

# 3. Evolution of Recent Structures

## 3.1 Introduction

The organisational structure and management of the health service remained fairly static over 35 years following the establishment of the Health Boards in 1971 arising from the enactment of the 1970 Health Act. The establishment of the HSE in 2005 marked the commencement of a significant period of change for the health system in Ireland during which the organisational management structures have changed on a number of occasions. The organisation is now moving into the post HSE era in line with Government Policy as outlined in *Future Health*. This is characterised through the establishment of the Health Service Directorate, the move towards a Purchaser / Provider Split and a commissioning model, and with the establishment of Hospital Groups requiring proposals to be developed for Community Healthcare Organisations.

In this context of changing structures over recent years, the project team felt it would be useful to outline briefly how the structures being reviewed have evolved and to reference a number of the core constructs, which have emerged within the health service structures, such as Community Care Areas, Local Health Offices, ISAs and the care group approach to service organisation and delivery to populations within geographic boundaries.

## 3.2 Health Boards 1971 - 2005

In 1971, responsibility for healthcare moved from the former Local Health Authorities to the Health Boards. They established a basis of provision for largely medicine/surgery and institutional care (acute hospitals and mental health hospitals and elderly hospitals). These were called the Hospitals and Special Hospitals programmes. The Health Boards developed the basis of a fledgling community service through a Community Care programme, comprised of 32 community care areas, which represented defined geographical areas of service delivery. It is this latter programme that became the basis and framework for the provision of a number of frontline services provided by the State to people in their homes and communities.

The European Observatory in their 2009 report referenced how the Irish healthcare system, in its initial phase of development, had been characterised by a high degree of decentralisation with the delegation of service delivery to the Health Boards (and prior to this to the counties). Delegation of planning, management and delivery functions for some specific services were also under the remit of the Health Boards.

As new responsibilities were conferred on the Health Boards in aspects of provision such as disability, child protection, child health, etc. the Community Care programme became larger in its resource structure and increasingly complex in nature. This was accelerated by the introduction of a succession of legislation and Government Policy initiatives in the latter part of the 1980s and throughout the 1990s. With each legislative introduction/amendment or policy direction, came a focus on resource and the three programmes were largely replaced by what was referred to in more recent years as the Care Group approach. The following examples reflect this.

- The mental health services began to implement significant change in line with the policy document "*Planning for the Future*".
- The disability sector saw a number of policy initiatives focused on improving the delivery of services to this care group i.e. the "Needs and Abilities" policy. The Government established a commission in 1993 which reported in 1996 on "*The Status of People with Disabilities – A Strategy for Equality*". The report underpinned significant reform and equality legislation, etc. which resulted in a significant refocusing of the models of service delivery to people with a disability.
- Since 1988 the Child and Family Services have seen the progression of the Child Care Act 1991 as amended and a resource and policy focus underpinned in part by crisis response articulated in a number of 'inquiries'.
- Since the publication of the *Primary Care Strategy* in 2001, Government policy has placed a strong emphasis on the development of primary care as the cornerstone of the health system, operating as the first point of contact for the public in terms of accessing appropriate and responsive services.

Many of these and other changes such as in child health were increasingly underscored by an emerging regulatory compliance requirement set out on a statute basis, bringing not only regulation but standards by which the regulatory compliance was measured.

The care group emphasis, as it has evolved, has challenged the structural approaches to service delivery which have sought to ensure the 'rights' and 'needs' of the care group on the one hand, and the necessity for integration both as a means of responding to whole populations and geographic areas on the other.

In terms of reorganising the management and structures to deal with the changing nature of service delivery the Health Boards introduced a model of general management in 1998, which moved away from the Director of Community Care model and established for the first time a general manager, with delegated responsibility for all primary and community services in the "Community Care Area". It is important to recognise that these Community Care Areas (in many cases) were co-terminous with counties. They were an important building block for the health service in terms of finance, workforce management and service planning. This period also saw the introduction of the Eastern Regional Health Authority (ERHA) in the Dublin region which sought to bring a more co-ordinated approach to the strategic planning and management of services.

The European Observatory noted following publication of the National Health Strategy 2001, that there was a growing perception that the Health Boards had developed services in very different ways, and thus there was a lack of consistency across the country. There was increasing levels of criticism and a growing demand for a national framework and approach to be put in place, to reduce fragmentation and to ensure a coherent and consistent implementation of national policy and resource management. Important in all of this was the sense that the Health Board members were politically appointed, principally made up of local authority councillors. As a result, loyalty to county priorities had a tendency to undermine the implementation of national strategies and priorities, particularly in relation to cancer care and the re-organisation of hospital and other services.

