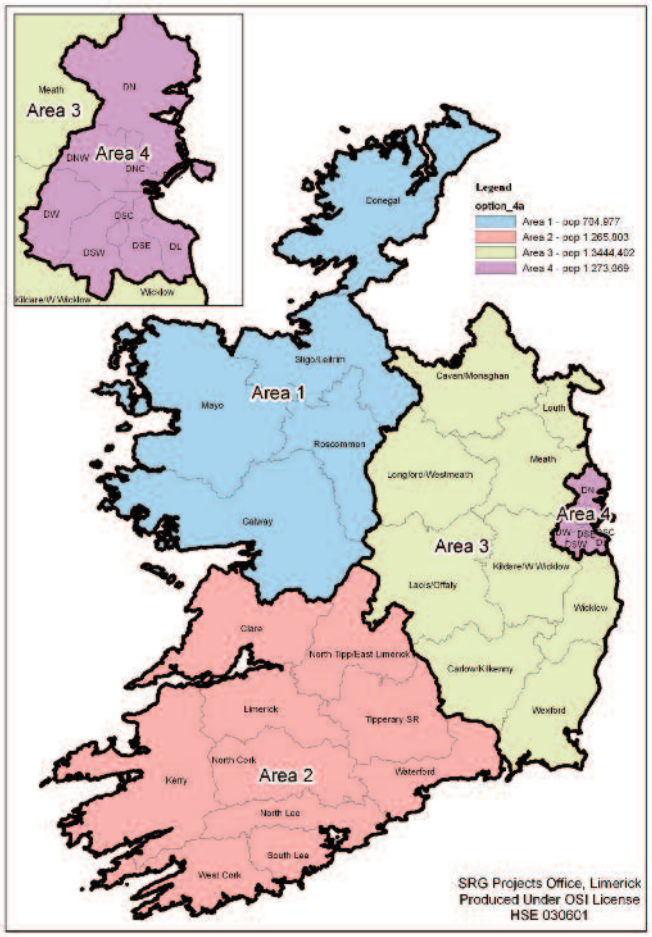
6.4.4 Option 4 – An Alternative Approach to Dublin

Option 4A

The issue of Dublin has been raised at many workshops, i.e. that Dublin is an area which needs to be treated differently and that approaches in the past have not worked. This issue has been identified by other state departments too (see *Putting People First – Action Programme for Effective Local Government, October 2012)*. The map below illustrates an alternative approach for health service delivery. In this example the all 4 Dublin Councils are joined together to form a discrete service area. To maintain relevant scale and size the rest of the country is broken up into three Areas for the rest of this option.



Population & Description Table – Option 4A		
Area	**Total 2011**	**Description**
1	704,977	Donegal LHO, Sligo/Leitrim/West Cavan LHO, Galway, Roscommon and Mayo LHOs
2	1,265,803	Clare LHO, Limerick LHO, North Tipperary/East Limerick LHO, Kerry LHO, North Cork LHO, North Lee LHO, South Lee LHO West Cork LHO, South Tipperary LHO, Waterford LHO
3	1,344,402	Laois/Offaly LHO, Longford/Westmeath LHO, Louth LHO and Meath LHO, Wicklow LHO; Cavan/Monaghan LHO; Kildare/West Wicklow LHO, Carlow Kilkenny LHO, and Wexford LHO
4	1,273,069	Dublin North LHO, Dublin North Central LHO and Dublin North West LHO; Dún Laoghaire LHO, Dublin South East LHO and Dublin South City LHO; Dublin West LHO and Dublin South West LHO
Average	***1,147,063***	
Max	***1,344,402***	
Min	***704,977***	

The following table details the advantages and disadvantages of this option against each criterion.

ASSESSMENT AGAINST CRITERIA – Option 4A		
Criteria	**Advantages**	**Disadvantages**
Internal Integration	▪ This option maintains primary care team boundaries. ▪ This option maintains LHO boundaries	▪ The Hospital Groups are split between different areas, only two Hospital Groups will deal only with one area, all the others will deal with two or more areas. ▪ Regional boundaries are not maintained. ▪ It does not maintain ISA boundaries. ▪ A number of areas will not match the 16 mental health areas i.e. Carlow Kilkenny and South Tipperary are not together and Waterford is not with Dún Laoghaire and Dublin South East

ASSESSMENT AGAINST CRITERIA – Option 4A		
Criteria	**Advantages**	**Disadvantages**
Demographics / Deprivation	▪ The biggest area is 1,344K and the smallest is 705K the average for this option is 1,147K.	
Self Sustaining / Manageability Factors	▪ The areas are of a sufficient size to become self-sustaining.	▪ The areas are so big they may warrant additional tiers of management.
Geographical / Physical / Cultural	▪ From a public perspective there would be good relatability to the Dublin area.	▪ The rest of the country is of such a scale that the relatability of the areas is in question.
External Integration Issues	▪ This proposal would ease working relationships with the Dublin local authorities and the Dublin health area.	▪ The population of the greater Dublin area, particularly Kildare and Wicklow, may be impacted as they would normally gravitate to Dublin for secondary care services.

