THE GAP
TWO WAYS TO CLOSE THE GAP
REDUCE DEMAND
Prevent disease.
Reduce avoidable future need.
INCREASE CAPACITY
Use our resources smarter and better.

Cancer Prevention Theatre Resource

September 2026 Ireland first dedicated cancer prevention theatre resource opened in the SIVUH to improve the lives of our community & reduce demand on our services

Cancer Prevention Centre

The country's first dedicated cancer prevention centre will open in Q2 2028 embedded in the community as part of the Bishopstown PCC

SW Surgical Onco-Prevention Programme

SW Surgical Onco-Prevention Programme

Advancing prevention. Delivering better outcomes.

SERVICE / RESOURCE	CANCER GENETICS SW 2022	SURGICAL PREVENTION SW 2026
Genetic testing	✕ No	✓ Yes
Genetics specialist consultant	✕ No	✓ Yes
Genetics counsellor	✕ No	✓ Yes
Genetics clinical specialist nurse	✕ No	✓ Yes
Genetics data manager	✕ No	✓ Yes
Wait time public diagnostic testing	2 years	8 weeks
Advanced Nurse practitioner	1	2
Wait time public predictive testing	2–4 years	8 weeks
DIEP free flap reconstruction	– Very limited	Plastic surgeon
Psychologist – cancer gene carriers	✕ No	✓ Yes
Dedicated theatre	✕ No	✓ Yes
Dedicated building	✕ No	Commenced
Programme Manager	✕ No	Committed

Embedded public pathway – **98%** patient satisfaction – **100%** staff satisfaction

SW Surgical Onco-Prevention Programme

	Non operative management	SW Risk Reduction Cost	Estimated Total Savings
Breast estimated 10-year cost	€76,619,896	€7,583,500	313 cancers prevented. €69,036,396 saved
Ovarian estimated 10-year cost	€13,500,000	€937,800	135 cancers prevented €12,562,200 saved
Total Breast/Ovarian programme	€90,119,896	€8,521,300	**448 cancers prevented** **€81,598,596 saved**

Strategic factors influencing regional theatre utilisation and elective capacity (2026)

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

Strengths

- European award-winning theatre utilisation programme
- Sustained productivity growth 2022-2025
- Unique national surgical cancer prevention programme
- Extended working models in active deployment
- Research directly informing operational change
- Weekly support to under pressure facilities
- Zero tolerance cancellation metric introduced

Weaknesses

- Elective care displaced by unscheduled demand
- Limited parallel processing capacity
- Insufficient protected day-bed capacity
- Absence of 23 hour ward infrastructure
- Lack of visibility of actual % utilisation of leased lists in private sector
- Manual data collection