In the course of the implementation of the Health Strategy in 2001 a number of other influencing factors came to bear on the necessity for change including the Hanley report on the reorganisation of the hospital service, the Brennan report on financing of the health service, the Action Plan for People Management to address human resource issues, as well as the Prospectus report on organisation reform. The necessity for statutory regulation and the plan for a Health Information and Quality Authority, as well as a Mental Health Commission were also important influences. The Government of the time decided in 2003, to establish the HSE as a single body responsible for the provision of health care and personal social services in Ireland. The Health Boards were abolished with the majority of their responsibilities and functions transferred to the HSE.

### **3.3 HSE 2005 – 2009**

Within the HSE structure, primary and community services were organised at a national level under a National Director, with responsibility for Primary, Community and Continuing Care (PCCC) Services. They were divided into thirty-two LHOs within four regions – the LHOs equated to the Community Care Areas in the Health Board system. A local manager was responsible for the delivery of all community services within the geographic area reporting to a regional manager. The four PCCC regions consisted of the West, South, Dublin Mid Leinster and Dublin North East. At national level there were also seven care group managers who focused on policy and operational implementation in respect of primary care, children and families, mental health, disability services, older people, palliative care and social inclusion. These managers together with the four regional managers worked under the national director on a national management team for PCCC. The Local Health Offices were the unit of management and delivery for all services outside of acute hospitals.

An important aspect in the development of the HSE was the intention to secure benefits of scale and effectiveness by standardising business processes in shared services, procurement, etc. Significant work was undertaken in this respect. Management, finance and HR resources were also restructured to enable the implementation of the strategic priorities set by the Government of the time.

While it was recognised as necessary to centralise authority and decision making in order to achieve these objectives, as time progressed there was an increasing sense that the process may have become overly centralised in the sense of a "command and control" model, to the detriment of innovation and responsiveness at local level. A high proportion of decision-making and issues needed escalation to national level for determination. Concurrently there was a growing emphasis on the necessity to develop an integrated model of care, in response to the demand for consistent and standardised delivery of services.

### 3.4 HSE 2009 – 2013

In this overall context, a decision was made in 2009 to simplify the organisational structures, to build stronger links between services and more connected team working. The reorganisation was also to commence a process for devolving responsibility for delivering services from national level to the four geographic PCCC regions. This was intended to shorten the distance between the public and those making decisions.

This restructuring involved the establishment of the Integrated Services Directorate, combining the National Hospitals Office and the Primary, Community and Continuing Care Directorate. In addition, four Regional Management Teams, led by a Regional Director of Operations and operating under the direction of the National Director for Performance and Financial Management and the National Director of Reconfiguration were established. The four Regional Directors of Operations were fully accountable and responsible for all local health and social care services.

In 2010 ISAs were created to form a governance structure which encompassed the services of both the Acute Hospitals and the Local Health Offices under one system. These were designed as the response to the need for a structure of integration where Local Health Offices were largely grouped around patient flows to local Acute Hospital in all 17 possible ISAs. The ISA placed the management of all of these services at local level under one structure. The plan envisaged for the full completion of the ISA structure, was impeded by the changed economic circumstances and not fully put into effect.

### 3.5 Primary Care Strategy Approach

Throughout this change process, since 2001, significant efforts have been made to implement the concept of Primary Care Teams and Health and Social Care Networks envisaged in the *Primary Care Strategy 2001 (A New Direction)*. The intention has been that these teams and networks would form the cornerstone of the system supporting the move away from an over reliance on acute hospital services to a more community based model of service delivery. The strategy defined primary care as being “an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and a strong emphasis on working with communities and individuals to improve their health and social well-being”.

The general principles underpinning primary care services include:

- a single point of entry with clear joined up integrated pathways of health and social care;
- universal services, locally available, community focused and easily accessible;
- a holistic approach that follows the individual/family/community over the whole life cycle;
- a whole population approach - organising and delivering services around the changing needs of individuals/families/communities and a focus on identified needs of the local defined population.

The objective of primary care services is to improve the health of the population by providing local access to multi-disciplinary Primary Care Teams and collaborating with specialised services to provide responsive and integrated care, achieved through:

- health and personal social care personnel working collaboratively in a multidisciplinary environment;
- working collaboratively with local communities;
- identifying and addressing local needs based on local needs assessment;
- identifying and working towards removing health inequalities;
- improving access to services;
- improving performance through national care standards and development of good quality information systems.

Primary Care Teams and Health and Social Care Networks were envisaged as the vehicles through which the strategy would be implemented and set out below are the details in relation to same:

### **Primary Care Teams (PCTs)**

Primary care was to be centred on the needs of individuals and groups of people to match their needs with the competencies required to meet them. A group of primary care providers would come together to form an inter-disciplinary team known as the Primary Care Team. The teams would serve small population groups of approximately 3,000 – 7,000 people depending on whether a team was in a rural or urban setting.