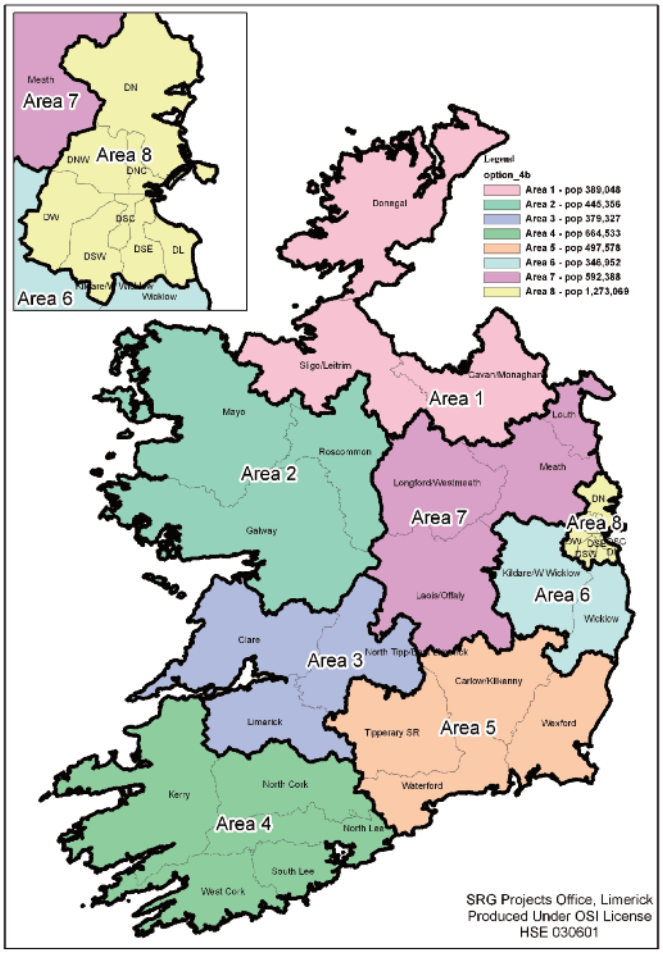
Resources

OPTION 4A	2013 Budget €m *	WTE
Area 1: Donegal LHO, Sligo/Leitrim/West Cavan LHO, Galway, Roscommon and Mayo LHOs	621	6,417
Area 2: Clare LHO, Limerick LHO, North Tipperary/East Limerick LHO, Kerry LHO, North Cork LHO, North Lee LHO, South Lee LHO West Cork LHO, South Tipperary LHO, Waterford LHO	983	11,821
Area 3: Laois/Offaly LHO, Longford/Westmeath LHO, Louth LHO and Meath LHO, Wicklow LHO; Cavan/Monaghan LHO; Kildare/West Wicklow LHO, Carlow Kilkenny LHO, and Wexford LHO	838	12,433
Area 4: Dublin North LHO, Dublin North Central LHO and Dublin North West LHO; Dún Laoghaire LHO, Dublin South East LHO and Dublin South City LHO; Dublin West LHO and Dublin South West LHO	1,156	10,186
National Total	**3,597**	**40,857**

**The financial figures are indicative of the budget within the proposed Community Healthcare Organisations in this option and do not include PCRS and Fair Deal resources.*

Option 4B

This option sets out a proposal which suggests eight successor Community Healthcare Organisations to the existing ISAs (from hereon this shall be referred to as "option 4B"). This option maintains former "LHO boundaries" except the Dublin Area where all four Dublin Councils are joined together to form a discrete service area. This option was to maximise in so far as possible primary and secondary care with an alternative approach to Dublin. However keeping Dublin as an entity in itself leaves Kildare/Wicklow area not being a natural configuration in that context as many of the secondary care flows would be to Dublin and there are geographical difficulties in this area.



Population & Description Table – Option 4B		
Area	**Total 2011**	**Description**
1	389,048	Donegal LHO, Sligo/Leitrim/West Cavan LHO and Cavan/Monaghan LHO.
2	445,356	Galway, Roscommon and Mayo LHOs
3	379,327	Clare LHO, Limerick LHO and North Tipperary/East Limerick LHO.
4	664,533	Kerry LHO, North Cork LHO, North Lee LHO, South Lee LHO and West Cork LHO
5	497,578	South Tipperary LHO, Carlow/Kilkenny LHO, Waterford LHO and Wexford LHO
6	346,952	Wicklow LHO, Kildare/West Wicklow LHO
7	592,388	Laois/Offaly LHO, Longford/Westmeath LHO, Louth LHO and Meath LHO
8	1,273,069	Dublin West LHO, Dublin South City LHO, Dublin South West LHO Dún Laoghaire LHO, Dublin South East LHO, Dublin North LHO, Dublin North Central LHO and Dublin North West LHO
Average	***573,531***	
Max	***1,273,069***	
Min	***346,952***	

The following table details the advantages and disadvantages of this option against each criterion.

