4. Consultation

4.1   Introduction

An important element of the overall approach to the ISA Review was to undertake a comprehensive process of consultation and dialogue with stakeholders, while being mindful of international experience and learning, along with the overall direction set by Government in *Future Health*:

- Map out appropriate successor bodies and related geographic areas for primary care and community services

- Bring forward proposals for appropriate governance models at area and sub-area levels

- Ensure the model supports the direction of travel towards a UHI environment

A real and candid engagement was adopted by the project team throughout the consultation process, and comments, feedback and submissions (formal and informal) on all aspects of the review were encouraged and welcomed by the team. Engagements took the form of a presentation which set out the context of the reform programme, an overview of the current ISAs and scope and approach to the project, followed by a structured engagement and open discussion. All members of the team were available to individuals and stakeholders to submit feedback and a dedicated email address, isareview@hse.ie was established to facilitate ease of access and to ensure that feedback was captured appropriately.

The project team used 3 key questions to frame the discussions,
- What criteria should be used in deciding on successor bodies?
- What would you take with you – what would you leave behind?
- What governance and management structure is required to deliver community services in the successor structures at area and sub-area levels that best serves our people?

The consultation was designed to capture experiences of the current structures, how effective or not they are, challenges around implementing change and opportunities for improvement in the context of the Community Healthcare Organisations. As the consultation / engagement process progressed, the project team ensured that all submissions were considered equally during the entire process. A process of consultation was arranged with a wide range of internal and external stakeholders who proactively engaged and made submissions to the project team. Appendix B

4.2   Phase 1 – Consultation Workshops ISA Teams

The first phase of the consultation took place between the 3rd and the 17th of July, 2013 during which the project team held an ISA specific workshop, for each of the 17 ISAs. In all, a total of 600 people participated in this process, encompassing a broad range of multidisciplinary professionals, support services, management and care staff reflective of the services provided in the ISA including representatives from the acute service, general practice, etc. The feedback from these sessions was captured in real time recording during the sessions and a brief summary of the emerging themes and issues are set out below:

- **What criteria should be used in deciding on successor bodies?**

Those attending the consultation workshops placed a significant focus on this question, in relation to the criteria to be used to determine the number and scale of Community Healthcare Organisations. The feedback identified 41 themes of which 24 could be said to be criteria. The remaining 17 referred to a number of embedded outcomes participants would like to see from the new structures such as value, integrity and culture. They reflect the positive values that healthcare professionals aspire to and want to identify within any new organisation construct. Integration, access, population (number, demography and density), Hospital Groups, local authorities and geography were the themes recurring most frequently.   These are reflected in chapter 6 in the context of identification of the number of Community Healthcare Organisations.

The establishment of the Hospital Groups and the emphasis or importance to be given to these planned structures in determining the community structures, was considered at each session. While a strong emphasis was placed on the need to have regard to Hospital Groups, the clear message from a range of clinicians and professionals was that it was not necessary for the Community Healthcare Organisations to be defined by them. The view was that with appropriate and agreed referral and clinical pathways and models of care that patients could travel smoothly through services and the system. A particular emphasis was placed on the relationship and interface between primary care services and the local hospital providing secondary care, rather than on an alignment with a particular Hospital Group.

The key criteria identified during the workshops, to be considered in the approach to designing a Community Healthcare Organisation are summarised below:

o Integration - this is both a disposition or behaviour on the one hand but also a structural requirement on the other. Capacity for internal integration between services and external integration in the health context with the new Hospital Groups and further with local authorities/other public services is an identified requirement of the new structure

o Access - Community Healthcare Organisations must facilitate not only ease of access but place a strong emphasis on progressing towards equity of access.

o Population - not only the actual size but also factors such as demography, multi-cultural make up, deprivation and natural 'flows' of people to services must be taken into account.

o Geography - the history, size, urban and rural factors, local identity, importance of County for communities and that which "makes sense" must also be incorporated.

o Local Authorities - many community services provided by the HSE, particularly in the personal social service category, have strong links with local authority services and a range of other statutory and voluntary agencies. It was recommended throughout the consultation that where possible, in identifying Community Healthcare Organisations, that the crossing of local authority boundaries should be avoided.

The foregoing criteria were the most emphasised in the engagements and featured in practically all discussion. They reflect a number of the criteria identified in literature as being important and relevant for consideration in the determination of Community Healthcare Organisations. These criteria, in addition to feedback received during other consultations and written submissions received were used to arrive at the design criteria for Community Healthcare Organisations as set out in Chapter 6.