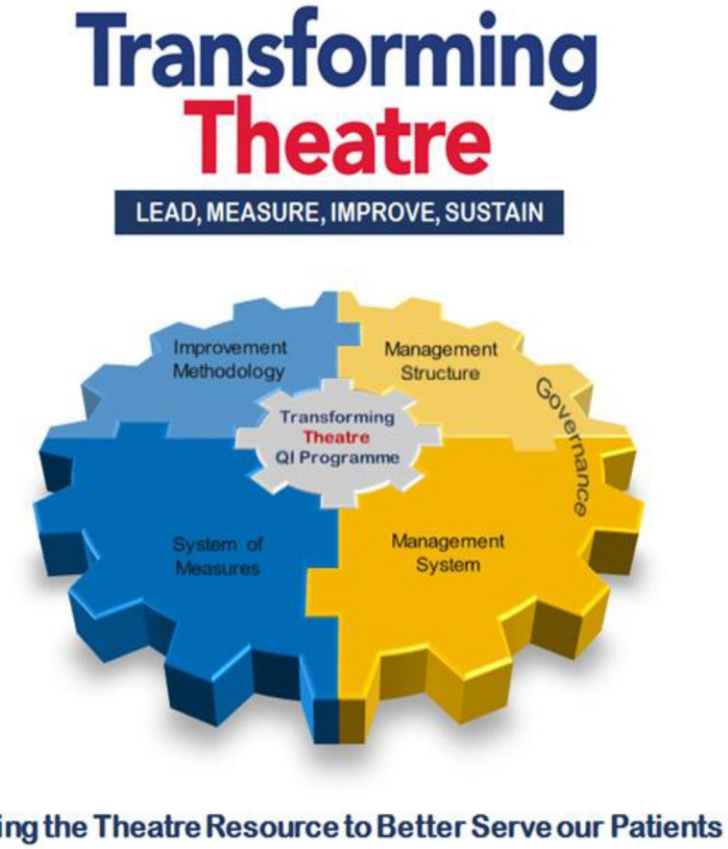
Opportunities

- Prevention programme to reduce future demand
- Expand evening and weekend utilisation & align operational hours
- Alternative surgical OPD pathway aligned with Sláintecare: “Right care, in the right place, at the right time and **by the right person**”
- Surgical hubs and targeted elective protection
- Project S: Align theatre with waiting list data

Threats

- Continued growth in unscheduled care
- Dependence on private theatre leasing
- Reputational risk from cancellations
- Workforce fatigue & IR risk

Thank You


Transforming
Theatre
LEAD, MEASURE, IMPROVE, SUSTAIN
Improvement Methodology
Management Structure
Governance
Transforming Theatre QI Programme
System of Measures
Management System
Using the Theatre Resource to Better Serve our Patients

Urgent Virtual Care

Clinical Leadership and Governance

"Ní Neart Go Cur Le Chéile"

Urgent and Unscheduled care:

1. Nature and scale of the challenge
2. Role of GP
3. UVC in Cork

Dr Diarmuid Quinlan

Cork based GP

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

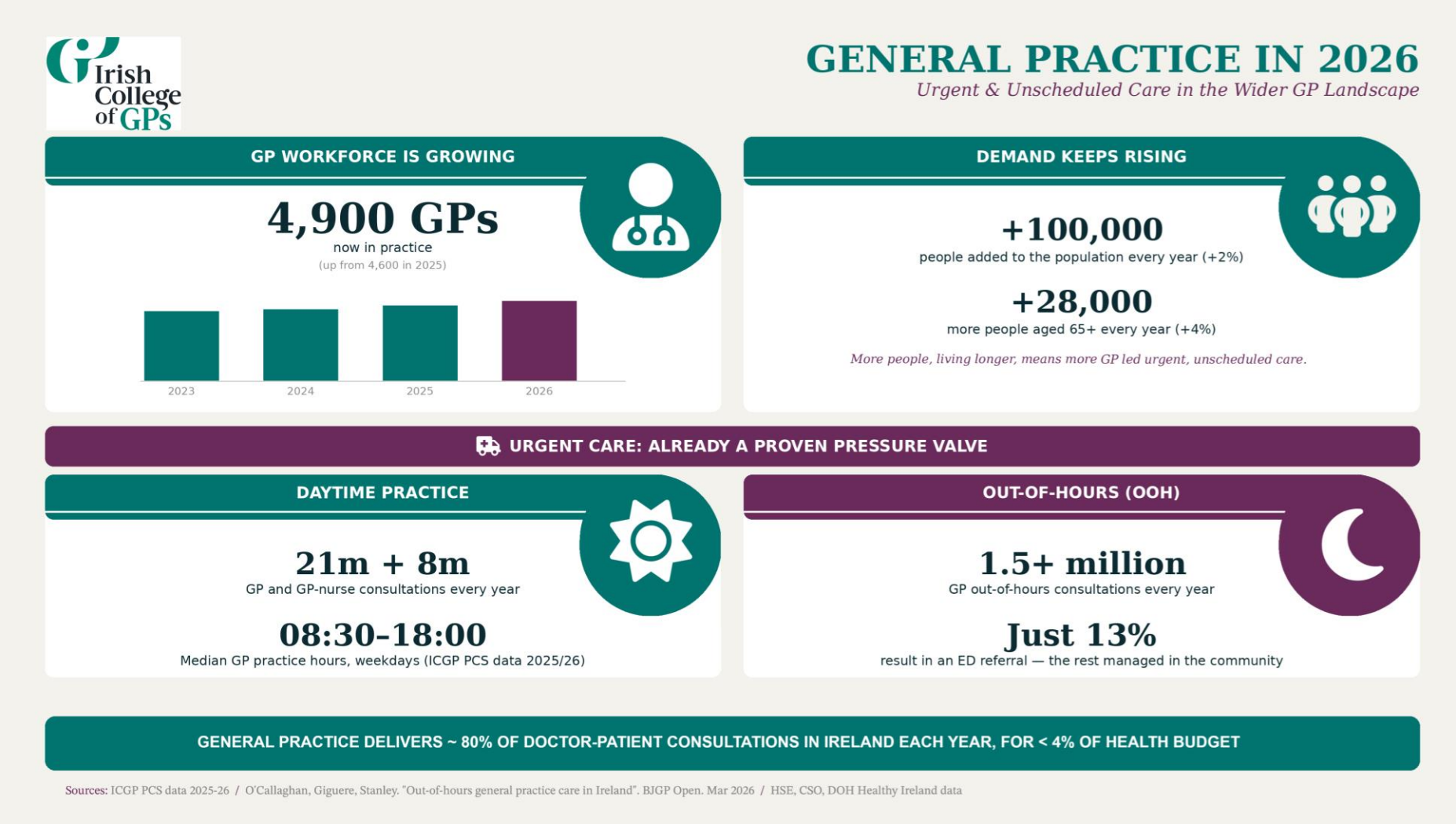
Urgent and Unscheduled Care Nature and Scale