ASSESSMENT AGAINST CRITERIA – Option 4B		
Criteria	**Advantages**	**Disadvantages**
Internal Integration	▪ LHOs are the building blocks for these new areas. ▪ All but two current ISA boundaries are maintained. ▪ With the exception of Boyle in Roscommon and PCTs in South Meath and Kildare and Wicklow, would maximise primary care and secondary care catchments.	▪ One area has only one hospital within it; the Hospital Groups are spread across multiple areas with the exception of the Mid West. ▪ Regional boundaries are not maintained. ▪ Mental Health areas are not maintained in all areas i.e. Midlands and Kildare or for Wicklow with Dún Laoghaire and Dublin South East.

ASSESSMENT AGAINST CRITERIA – Option 4B		
Criteria	**Advantages**	**Disadvantages**
Demographics / Deprivation	▪ The biggest area is 1,273K and the smallest is 347K the average for this option is 574K	
Self Sustaining /Manageability Factors	▪ Each area is a viable size to become self-sustaining. ▪ The areas aren't too large to warrant additional layers of management.	
Geographical / Physical / Cultural	▪ The LHOs of Kildare and W/Wicklow and the LHO of Wicklow are not a workable option due to travel patterns and primary and secondary care flows.	▪ Relatability – the Midlands with Louth and Meath may not make sense to everyone ▪ Cavan/Monaghan with Donegal and Sligo/Leitrim is new from a health perspective, however this is well recognised from joint border working arrangements. (Louth has not been included in this border area to match the new proposed Regional Assemblies)
External Integration Issues	▪ This area does offer advantages for improving cross border connectivity. ▪ Co. Cavan is no longer divided between two areas thus making linking with local authorities easier for HSE staff and vice versa	

Resources

OPTION 4B	2013 Budget €m*	WTE
Area 1 Donegal LHO, Sligo/Leitrim/West Cavan LHO and Cavan/Monaghan LHO.	329	3,033
Area 2 Galway, Roscommon and Mayo LHOs	374	4,399
Area 3 Clare LHO, Limerick LHO and North Tipperary/East Limerick LHO.	308	3,713
Area 4 Kerry LHO, North Cork LHO, North Lee LHO, South Lee LHO and West Cork LHO	513	6,046
Area 5 South Tipperary LHO, Carlow/Kilkenny LHO, Waterford LHO and Wexford LHO	349	4,069
Area 6 Wicklow LHO, Kildare/West Wicklow LHO	209	3,923
Area 7 Laois/Offaly LHO, Longford/Westmeath LHO, Louth LHO and Meath LHO	360	5,488
Area 8 Dublin West LHO, Dublin South City LHO, Dublin South West LHO Dún Laoghaire LHO, Dublin South East LHO, Dublin North LHO, Dublin North Central LHO and Dublin North West LHO	1,156	10,186
National Total	**3,597**	**40,857**

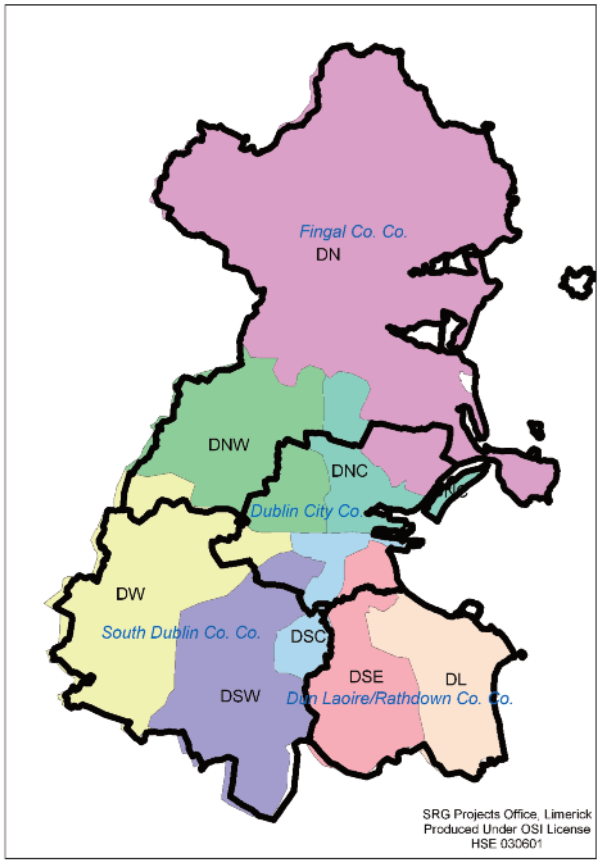
**The financial figures are indicative of the budget within the proposed Community Healthcare Organisations in this option and do not include PCRS and Fair Deal resources.*

