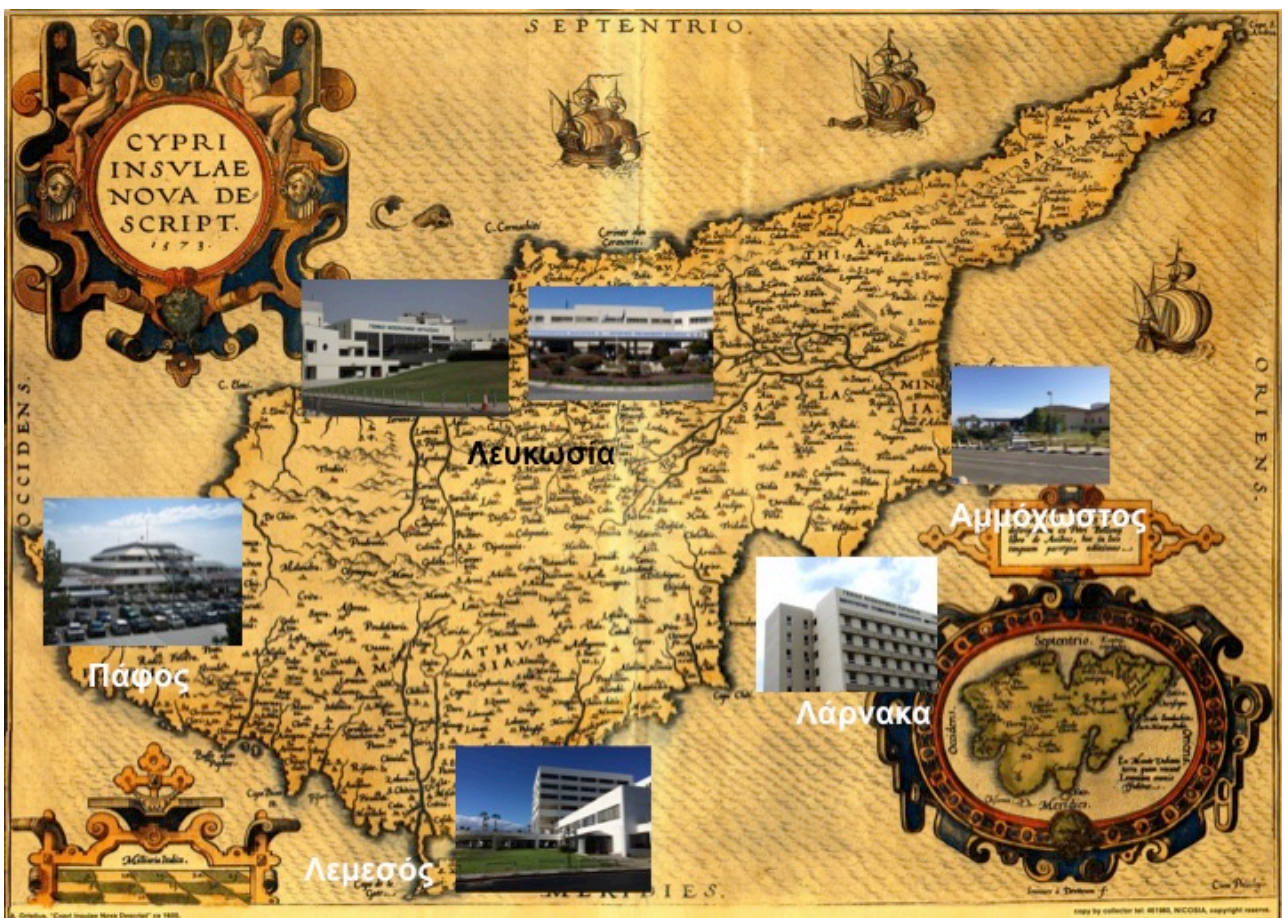


Designing the organizational structure of new autonomous organizations

Support to the Health Reform Programme of Cyprus Government

Alexandre Lourenço – 16 March 2015



Internal Ministry of Health document for Official Use Only

Executive Summary

Over the last two decades, there have been proposals to reorganize the Ministry of Health (MoH) and transfer some administrative authority to public hospitals. According to these proposals, public hospitals would be converted into public legal entities, allowing them a considerable degree of autonomy to manage their resources while remaining accountable to the MoH. The Revised Memorandum of Understanding (MoU), as it stands on September 2014, requires the MoH to take action on restructuring public hospitals. The MoH released a draft bill related to the autonomy of public hospitals for consultation on 11th December 2014.

Several weaknesses of the current governance model have been previously identified, and corroborated by the present mission. To address these weaknesses and steward the overall process of provider autonomisation it is recommended to create a taskforce that will work over the next 3-5 years to manage the overall process of change, assure stakeholder participation, and develop planning, quality management, financial management, human resources management, information and evaluation tools. This taskforce will be also responsible for assessing and publicizing performance of each hospital and their *Board of Directors* (BoD) and *Executive Board* (EB).

Considering the international evidence, and the conclusions of public consultations and meetings, it is recommended that the corporate governance model consists in a two-tier system with two separate boards: an Executive Board chaired by a Chief Executive Officer for day-to-day management and a supervisory Board of Directors, *presided over by a Chairman* to oversee the Executive Board. This ensures a distinction between management by the Executive Board and governance by the Board of Directors, allowing clear lines of authority.

The recommended composition of the Board of Directors takes into account different stakeholders, namely the patients, the direct *shareholders* (*i.e.* Ministry of Health, Ministry of Finance), the health professionals and the management team. Members of the Executive Board are selected through an independent recruitment and selection process. It shall consist of a Chief Executive Officer (CEO), a Chief Medical Officer (CMO) who is also Deputy CEO, a Chief Primary Healthcare Services Officer (CPHSO) who is also the Deputy Chief Medical Officer, a Chief Nursing Officer, a Chief Scientific Officer (CSO), a Chief Financial Officer (CFO), and a Chief Operations Officer (COO).

In order to engage professionals and promote continuous quality improvement, the Governance Model considers a *Scientific Council* chaired by the Chief Executive Officer. The Scientific Council shall involve all members of the Executive Board, Division Directors, Nurse Coordinators, and Head of Departments, as well as other health professions as decided by the Executive Board.

The functional management level is structured into divisions, departments and functional units. The department is the basic unit of organization, working alone or integrated into divisions. Autonomous Organisation (AO) departments and divisions can be (a) Clinical Departments/Divisions, usually associated with medical specialties, (b) Scientific Support Departments, or (c) Administrative Support Divisions/ Departments. To support Clinical Departments/Divisions, Nursing Services are organized according to different hospital settings, allowing flexibility and breaking the "silo" effect that some traditionally structured organizations experience.

The report also assumes that the organizational structure should vary from hospital to hospital: larger hospitals have more complex organizational structures and smaller hospitals tend to have much simpler organizational structures. So, Cypriot AO can be classified in 4 levels of complexity according to dimension.

List of Abbreviations

AO	Autonomous Organization
BoD	Board of Directors
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operations Officer
CPHSO	Chief Primary Healthcare Services Officer
CSO	Chief Scientist Officer
EC	European Commission
EHR	Electronic Health Record
EMD	Executive Medical Director
ERN	European Reference Networks
EU	European Union
GDP	Gross domestic product
GoC	Government of Cyprus
HIO	Health Insurance Organization
HiT	Health systems in Transition series of the European Observatory
ICT	Information and communication technology
IMF	International Monetary Fund
MoH	Ministry of Health
MoU	Memorandum of Understanding
NHS	National Health (Insurance) System
OECD	Organization of Economic Cooperation and Development
OS	Outpatient Services
PAR	Public Administration Reform
PHC	Primary health care
SC	Scientific Council
SHM	Senior Health Manager
WB	World Bank
WHO	World Health Organization

Preface

This report was prepared as a part of the World Health Organization support to the Health Reform Programme of the Cyprus Government.

The objectives of the report are to analyse the functions currently performed and services provided, propose revisions to the functions of the new autonomous organisations, and propose an initial organizational structure of the newly autonomous hospitals and district health services, with an explanation of the rationale behind it.

The author is grateful for suggestions and advice received during consultations with government officials of the Republic of Cyprus, primarily representatives of the Ministry of Health.

Contents

EXECUTIVE SUMMARY	2
LIST OF ABBREVIATIONS	4
PREFACE	5
CONTENTS	6
TERMS OF REFERENCE	7
WORK UNDERTAKEN (MOST RELEVANT)	10
SITUATION ANALYSIS AND FINDINGS	12
PROPOSALS/RECOMMENDATIONS	19
AUTONOMY IMPLEMENTATION TASK FORCE	19
CORPORATE MANAGEMENT LEVEL BOARD OF DIRECTORS AND EXECUTIVE BOARD	19
SCIENTIFIC COUNCIL AND ADVISORY COMMITTEES	28
INTERNAL AUDITING	30
EXTERNAL AUDITING	31
EXECUTIVE BOARD RECRUITMENT, SELECTION PROCESS, AND REMUNERATION	32
FUNCTIONAL MANAGEMENT LEVEL DIVISIONS, DEPARTMENTS AND FUNCTIONAL UNITS	34
THE PRIMARY CARE DIVISION	50
REFERENCES	51
ANNEX - HOSPITAL ORGANIZATION CHARTS	53
FAMAGUSTA GENERAL HOSPITAL ORGANIZATIONAL CHART	53
LIMASSOL GENERAL HOSPITAL ORGANIZATIONAL CHART	54
NICOSIA GENERAL HOSPITAL ORGANIZATIONAL CHART	55

Terms of Reference

The Ministry of Health and the World Health Organisation have agreed to collaborate on accelerating implementation of the 2014-2016 health reform programme of the Government of Cyprus. The reform programme will modernize, rationalize and substantially improve the quality of Cyprus's health care delivery, ensure equitable access and the sustainability of its financing, and modernize its governance.

The Ministry of Health has begun implementation of reform of Cyprus's health sector, aiming to achieve Universal Health Coverage, equity and solidarity in access and financial contributions, while ensuring free choice of health providers for all beneficiaries, and financial viability. While plans for the reform partly date back to the early nineties, it has gained momentum through the Memorandum of Understanding (MoU) agreed with the European Commission, the European Central Bank and the International Monetary Fund ('the Troika') in November 2012 and its subsequent revisions, in which ambitious deadlines for important milestones and final results were fixed.

A Reform Plan stating the actions to be undertaken to fulfil these obligations has been drafted by the Ministry. According to this plan, legislative changes necessary for the reform have to be approved by the House of Representatives by end-November 2014; and legislative changes relating to implementation have to be approved by end December 2014. In addition, several preparatory activities, studies, costing and budgeting exercises have to be conducted in the short term.

The Minister of Health has nominated a Core Reform Implementation Team (CRIT) within the Ministry. The CRIT will have overall responsibility for the reform. It will be complemented by a Broader Reform Implementation Team consisting of all Directors of Departments and Directorates within the Ministry of Health with their respective teams, as well as of representatives from other related Organizations and Departments of the Government, including the Health Insurance Organization, the Legal Service of the Republic, the Accountant General, the Department of Public Administration and Personnel, the Commissioner for the Reforms in the Public Sector (currently not applicable) and the Directorate General for European Programmes, Coordination and Development.

In order to provide support to these teams, the Ministry of Health has made an agreement with the World Health Organization to set up and lead an Implementation Support Team (IST) in order to provide expert guidance and technical support to maintain the momentum of the reform. The Implementation Support Team will provide capacity building support to the Core Reform Implementation Team on implementation modalities, including advice, coaching, training, technical assistance, troubleshooting and assistance in overcoming obstacles to implementation. While

expert advice will be provided on the formulation of specific decisions, this advice is expected to be aligned with the framework of government decisions and agreements with the Troika, and consistent with the policies of the World Health Organization as directed by its Member States.

One of the objectives of the reform is to ensure access to a mix of high quality public and private care – hospital care, specialized ambulatory care, primary care and public health. In this context, the public health sector will transition towards autonomous organizations, operating as public legal entities, organized into five regions, bringing together the public hospitals and primary healthcare centres for each region under one umbrella, and one specialist institution, Archbishop Makarios III Hospital for Children, making a future total of six autonomous organizations.

More specifically, autonomy of public hospitals is a precondition for establishing hospital networks and for the viable operation of the NHS. Autonomisation is currently envisaged as their evolution into modern, independent entities, operating under public law, with legal, financial, management and scientific autonomy, adopting international best practices and conforming to high quality and efficiency standards. Furthermore, it is aiming at transforming the hospitals into attractive working places for distinguished and committed medical, **nursing** and paramedical staff, where some hospitals could evolve into University Hospitals offering international standards of high quality, state of the art services.

The reform will allow hospitals, in combination with other health facilities (including primary care centres), located in specific administrative areas to form individual autonomous organisations. For the existing public hospitals this implies changes in current structures (i.e. creation of executive management positions and other positions/teams/departments currently missing - such as for managing Human Resources, Marketing, and Health and Safety - and change job descriptions and terms and conditions of employment (Schemes of Service). Changes to job descriptions and terms of service will address duties, reporting lines, evaluation and assessment, career opportunities and promotion.

Each autonomous organisation will have the ownership and responsibility to manage its own human and other resources. Terms and conditions of service of current civil servants will be maintained. Staff recruited after autonomisation may be employed under different terms and conditions, for example under fixed-term employment contracts. This implies maintaining more than one category of employees through a transitional period.

In addition, the current network of public health centres and private practitioners will be transformed into a network of family health units where primary care teams, including specialized family doctors, will take active responsibility for managing the overall health care needs of the people that choose to register with them.

Specific short-term expertise is now required to support the Ministry of Health in addressing five principal tasks:

- (i) designing the organizational structure of the new autonomous organizations;
- (ii) determining staffing levels;
- (iii) developing Job Descriptions for staff in the new organizational structures;
- (iv) developing Terms and Conditions of Service for newly recruited staff in the new organizational structures, and preparing new Employment Contracts for each staff category; and
- (v) developing related Schemes for Performance Management, Performance Evaluation, Career Development and Promotion, and disciplinary procedures.

This work will serve as a basis for negotiating the implementation of this pillar of the reform programme. It will build on existing policies relating to overtime payments and other incentives recently negotiated with trade unions and other employee organisations, and the Ministry of Health will provide full documentation and briefing on all such relevant initiative. This Report addresses the first principal task: designing the organizational structure of the new autonomous organizations.

Work undertaken (most relevant)

Friday, 21/12/2014

Meeting with the Director of Nursing Services Mr Andreas Xenophontos

Meeting with the Chief Health Officer Dr Olga Kalakouta

Meeting with the Acting Director Health Services Ms Egli Constantinou

Monday 24/11/2014

Meeting with Patrick Jeurissen (WHO consultant/ Chief Strategy and Knowledge Management Group, Ministry of Health, Welfare and Sport, Netherlands) and Mrs Sarah Thomson (WHO Senior Health Financing Specialist)

Tuesday 25/11/2014 - Paphos General Hospital

10.00 Meeting with the Director of the Hospital Dr Spyros Georgiou

10.30 Meeting with the Nursing Officer in charge of the Hospital Mrs Chrystalla Kontou

11.00 Meeting with the Directors of the Clinics/ Departments, Pharmacy, Laboratories and Senior Medical Officer Primary Health Care in the presence of the Director of the Hospital and the Nursing Officer in charge

12.00 Meeting with the Senior Medical Officer Primary Health Care Dr Thelma Shaeli)

Wednesday 26/11/2014 - Limassol General Hospital

09.00 Meeting with the Acting Director of the Hospital Dr Panicos Avraamides

09.30 Meeting with the Directors of the Clinics/ Departments, Pharmacy, Laboratories and Senior Medical Officer Primary Health Care (Dr Zambakides) in the presence of the Acting Director of the Hospital and the Nursing Officer in charge

11.00 Meeting with the Nursing Officer in charge of the Hospital Mrs Constantinidou

11.30 Meeting with the Senior Medical Officer Primary Health Care (Dr Zambakides)

Thursday 27/11/14

9.30 Meeting with Xenia Ashikales for legal status of autonomous organizations

12.30 Meeting with PASYKI (Pancyprian Union Government Doctors) for Organizational Structure Autonomous Organizations

15.00 Meeting with PASYNO (Pancyprian Union Nurses) for Organizational Structure Autonomous Organizations

Friday 28/11/14

8.00 - 9.00 Meeting with Act. General Director of MoH and PSO (for PHC and Organizational Structure Autonomous Bodies)

11.00 Meeting with PASYDY (Pancyprian Union Public Servants-General Nursing Branch) for Organizational Structure Autonomous Organizations

Monday 01/12/2014:

09.30 Meeting with the Acting Director of the Ammochostos Hospital Dr Florentia Zeitouni
10.00 Meeting with the Nursing Officer in charge Mrs Trisokka.
10.30 Meeting with Directors of the Clinics/ Departments, Pharmacy, Laboratories in the presence of the Acting Director of the Hospital and the Nursing Officer in charge.
12.00 Meeting with the Director of the Larnaca Hospital Dr Evangelos Evangelou
12.30 Meeting with the Nursing Officer in charge Mrs. Milona
13.00 - 13.30 Meeting with Directors of the Clinics/ Departments, Pharmacy, Laboratories in the presence of the Nursing Officer in charge.
17:00 Meeting with Medical Officers of PA.SY.DY union (cancelled by the Union Medical Officers)

Tuesday 02/12/2014:

08.30 Meeting with the Executive Medical Director of Archbishop Makarios Hospital, Dr Matsa Petros
09.00 Meeting with the Nursing Officer in charge Mrs. Papaioannou in the presence of the Acting Director of the Hospital
09.30 -10.30 Meeting with Directors of the Clinics/ Departments, Pharmacy, Laboratories in the presence of the Acting Director of the Hospital and the Nursing Officer in charge.
11:15- 12:45 Meeting with the Acting Director of the Cyprus Institute of Neurology and Genetics (CING).
13.00 Meeting with the Executive Medical Director of the Nicosia General Hospital Dr Matsa Petros
13.30 Meeting with the Nursing Officer in charge Mrs Antoniou.
14.00 - 15.00 Meeting with Directors of the Clinics/ Departments, Pharmacy, Laboratories in the presence of the Director of the Hospital and the Nursing Officer in charge.
19:00 Meeting with Pancyprian Medical Association (PIS) accompanied by Dr Avraamidou.