- **What would you take with you?**

The second question was selected by the project team based on the widely acknowledged view that there are many aspects of the current structures and systems which are working well. It would be prudent to ascertain what elements are considered to be functioning well and also to elicit which aspects should be amended or dropped altogether. It was also important in this question to establish the reasons for retention or amendment of particular elements. It also highlighted the requirement to ensure, in as far as possible, that the Community Healthcare Organisations do not impact negatively on existing positive service delivery models and user outcomes. The positive characteristics identified were relatively common to most engagements.

o Integration - the ISA model had resulted in an improved relationship between primary and secondary care services. The establishment of the initial two Hospital Groups has demonstrated that while there were challenges to integration, it is still feasible. Integration in community services within the existing ISAs was described positively and necessary to be maintained as the new national Divisions develop.

o Clarity of Roles - The ISA Manager position was identified as having been a positive experience, particularly in having a senior manager to decide on priorities or points of conflict that arose in respect of the various care groups within the community or between the community and hospital services. It was felt that it was necessary to ensure that in the Community Healthcare Organisations there is clarity of role and function on a similar basis to ensure effective and responsive decision making.

o   Primary Care Teams and Health and Social Care Networks - The work and progress of recent years towards realising the concepts enunciated in the *Primary Care Strategy*, particularly in the recent challenging economic environment, was acknowledged. The new structures would have to address the exact role and definition of primary care and prescribe a practical management and governance structure. The absence of this to date was viewed as a strong disadvantage and impediment to implementing the strategy.   The consultation clearly identified the need for a robust primary care management structure to be a priority in the establishment of the Community Healthcare Organisations. This is borne out in the assessment by the former HSE Board as to the challenges in progressing primary care without clarity of governance.

o   Formal Frameworks and Existing Relationships - Significant emphasis was placed on the current formal and informal relationships that exist between ISAs and a range of other service providers and agencies. Positive benefits accrue when these relationships are developed with other statutory providers to NGOs, advocacy groups and the political public representative system and the wider public.

o   Local Autonomy - Some instances of local autonomy were highlighted as being positive in enabling a timely responsive service. Local autonomy, when it was evident, was experienced as a positive characteristic. However, it was indicated as being insufficiently prevalent and limited in scope to make a marked difference. It would be necessary for any new structure to be able to set out national direction and standards and also facilitate local autonomy to respond to the local environment.

o   National Direction and Frameworks – It was acknowledged by most participants that the system required a strong national direction and comprehensive national frameworks and agreed models of care for each care group to govern the implementation of services at local level.   The sense was that the balance was not yet right between achieving this national requirement and supporting local autonomy and innovation in the implementation of models of care and delivery of local services.

o   Clinical Governance / Management - There has been a clear trajectory towards improving clinical governance.   However, encouraging clinicians to have formal roles in corporate governance and management was viewed as a critical component in any new structures.

- **What would you leave behind?**

Contributions also focused on current system deficits and the need to address these.

o   In this context many participants noted the absence of suitable integrated ICT systems and commensurate infrastructure necessary for a modern day health system. An ICT system is needed which would incorporate a patient management system providing timely performance data and outcome measurement, with a unique client identifier.

It was recognised that substantial investment would be required in implementing significant baseline ICT systems. However, there was a clear request also that these large scale national projects should not prevent shorter term smaller ICT projects being implemented which could support the local implementation of significant change programmes in parallel with the implementation of the large national projects.

o   The absence of an appropriate ICT system contributes in part to another characteristic that many would like to see an end to – information request overload. The repeated demands of various national systems for information were viewed as more excessive, repetitive and demanding of resources than necessary.

o   Disparity remains a feature of services and eligibility criteria in relation to access is not standardised for a large number of services.

o   The feedback highlighted that as a result of the economic downturn and associated moratorium the recruitment process had become overcomplicated and as a result it had caused significant difficulties locally. A speedy decision making process is necessary at all levels to support the recruitment of priority agreed posts.

o   Formal education and the informal systems of mentoring and developing leadership / management skills were viewed as a critical aspect, which due to a number of factors including the economic environment, have been under-resourced over recent years.   The

moratorium coupled with the various exit schemes had contributed to a loss of 'corporate knowledge' but also the traditional systems of identifying and developing local management capacity. An important issue that requires to be addressed is that the future will be dependent on dealing with this challenge through leadership development and succession planning.

- **What community management arrangements are required to deliver services in the new bodies – area and sub-area?**

This focused on a number of key areas within the Community Healthcare Organisations. In particular how the issue of primary care teams and networks could be resolved in a practical and implementable way while also addressing the requirement of mental health and social care.   In addition to these discussions at sub-area level, there was also detailed discussion on the senior management team level envisaged for the successor bodies.