Option 4C

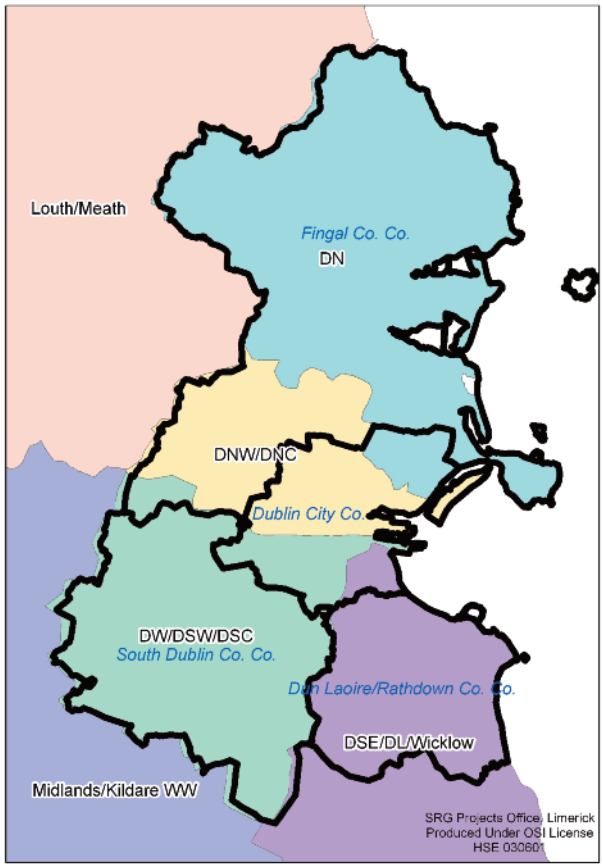
This option is to show the 4 County Councils in Dublin overlaying the former Local Health Office Boundaries.

Area	Total 2011
Dublin City	527,612
Dún Laoghaire – Rathdown	206,261
Fingal	273,991
South Dublin	265,205

The following map sets out the Dublin LHOs with the Local Authority boundaries overlaid in black



The following map sets out the *Vision for Change* areas with the Local Authorities superimposed on it.



Population table – Option 4C – Populations of Dublin Local Authorities	
Area	**Total 2011**
Dublin City	527,612
Dún Laoghaire – Rathdown	206,261
Fingal	273,991
South Dublin	265,205
Total	**1,273,069**

The following table details the advantages and disadvantages of this option against each criterion.

ASSESSMENT AGAINST CRITERIA – Option 4C		
Criteria	**Advantages**	**Disadvantages**
Internal Integration		▪ Clearly cuts across all Local Health Offices, and ISAs and Mental Health areas, this would impact from a change management perspective especially in the context of financial and data management systems. ▪ Significant reconfiguration would be required with this solution. ▪ Due to the close proximity of the major hospitals almost all would fall into the area of Dublin City, Fingal would just have Connolly Hospital, South Dublin would have ANMCH and Dún Laoghaire would have St Michael's and St Colmcille's Hospitals.
Demographics / Deprivation		▪ Three of the new areas in this solution have very small populations; if equity of approach was taken towards the rest of the country then there would be a very limited reduction in overall ISA numbers from the current 17.
Self Sustaining / Manageability Factors		▪ Areas of this size are too small to be self sustaining.
Geographical / Physical / Cultural		▪ Culturally this would be a difficult change to adopt for health care services.
External Integration Issues	▪ For Dublin this would be a positive step towards integration with local authorities.	

6.5 Options Appraisal Process

Having regard to the consultation process and best practice approaches, the project team developed key criteria to guide decision making on the number, scale and geography of the Community Healthcare Organisations. However, it must be recognised that no one factor in itself is capable of determining the outcome.

Four main options were identified and in respect of two of these, option 2 and 4, a number of variations were identified. In total therefore seven options were identified for consideration.

The criteria identified are: Internal Integration; Demographics/Deprivation; Self sustaining / Manageability Factors; Geographical/Physical/Cultural; External integration issues – These are elaborated on 6.3.1. In the context of these criteria particular note and consideration was given to

- Co-terminosity with Hospital Groups;
- Maximising primary and secondary care pathways;
- Co-terminosity with Local Authorities;
- An alternative approach to Dublin.

A proposal or number of proposals were developed for each approach. In total therefore the project team has developed comprehensive information in respect of seven proposals, which are outlined and discussed in detail in this chapter. If the dominant weighting is placed on the four considerations above the following emerges.

6.5.1 Phase 1

- **Co-terminosity with Hospital Groups**
  Option 1 – this proposal places an emphasis on the closest fit and co-terminosity with the Hospital Groups. This identifies 6 successor Community Healthcare Organisations to the existing ISAs. It should be noted that due to the location of the hospitals in some former LHOs which have hospitals from a number of the groups in them, it is not possible to assign each hospital a discrete catchment area.

- **Maximising Primary and Secondary Care Pathways**
  Option 2A - emphasises the relationship between the PCT and Networks and secondary care pathways. This identifies nine successor community organisations to the existing ISAs.
  Option 2B - is based on the same premise as option 2A, however it puts a particular emphasis on securing benefits of scale, equivalent to that of the hospitals in terms of size, etc. This identifies 6 successor community organisations to the existing ISAs with a different geographic configuration to option 1.