Expanding population

- Ageing population
- Multimorbidity (CDM x8, Mental Health, Dementia, Frailty)
- Polypharmacy

- COVID-19
- GMS expansion
- Ageing GP workforce

General Practice in 2026



HSE Corporate Plan

Our Vision, Mission, Values

Healthy Communities 1

OUR COMMITMENT

Together, we will create supportive environments for people to live healthier and for longer.

- A Enhance population based planning and delivery with focus on early intervention.
- B Address the wider determinants of health.

Right Care 2

OUR COMMITMENT

You will experience high quality, safe, coordinated care.

- A Deliver value in health and social care.
- B Partner with patients/ service users and voluntary organisations.

Right Place 3

OUR COMMITMENT

You will receive care in the setting most appropriate for your needs.

- A Deliver coordinated care closer to home.
- B Deliver physical capacity to meet areas of the greatest demand.

Right Time 4

OUR COMMITMENT

You will be able to access services when you need them.

- A Improve equity of access.
- B Reduce the time that people are waiting.

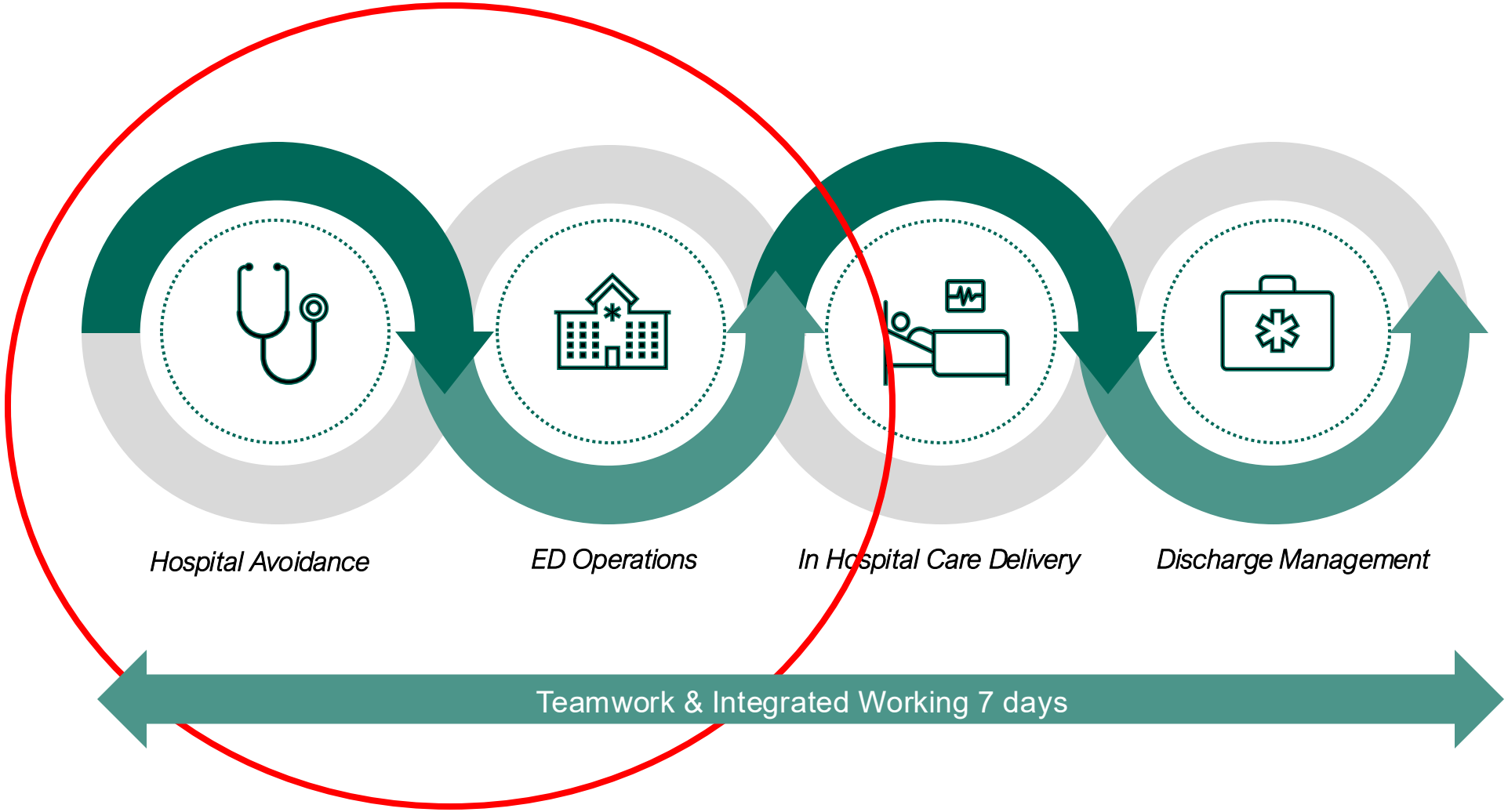
Strong Foundations 5

OUR COMMITMENT

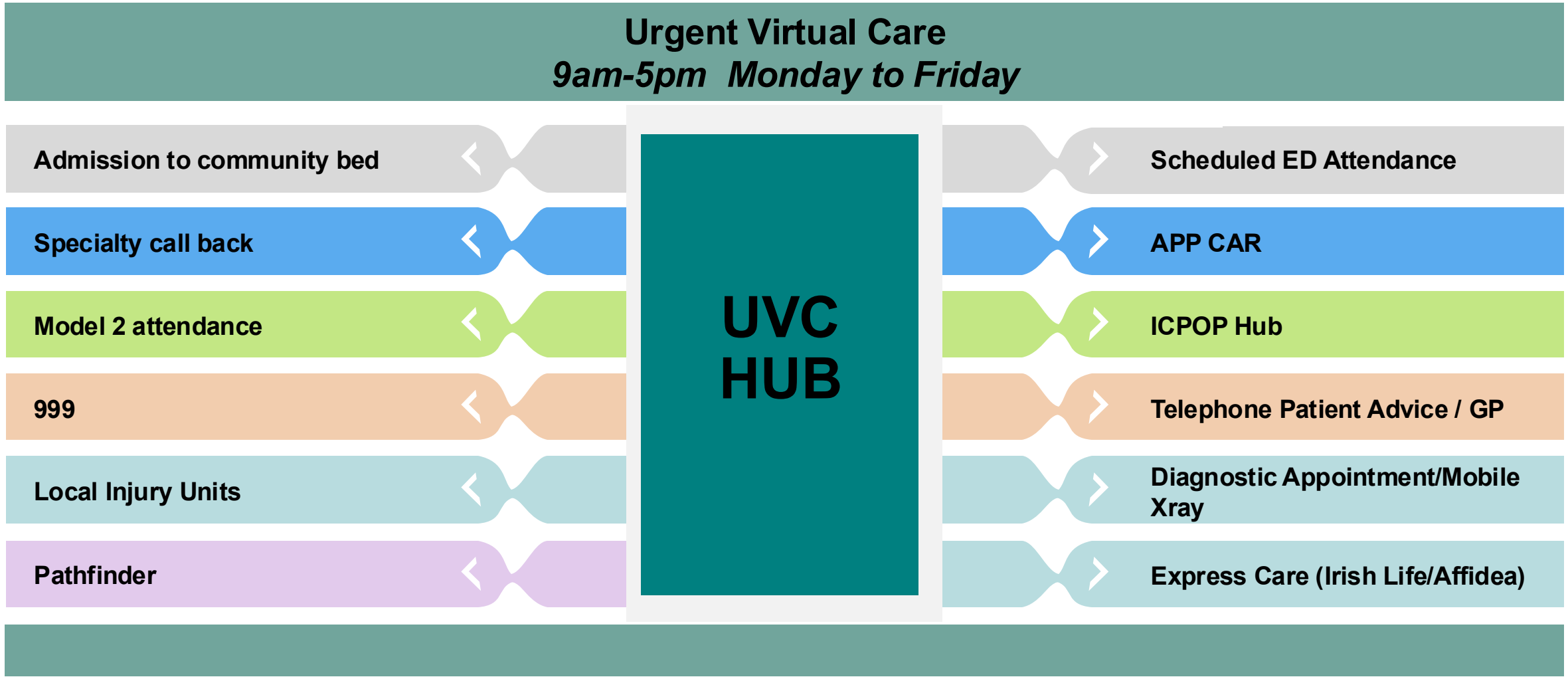
We will invest in our people, the right capabilities and digital enablers to support a culture where teams are empowered to innovate and deliver excellent care.