Wednesday 03/12/2014

08:30-10:30 Meeting with the Director of Oncology Center
13:00 Meeting with the Act. Director of HIO (DRGs/PHC) accompanied by Ministry of Health officials.

Thursday 04/12/2014

08:00-09:00 Meeting with the Acting Director of Medical Services Dr Elisabeth Constantinou, MoH
11.00 Meeting with Minister of Health in order to present him Autonomous Organisation Governance Model

Situation analysis and findings

Cyprus is a small country with a highly centralized public administration system. The Ministry of Health directly controls public health care services. Most of the system’s organizational, administrative and regulatory functions take place at the state level; the lower administrative levels work together with the central administration primarily on public health and health promotion initiatives (Theodorou et al. 2012).

The Ministry of Health is organized into various departments including State General Laboratory, Pharmaceutical Services, Medical and Public Health Services, Mental Health Services, Dental Services and Nursing Services. These last five departments vertically manage the services within the hospital setting. Additionally, facility management staff working in the public sector are employed by the Ministry of Public Works, while their administrative and other non-health professionals are employees of the Ministry of Finance.

The legal framework in which the public sector health facilities are currently operating is that which applies to government services in general. As such, one could argue that the organization of the health system is quite simple, lacking multiple administrative levels, multiple agencies and other complexities (Theodorou et al. 2012). Recently, The World Bank (WB) stated that the Cypriot health public sector still largely follows rules shaped during colonial times: (i) public sector health facilities are an integral part of the Ministry of Health (MoH) and its Departments, leading to centralized control and limited managerial decision-making capacity at facility level; (ii) health staff are civil servants hired and allocated to their posts by the central civil service staffing system and promoted largely according to seniority; and (iii) strict line-item budgeting process reduces flexibility and financial decision making (The World Bank 2014).

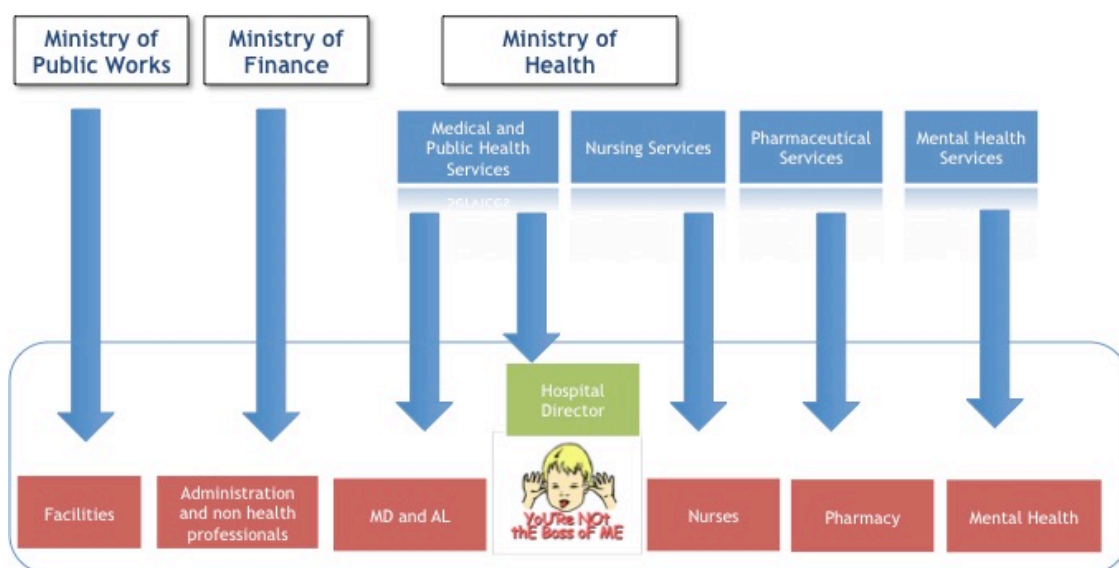


Figure 1. Vertical lines of command within the Ministry of Health and Hospitals.

These characteristics restrain the management role of the Hospital Director. In fact, s/he is not the hierarchical superior of the hospital employees. Generally, the Hospital Director is a Medical Doctor holding a Master in Public Health or in Health Administration who by seniority is appointed by the Department of Medical and Public Health Services. Usually, their career begins as general practitioners, then they are promoted as Senior Medical Officers and appointed as Primary Health Care Centre directors, then as Chief Medical Officers, and then as Hospital Directors. Eventually, they can achieve the position of Director of the Medical and Public Health Services Department in the MoH. Perversely, the pay grade of a Hospital Director (A15) is lower than the pay grade of Clinic/Department Director (A16). Usually, the “vertical” levels of pay grades correspond to the responsibility of, and requirements needed for a certain position. So, it is assumed by the wage payment system that the Hospital Director has less responsibility than the Clinic/Department Director. All Hospital Directors recognized that their role is an administrative post relying on influence, without the power and ability to manage or enforce measures within the hospital.

Current organizational charts for Ammochostos (also known as Famagusta), Limassol and Nicosia General Hospitals are shown in Annex 1. Those of Larnaca and Paphos General Hospitals were not available but are broadly comparable to those of Ammochostos and Limassol. A full analysis of staffing for all facilities, current at August 2014 for location at October 2014 for all other data, was provided by MoH and is available as an Excel file. It has not been included in the report due to its scale and complexity.

Over the last two decades, there have been proposals to reorganize the Ministry of Health and transfer some administrative authority to public hospitals (Theodorou et al. 2012). According to these proposals, public hospitals would be converted into legal public entities, allowing them a considerable degree of autonomy to manage their resources while remaining accountable to the Ministry of Health. In 2004 the Council of Ministers approved the legal framework for the reorganization of public hospitals (Decision No. 60 377). On the 12th of July 2007, the Council of Ministers, following a decision in June 2006 on the approval of the principle of transforming government hospitals into autonomous bodies (a legal entity governed by public law), approved a set of guidelines to be incorporated in a draft bill. These guidelines concern issues such as the establishment of a legal entity to manage the government hospitals, other issues of a managerial nature, as well as human resource issues (Planning Bureau 2008). In 2008, it was concluded that the re-organization of public hospitals is a necessary and vital prerequisite for the implementation of the National Health Insurance System (NHS) and should be completed prior to adopting the outpatient part of the Scheme. However, the re-organization of public hospitals did not progress as originally anticipated.

In April 2013, the Council of Ministers approved an action plan for restructuring public hospitals. WB summarises the action plan as:

- *To organize all public hospitals and PHCCs into 5 health regions by 1 January 2014, each with a consolidated, comprehensive budget, under the MPHS Department, and create 6 unified region & hospital management teams each under the authority of an Executive Medical Director (EMD), accountable to the Director of MPHS, who would combine the role of chief executive and medical director. The MoH's intention is for the 4 regional management teams of Larnaca, Famagusta, Paphos and Limassol to combine management of the hospital and the region. However, Nicosia would have a slightly different structure: the Nicosia regional management team would manage the region and Nicosia General Hospital (NGH), but Archbishop Makarios III Hospital (AMH) would have its own management team reporting to the Nicosia region-NGH management team EMD. As at present, primary healthcare center (PHCC) heads will report directly to the Executive Medical Director of the hospital in each of these 5 regions, and the EMD may assign a medical officer in the hospital to management tasks related to the PHCCs. The action plan does not yet specify whether PHCCs will have their own budgets, separate from the hospital budget, though MoH considers that this would be desirable.*
- *All MoH staff working in the region's facilities (including nurses and pharmacists) will be assigned to the MPHS Department. Although the MoH action plan does not propose assignment of staff of other Ministries working in health facilities to the health regions, the option of delegating authority and perhaps transferring functions and staff from central administrative departments to the MoH's regions is desirable and is likely to be considered as an option by the GoC as part of its Public Administration Reform (PAR) program over a longer time frame.*
- *The MoH's aim is to gradually transfer management authority from the MPHS Department to these regions, though precise details and timetable are not yet indicated. The intention is to give regions enough authority to make better use of public health infrastructure, equipment, staff and other resources within their region, though the legal and regulatory basis for doing this is not specified in the Action Plan.*
 - *The MoH proposes the management team to consist of EMD and Directors of Nursing, Human Resources, Financial Management, and Buildings & Equipment. Management team members will be full time managers. The management team will be responsible for the administration and management of the resources used in the hospital and all those who work in the hospital will be accountable to the management team. To have effective authority, the EMD needs to be appointed and paid at a superior grade to all staff in the hospital. In the shorter term, the MoH action plan proposes that management team members will have to be seconded from amongst existing staff because of the freeze on hiring and on creation of new posts. The aim is to gradually give greater administrative, financial and operational*

autonomy to public hospitals, which is necessary to enable them to become more flexible and more efficient so as to survive in competition with the private sector under the NHS. The MoH's action plan does not explicitly include policy about increasing and delegating management authority within the primary care system, nor does it include plans for restructuring pharmacy services that will be provided by the private sector once the NHS is implemented. However, the MoH has a separate well- developed plan for restructuring primary healthcare sub-centers to reduce costs.

- *Over the longer term, the MoH action plan proposes to introduce performance indicators for health facility staff and pay staff bonuses based on performance. As noted above, this proposal needs to be considered and discussed in the context of wider civil service reform, given that the GoC has decided to retain civil service status for hospital personnel. Although PAR is expected to link pay progression and promotion to performance appraisal in future, there is no proposal to introduce performance-based bonuses.*
- *To develop and enhance external accountability and internal control systems over public hospital's quality, use of all resources and management of personnel, though precise details and timetable are not yet indicated.*
- *To upgrade public hospitals' infrastructure and functionality to increase quality and efficiency to the level needed to enable them to compete with private hospitals, based on the 2009 Roadmap and related advice of McKinsey.*

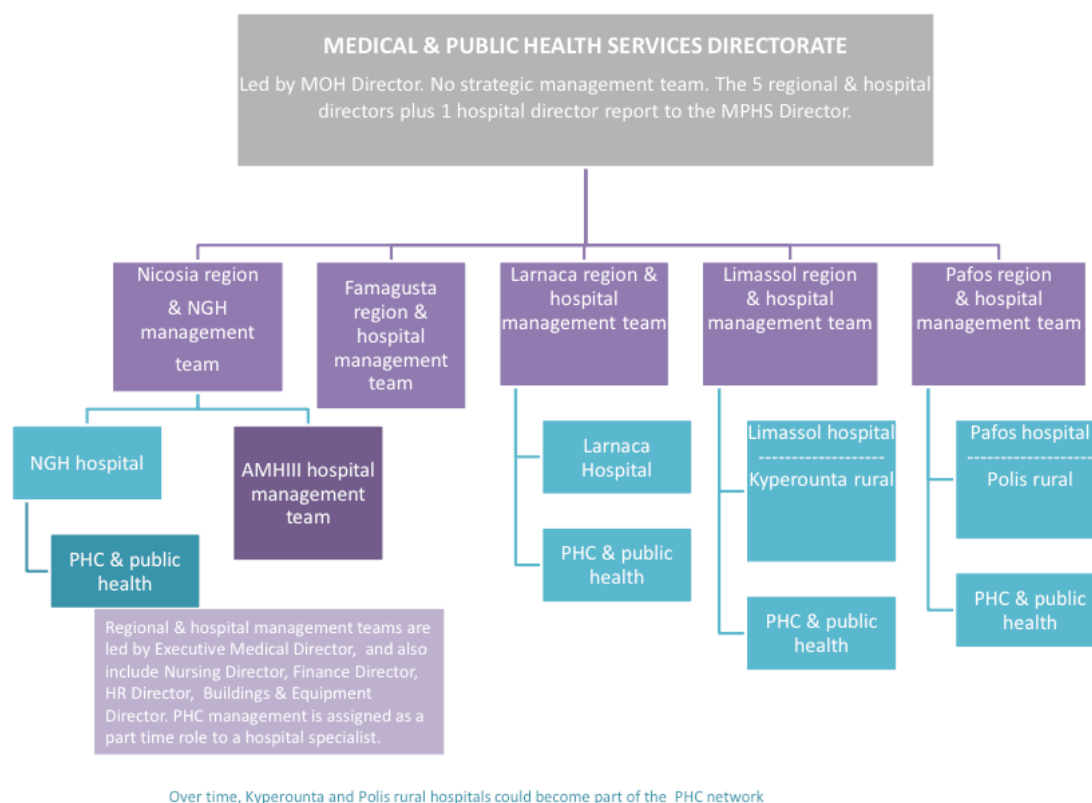


Figure 2. MoH Restructuring Proposal Approved by Council of Ministers in April 2013 (The World Bank 2014).

WB in the Report completed in May 2014, produced several recommendations to the above action plan:

- (i) the proposal of organizing public health facilities under five regions is not appropriate for Cyprus's population size and geography. On the other hand a more practical option would be to begin with a *single* national "network headquarters" for the entire public health facility network with its own strategic management team, headed by a Chief Executive, to carry out strategic management and oversight for the whole health facilities network; however, underneath this national strategic management team, there should be increased delegation of operational management authority for health facilities to management teams in each region, which would report to the Chief Executive; options for 2-4 regions reporting to the national headquarters could be considered;
- (ii) to strengthen leadership and profile of primary health care in the management of the health facility network by having a full time Director responsible for PHC in the national network headquarters;
- (iii) to open the position of Network Chief Executive Officer and hospital Director posts to non-doctors;

- (iv) to develop new modality for the selection, contracting, training and career paths for management teams based on competitive selection and renewable fixed term contracts;
- (v) to develop professional oversight and development under new management structures;
- (vi) to identify opportunities for joint or shared services as in a small health system, economies of scale can be achieved by retaining some central servicing functions that provide joint services to all hospitals and the regional networks of primary healthcare facilities (e.g. procurement and logistics management services, human resource development, health information system and ICT support); and
- (vii) to create new structures and metrics for external accountability and internal control: creation of internal audit functions within the new Health Services Department and other internal checks and balances for delegated personnel and administrative management functions are likely to be needed as part of reforms to delegate greater financial and personnel decision authority to health facilities.