- **Co-terminosity with Local Authorities**
  Option 3 - places an emphasis on local authority boundaries and the new proposed Regional Assemblies. This identifies nine successor community organisations to the existing ISAs.

- **An Alternative Approach to Dublin**
  Option 4A - places a particular emphasis on the greater Dublin area, which was identified during the consultation process as potentially requiring a different approach to the rest of the country. This has also featured in previous discussions on reorganisation. The illustration in this option separates Dublin and breaks the remainder of the country into three areas. In this option the focus less on how the rest of the country is to be divided– a single Dublin body is the key issue reflected.
  Option 4B - The illustration in this option separates Dublin and breaks the remainder of the country broadly similar to option 2A. This has the benefit of both an alternative approach to Dublin and also maximises primary and secondary care pathways for the rest of the country. There are however issues surrounding the geographical isolation of Wicklow and Kildare when this approach is taken as they would gravitate towards Dublin and do not form a natural Community Healthcare Organisation area. This area in itself would not maximise secondary care/primary care interface and also it would isolate east Wicklow.

  Option 4C - This proposal only shows Dublin, and illustrates the four Local Authorities in Dublin superimposed over the previous ten LHOs. This would involve significant reconfiguration for the Health Service especially from a financial and data reporting perspective and may not form Community Healthcare Organisation areas which would be sufficiently large enough to become self sustaining. It would also lessen natural primary and secondary care linkages

6.5.2 Phase 2

In its deliberations a number of key considerations were identified and examined by the project team, namely:

- Emphasis on Community and Integration
- Local Authorities
- Childcare Services
- Efficiency of Scale
- Design of Governance and Management Structures at Area and Sub-Area level
- Supporting UHI Environment.

The implications of each of these was examined:

- ***Emphasis on Community and Integration***

  Informed by the literature and from experience in both service delivery and change management, an important consideration throughout the consultation process centred around striking the right balance between two considerations:

  - Sufficiently large scale to justify the organisational architecture, business and service capability.
  - Sufficiently small scale to provide the local agility, community connectivity and responsiveness required to deliver effective integrated care on a sustainable basis.

  Much of the deliberation of the project team and throughout the consultation process has come back to these issues. Ultimately, having considered all of the evidence striking this balance appropriately in an Irish context is a matter of judgement. It is appropriate therefore that the final decisions in these matters will be determined by Government. The responsibility of the project team has been to establish a strong evidence base to support decision making and bring forward a recommendation based on the project team's best judgement, as to the proposal best suited to meet the needs of the Irish Health System. The proposal needs to safely support the delivery of services through the next transition phase to the ultimate destination of a commissioning model with a purchaser/provider spilt and a UHI environment.

  The project team has been struck by the importance which has been placed by stakeholders on developing an organisational structure (number, scale and boundaries) and governance model, which will meet the needs of people in terms of community service provision and can ensure appropriate integration with other health services such as hospitals as well as the wider public sector. *Healthy Ireland* stressed the importance of identifying local structure for implementation of the strategy and how they can be supported to work on common agendas. It is at this local level that individuals, community and voluntary groups and projects, sporting partnerships, local schools, businesses, primary care teams, community Gardaí, etc. can interact to work together. This wider concept of community was emphasised throughout the consultation, indicating a requirement for the new Community Healthcare Organisations to be developed in a way that supports and enables communities to meet the needs of their people.

- ***Local Authorities***

  The importance of maximising the capacity for effective engagement and integration in service delivery, between the new provider organisations on the community side with local authorities, was emphasised throughout the process. Each of the Divisions within the Health Service Directorate highlighted specific requirements which are important into the future. The necessity for close engagement in relation to planning and development were obvious for all. Equally there are well established arrangements in respect of ambulance and emergency services generally, including emergency planning, transport and other related issues.

  It is important to recognise and plan for effective collaboration in relation to social care services for older people and people with a disability, including all aspects of housing and engagement with voluntary sector partners. This is equally important for example in the mental health services where the issues of residential accommodation are important as is the development of cross sector initiatives in the areas of suicide prevention, etc.

  The necessity for a whole of government approach to the health and wellbeing of the population as articulated in government approved policy *Healthy Ireland*, will require significant collaboration between the health service and local government at all levels to ensure the necessary cross sectoral approaches, which are at the root of effectively tackling the determinants of health, in a long term sustainable manner.

The development of models such as the County Committees for Childcare and county wide initiatives around Ageing Well Networks, etc. provide potentially beneficial frameworks for effective integration of services into the future which will better serve local communities and maximise the utilisation of resource on a cross-sectoral basis.

Apart from all of these aspects, identification with counties in an Irish context is very strong and the project team was encouraged not to breach the integrity of counties if possible in the development of the Community Healthcare Organisations. The importance of local government and county constituencies in terms of local accountability and communication were also emphasised. While these are important they need to be balanced with wider considerations in terms of health service provision relating to resource allocation and delivery of services to an appropriate scale of population.