- A Strengthen our workforce and learning culture.
- B Integrate clinical and operational governance.
- C Enhance efficiency and shared decision making through digital enablers.

The 4 pillars of Urgent and Emergency Care



Overview


Urgent Virtual Care
9am-5pm Monday to Friday
Admission to community bed
Specialty call back
Model 2 attendance
999
Local Injury Units
Pathfinder
UVC HUB
Scheduled ED Attendance
APP CAR
ICPOP Hub
Telephone Patient Advice / GP
Diagnostic Appointment/Mobile Xray
Express Care (Irish Life/Affidea)

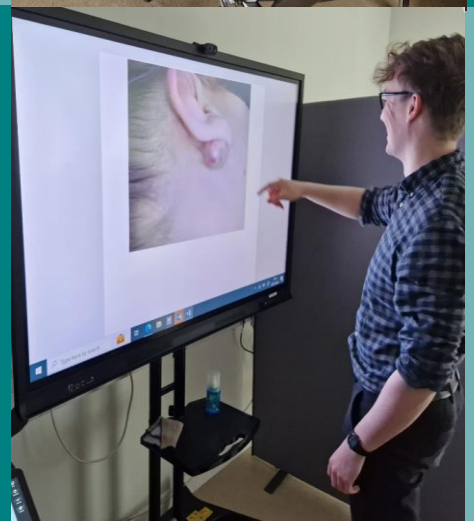
Overview

10,000

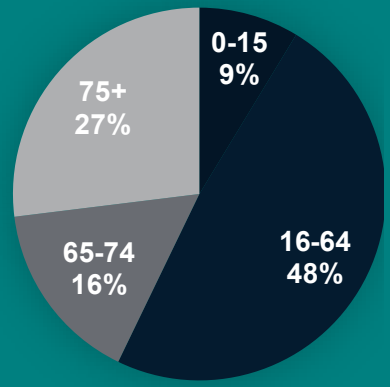
Referrals through the service since November 2024