The Revised MoU, as it stands on September 2014, requires the MoH to take action on restructuring public hospitals under paragraph 3.2: To strengthen the sustainability of the funding structure and the efficiency of public healthcare provision, the following measures will be adopted... *(b) All necessary legislative changes related to the implementation of the Health Reform Plan will be approved by the House of Representatives by end-November 2014 aiming at full implementation of the Plan by Q2-2015. The reform plan will take into account the restructuring of all public hospitals/public health facilities, the Ministry of Health, the Health Insurance Organisation (HIO), and other associated facilities/organisations. It will also take into account the findings of the functional review of the health sector public entities and the analysis of the function and structure of the Ministry of Health. The reform plan will provide for autonomisation of all public hospitals/public health facilities. Public hospitals will complete the shadow-budgeting for all inpatient cases on diagnoses-related groups by Q3-2014 and for all in- and outpatient activities by Q4-2014; by Q3-2014, the detailed restructuring plan of the public primary healthcare centres will submitted for consultation with program partners.* This revision evolves from previous revisions of MoU, which mentioned the implementation of the action plan approved by the Council of Ministers at end-June 2013 and aim at full implementation by Q2- 2015. The Council of Ministers' decision was one of the additional permanent expenditure measures for 2013 which were adopted by Cyprus prior to the granting of the first disbursement of financial assistance, based on an earlier MoU requirement to adopt a restructuring plan for public hospitals, improving quality and optimizing costs and redesigning the organizational structure of the hospital management, by putting into practice recommendations from the 2009 "Public Hospital Roadmap". This roadmap, prepared for the MoH with advice from McKinsey & Company, was intended to prepare the Cyprus public hospitals for implementation of the 2001 NHS legislation, and included restructuring to give

hospitals greater autonomy alongside other improvements in quality, efficiency and marketing to enable public hospitals to attract patients and offer services that would be competitive with the private sector on quality and cost. However, the measures in the action plan are beneficial in their own right, regardless of the form of NHS that is implemented and the timeframe for NHS implementation.

Showing strong determination, on September 2014, the Council of Ministers approved new basic principles for the “autonomisation” process. After public consultations, the Ministry of Health released the draft bill related to the autonomy of public hospitals on 11th December 2014, the title of which translates as “The establishment of General Hospitals Organizations Bill”.

In a statement, the ministry said the draft bills constituted Troika requirements and were the result of prolonged public consultations between the Health Minister and various stakeholders over the past three months. The draft bills were prepared with the support of international bodies such as the World Health Organisation and the European Union, the statement said. According to the statement, “the draft bill describes the creation of five autonomous organisations – one per district – which will house hospitals and primary healthcare centres in each district.” “Once autonomous, public hospitals achieve legal, administrative, financial and scientific independence, and are strengthened with mechanisms that ensure quality healthcare to patients,” the statement said. (Anastasiou 2014)

The draft bill on hospital autonomy does not include the articles relating to the hotly contested labour issues. “These issues will be discussed by representatives of the employees themselves with the Personnel and Labour committees, in line with due process,” the statement said. Consultations between the Health ministry and political parties are expected to commence immediately. “These draft bills form the cornerstone of much-needed health reform in Cyprus,” the Health Ministry said. “In this context, we fully expect the constructive cooperation of all parties involved, with a view to promoting the proposed reforms so that benefit creation to Cypriot citizens can start,” it added. (Anastasiou 2014)

Proposals/Recommendations

The governance model for the creation and development of autonomous organizations is complex and is dependant on the governance model of the Ministry of Health. The World Bank already analysed several issues on the function and structure of the Ministry of Health, reviewed the action plan for restructuring public providers as approved by the Council of Ministers at end-June 2013, produced a number of recommendations, and identified a number of challenges in the public health services delivery network. The current report is focused on organizational structure of new autonomous organizations.

The draft bill released on 11 December 2014 that establishes agencies governed by public law, having the responsibility for the operation, management, control, supervision and development of public hospital, already considered some recommendations presented to the Ministry of Health by this consultant, which are reiterated in this report.

Autonomy implementation task force

1. Several weaknesses of the current governance model have been previously identified, and corroborated by the present mission. To address these weaknesses and steward the overall process of providers autonomisation it is recommended to create a taskforce that will work over the next 3-5 years with the aim of managing the overall process of change, assure stakeholder participation, and develop planning, quality management, financial management, human resources management, information tools and evaluation tools. This taskforce will be also responsible for assessing and publicizing performance of each hospital, their Board of Directors and Executive Board. The task force will act as a holding of public providers with additional competences to define and develop shared services, outsourcing services and contracts, training and continuous education, and communication plan.
2. Additionally, as a “holding company of public providers”, the task force would have the ability of manage (including the ability to transfer) personnel between the different AOs in order to ensure adequate healthcare provision to the population and to maximize efficiency and quality to the whole network.
3. The taskforce will work closely with the primary health care reform team.

Corporate Management Level | Board of Directors and Executive Board

Boards were developed as a result of the industrial revolution, the growing commercial complexity of business and the gradual separation of ownership from control. Boards represented the interests of absent owners or shareholders, and management became the agents of the board (Orlikoff and Pointer 1999).

Glouberman and Mintzberg (2001a) identify “four worlds” in the hospital setting—care, cure, control, and community—that function to a large part independently and under different mind-sets. The world of *care*, provided especially by the nurses who function within their own hierarchy of authority, but also other specialists who provide basic care. Since that connects directly to the hospital administration, nursing and other care management can be described as *in* but also *down*, again focusing on the delivery of patient services. The world of *cure* - formally that of the medical community, which functions through its arrangement of chiefs and committees. They manage *down*—into the operations—but *out*, because the physicians do not report into the hospital’s hierarchy. The world of *control*— that of conventional administration—most decidedly *in*, since the managers here are ostensibly responsible for the entire institution, but also equally clearly *up*, since they are also removed from direct involvement in the operations. Finally, the world of *community*, formally represented by the trustees of the hospital, informally by those people who volunteer their efforts to it. They are neither directly connected to the hospital’s operation nor personally beholden to its hierarchy— they, in other words, are both up and out. Glouberman and Mintzberg (2001a) conclude that the “*hospital ends up being not one organization but four, as each part structures itself in an independent way*”. So, it is so “enormously difficult” to manage hospitals. The question is how the governance model for each hospital system addresses these worlds in order to provide quality of care?

A range of board structures and models are used in health services (e.g. non-executive boards, executive boards and unitary boards) (Orlikoff and Pointer 1999). Searching for an ideal board model and its membership is ultimately futile - more evidence is available about the conditions under which boards failed (Chambers 2006). Carver and Carver (2001) argue that key governance principles can work with whatever structural arrangements are chosen.

Garratt (2010) suggests that there are two main dimensions of the board's role, what he calls ‘conformance’ and ‘performance’. Conformance involves two main functions: external accountability including compliance with legal and regulatory requirements and accountability to shareholders or other stakeholders, and supervision of management through oversight, monitoring performance and making sure that there are adequate internal controls. By contrast, the performance dimension is about driving the organisation forward to better achieve its mission and goals. This again consists of two main functions, policy formulation and strategic thinking, to take the organisation forward. This framework suggests that boards need to be concerned with both the conformance and performance dimensions of corporate governance.

	Short term focus on 'conformance'	Long term focus on 'performance'
External focus	<p><i>Accountability</i></p> <ul style="list-style-type: none"> Ensuring external accountabilities are met, e.g. to stakeholders, funders, regulators. Meeting audit, inspection and reporting requirements 	<p><i>Policy formulation</i></p> <ul style="list-style-type: none"> Setting and safeguarding the organisation's mission and values Deciding long-term goals Ensuring appropriate policies and systems in place
Internal focus	<p><i>Supervision</i></p> <ul style="list-style-type: none"> Appointing and rewarding senior management Overseeing management performance Monitoring key performance indicators Monitoring key financial and budgetary controls Managing risks 	<p><i>Strategic thinking</i></p> <ul style="list-style-type: none"> Agreeing strategic direction Shaping and agree long-term plans Reviewing and deciding major resource decisions and investments

Figure 3. The main functions of boards (Chambers et al. 2013).

Chambers (2006) suggests that *the challenge for health services boards is not therefore to embark upon a quest for the perfect structure or model but to acknowledge the need for clarity of purpose in order to steer high performance organisations towards providing or securing safe and high quality health care for patients. Evidence from empirical studies indicates the importance of taking into account the internal and external environment in the choices that boards make about diversity, board size, proportion of insider and outsider directors, strategic focus and the balance of time spent on advisory/partnering as distinct from monitoring functions* (Chambers et al. 2013). An extended literature review identified linkages between different contexts and desired outcomes and further modified as a result of the relative lack of empirical evidence around the importance of a high level of trust on boards (Chambers et al. 2013):

- The benefits accrued by larger boards, particularly in relation to increased monitoring, and are outweighed by higher agency costs, informational asymmetry and communication and decision-making problems.
- Improved monitoring can come at a cost of weaker strategic advising and greater managerial myopia. Firms with boards that monitor intensely exhibit worse acquisition performance and reduced corporate innovation.
- Board processes (the way that information is gathered, knowledge is built and decisions are made) are more important than structure and composition.
- Evidence suggests that top-performing non-profit boards in the USA use more recommended board practices, such as board self-evaluation and development programmes.
- Studies comparing corporate and philanthropic models of governance in health care suggest that corporate models are associated with increased operational efficiency and increased market share.
- For high-performing hospitals and those with better performance in processes of care and mortality there is greater physician involvement at board level, a quality subcommittee and

greater expertise and formal training in quality; quality is reported as a higher priority for board oversight and CEO performance evaluation; boards are significantly more familiar with current performance and significantly more involved in reviewing quality data; more time is spent on clinical quality at board meetings (greater than the time spent on financial performance) and there is evidence of will–execution–constancy of purpose.

- Boards with strong financial performance exhibit stronger internal behavioural dynamics, for example the chairperson's relationship with the CEO, level of challenge and openness in decision-making, interpersonal climate and systematic implementation of board processes such as the timely sharing of relevant and accurate information, advising and challenging management and regular board education.
 - Boards of high-performing hospitals are more fully engaged in key governance processes, including a strong strategic focus, and the prevailing governance culture is more interactive and proactive.
4. Following the public consultations and meetings it is recommended the development of a two-tier system with two separate boards, an Executive Board for day-to-day management and a supervisory Board of Directors for oversight of the Executive Board. This ensures a distinction between management by the EB and governance by the *BoD*, allowing for clear lines of authority. The aim is to prevent a conflict of interests and too much power being concentrated in the hands of one person.
 5. The *BoD* role and composition is defined by the draft bill as having the responsibility for the operation, management, control, supervision and development of public hospitals.
 6. The *BoD* represents the “shareholder/owner” and shall consist of:
 - a. The Chairman representing the Government;
 - b. The Deputy Chairman representing the Government;
 - c. One representative of patients;
 - d. Two appointed member representing the Government;
 - e. Two member representing the General Directors of the Ministries of Finance and Health;
 - f. Two members of the Executive Board, the Chief Executive Officer who shall act as Secretary of the Board, a Deputy Chief Executive Officer who shall be the Chief Medical Officer.
 7. Persons appointed *BoD* members must have moral and professional reputations, no conflict of interest (publicly declared), high academic qualifications and relevant experience.
 8. The Chairman of the *BoD* has the casting vote.

9. Board meetings must be recorded in minutes to be approved at the next meeting.
10. The *BoD* meets at least monthly and also whenever called by the Chairman or at the request of five of its members.
11. The *BoD* approves the Strategic/ Business Plan, Annual Budget and AO internal regulations.
12. When there is a conflict of interests with any member of the *BoD*, the respective member will leave the room during decision-making.
13. The *Executive Board* is presided by the Chief Executive Officer (CEO) and shall consist additionally on:
 - a. Chief Medical Officer (CMO) and Deputy CEO
 - b. Chief Primary Healthcare Services Officer (CPHSO) and Deputy CMO
 - c. Chief Financial Officer (CFO)
 - d. Chief Nursing Officer (CNO)
 - e. Chief Operations Officer (COO)
 - f. Chief Scientist Officer (CSO).

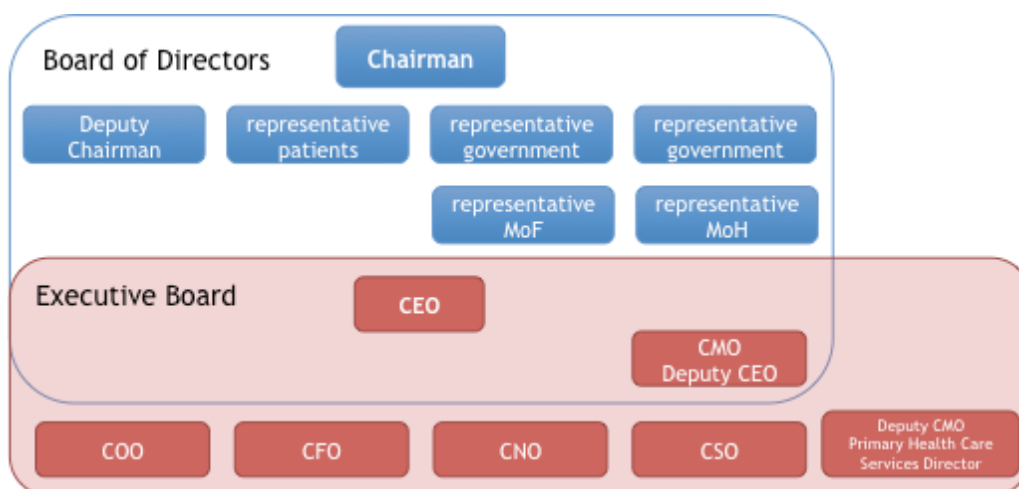


Figure 4. Proposal for the Board of Directors and the Executive Board.

14. The Executive Board meets at least weekly and also whenever called by the CEO or at the request of three of its members or the Chairman.
15. The rules of procedure of the Executive Board are set by the board itself at its first meeting and are approved by the BoD.
16. The managerial and scientific decisions of the Executive Board do not require validation by the BoD, unless if they are related to legal matters or exceed the approved budget.

17. The CEO reports to the *BoD* and is charged with maximizing the value of the entity, provides for the operational, financial oversight of the facility and serves as the primary spokesperson and representative of the facility in the medical, business and general community.
18. The CEO's main duties are to:
 - a) Coordinate the activity of the Executive Board and the Scientific Council, and conduct its meetings;
 - b) Ensure proper implementation of the board of directors' resolutions;
 - c) Legally and formally represent the AO;
 - d) Propose to the Board of Directors the Strategic/ Business Plan, Annual Budget and AO internal regulations, as well as other forward management tools provided by law or regulations, and ensure their implementation;
 - f) Systematically monitor and evaluate the activities developed by the AO, particularly in terms of quality and efficiency of services provided;
 - g) Monitor the implementation of the budget, applying measures to correct deviations from forecasts;
 - e) Exercise the powers delegated to her/him.
19. The CMO provides senior executive leadership for the AO in facilitating medical staff interactions with the Executive Board and the BoD and to assure effective and efficient delivery of quality medical care.
20. The CMOs specific duties are to:
 - a) Coordinate the development of action plans submitted by various medical specialties services and departments to integrate into the global action plan of the hospital;
 - b) Ensure adequate integration of medical activity, including through non-compartmentalized capacity utilization;
 - c) Oversee the scientific activities of the AO, including basic and applied research projects, as well as the development of new processes, technologies or products.
 - d) Propose measures needed to improve the organizational, functional and physical structures of specialties, within recognized efficiency and effectiveness parameters that produce the best results given the available technology;
 - e) Approve the clinical guidelines, determined by relevant heads of units, for the prescription of medicines and ancillary diagnostic and therapeutic exams and clinical protocols adapted to the most frequent pathologies and be accountable to the board for their suitability in terms of safety, quality and cost-effectiveness;

- f) Propose to the BoD, where appropriate, external evaluation of compliance with clinical guidelines and protocols, in collaboration with the medical education institutions and scientific societies;
 - g) Develop and implement instruments of quality assurance and risk management;
 - h) Decide on technical conflicts between medical specialties;
 - i) Decide issues that may be present on medical ethics, provided that the use is not possible, in due time, the ethics committee;
 - j) Participate in the management of medical personnel, particularly in the admission procedures and internal mobility, hearing the respective specialty directors;
 - k) Ensure the continuous education of the medical staff;
 - l) Monitor and systematically evaluate other aspects of medical practice and the training of doctors.
21. The CMO has a deputy responsible exclusively for Primary Health Care Services - Chief Primary Healthcare Services Officer (CPHSO).
22. The CNO plans, implements and evaluates delivery of overall patient care. He/she provides managerial support to the CMO by providing supervision and evaluation of all nursing personnel. He/she contributes to the program, nursing, and facility through commitment to nursing goals, the supervision of clinical staff and participation in the community relations program ensuring patient quality of care is paramount.
23. The CNO's specific duties are to:
- a) Coordinate the preparation of nursing action plans to be integrated in the hospital global action plan;
 - b) Cooperate with the CMO in the consistency of the action plans of the different specialties;
 - c) Contribute to the development of policies or directives of training and research in nursing;
 - d) Set standards for nursing care and evaluation indicators of nursing care provided;
 - e) Develop proposals for the management of the nursing staff, in particular participating in the admission process and deployment of nurses;
 - f) Promote and monitor the evaluation process of nursing staff;
 - g) Propose the creation of an effective system of classification that allows users to determine needs in nursing care and ensure its preservation;
 - h) Prepare studies for determination of costs and benefits in the context of nursing care;
 - i) Monitor and systematically evaluate other aspects related to the exercise of the nursing activity and the training of nurses.