- o **Primary Care Team Level** – An effective management and governance structure for Primary Care Teams has not been successfully implemented in a comprehensive and consistent way and this has resulted in challenges around the implementation of the *Primary Care Strategy.* The PCTs to date have no recognised management or leadership structure. It was identified in consultations, that any new structure needed to recognise the PCT as the core services building block and that this critical block needed an appropriate support, leadership and management structure. The structure needs to deal with the PCT co-ordination requirements and facilitate the PCT to deal with complex cases. Key Worker functions were identified as having significant potential in contributing to a system that supports the co-ordination of complex cases needing input from different professionals. GP involvement was identified as a key requirement, which must be addressed contractually and in structural terms.

- o **Primary Care Network Level**

    The consultations unanimously proposed that a Network needed to be a multiple of PCTs, with its own management and governance structure and clarity of relationship with the structures of specialised services from the perspective of integration. Each Network in having a manager would take 'ownership' of its population, have increasing levels of earned autonomy in relation to budgetary and human resource control and responsibility for enabling access of that network population to other specialised services..

    It is necessary for the span of control of the Network Manager to be clarified. The Network Manager needs to have full management responsibility and authority for the primary care services within the network. Significant discussion took place on the possibility of this, given the clinical requirements of the various disciplines in primary care and the standards and governance requirements underpinning them.

    Throughout the discussions, the importance of direct GP involvement was emphasised, particularly the need to develop mechanisms for effective participation of GPs within the governance and management structure of the system to ensure effective implementation of the reform programme envisaged for primary care.

    Scale and size of Network was an important feature in the context of Network Management and span of control challenges.

    In discussing the management and governance options and issues it was noted in the consultation that in some cases the PCT was strong and identifiable as originally mapped.   In others, such as large county towns, it made sense to focus more exclusively on the Network. In recognising the PCT and Network as the building blocks this flexibility was strongly requested for the future based on 'what makes sense'.

- o **Successor Body (Top Team) Level** - The consultation emphasised the need for the organisations to succeed the ISA as needing to be comparable with the Hospital Groups. This would assist with the objective of moving from a hospital centric system of care. The size would have to be significant from an economy of scale perspective to support a management architecture and clinical leadership team, together with the necessary ICT, Estate and other support functions. However, it should also be of a scale which can connect

with local communities and develop productive relationships within the health service and between the health service and other public sector organisations, community and other voluntary groups.

The Networks and their management systems would need to build up into an organisation of multiple Networks, with specialised services and be managed at that organisational level with sub-structures appropriate to the requirement of size or complexity.

The new organisation at its top level needs to be fit for purpose, reflective of function in order to discharge business requirements.

Possible roles suggested by people for such a top level included;

CEO (Chief Executive Officer), COO (Chief Operations Officer), CFO (Chief Financial Officer) GP Clinical Director, Chief Nursing Officer, Mental Health Executive Clinical Director, Quality and Patient Safety Manager, HR Manager, Communications Manager.

There should be arrangements to ensure that services are informed by user representatives.

Arrangements should be in place to ensure that there is structured engagement with the acute hospitals.

At senior management team level of the new Community Healthcare Organisation, the skill set needs to be strategic and reflective of the clinical complexity of the new entity and members should have the professionalism and experience to manage a large organisation.

Most common to the consultation was that management structures at all levels need to be appropriately designed.

In general it was felt that the Community Healthcare Organisations, in terms of overall governance, should follow a similar path to the Hospital Groups with the organisations initially established on an administrative basis. In the context of reorganisation of acute services into hospital groups, there emerged an inferred expectation within the system that any revised structures of Community Healthcare Organisations would also see them established as legal entities in due course, similar to the potential that exists for the hospital groups. Many of those providing feedback assumed that there would be a requirement for the establishment of a board, similar to that envisaged for the Hospital Groups. Where such views were expressed, it was felt that the membership of such a board, if developed, should be determined based on the competencies required for effective governance which should include appropriate representation from local communities. In addition it was felt, to ensure effective integration, that a board member with a hospital perspective would be beneficial.

Consultation was also conducted at national level in the service with the project team meeting a number of contributors. These included the recently established five new service Divisions (Mental Health, Social Care, Acute Services, Primary Care, Health and Wellbeing). In addition the project team engaged with the emerging Child and Family Agency. The wider Leadership Team of the HSE were consulted with collectively in a formal engagement, with follow up meetings and engagement as necessary. There was widespread support for many of the selection criteria put forward in the ISA consultations and significant input into the draft deliberations of the project team on both the new structures and options for Government on the layout and number of new organisations.