- ***Childcare Services***

  Many of the issues referenced above relating to local authorities and integration are also relevant to the Child and Family Agency and were emphasised throughout the consultation process. The setting up of the new Child and Family Agency will place an onus on both agencies to ensure collaboration and a seamless service to achieve good outcomes for children.

- ***Efficiency of Scale***

  Clearly, given the overall economic situation, it is imperative that the organisational structure within the health service is fit for purpose and maximises benefits in terms of efficiency of scale in the use of shared service platforms, eliminating the duplication of management structures. At the same time, as outlined earlier, the benefits in terms of value for money which can be achieved through scale must be balanced in ensuring that the Community Healthcare Organisations are fit for purpose in delivering high quality outcomes and a sustainable service model to support local communities into the future. In this context all of the options and proposals brought forward in this report recommend a reduction in the number of current ISAs. The various options recommend a variety of six, eight or nine Community Healthcare Organisations.

- ***Design of Governance and Management Structures Area and Sub Area Level***

  An important focus of the deliberations of the project team has been to assess the balance of advantage of these proposals in the context of the criteria outlined in this chapter. However, the project team has also taken account of the impact of the boundaries, number and scale of the Community Healthcare Organisations on the governance and management model required to successfully implement the change programme. The proposals will not give rise to unnecessary layers of management which may be inefficient from a cost point of view but also in terms of minimising the number of layers from the head of the organisation to the front line. It is important to emphasise also that there will continue to be a national focus in the development of integrated financial and HR systems as well as a shared service platform across the wider health sector.

- ***Supporting UHI Environment***

  The project team is also cognisant in determining boundaries, number and scale of Community Healthcare Organisations that these would need to support the governance and management structure required to deliver on the phased implementation of a commissioning model with a purchaser / provider spilt operating within a UHI environment.

6.5.3 Discussion on Options

In reviewing all of the above and considering the options identified earlier informed by these considerations the project team identified two options i.e. six or nine Community Healthcare Organisations as best fits to achieve delivery on the considerations identified. These two options as well as specific consideration of Dublin were then the subject of further analysis.

- **Options Around Six Community Healthcare Organisations**

  In considering the options with proposals for six Community Healthcare Organisations there was a clear view within the project team and evident in the consultation process in relation to the preference among these options.

  Notwithstanding that option 2B was developed on the basis of rolling up option 2A to achieve the level of scale more comparable to the Hospital Group; the proposal on reflection held considerable disadvantages in that it was clear that a number of areas were regional in scale (particularly Areas 1, 2 and 3 in this proposal). Area 1 and 2 between them covered over half the geography of the country as well as half the population. The sub structures required under this heading would be significant and in addition there was a strong view that these areas would not facilitate the level of connectivity required at local community level to achieve the objectives of the overall strategy of *Future Health* and indeed the emphasis and criteria outlined in this report.

  Of these options, option 1, which maximises the alignment with the Hospital Groups, was regarded as a far more viable option than option 2B.

  It remains a challenge to option 1 that some of the areas were regional in scale and would require levels of sub structure, which while being less than option 2B were more than option 2A. In addition while this option did align broadly with the local authority at county level, option 2A provided a better fit, while also maximising the primary / secondary care interface. Option 1 also loses the benefit of the border connectivity.

- **Options around nine Community Healthcare Organisations**

  Option 2A emphasised the relationship between the Primary Care Team and Networks and secondary care pathways. Very significant work has been done on patient flows and primary care catchment referrals to secondary care over the past number of years, both in the original establishment of the HSE, the establishment of regional boundaries and in particular ISA structures thereafter.

  It is noted that Option 3 placed an emphasis on local authority boundaries and the new proposed Regional Assemblies. It was clear at an early stage that the scale of the Regional Assemblies – three proposed for Ireland – were of such a scale that to be too large to meet the majority of the criteria outlined by the project team. At the same time however, the Regional Assemblies are drawn together from the local authority boundaries.

  Option 2A and Option 3 gave rise to very similar proposals identifying nine Community Healthcare Organisations even though there was a fundamentally different approach taken to their development. While there are some minor differences between the proposals under both options, it was considered that Option 2A was the more appropriate of these two, as it met a broad range of the criteria, but in particular met the key requirement of linking the PCTs/Networks and secondary care while also providing a very strong basis for linkage with local authority boundaries, both in the context of county councils and the proposed Regional Assemblies in the future.

  The approach outlined in Better Local Government - *"Putting People First – Action Programme for Effective Local Government, October 2012"* in respect of the Regional Assemblies and their role for high level spatial planning around larger geographic areas, provides a useful model for potential future collaboration between local government and the nine Community Healthcare Organisations identified in Option 2A.

In the future consideration might also be given to reorganisation of the Regional Fora within the health service along these lines to develop collaboration at a regional level between local authorities and the health service which hasn't been sufficiently evident to date.

This higher level process for engagement could also address the anomalies within the proposal, whereby North Tipperary and South Tipperary are split between the proposed Mid-West and the South-East areas. Similarly this Regional Assembly approach may provide a mechanism to provide the high level of collaboration required in Dublin and the greater metropolitan area.