24. The CSO provides senior executive leadership in facilitating scientific staff interactions with the Executive Board to assure effective and efficient delivery of support, diagnostic and therapeutic services.
25. The CSO's specific duties are to:
- a) Coordinate the development of action plans submitted by various departments lead by scientific staff to integrate into the global action plan of the hospital and cooperate with the CMO in their consistency;
 - b) Ensure adequate integration of the scientific activity, including through a non-compartmentalized capacity utilization;
 - c) To propose measures needed to improve the organizational, functional and physical structures of departments, within recognized efficiency and effectiveness parameters that produce the best results given the available technology;
 - f) Develop the implementation of instruments of quality assurance and risk management;
 - i) Participate in the management of scientific personnel, particularly in the admission procedures and internal mobility, hearing the respective specialty directors;
 - j) Ensure the continuous education of the scientific staff;
 - l) Monitor and systematically evaluate other aspects of practice and the training of scientific staff.
26. The CFO administers, directs and monitors all facility financial activities and keeps the CEO, the Executive Board, the BoD informed of the financial condition of the facility.
27. The CFO's specific duties are to:
- a) Work with the CEO, Executive Board and intermediate level management to develop financial goals and objectives for the AO;
 - b) Provide proactive, sound guidance regarding management of assets and investments, and financial trends within the AO;
 - c) Works with intermediate level management to implement financial plans and to monitor progress toward financial goals;
 - d) Be actively involved in corporate performance and the growth of a team-oriented culture;
 - e) Establish a five-year strategic financial plan for the AO, in conjunction with the Business Plan, as part of the AO's strategic planning process;
 - f) Employ a system of responsible accounting, including budget and internal controls;
 - g) Ensure that monthly financial statements are completed and distributed on a timely basis;
 - h) Ensure that all balance sheet accounts are reconciled on a monthly basis and a system of internal controls is in place to facilitate a clean audit opinion with no audit adjustments or internal control deficiencies noted;

- i) Maintain effective revenue cycle processes to keep patient accounts receivable at an acceptable level and also increasing the AO's cash flow;
 - j) Maintain a thorough working knowledge of reimbursement payment methodologies, including: contractual accounting, payment calculations, billing requirements and compliance issues;
 - k) Take responsibility for maximizing cash flow consistent with sound credit and collection policies while maintaining good rapport with the community; financial reporting with detailed analysis of financial statements and variances from budget; audits of financial statements and internal controls; examination of insurance policies to ascertain that AO assets are properly insured against loss;
 - l) Monitor capital asset expenditures and depreciation; prepares annual operating budgets with input and involvement at the departmental level, as well as capital budgets and cash flow projections;
 - m) Keep the Executive Board members aware of all key financial developments.
28. The COO plans, directs and coordinates the AO's operations. Duties and responsibilities include formulating policies, managing daily operations, and planning the use of materials and human resources to meet the objectives and mission of the facility as set by the BoD and implemented by the CEO.
29. The COO's specific duties are to:
- a) Take operational responsibility for the executive AO operations;
 - b) Manage the international accreditation process within a short period of time, as well as maintaining the accreditation status over time;
 - c) Oversee AO budget, services, procurement, and policy activities directly related to providing services to achieve the objective stated by the Executive Board;
 - d) Collaborate with AO Executive Board members to develop the facility vision, strategy, service models, and marketing action plans;
 - e) Provide operational support to the development of contract proposal development, risk management, and supplier contract negotiations;
 - f) Direct and coordinate activities of facility departments concerned with the security, cash management, IT and logistic/supply;
 - g) Review and manage financial statements, AO care activity reports, and other performance data to measure productivity and goal achievement and to determine areas needing cost reduction and program improvement;
 - h) Establish and implement departmental policies, goals, objectives, and procedures, conferring with board members, organization officials, and staff members as necessary to achieve the stated objectives of the Board of Directors;

- i) Manage the overall facility and physical plant from a maintenance and maximum utilization perspective.
- j) Ensure proper safety, environmental and community standards are being maintained.
- k) Coordinates intermediate level of management, and implement productivity plans and benchmarks to monitor progress toward productivity goals;
- l) Ensure monthly productivity reports are completed and distributed on a timely basis.

Scientific Council and Advisory Committees

- 30. In order to engage professionals and promote continuous quality improvement, the AO has a *Scientific Council* chaired by the CEO. The *Scientific Council* shall involve all members of the Executive Board, Division Directors, Nurse Coordinators, and other professionals in representation of other Health Professionals by decision of Executive Board. The number of members should not be more than 20.
- 31. The *Scientific Council* has an advisory role to the *Executive Board* within the scope of clinical governance.
- 32. The *Scientific Council* can create technical support committees that are designed to work with the Executive Board on its own initiative or at the request of, in matters within their competence.
- 33. Each *Scientific Council* have at least the following mandatory committees:
 - a) Ethics committee;
 - b) Quality and Patient Safety committee;
 - c) Infection control committee;
 - d) Pharmacy and therapeutics committee.
- 34. Other technical support committees can be established under the law, according to AO needs and standard of care, when justified, being their structure, composition and operation included in the rules of procedure.

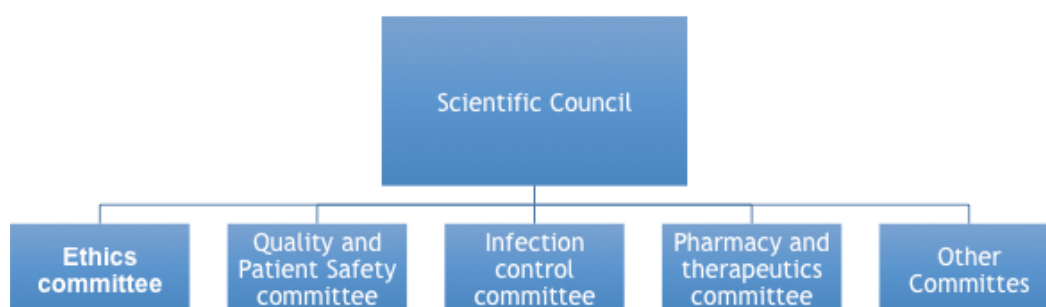


Figure 5. Scientific Council and Committees.

35. The Scientific Council, upon proposal by the CMO, appoints the President and members of the technical support committees. The technical support committees have a maximum of 9 members.
36. Technical support committees shall prepare and submit to the Scientific Council, by 15 September of each year, the annual program of activities for the following year and by 28 February report activities of previous year.
37. The Ethics Committee is an advisory body, multidisciplinary and independent, whose activity is governed by a specific Regulation, approved by the Scientific Council, with the aims to reflect on the ethical aspects incumbent on hospital activity, healthcare, teaching and research.
38. It is the Ethics Committee duty to consider and advise on all ethical aspects of clinical practice developed by the AO, to rule on scientific research protocols, promote the dissemination of the general principles of bioethics by means judged suitable, in particular through studies, opinions and other documents or initiatives.
39. The Quality and Patient Safety Committee is chaired by CMO or the CNO and has the aim to promote and develop a culture of quality and safety, matching the strategic goals of the AO. The activity is translated on the continuously quality and efficiency improvement of health care provided, promoting safety of patients and professionals.
40. The Pharmacy and Therapeutics Committee is chaired by the CMO and is constituted additionally by four medical doctors and four pharmacists, at least one of them being a clinical pharmacist.

41. The Pharmacy and Therapeutics Committee has the following duties: a) Participate in the development, implementation and monitoring of AO the drug policy, with periodic review of the Drugs Hospital Form, technical and scientific evaluation of applications for use/introduction of medicines, supported by scientific evidence and opinions of experts; b) The development and adoption of clinical guidelines in collaboration with medical experts in each area, and evaluation of their use, results and impact in terms of cost-effectiveness.
42. In connection with Pharmacy and Therapeutics Committee there is an Antimicrobial Resistance Subcommittee, consisting of three doctors and a pharmacist, one of whose relevant elements in clinical microbiology and other belonging also to the Infection Control Committee.
43. The Committee on Infection Control is a multidisciplinary body of technical support that has its primary purpose the prevention of infections associated with health care.
44. The Committee on Infection Control has the following duties: a) prepare the Operational Plan for Prevention and Infection Control and implement an evaluation system of the actions undertaken; b) implement policies and procedures for the prevention and control of infection and antimicrobial resistance and monitor them through periodic audits, in conjunction with the Quality and Patient Safety Committee; c) review of procedures every time that evidence justify it; d) to plan and implement epidemiological surveillance in accordance with national programs; e) to investigate, monitor and notify infection outbreaks, aiming its effective prevention; f) provide consultancy in the area of antimicrobial resistance; g) monitor the infection risks associated with new technologies, devices, products and procedures; h) collaborate with the Executive Board and the “Logistics, Procurement and Infrastructure Division” in the definition of adequate clinical and non-clinical equipment characteristics; i) make, in conjunction with the Occupational Health Service, the biological risk assessment in each clinic and develop specific recommendations, as appropriate; j) to advise on the planning and follow the execution of works in order to ensure adequate prevention nosocomial infections; k) Participate in the development and monitoring of training programs, campaigns and information strategies, and research programs related to nosocomial infections.

Internal Auditing

45. The AO must have an internal auditor with the proper qualifications, appointed by the *BoD*, who shall make internal control in accounting, financial, operational, IT and human resources fields.

46. As part of their functions, the auditor should provide the BoD with analysis and recommendations on the audited areas in order to improve services effectiveness, and propose audits by third parties.
47. The auditor is appointed for a term of three years, renewable once only.
48. In order to obtain adequate information for the development of audit, the auditor has free access to records, computers, facilities and hospital staff, with the exception of access to individual medical records of users.
49. The auditor shall prepare an annual audit plan.
50. The auditor shall, every six months, a report on its work to which they cover the checks, the deficiencies and the corrective measures to be taken, to be submitted by the Board to the Ministers of Finance and Health.
51. The auditor's activities should be coordinated with the Auditor General.

External Auditing

The external auditor is responsible for controlling the legality, regularity, financial management and property management of the AO, providing a fair and accurate representation of its financial position by examining information such as bank balances, bookkeeping records and financial transactions. This proposal must consider the provisions of the Cyprus law and will require the involvement of the Auditor General and the Treasury.

52. The external auditor is appointed by the *BoD* from statutory auditors or audit firms accounts for a period of three years, renewable once only.
53. The external auditor has always an alternate who is also the statutory auditor or firm of auditors.
54. The external auditor is responsible, in particular to:
 - a) Check that the books, accounts and documents that serve to support it;
 - b) Advise on the exercise management report and certify the accounts;
 - c) Monitor management through balance sheets, statements and documented budget execution, on a regular basis;
 - e) Propose an external audit when deemed necessary or appropriate;

- f) Advise on any other matter relating to economic and financial management to be submitted for consideration by the BoD;
- g) Advise on the acquisition, leasing, sale and encumbrance of real estate;
- h) Advise on investments and loans;
- i) Prepare reports of their supervisory work, including a comprehensive annual report;
- j) To issue opinions on matters referred to it by the BoD and the Executive Board;
- l) Verify the valuation criteria adopted to a correct assessment of the assets and profits.

Executive Board | Recruitment, selection process, and remuneration

55. The Executive Board members are selected through an independent recruitment and selection process.

Table 1. Indicative Executive Board qualifications.

Position	Education	Experience
CEO	Master's degree in Business Administration, Healthcare Administration or related field.	Minimum of ten (10) years large structure facility management experience with increasing levels of responsibility. Previous executive management position of provider with minimal budget or number of employees (adapted to the dimension of the AO).
CMO	Medical Doctor degree required from an accredited medical school. Current licensure required (with a minimum of 8 years total training). Medical Association Certification in specialty and Master's degree in Health Management or related field.	Minimum of seven (7) or more years of clinical practice, participation in a leadership role in medical staff organization activities, and through management experience within a health care delivery system. Three to five years of medical management. Medical research experience.
CPHSO	Medical Doctor degree required from an accredited medical school. Current licensure required (with a minimum of 8 years total training). Medical Association Certification in Family Medicine Specialty. Community Medicine or General Practise Medicine. Master's degree in Health Management or Public Health preferred.	Minimum of five (5) or more years of clinical practice, participation in a leadership role in medical staff organization activities, and through management experience within a health care delivery system. Three to five years of medical management. Medical research experience.
CNO	Graduate of an accredited registered nurse program. Four year/Bachelor's Degree in Nursing Science and Master's degree in Health Management or related field.	Minimum five (5) years of nursing management position.
CSO	Professional Master's degree in	Minimum five (5) years of management

	pharmacy (Pharm.D.) or Medical Diagnostics or other Health Science.	position.
CFO	Bachelor’s and Master’s degree in Accounting, or Certified/Chartered Accountant and Masters in Healthcare administration, or related field.	Minimum of five (5) years facility financial management experience required; prior hospital CFO experience, preferred.
COO	Bachelor’s and Master’s degree in Business Administration, Healthcare Administration or related field.	Minimum of five (5) years hospital or major health care facility administration experience.

56. It is recommended that all Chief positions will be appointed on a 5-year contract. According to competencies found they may be new recruits or from the already existing staff, being able to return to their position upon completion of the contract.
57. After the conclusion of the selection process, the executive board must present in 60 days for approval a five years Strategic/ Business Plan to the BoD.
58. If the within 90 days of the manager's appointment, the Strategic Plan isn't approved by the BoD the act of appointment is considered null without any kind of compensation.
59. Each member of the Executive Board will sign a management contract with the BoD according to the Strategic Plan approved. The management contract should consider three key areas: 1) general and strategic guidelines; 2) annual objectives; 3) Remuneration.
 - a. General and strategic guidelines
 General and strategic guidelines for the mandate consider the general principles of careful management and economic and financial sustainability, the general principles of clinical governance and the specific principles of careful management and economic and financial sustainability.
 - b. Annual objectives
 The annual objectives for the mandate have desideratum as goal setting, being based on a set of indicators to assess the degree to which specific guidelines referred to the BoD. Support indicators for the formulation of objectives are based on a measurement of absolute performance, culminating in overall performance index (based on balanced scorecard). The objectives are defined for each year of the five years and are annual evaluated. Exceptionally, the objectives can be annual reviewed.

 The common indicators to all members of the Executive Board Members are grouped into three groups: 1) Economic and Financial Performance (relative weight 40%); 2) Access and care performance (relative weight 40%); 3) Perceived Quality (relative weight of 20%).

c. Remuneration

The remuneration considers a fixed salary and management bonuses.

CEO salaries should depend on the size, services provided and technical endowment of each AO.

The fixed salary of Executive Board members should be indexed to 80% of the obtained remuneration for the CEO.

The management bonuses awarded to all board members should be determined according to the degree of compliance of the performance index (based on balanced scorecard methodology).

Executive board members are dismissed in case of the respective performance evaluation is negative (bellow a pre-defined threshold).

Table 2. Example of performance index measurement and the respective financial bonus.

Performance Index (degree of compliance)	Management Bonus up to 45% x Annual Salary (AS)
= 120%	0,45 x AS
110,0% < Objectives < 119,9%	0,37 x AS
100,0% < Objectives < 109,9%	0,29 x AS
90,0% < Objectives < 99,9%	0,17 x AS
80,0% < Objectives < 89,9%	0,09 x AS
Objectives < 80,0%	0.00
< 60,0%	Executive Board is dismissed

Functional Management Level | Divisions, Departments and functional units

- 60. AOs are structured into divisions, departments and functional units.
- 61. The department is the basic unit of organization, working alone or integrated into divisions.
- 62. Functional units are specialized aggregations of human and technological resources, integrated in departments or divisions, or shared by different departments or divisions.
- 63. AO departments and divisions can be:
 - a. Clinical Departments/Divisions, usually associated with medical specialties;
 - b. Scientific Support Departments;
 - c. Administrative Support Departments/Divisions.
- 64. Each Clinical Division is managed by a Senior Health Manager appointed by the Executive Board on a proposal from the COO. A Clinical Director seconds the Health Manager. This Clinical Director is appointed by the Executive Board among the Head of Departments on a proposal from the CMO.