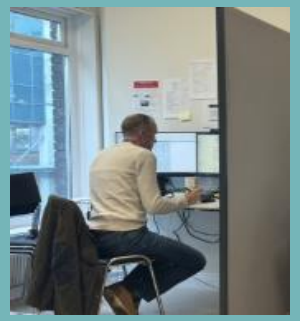
73%

Patients managed without a direct ED attendance



Age Range





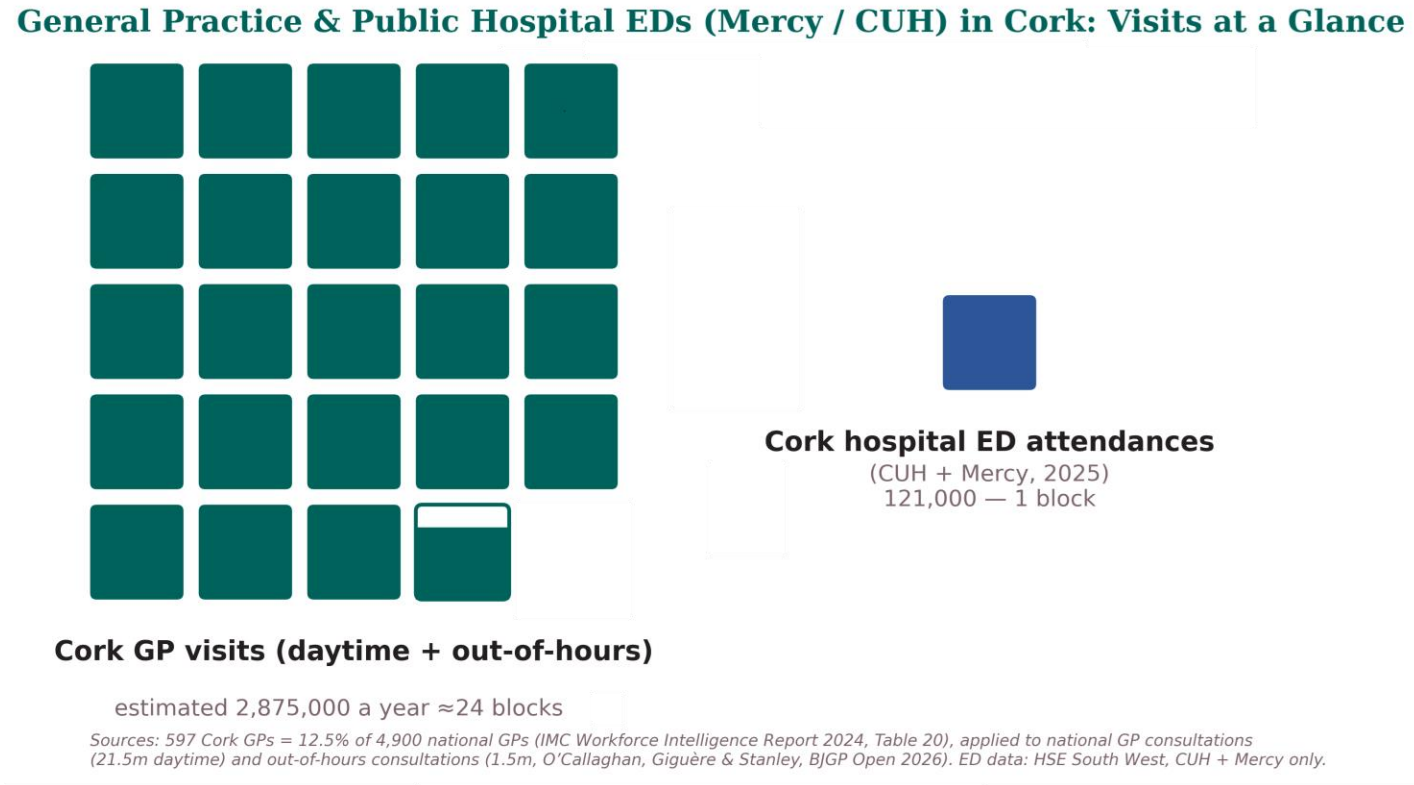
Urgent Virtual Care in Cork

Right Care, Right Place, Right Time

Person with:

- **Prolapsed disc & intractable pain**: MRI scan
- **Possible clot in leg (? DVT)** Doppler scan
- **New onset chest pain:** Chest pain clinic
- **Fall & head trauma:** CT brain

General Practice and Public Hospital EDS (Mercy / CUH) in Cork: Visits at a Glance