Option 2A therefore meets a very significant number of criteria outlined providing the best range in terms of population and resources; significantly reducing by nearly 50% the number of ISAs; while not requiring additional layers or sub-layers of management within the Community Healthcare Organisations proposed under this option. This option has a population average of 510K with a modest range of population from 364K to 674K.

- **Dublin Issues**

  The remaining options and proposals flowed from a recognition of particular challenges associated with the Dublin area, both in terms of the density of population within a relatively small geographic area compared to the rest of the country and also the alignment with local authorities. Given the importance of relationship with local authorities, the project team looked carefully at the options in this regard. The challenge in dealing with particular issues in Dublin (around social inclusion, homelessness, drug and alcohol addiction services, housing issues across a range of services) it required a consideration of the potential of developing one organisation for Dublin. The details of this are set out in Options 4A, 4B and 4C.

  Option 4A sets out Dublin as an option on its own with a population of 1.3 million people and with the areas across the country of equivalent scale in population size. It was evident early on that similar to the scale of Regional Assemblies and existing regions, that such bodies outside of Dublin would be too large and not meet a significant number of the criteria or requirements of the health sector in respect of delivery of community services.

  The alternative therefore was to broadly apply option 2A to the scenario while maintaining Dublin as an area on its own and in this context a proposal with eight areas emerges, this is Option 4B. Many areas remain the same as option 2A, however area 6 Kildare Wicklow emerges as a challenge, not being a natural configuration. It also poses challenges as many of the secondary care flows would be to Dublin. In addition there are significant challenges with one area of the scale of 1.3 million people and a resource in the order of €1.9bn, while the remaining range on average at 500,000 population and a budget of between €380m -€700m.

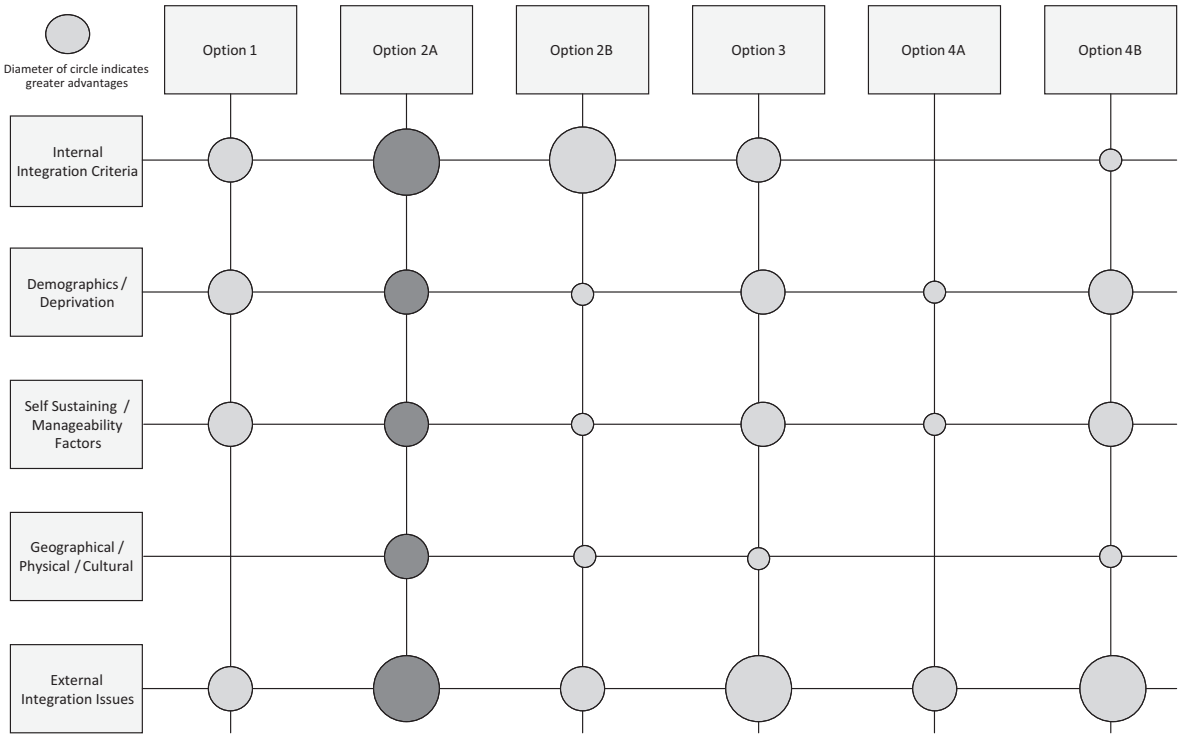
  Such an arrangement, while providing benefits in relation to the challenges of social inclusion and local authority issues, provide significant disadvantages both in terms of the hospitals and the wider community services. There is also a concern of significant imbalance between Dublin and the rest of the country if such a model was developed. With the concentration of both hospital and community services in Dublin of such a scale that they would undermine the potential benefits of a UHI environment and a commissioning purchaser / provider spilt.