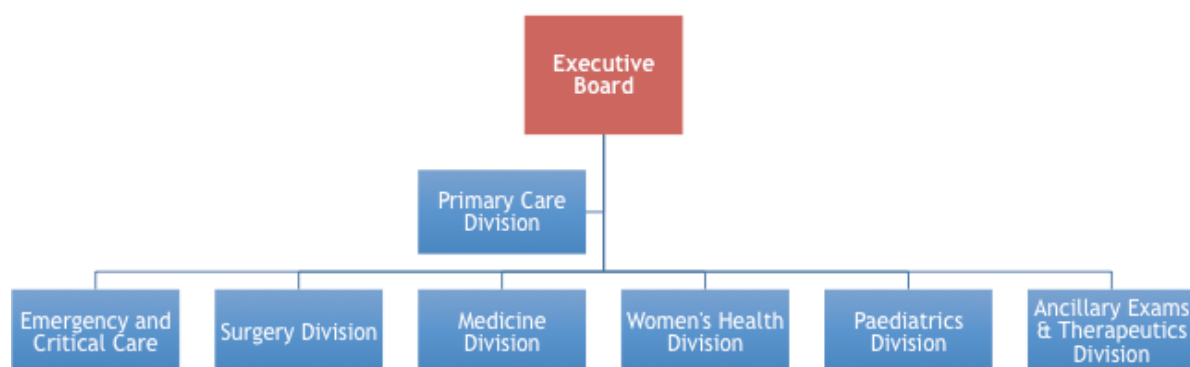


Figure 6. Example of Clinical Divisions.

65. The Senior Health Manager (SHM) is responsible, with the safeguarding of technical and scientific expertise allocated to other professionals, to:
- a. Practice an internal information policy which allows professionals to understand the operation and the measures/policies executed by *Executive Board*;
 - b. Achieve coherence and propose action plans prepared by the various departments of the division with a view to their integration in the AO's business plan;
 - c. Ensure the efficient use of installed capacity, in particular by making full use of existing equipment and infrastructure and the diversification of working time arrangements, in order to achieve an optimal rate of utilization of available resources;
 - d. Develop, propose and adopt appropriate measures to take maximum advantage of the installed capacity, including through a not compartmentalized using of it;
 - e. Promote, coordinate and schedule the technical and scientific initiatives and research of the various de that are part of the department;
 - f. Prepare information, reports and other documents at suitable intervals and submit them to the executive board in order to keep it constantly informed;
 - g. Ensure maximum integration of the activity of the departments of the division, including through facilities and equipment sharing, multidisciplinary action and development of joint projects, in particular through matrix structures and cross-cutting of care;
 - h. Develop the implementation of technical quality assurance instruments;
 - i. Ensure the continuous education and training of staff, namely that promotes multidisciplinary and intersectional aspects and the implementation of the human resources policy outlined by the Executive Board.

Table 3. Senior Health Manager qualifications.

Position	Education	Experience
SHM	Bachelors and Master’s degree in Business Administration, Healthcare Administration or related field.	Five (5) years of job related experience, including one year of supervisory experience. Knowledge, Skills, and Abilities Required: Have knowledge of budgets and budget process including mathematical and accounting skills, ability to make sounds financial decisions. Ability to proceed on own initiative using independent judgment and discretion. Possess excellent verbal and written communication skills, leadership, organizational skills, and interpersonal and time management skills. Familiarity with medical records administration, and knowledge of clinic and physician/patient protocols.

66. Each Clinical Department has a Head of Department appointed by the Executive Board on a proposal from the CMO among medical doctors. Exceptionally, some Head of Departments appointed by the Executive Board on a proposal from the CSO among the scientific staff (e.g. Physiotherapy).

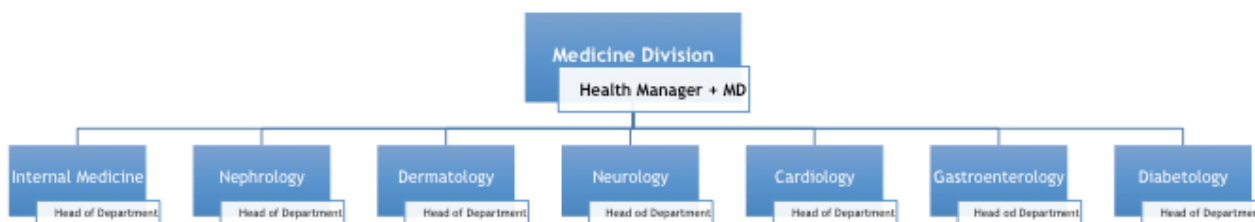


Figure 7. Example of a Division structured into Clinical Departments.

67. The Head of Department is responsible, with the safeguarding of technical and scientific expertise allocated to other professionals, specifically to:

- a. Define the provision of care organization and issue guidance on compliance with the standards issued by competent authorities;
- b. Prepare the annual plan of activities and the management report and submit them for consideration by the Division Director;
- c. Analyse activity and budget execution on a monthly basis, and if necessary, propose corrective measures to the Division Director or the Executive Board;
- d. Ensure the productivity and efficiency of healthcare provision and assure it systematic evaluation;
- e. Promote the application of quality control programs and productivity, ensuring continuous improvement of health care quality;

- f. Ensure the organization and constant updating of clinical processes, including through the review of admissions decisions and discharges while maintaining a system of appropriate and timely coding;
 - g. Propose to the CMO or the Division Director, when necessary, the conduction of clinical audits;
 - h. Ensure the state of the art of the procedures used, promoting improvement and training of staff, and organize and oversee all training and research activities;
 - i. Examine and determine appropriate action in response to complaints from clients;
 - j. Ensure the proper management of human resources, including internal assessment of the overall performance of the professionals;
 - k. Exercise disciplinary authority over all personnel;
 - l. Promote the maintenance of an effective internal control system to ensure the safeguarding of assets, the integrity and reliability of the information system and compliance with the laws, regulations and applicable standards, and the monitoring of the defined global objectives;
 - m. Ensure timely and correct registration of accounting for clinical procedures and the administration of goods and equipment;
 - n. Ensure the proper management and consumption control of the most significant goods, including medicines and clinical material.
68. In surgical departments, the Head of Department has additional responsibility for surgical procedures/guidelines undertaken within the department, and for the validation of the surgical proposals (i.e. if they comply with the clinic guidelines), reinforcing clinic consistency, motorization and evaluation processes. Still, this does not reduce the individual responsibilities of the leading surgeon (team leader) and the other members of the surgical team, in respect to their specific skills and actions.
69. To provide non medical care or support the provision of care, each AO has Scientific Support Departments and scientific functional units, namely:
- a. Department of Pharmacy;
 - b. Department of Nutrition & Food Services;
 - c. Department for Coordination of Care;
 - d. Quality and Patient Safety Department;
 - e. Prevention and Infection Control Department;
 - f. Accreditation and Certification Department.
70. Each Scientific Support Departments has a Head of Department appointed by the Executive Board on a proposal from the CSO among scientific personnel (e.g. Department of

Pharmacy, among pharmacists) or on a proposal from the CMO or CNO according to the internal AO rulings. To promote shared services and maximize efficiency, Scientific Support Departments and scientific functional units can belong to Clinical or Support Divisions.

71. To support provision of care the Clinical Departments/ Divisions, Nursing Services are organized according to different hospital settings:
- a. Primary Care Coordination
 - 1) Health education, school health care
 - 2) Long term care network
 - b. Inpatient Coordination
 - 1) Intensive Care;
 - 2) Intermediate Care;
 - 3) Paediatric ward;
 - 4) Different inpatient wards according to hospital complexity.
 - c. Surgery Coordination
 - 1) Operating theatre & recovery room;
 - 2) Ambulatory surgery Centre and Special Exams.
 - d. Women and New-borns Coordination
 - 1) Delivery ward& Gynaecology emergency room
 - 2) Obstetrics & Gynaecology Outpatient
 - 3) Obstetrics inpatient & Neonatology ward
 - e. Outpatient Coordination
 - 1) Outpatient clinic
 - 2) General Day care centre
 - 3) Oncology day care centre
 - 4) Dialysis
 - f. Accident and Emergency Coordination
 - g. Transversal programs and pathways coordination

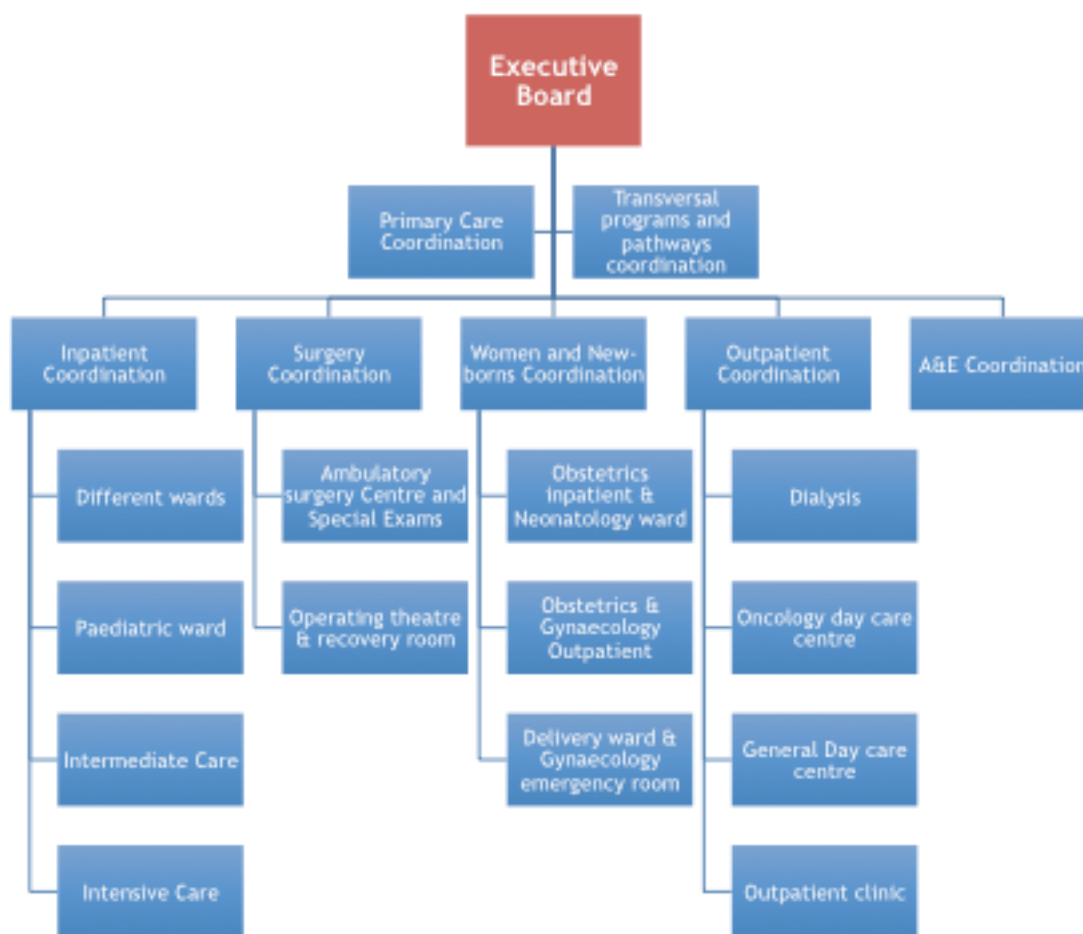


Figure 8. Example of Nursing Services structured into “Coordination” areas.

72. Each clinical area has a Nurse Manager appointed by the Executive Board on a proposal from the CNO among nurses. Clinical areas aggregated into Nursing Coordinations. Nursing Coordinations are supervised by a Nurse Coordinator appointed by the Executive Board on a proposal from the CNO among Nurse Managers.
73. The Nurse Manager’s specific duties are to:
- Supervise nursing care and coordinate technically the nursing activity;
 - Assist with the preparation of action plans and their department reports and promote the optimal use of resources, with particular emphasis on the control of goods consumption;
 - Set the nursing activities, in particular by defining the specific obligations of nurses and ancillary staff that works with them, proposing measures to adapt the available resources to needs, particularly when preparing schedules and vacation plans;
 - To propose the level and type of qualification required to nursing staff on the basis of nursing care provided;

- e. To develop, in coordination with the Department Head, the strategy and the annual reports for the nursing activities;
- f. To develop working methods that favour a better performance level of nursing staff and ensure the quality of nursing care provided;
- g. To promote the dissemination of information relevant to the nursing staff.

74. Clinical Departments/Divisions and Nursing Coordinations work in a Matrix Management Structure allowing flexibility and breaking the "silo" effect that some traditionally structured organizations experience. The COO assures quality and efficiency of care through the coordination between the medical departments and nursing services.

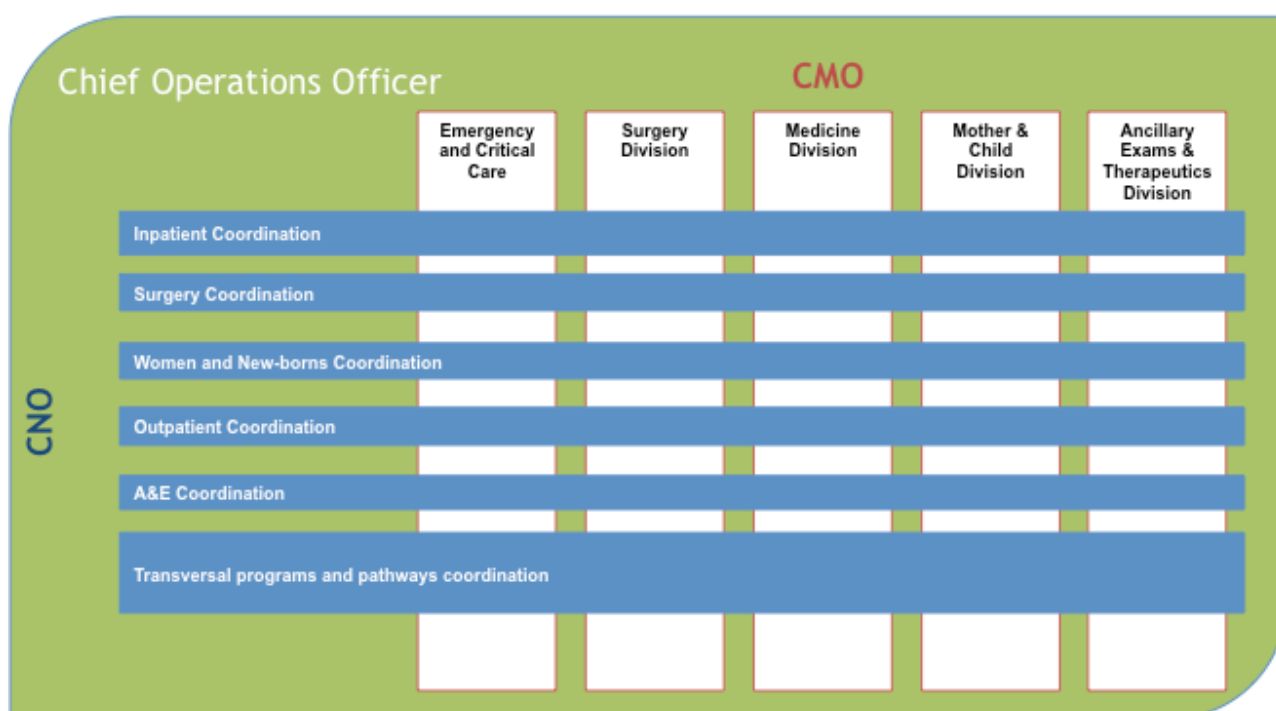


Figure 9. Example of Matrix Management Structure between medical departments and nursing services.

75. Whenever required, the hospital must develop clinical pathways that allow patient-centred care. Several chronic conditions are candidates to develop a patient-centred care approach. On good example is a diabetic’s outpatient clinic where different medical specialties’ and other health professionals cooperate in order to provide best care available to a diabetic patient.
76. Additionally, Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare requires the European Commission to support Member States in the development of European Reference Networks (ERN) composed of healthcare providers and Centres of Expertise. The main added value of the ERN and of the Centres of Expertise is the improvement of access to both diagnosis and high-quality, accessible and cost-effective healthcare for patients who

have a medical condition requiring a particular concentration of expertise or resources, particularly in medical domains where expertise is rare. ERN could also be focal points for medical training and research, information dissemination and evaluation, especially for rare diseases. Article 12 of the Directive requires the Commission to adopt a list of criteria that the networks must fulfil, and the conditions and criteria that providers wishing to join networks must fulfil. The Commission is also required to develop and publish criteria for establishing and evaluating European Reference Networks. This has been achieved through the adoption of: a delegated decision listing the criteria and conditions that healthcare providers and the ERNs should fulfil, and an implementing decision containing criteria for establishing and evaluating ERNs, including the exchange and dissemination of information about the ERNs. Both decisions were adopted on 10 March 2014 and entered into force in May 2014. Recognizing the importance of this process to Cyprus, it is recommended that the MoH analyse the areas that can potentially join ERN in order to tackle complex or rare medical conditions that require highly specialized healthcare and a concentration of knowledge and resources.