Based on CORK ED DATA supplied + GP National Visits rate applied to Cork GPs

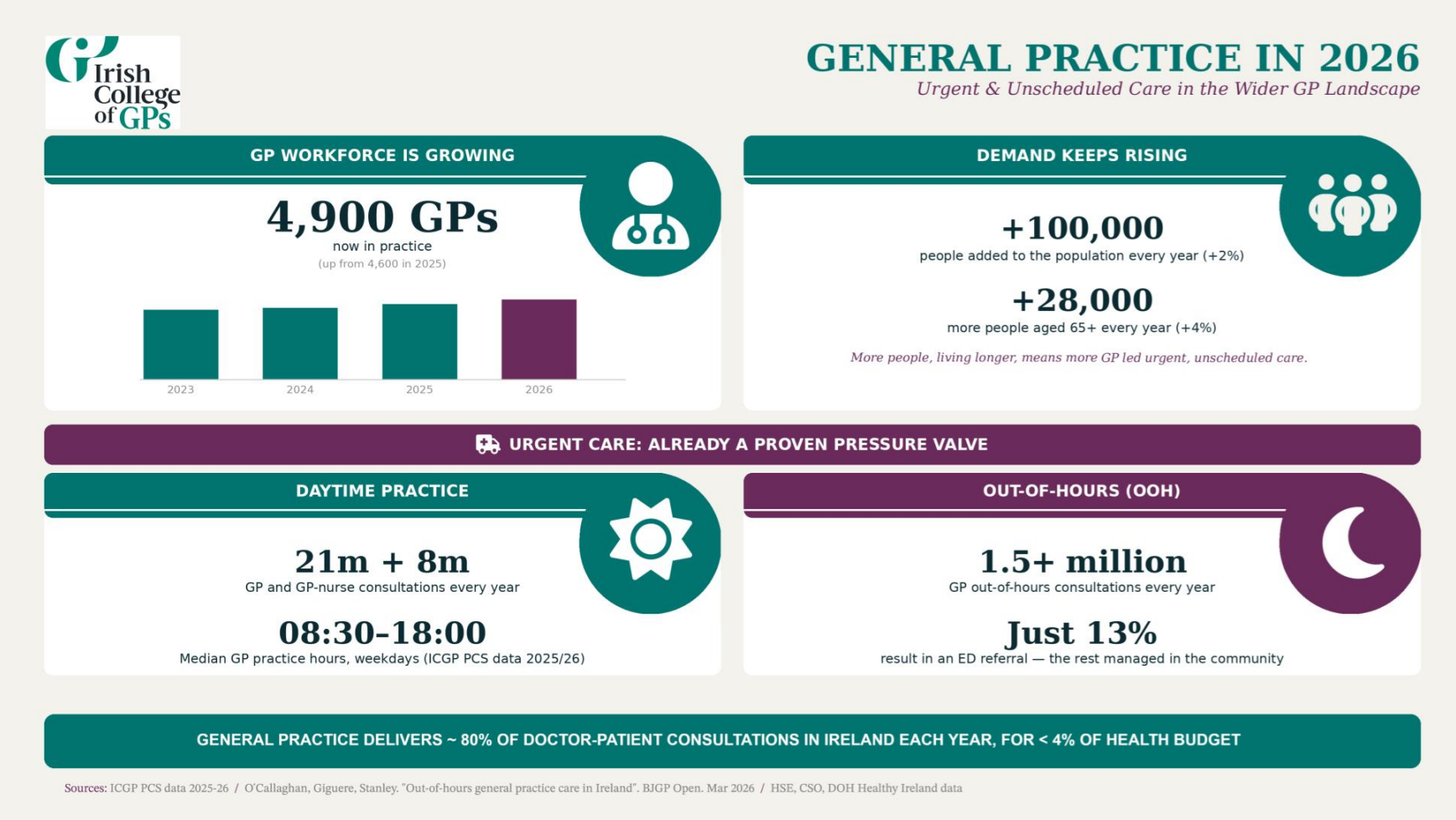
Urgent and Unscheduled care…

“Ní Neart Go Cur Le Chéile"

Whole system perspective

- Communication with stakeholders
- Governance of clinical decisions
- Resourcing: “End-to-end”
- Evaluation: “End-to-end”

General Practice in 2026



Panel Discussion

Moderator – Dr Colm Henry, Chief Clinical Officer

- **Sara Long** , REO, HSE Dublin and North East
- **Eamonn Rogers**
- **Dr Ellen Cosgrave**
- **Prof. Pat Nash**
- **Prof. Mark Corrigan**
- **Dr Diarmuid Quinlan**

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Closing Remarks

Dr Colm Henry
Chief Clinical Officer

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Conclusion of Breakout Session

Please proceed to The Auditorium (Levels 3 / 4 / 5)
for the Closing Ceremony

Next session commences
at 16:00

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Imeacht Gaolmhar | Associated Event