  Option 4C gives consideration to configuring Dublin with the four local authority areas. However this option proves particularly challenging for the health services given the existing financial, HR, planning and data systems as these have been developed on the basis of the LHO (and the old Community Care Areas). It is not possible to configure the Dublin local authorities in a way which does not significantly cut across these existing boundaries.

  It is clear however, that for certain services, it may be advisable to develop a mechanism to support an approach for planning and other purposes across Dublin as a whole. It is the view of the project team that such a mechanism could be developed as part of the regional assembly arrangements, which are being developed through local government. A Dublin wide group could be developed to engage with the health sector specifically in relation to these issues to ensure the type of integrated approach that is required.

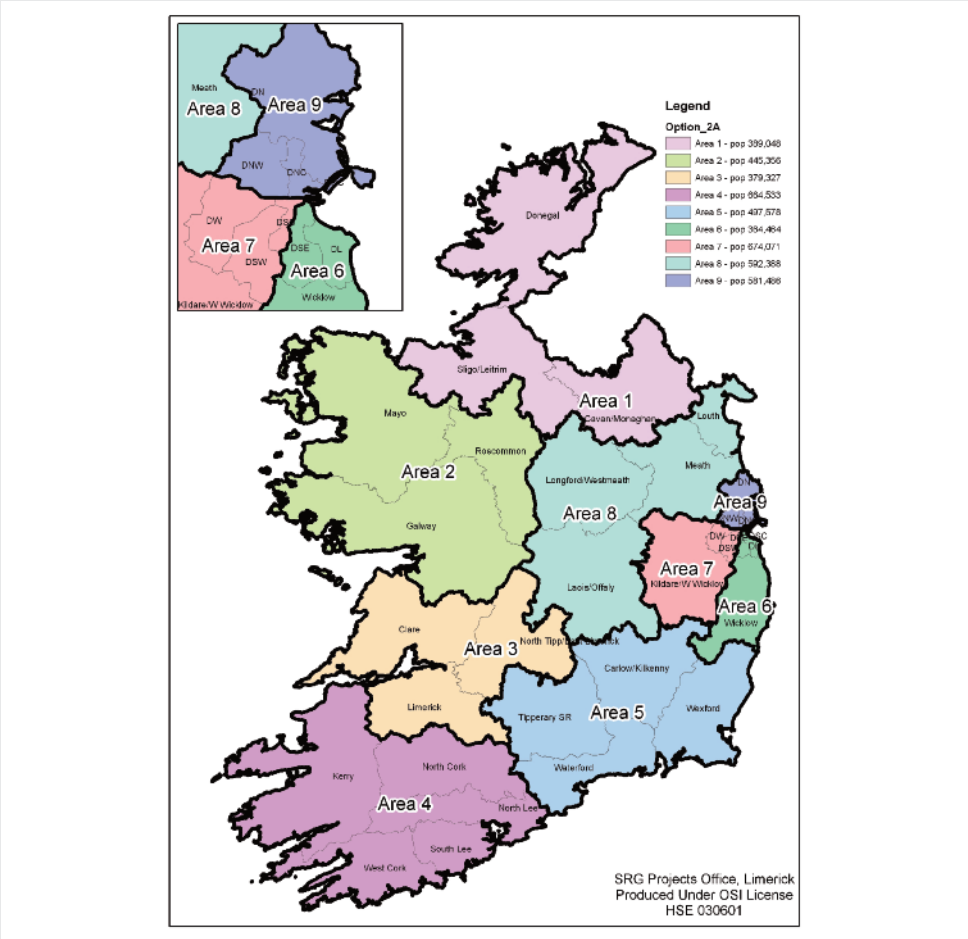
6.5.4 Evaluation of Options Against Decision Criteria

The following schematic illustrates how each option is evaluated against each of the decision criteria discussed in this chapter



It is clear from the above schematic that Option 2A and to a lesser extent Option 3 offer greater advantages when evaluated against the various criteria. (Option 4C is not evaluated here as it was only specific to Dublin counties).

6.6 Outcome of Option Appraisal and Recommended Option



- Option 2A, is considered the most appropriate proposal to recommend as:
    - it met a broad range of the criteria;
    - met a key requirement of linking the Primary Care Networks and PCTs and secondary care;
    - while also providing a very strong basis for linkage with local authority boundaries, both in the context of county councils and the proposed Regional Assemblies in the future;
    - provides the best fit in striking the right balance between an organisation of sufficiently large scale to justify organisation and business capability, while at the same time being sufficiently small scale to provide the local community connectivity and responsiveness required to deliver integrated care.
- It would be advisable to develop a mechanism to support an approach for planning, social inclusion and related purposes across Dublin as a whole. This could be developed as part of the Regional Assembly arrangements, through which a Dublin wide group could be developed to engage with the health sector.

  In the future consideration might also be given to reorganisation of the Regional Fora within the health service along these lines to develop collaboration at a regional level between local authorities and the health service which hasn't been sufficiently evident to date.
- The option 2A of nine Community Healthcare Organisations is recommended.