77. Support divisions are based on an organizational model endowed with performance flexibility, shared resources and adjustment capacity to give responses to the objectives defined by the Executive Board. Support divisions carry out their duties cross-providing services to various structures, within logic of process management, complementary action and focus on results.
78. Each Support Division is managed by a Director appointed by the Executive Board on a proposal from the COO or the CFO.
79. The Support Division Director's specific duties are to:
 - a. Submit to the Executive Board the annual plan of activities and budget, including the departments / units that integrate it;
 - b. Implement, in conjunction with the departments/ units constituting the division, initiatives and the necessary measures to comply with the budget;
 - c. Ensure adequate coordination of departments/ units, sharing resources and creating synergies;
 - d. Identify opportunities for improvement in revenues and reduction of costs;
 - e. Develop an information policy that, according to the corporate communication strategy, may make known to professional services / units in the guidelines of the *Executive Board*;
 - f. Operationalize the strategic guidelines on quality defined by the *Executive Board*;
 - g. Promote an adequate information system for management;

- h. Propose cooperation or support agreements, service delivery contracts or agreements with public and private institutions, within the framework of its activities;
 - i. Ensure the correct articulation and response to the various AO structures;
 - j. Exercise such other powers as are delegated to or sub-delegated by the Executive Board or its members.

- 80. Each Support Department is managed by a Head of Department appointed by the Executive Board on a proposal from the COO or the CFO, and are responsible for plan and direct all the activity of the department, and to ensure the efficient use of resources within the strategic and operational guidelines established the Executive Board. The Head of Department will:
 - a. Develop, in conjunction with the Division Director the annual plan of activities and respective budget;
 - b. Analyse monthly activity and budgeted execution, and if necessary, propose corrective measures to the Division Director or the Executive Board;
 - c. Promote the maintenance of an effective internal control system to ensure the safeguarding of assets, the integrity and reliability of the system information, compliance with laws, regulations and standards, as well as the monitoring of global goals defined;
 - d. Ensure the proper management of human resources, including internal assessment of the overall performance of professionals and maintain the discipline, ensuring full compliance by all staff.

- 81. Support Divisions are:
 - a. Customer Service Division:
 - 1. Customer service Department;
 - 2. Spiritual and Religious Guidance Department;
 - 3. Social Services.
 - b. Business Control Division, which includes:
 - 1. Management control Department;
 - 2. Financial Department;
 - c. Human resources Division, which includes:
 - 1. Human Resources Management Department
 - 2. Occupational Health Department;
 - 3. Training and Continuous Education Department;
 - d. Logistics, Procurement and Infrastructure Division, which includes:
 - 1. Hotel Services Department (laundry, kitchen, housekeeping and mortuary);
 - 2. Logistics Department;

3. Procurement Department;
4. Central sterile services Department;
5. Hospital Maintenance Department;
6. Security, Parking and Transportation Department.

82. Other support departments are:

1. Internal Audit Office;
2. Communication and Public Relations Office;
3. Information and Communication Technology Department;
4. Legal Department.

83. Relative remuneration between senior executive positions would operate in a relatively narrow range, with the remuneration of the Senior Health Manager, for instance, potentially at 70% of that of the Chief Executive Officer. Table 4 illustrates a potential range for senior staff.

Table 4. Example of remunerations (it is relevant to highlight that there wasn't any financial analysis or discussion with stakeholders).

Position	Remuneration	Plus
Chief Executive Officer (CEO)	100%	Performance Bonus
Chief Medical Officer (CMO)	90% CEO	Performance Bonus
Chief Primary Healthcare Services Officer	85% CEO	Performance Bonus
Chief Financial Officer (CFO)	80% CEO	Performance Bonus
Chief Operations Officer (COO)	80% CEO	Performance Bonus
Chief Nurse Officer (CNO)	80% CEO	Performance Bonus
Chief Scientific Officer (CSO)	80% CEO	Performance Bonus
Senior Health Manager	70% CEO	Performance Bonus
Other management positions	-	Performance Bonus

Organizational complexity (Mintzberg 1979) depends mainly on two criteria:

- The larger the horizontal differentiation becomes, higher the number of units or departments is (Mintzberg, 1979). This creates additional costs because it increases the needs for coordination and the amount of information that has to be processed (Obel and Burton, 1998).
- The vertical differentiation depends on the number of hierarchical levels between the "top management" and the bottom of the hierarchy. It increases the coordination and information processing costs (Mintzberg, 1979; Obel and Burton, 1998)

So, organizational structure should vary from hospital to hospital: Large hospitals have complex organizational structures and smaller hospitals tend to have much simpler organizational structures. Cypriot hospitals can be classified in 4 levels of complexity according to dimension.

Table 5. Hospitals characterization: number of acute beds, total costs and number of staff.

Hospital	Acute Beds	Costs	Staff	
Γενικό Νοσοκομείο Αμμοχώστου Famagusta General Hospital	74	19 414 659,77 €	385	Level 1
Γενικό Νοσοκομείο Πάφου Paphos General Hospital	137	37 427 957,54 €	689	Level 2
Γενικό Νοσοκομείο Λάρνακας Larnaca General Hospital	166	43 480 083,17 €	710	Level 2
Γενικό Νοσοκομείο Λεμεσού Limassol General Hospital	345	82 704 554,23 €	1 271	Level 3
Γ. Ν. Λευκωσίας + Νοσοκομείο Αρχ. Μακάριος III, Λευκωσίας Nicosia General Hospital	698	183 947 915,23 €	2 825	Level 4

85. Using the same argument, pay grades of management positions should also be determined by the complexity of the institution.

Table 6. Indicative of CEO pay grade according to AO complexity.

CEO Position	Pay grade	Plus
Famagusta General Hospital	65%	Performance Bonus
Paphos General Hospital	75%	Performance Bonus
Larnaca General Hospital	75%	Performance Bonus
Limassol General Hospital	85%	Performance Bonus
Nicosia General Hospital	100%	Performance Bonus

The duration of the mission did not allow sufficient time to comprehensively address deliverable 2 'Any proposed revisions to the functions of the new autonomous organisations, with an explanation of the rationale behind them'. Moreover, the rationale for revising the functions must relate to the strategic objectives and health system priorities determined by the new legal framework, which is currently at the consultation draft stage.

The recommendations of paragraphs 86 and 87 are, therefore, general recommendations on how the determination of potential functional changes. The task will involve economic evaluation tools and market analysis for non-clinical services; and equity, accessibility, cost-effectiveness and clinical analysis for clinical services. How best to proceed remains pending and should be discussed with the WHO consultants engaged in the second stage of the technical assistance addressing District Health Services Autonomy.

86. The current services portfolio of each AO needs to be revised, namely to assess the suitability of services supply at the national, regional and local levels, accordingly with the population's health needs. By definition medical services must assure high quality of care by having adequate resources and a minimum threshold number of cases to assure expertise is maintained - it is well known that critical mass, peer regulation and continuing education are essential to assure quality of care and state of the art care provision. Units unstaffed are prone to provide care below state of art. Additionally, the existence of understaffed services

decreases the ability to manage schedules and inter-changeability of roles, damaging resolution capacity and increasing waiting times.

87. Additionally, AOs should take steps to focus their business on their core competency—the delivery of healthcare services. Within this strategy, hospitals may consider outsourcing any function outside the direct delivery of healthcare that is either underperforming, requires specialized skills, or requires substantial infrastructure or other resources. AOs should consider (a) reasons for outsourcing, (b) obstacles to outsourcing, (c) best practices of outsourcing, and (d) implications for hospital management. Some of the most common tasks outsourced include revenue cycle services, human resources, benefits administration, information technology, laundry, housekeeping, food services, and, in some cases, clinical services that the provider is not well-equipped to provide without the assistance of a third party, or that a third party is able to provide the service at a higher quality and/or at a lower cost than the provider could do itself.
88. It must be emphasised that medical professionals should have an exclusively contractual relationship with the AO in order to assure focus and commitment to the organization. Moreover, professionals' remuneration schemes should consider productivity and financial incentives to achieve and maintain quality with objective criteria to reward the best performing professionals.
89. Furthermore, the use of private practitioners in public hospitals may adversely affect the legitimate rights and interests of patients, particularly the risk of them not being properly informed about which entity is providing care. This might lead to a lack of transparency in the relationship between the patient and the provider, with possible injury of their rights, including their freedom of choice and fairness of treatment.

Famagusta General Hospital

90. According to the current services portfolio, Famagusta General Hospital should be organized in the following Clinical Departments/Divisions (Head of Clinical Department positions should only be created if there exists 3 or more physicians with the respective medical specialty; until the position is created, the existing physicians will be hierarchically coordinated by the Division Medical Director):
 - a. Primary Care Division
 - b. Emergency and Critical Care
 - 1) A&E
 - 2) Critical care
 - c. Surgery Division
 - 1) General Surgery

- 2) Anaesthesiology
- 3) Trauma & Orthopaedics
- 4) Ophthalmology
- 5) Gynaecology & Obstetrics
- d. Medicine Division
 - 1) Internal Medicine
 - 2) Hyperbaric Medicine
 - 3) Nephrology
 - 4) Diabetology
 - 5) Gastroenterology
 - 6) Paediatrics
 - 7) Thalassaemia Centre
- e. Diagnostics & Therapeutics Division
 - 1) Laboratories
 - 2) Blood Centre
 - 3) Radiology
 - 4) Speech-language pathology
 - 5) Physiotherapy

Paphos General Hospital & Larnaca General Hospital

91. According to the current services portfolio, Paphos General Hospital and Larnaca General Hospital should be organized in the following Clinical Departments/Divisions (Head of Clinical Department positions should only be created if there exists 3 or more physicians with the respective medical specialty; until the position is created, the existing physicians will be hierarchically coordinated by the Division Medical Director):

- a. Primary Care Division
- b. Emergency and Critical Care
 - 1) A&E
 - 2) Critical care
- c. Surgery Division
 - 1) General Surgery
 - 2) Anaesthesiology
 - 3) ENT
 - 4) Trauma & Orthopaedics
 - 5) Ophthalmology
 - 6) Gynaecology & Obstetrics
 - 7) Urology
- d. Medicine Division
 - 1) Internal Medicine

- 2) Hyperbaric Medicine
 - 3) Nephrology
 - 4) Diabetology
 - 5) Gastroenterology
 - 6) Paediatrics
 - 7) Cardiology
 - 8) Neurology
 - 9) Dermatology
 - 10) Thalassaemia Centre
- e. Diagnostics & Therapeutics Division
- 1) Laboratories
 - 2) Blood Centre
 - 3) Radiology & Medical Imaging
 - 4) Speech-language pathology
 - 5) Physiotherapy

Limassol General Hospital

92. According to the current services portfolio, Limassol General Hospital should be organized in the following Clinical Departments/Divisions (Head of Clinical Department positions should only be created if there exists 3 or more physicians with the respective medical specialty; until the position is created, the existing physicians will be hierarchically coordinated by the Division Medical Director):

- a. Primary Care Division
- b. Emergency and Critical Care
 - 1) A&E
 - 2) Critical care
- c. Surgery Division
 - 1) General Surgery
 - 2) Anaesthesiology
 - 3) ENT
 - 4) Trauma & Orthopaedics
 - 5) Ophthalmology
 - 6) Urology
- d. Medicine Division
 - 1) Internal Medicine
 - 2) Hyperbaric Medicine
 - 3) Nephrology
 - 4) Diabetology
 - 5) Gastroenterology

- 6) Cardiology
- 7) Neurology
- 8) Dermatology
- 9) Endocrinology
- 10) Haematology
- 11) Oncology
- e. Mother & Child Division
 - 1) Gynaecology & Obstetrics
 - 2) Paediatrics
 - 3) Thalassaemia Centre
- f. Diagnostics & Therapeutics Division
 - 1) Laboratories
 - 2) Blood Centre
 - 3) Radiology & Medical Imaging
 - 4) Nuclear Medicine
 - 5) Speech-language pathology
 - 6) Physiotherapy

Nicosia General Hospital

93. According to the current services portfolio, Nicosia General Hospital should be organized in the following Clinical Departments/Divisions (Head of Clinical Department positions should only be created if there exists 3 or more physicians with the respective medical specialty; until the position is created, the existing physicians will be hierarchically coordinated by the Division Medical Director):

- a. Primary Care Division
- b. Emergency and Critical Care
 - 1) A&E
 - 2) Critical care
- c. Surgery Division
 - 1) General Surgery
 - 2) Anaesthesiology
 - 3) ENT
 - 4) Trauma & Orthopaedics
 - 5) Ophthalmology
 - 6) Urology
 - 7) Vascular & Cardiothoracic Surgery
- d. Medicine Division
 - 1) Internal Medicine
 - 2) Hyperbaric Medicine

- 3) Nephrology
 - 4) Diabetology
 - 5) Gastroenterology
 - 6) Cardiology
 - 7) Neurology
 - 8) Dermatology
 - 9) Endocrinology
 - 10) Haematology
 - 11) Oncology
- e. Women's Health Division
- 1) Gynaecology
 - 2) Obstetrics
 - 3) Breast Centre
 - 4) Infertility
- f. Paediatrics Division
- 1) Genetics
 - 2) Paediatrics
 - 3) Paediatric Cardiology
 - 4) Paediatric Endocrinology
 - 5) Paediatric Hepatology
 - 6) Intensive Care
 - 7) Paediatric Nephrology
 - 8) Paediatric Neurology
 - 9) Paediatric Oncology
 - 10) Paediatric Psychiatry and Psychology
 - 11) Paediatric Pulmonology
 - 12) Paediatric Surgery
 - 13) Thalassaemia
- g. Diagnostics & Therapeutics Division
- 6) Laboratories
 - 7) Blood Centre
 - 8) Radiology & Medical Imaging
 - 9) Speech-language pathology
 - 10) Physiotherapy
 - 11) Nuclear Medicine

The Primary Care Division

The evolution of health care, characterized by the ageing population, increasing technical complexity and the need for multidisciplinary approach, for citizen-centred provision of care and oriented to obtain health gains, made the restructuring of healthcare centres inevitable, with special emphasis being given on assuring “good” primary care. It is generally accepted that “good” primary care assures (1) First-contact access for each new need; (2) Long-term person - (not disease) focused care; (3) Comprehensive care for most health needs; (4) Coordinated care when it must be sought elsewhere; as well as the three related aspects of community orientation, family-centeredness, and cultural competence.

To assure the development of primary health care services within the AO it is indispensable to address their particularities through a specific intermediate management structure with its own budget.

94. As all other Divisions, the Primary Care Division is managed by a Senior Health Manager appointed by the Executive Board on a proposal from the COO.
95. This manager works closely with the Chief Primary Healthcare Services Officer (CPHSO) – succeeds on the functions of the CMO - and the Nurse Coordinator for Primary Care, and jointly they constitute Primary Care Board.
96. The Primary Care Board has the following specific duties:
 - a) Develop multi-annual and annual plans for primary health care services, including budget, and submit them for approval by the Executive Board;
 - b) Systematically monitor and evaluate the primary healthcare activities, particularly in terms of quality and efficiency of services provided;
 - c) Monitor the implementation of the budget, applying measures to correct deviations from forecasts;
 - d) Promote the effective utilization of the information and communication system, including the electronic health record and clinical coding;
 - e) Promote coordination and integration of care between primary health care units and with hospital services;
 - f) Establish procedures to ensure the continuous improvement of quality of healthcare;
 - g) Approve clinical guidelines for prescription medicines and supplementary diagnostic and therapeutic and clinical protocols adapted to the most frequent pathologies;
 - h) Decide on technical conflicts;
 - i) Exercise the powers delegated by the Executive Board.