4.3   Phase 2 – Consultation with Internal and External Stakeholders

Outside of the acute hospital system there is a wide range of interested parties associated with various aspects of the delivery of health services. This is reflective of the varied and complex range of services provided to communities across all of the different care groups. A cohort of internal and external stakeholders were identified to take part in the consultation, along with a number of stakeholders who contacted the project team, and they proactively engaged and made submissions to the project team. Appendix B

In addition to their representative contribution, they provided an interesting perspective which was external to the HSE. Whether the consultation was with a service provider, an umbrella organisation for providers, an advocacy/lobby group or a professional association, they all gave generously and enthusiastically of their time. The project team noted that many participants from different disciplines

and organisations expressed common views. Stakeholders were also invited to make written or further submission. The key points are summarised as follows;

- Safe and quality based care is the greatest priority.
- International and national best practice guidelines need to be evident in the services provided by the structures
- Client terminology (patient, user, client) needs to be more considered in the context of the specific service being provided.
- Integration defined by clear, understandable and simple pathways is critical.
- The Money Follows the Patient model needs consideration as to how it will apply and what will be the means of managing while we are getting there.
- External resources need to be used more to enhance service provision and choice.
- Clear achievable goals need to be set.
- While there are deficits in communication within and between structures there are some positive examples of good communication at local level.
- Discharge planning is a particular pathway that needs improvement.
- Decision making authority needs to be clear and local in as much as possible without compromising standards.
- More sophisticated Service Arrangements / Agreements are necessary to reduce bureaucracy and increase outcome focus.
- Resource allocation methodologies while improved are as yet under developed.
- Innovation is not facilitated in many aspects of current structures.
- The private sector has a role in the commissioning concept and should be exploited to benefit communities.
- Appropriate competition is positive in improving standards.

There was also consultation on a cross border basis with Northern Ireland.

4.4   Importance of Community

An essential theme which was threaded through the feedback from the consultation processes, both in the first and second phase, was the importance of fostering the notion of community as a core value underpinning the reorganisation and design of Community Healthcare Organisations delivering health and personal social services across the country.

The health service staff working in the delivery of community services, voluntary sector bodies, GPs, as well as external partners, all emphasised this point to varying degrees. What was emphasised in particular was the importance in Ireland, of enabling local communities to support their own people through the life cycle. Community in this sense related to the wider network of organisations and supports, which are at the heart of local communities, ranging from local voluntary organisations of all kinds, not just in the health sector, farming organisations as well as groups such as the ICA or the GAA and other sporting bodies which span both rural and urban communities. It is in the engagement between these informal networks and the more formal state provided agencies such as the health service, local authorities, community Gardaí, local schools, educational institutions, community welfare and other support services, come together in a way that support and enable communities to meet the needs of their people.

A clear message in the consultation was that in designing and shaping the Community Healthcare Organisations, we should ensure that they were organised in a way which would continue to support the development of this holistic approach to community. This would maximise the opportunities of promoting the health and wellbeing of people in the broader sense envisaged in the policy document *Healthy Ireland.*

4.5   Summary – Chapters 3 & 4

What's Important

- Integrated Care for People and their families
- Equity of access
- Choice for people in what services they receive and how they receive them
- Responsive and flexible services
- Local Identity
- Linkages with local communities and public bodies
- Sustainable cultural and organisational change
- Delivering high quality and safe services

Areas for improvement

- Autonomy to deliver services to local populations
- Engagement with stakeholders, advocacy groups and service users
- Focus on outcomes
- Standardise eligibility
- Evidence based decision making
- Manpower and recruitment planning
- ICT and standardised business processes
- How we collect and manage information about the services we provide

- Patients need to experience an integrated response in appropriate settings.

- Organisational structures must be designed to support this.

- From the international evidence, for integration to be effective, it requires careful and sustained work, learning from progress and not undertaking too much change or too complex a range of services at any one time. When these issues are taken collectively, the project team formed the view that it is of critical importance to provide the necessary clarity around the primary care teams and networks. Effective arrangements need to be put in place to engage with and ensure participation by GPs, whose involvement is fundamental if the Community Healthcare Organisations are to be successfully implemented.

- Governance and management structure for PCTs and Networks is critical as is clarity around arrangements for GP engagement in the process.

- The importance of integration of the care groups within community services in the first instance i.e. primary care, mental health, social care within an overall Health and Wellbeing population approach and secondly the integration of these services with acute hospitals and other external partners is essential.

- Overall, at all of the engagements with ISAs there was a clear articulation of the necessity for the development of a structure that suited the need of the "community services". This encompasses the full breadth of primary care and health and personal social services, taking on board the wider determinants of the health status of the population. It also needs collaboration across the key sectors, e.g. local authorities, Child & Family Agency, education, Gardaí, social protection, etc.