References

- Anastasiou, A. 2014. NHS draft bills ready. Available at <http://cyprus-mail.com/2014/12/12/nhs-draft-bills-ready/> (accessed 12-12-2014).
- Carver, J. 2000. Leadership du conseil d'administration: The Policy Governance Model". *Canadian journal Gouvernance - revue internationale* 2: 100-8.
- Carver, J., and M. Carver. 2001. Le modèle Policy Governance et les organismes sans but lucratif. *Canadian journal Gouvernance - revue internationale* 2: 30-48.
- Chambers, N. 2006. *Governance and the work of health service boards*. In *Healthcare Management*, edited by K. Walsh and J. Smith, 267-85. Maidenhead: Open University Press.
- Chambers, N., G. Harvey, R. Mannion, J. Bond, and J. Marshall. 2013. Towards a framework for enhancing the performance of NHS boards: a synthesis of the evidence about board governance, board effectiveness and board development. *Health Services and Delivery Research* 1: 1-138.
- Cleverley, W.O., and A.E. Cameron. 2007. *Essentials Of Health Care Finance*, Sixth ed. Sudbury: Jones and Bartlett Publishers.
- Foresight Centre for Governance. 2013. *The Healthy NHS Board 2013 - Principles for Good Governance*. London: NHS Leadership Academy.
- Gabe, J., and M. Calnan. 2009. *The New Sociology of the Health Service*. Oxon: R.
- Garratt, B. 2010. *The Fish Rots From The Head: The Crisis in our Boardrooms: Developing the Crucial Skills of the Competent Director*, Third ed. London: Profile Books Ltd.
- Glouberman, S., and H. Mintzberg. 2001a. Managing the care of health and the cure of disease--Part I: Differentiation. *Health Care Manage Rev* 26: 56-69; discussion 87-9.
- Glouberman, S., and H. Mintzberg. 2001b. Managing the care of health and the cure of disease--Part II: Integration. *Health Care Manage Rev* 26: 70-84; discussion 7-9.
- Goodwin, N. 2005. *Leadership in Health Care: A European Perspective* Oxon: Routledge.
- Goodwin, N., R. Gruen, and V. Iles. 2006. *Managing Health Services*. Maidenhead: McGraw-Hill International,.
- Hill, C., and G. Jones. 2004. *Strategic Management Theory: An Integrated Approach*. Boston: Houghton Mifflin Company.
- Kevin D. Lyles, E.S.C.H., Esquire Ashley Lykins. 2010. Healthcare Outsourcing Overview: Staying Focused in Uncertain Times. *Teaching Hospitals & Academic Medical Centers Practice Group* 7: 1-5.
- McKinsey & Company. 2010. *Implementing the shared vision for the Cyprus Health System*. 131. Nicosia, Cyprus: McKinsey & Company.
- Ministry of Labour Welfare and Social Insurance. 2014. *Cyprus National Social Report 2014*. 21. Nicosia: Ministry of Labour, Welfare and Social Insurance,.
- Mintzberg, H. 1979. *The Structuring of Organizations*. Englewood Cliffs: Prentice-Hall.
- Orlikoff, J.E., and D.D. Pointer. 1999. *Board Work: Governing Health Care Organizations* First ed. New York: Jossey-Bass Publishers.
- Planning Bureau. 2008. *Lisbon Strategy - Renewed National Reform Programme of the Republic of Cyprus*. Cyprus: Planning Bureau.
- Republic of Cyprus, European Commission, European Central Bank, and International Monetary Fund. 2014. *Revised Memorandum of Understanding on Specific Economic Policy Conditionality - September 2014*. Nicosia.
- Roberts, J., J. Henderson, L. Olive, and D. Obaka. 2013. A Review of Outsourcing of Services in Health Care Organizations. *Journal of Outsourcing & Organizational Information Management*: 1-10.

Ronen, B., J.S. Pliskin, and S. Pass. 2006.*Focused Operations Management for Health Services Organizations*. San Francisco: Jossey-Bass.

The World Bank. 2003.*Reforming Public Institutions and Strengthening Governance - Implementation Update*. In *A World Bank Strategy*. Washington, USA: The World Bank.

The World Bank. 2014.*Analysis of the Function and Structure of the Ministry of Health of the Republic of Cyprus*. Nicosia: The World Bank,.

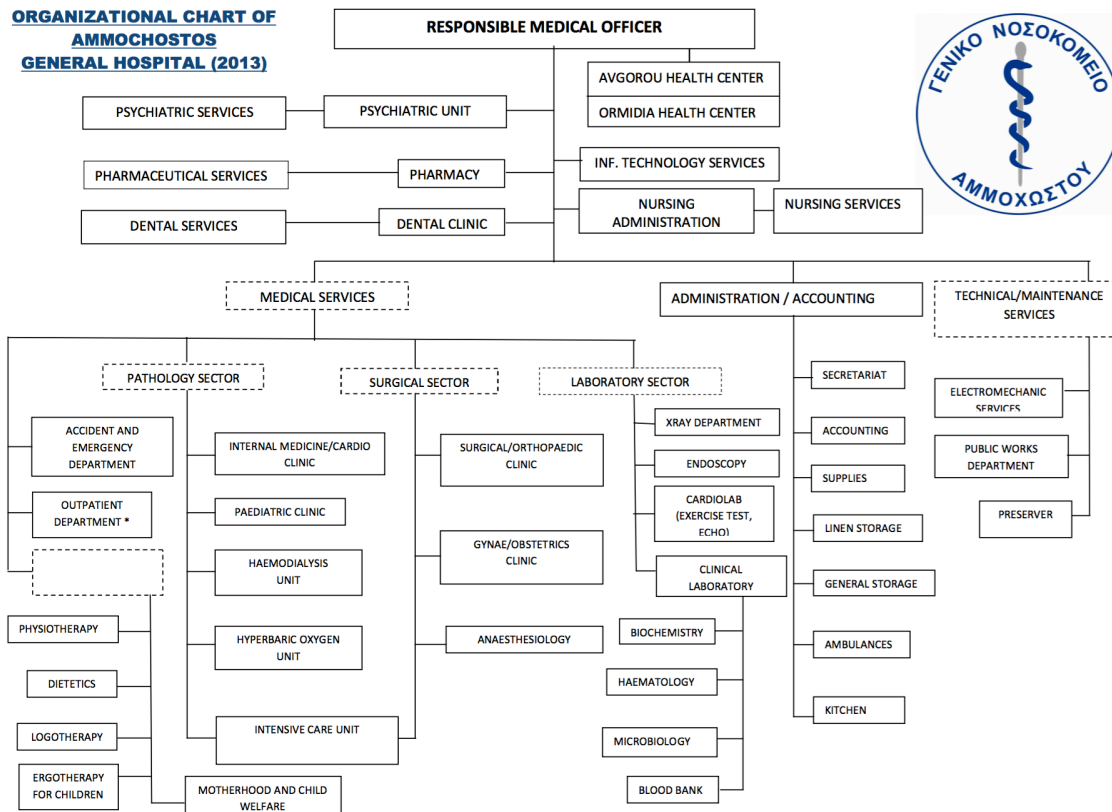
Theodorou, M., C. Charalambous, C. Petrou, and J. Cylus. 2012. Cyprus: Health system review. *Health Systems in Transition* 14: 1–128.

Vissers, J., and R. Beech. 2006.*Health Operations Management: Patient Flow Logistics in Health Care*. Oxon: Routledge.

Annex - Hospital Organization Charts

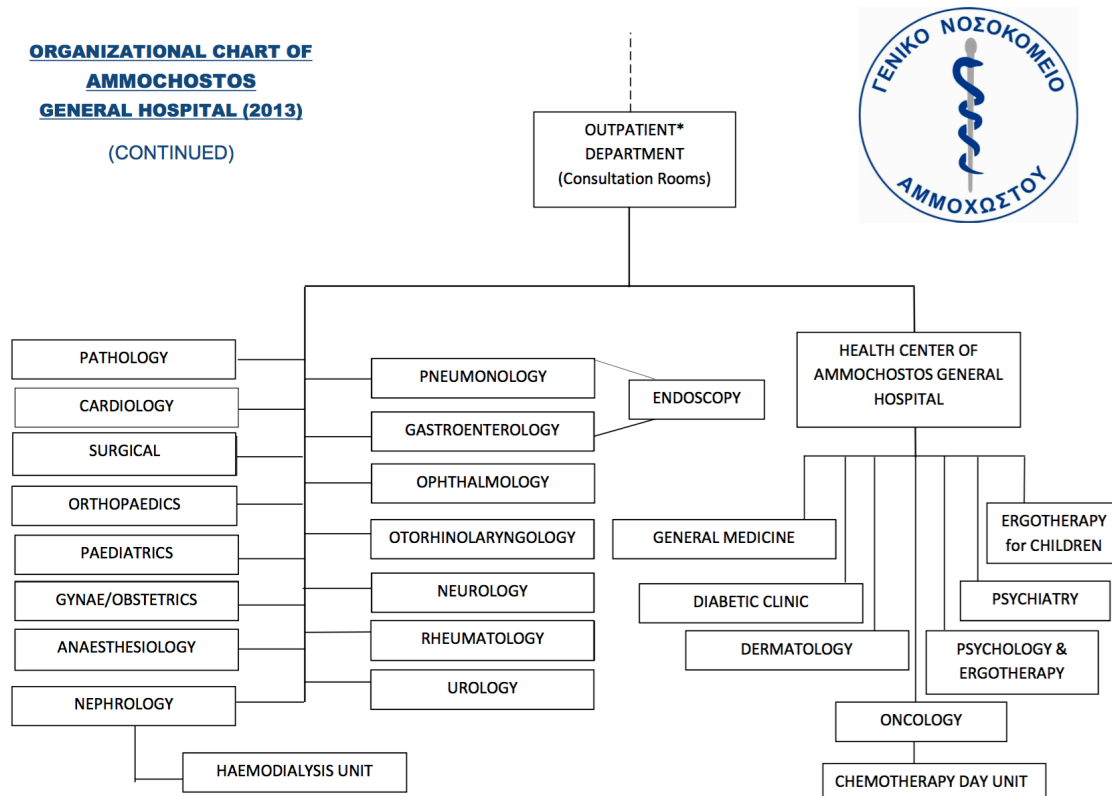
Famagusta General Hospital Organizational Chart

ORGANIZATIONAL CHART OF AMMOCHOSTOS GENERAL HOSPITAL (2013)

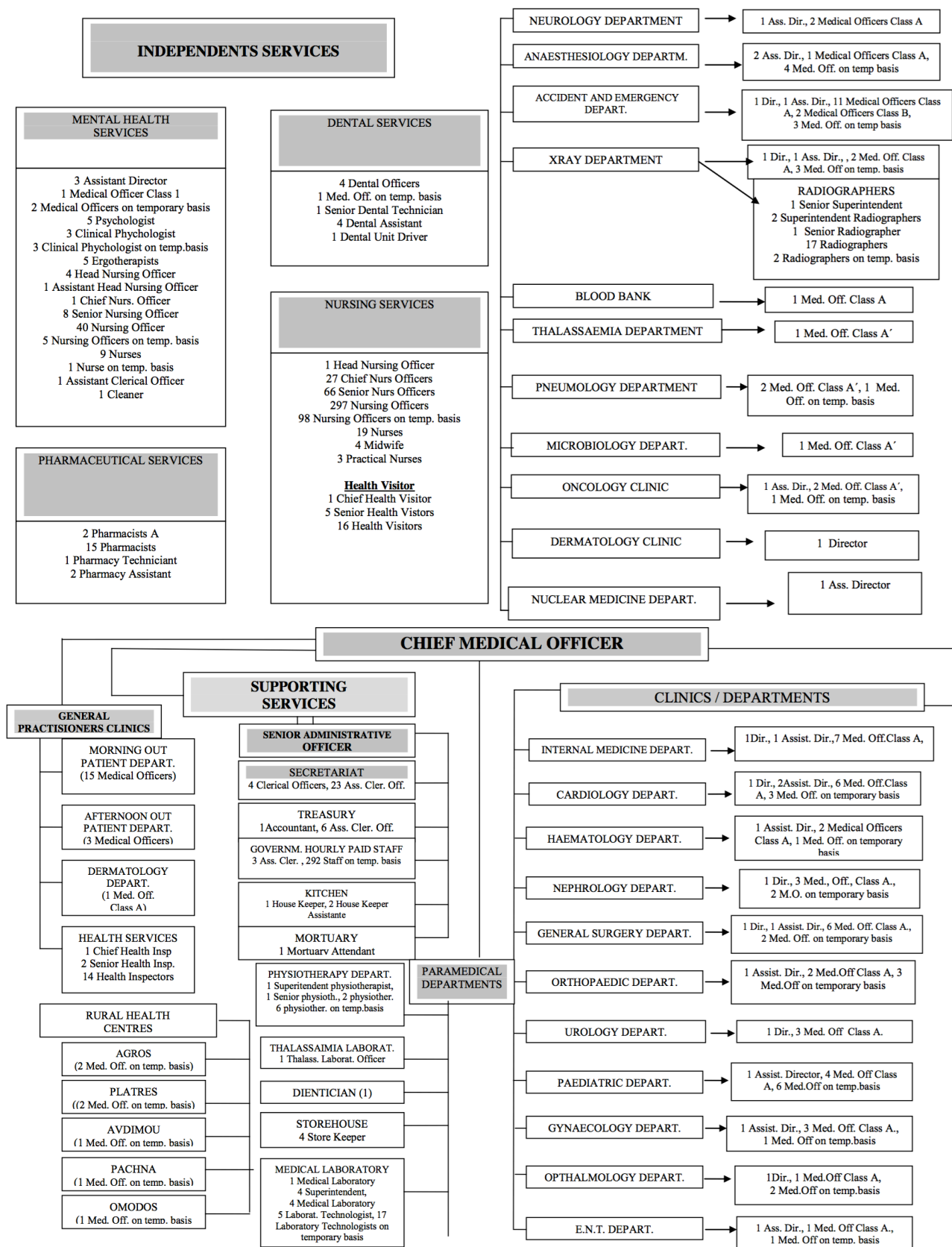


ORGANIZATIONAL CHART OF AMMOCHOSTOS GENERAL HOSPITAL (2013)

(CONTINUED)

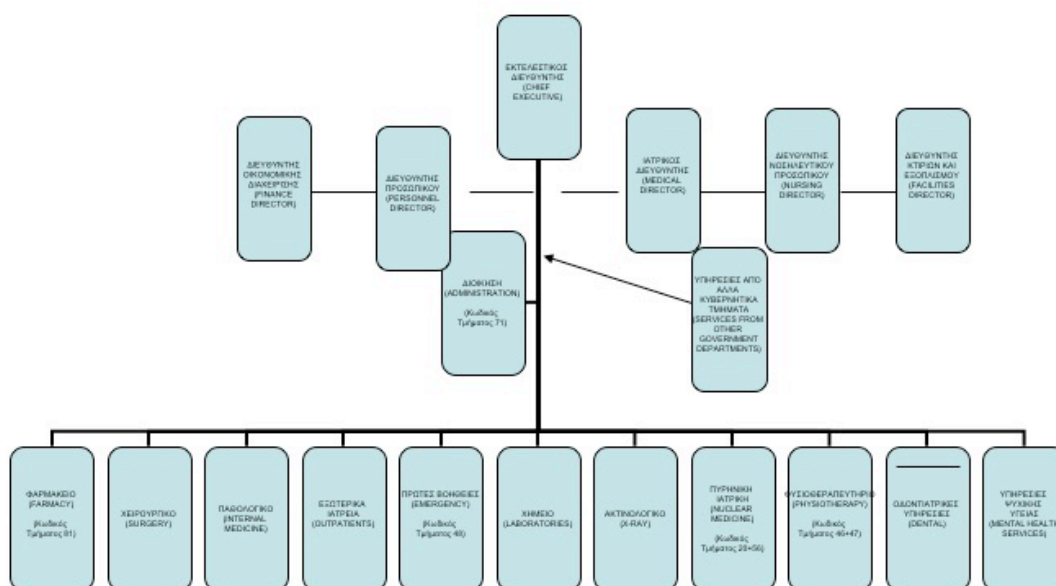


Limassol General Hospital Organizational Chart

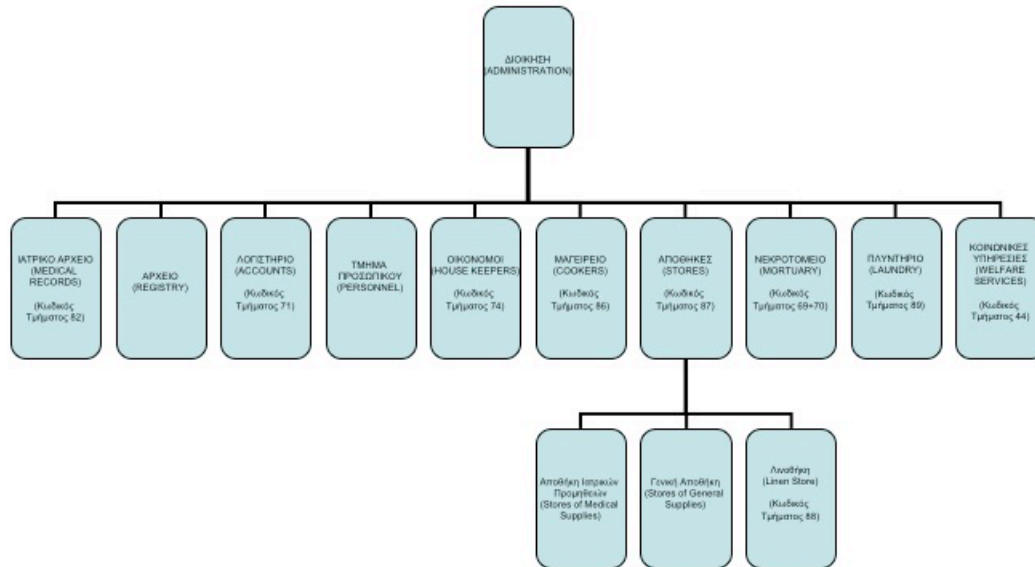


Nicosia General Hospital Organizational Chart

Νέο Γενικό Νοσοκομείο Λευκωσίας

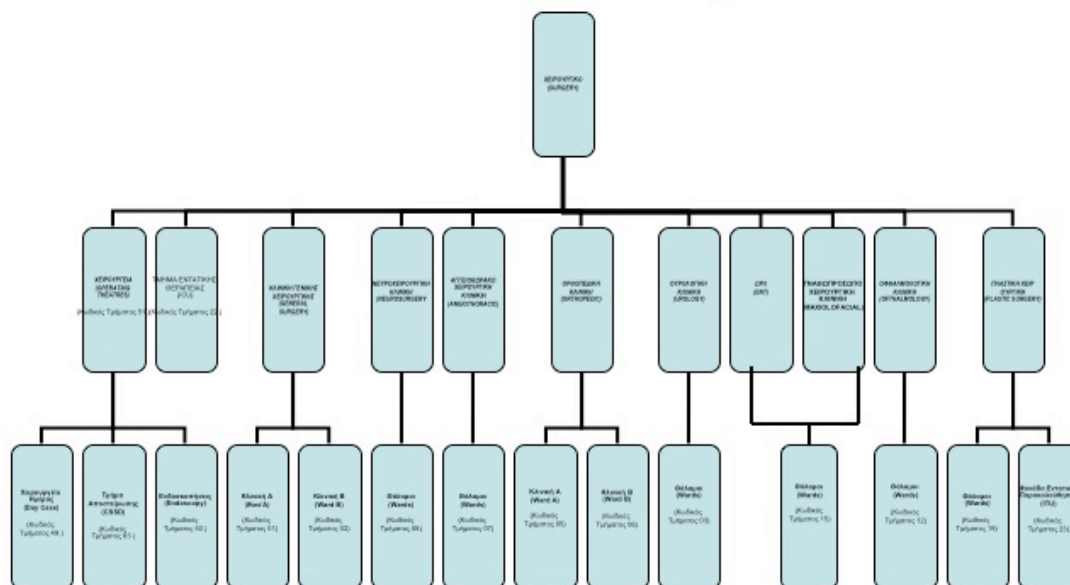


Νέο Γενικό Νοσοκομείο Λευκωσίας



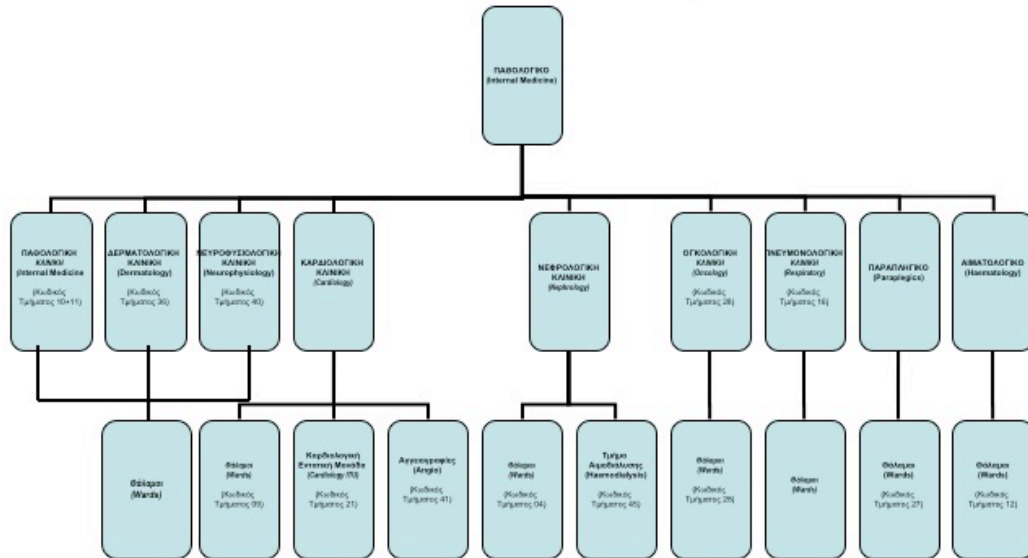
2

Νέο Γενικό Νοσοκομείο Λευκωσίας

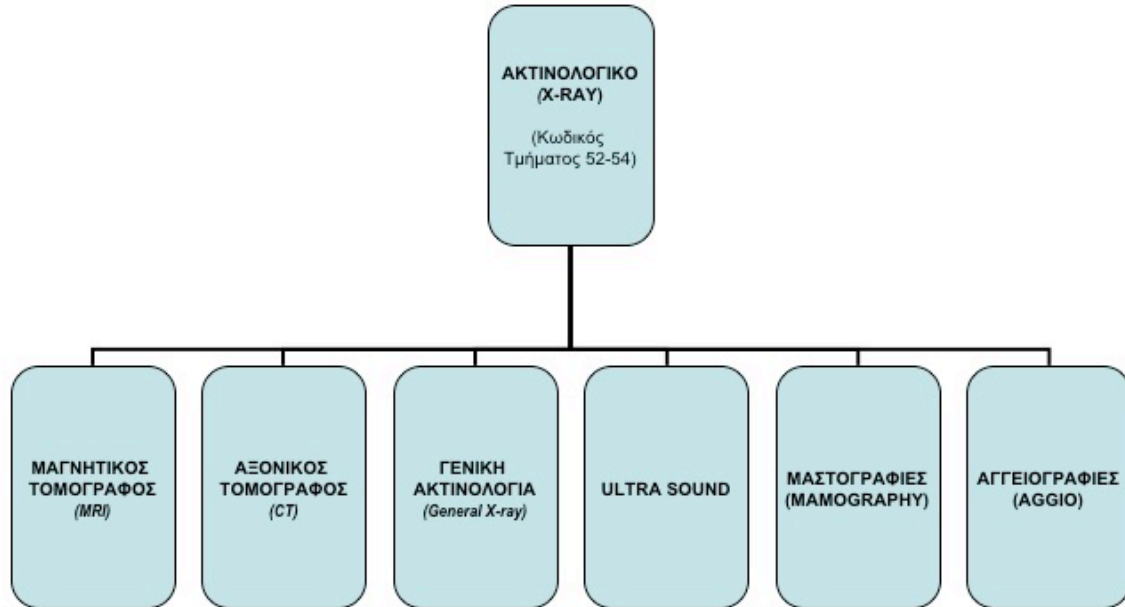


3

Νέο Γενικό Νοσοκομείο Λευκωσίας

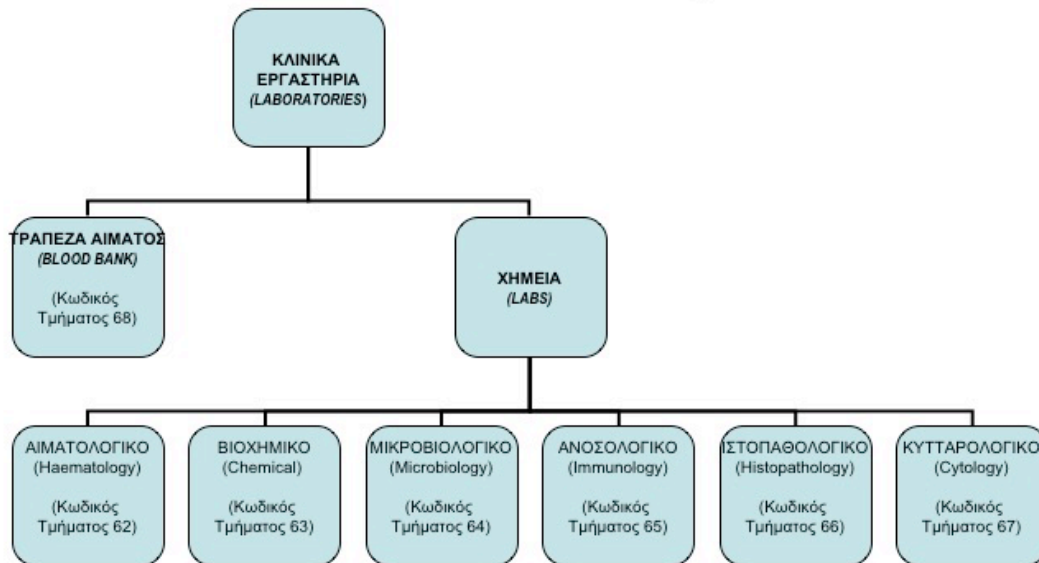


Νέο Γενικό Νοσοκομείο Λευκωσίας



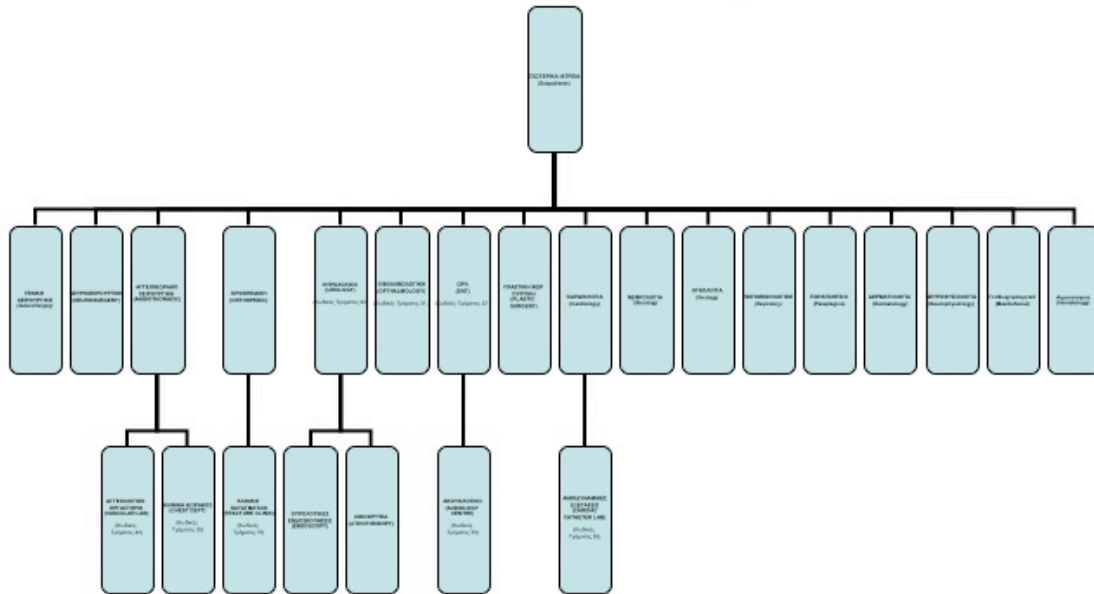
5

Νέο Γενικό Νοσοκομείο Λευκωσίας

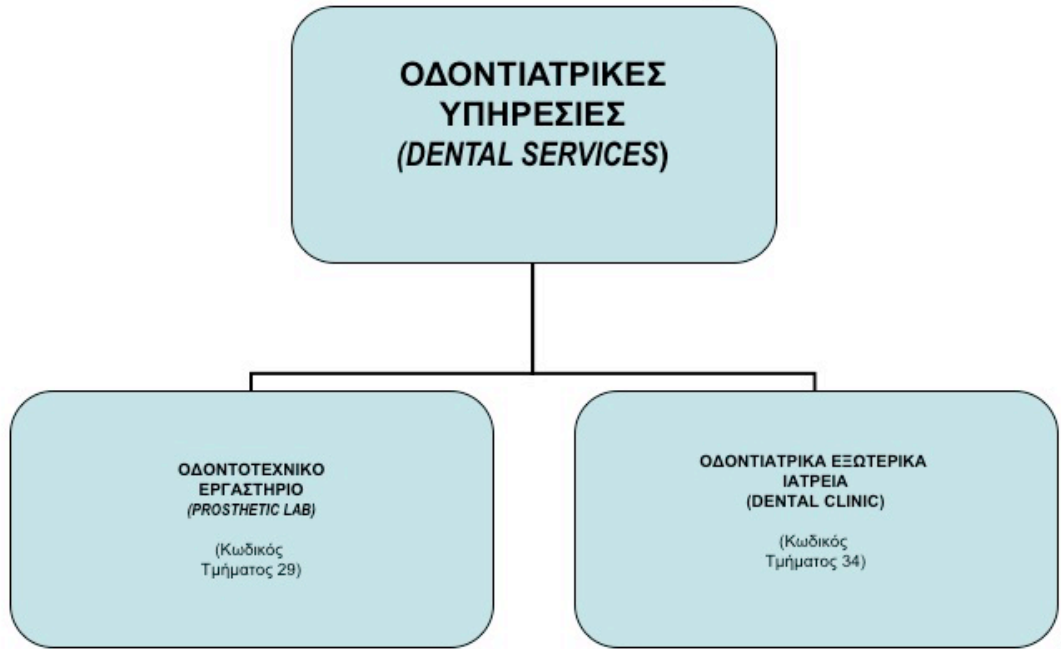


6

Νέο Γενικό Νοσοκομείο Λευκωσίας

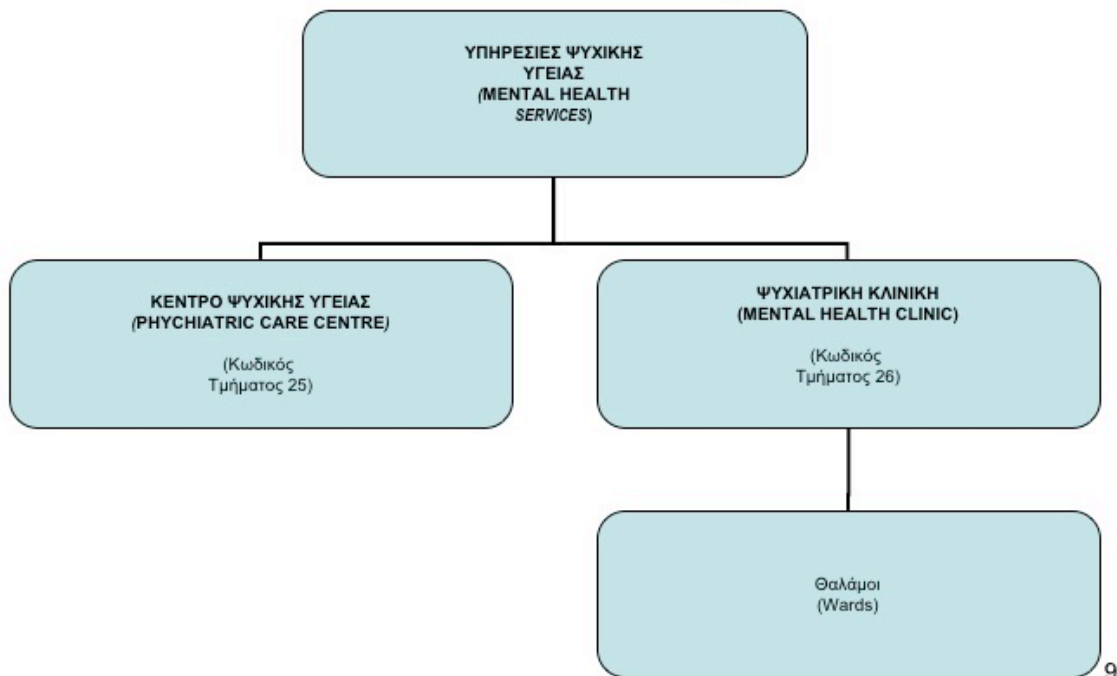


Νέο Γενικό Νοσοκομείο Λευκωσίας



8

Νέο Γενικό Νοσοκομείο Λευκωσίας



9