### **Health & Social Care Networks (HSCNs)**

It was envisaged that a wider network of health and social care professionals would be formed who would work with a number of primary care teams. Members of the network would work with more than one primary care team.

Fundamental to each change which has taken place since 2005 has been the intention to put primary care and the related network of services at the centre of health service provision. This is to ensure that these are linked effectively to the specialised services in mental health and social care, while at the same time ensuring streamlined and appropriate access to, and early discharge from, acute hospital services. The clear intention has been to develop a model which would move the Irish system away from an overly hospital centric focus, to one which is centred around the individual, their families and local communities.

With the development of LHOs and subsequently ISAs, serious efforts were made to develop an integrated approach to service delivery which sought to deliver as many services as possible through PCTs and HSCNs. Consultation and discussion took place with HSE professionals at local level, as well as GPs and their representatives to develop and agree a framework for the management and governance of the primary care teams and networks within the system. Notwithstanding the efforts of all involved, we have not been successful over the intervening twelve years in systematically implementing the model in a comprehensive and consistent way across the country.

### **Report to HSE Board 2011**

Given the challenges involved, the matter was considered by the HSE Board in 2011 and the following challenges identified as barriers to implementation;

- Competing demands on existing staff with many teams indicating that they are not adequately resourced and trained
- Staff difficulty moving from a traditional hierarchy to a more collaborative style
- Lack of co-located team members
- Issues with engagement and participation by GPs and HSE staff
- Organisation and governance/management structures in primary care are weak and much less developed than those in hospitals
- Lack of administration support, ICT infrastructure, and suitable accommodation
- Health system overly oriented towards acute hospitals
- Lack of access to specialist consultants and diagnostic services
- Need for a new GP contract
- Issues with legislation in relation to eligibility
- Provision of chronic disease management in the community
- Reactive rather than proactive approach
- Insufficient performance metrics.

### **Questionnaire – Analysis of Existing Structures at ISA Level**

In order to establish the current position in respect of the existing management and governance structures at ISA level a survey questionnaire, comprising of 6 sections with 12 questions was issued to all 17 ISAs. The returns from the questionnaire coupled with the consultation process that involved each ISA management team assisted in an analysis of the existing management and governance structures. (Appendix C)

The 6 areas covered by the questionnaire were as follows:

- ISA Management and Governance;

- Primary Care Teams (PCTs);
- Health and Social Care Networks (HSCNs);
- Management and Governance; Mental Health Services
- Management and Governance; Older People Services
- Management and Governance; Disability Services

Overlaid on all of these was a focus on the implementation of a population health approach which is intended to maximise the health and wellbeing of the population.

All 17 ISAs responded to the survey with varying levels of detail provided across the range of questions posed. Based on the responses the following summarises the key findings:

- While all of the ISAs provide, in broad terms, the same range of services across care groups and different settings no two ISAs have the same management and governance arrangements.
- In each ISA the Area Manager leads the Area Management Team but there is huge variance in the sizes, composition and range of disciplines involved in the Area Management Teams across the 17 ISAs. While many of the management functions are similar in the ISAs the management grading structures are inconsistent across the country. In many areas the General Manager / Operational Manager has excessive numbers of managers directly reporting to her/him (on average 25 and up to 40). There are varied arrangements in place for the provision of support services, e.g. Finance, HR and Estates. Clinical representation on Area Management Teams is very varied with no clinician having responsibility for services beyond their professional domain. While each area has an Executive Clinical Director for mental health services there are no corresponding roles or standard structures in other services such as primary care, older persons and disability Services. Some ISAs have provided unique approaches to resolving the cross-discipline managerial challenges. While there is strong evidence of good collaborative working arrangements the management structures in place do not facilitate optimal integrated working.
- Particular attention is given to assuring quality and patient safety within the ISAs and all have a Quality and Risk Committee in place to support the ISA management teams. Some ISAs have a large number of committees in place which places an obvious resource burden on local managers and clinicians.
- There is strong evidence that individual care group management structures are still very much in place across most ISAs reflecting historical funding and management arrangements. The specialised services of disability, mental health and older people services have more defined management structures in many ISAs with single managers being accountable for services for these specific care groups. Without having well defined and standardised models of care and related care pathways, protocols and procedures it has been difficult to effectively integrate these specialised programmes within primary care and between community services and the acute hospital services.
- While Health and Social Care Networks have been developed to varying degrees there is no HSCN in the country operating as a managed network with all services managed by one manager.
- Primary care teams are generally self-managed, with a rotating chairman and actively supported by primary care managerial staff, sometimes in a mentoring role. In the main, clinical staff report through their professional line.
- Most ISAs have progressed mental health management structures in line with *Vision for Change*.

The learning from this chapter has been considered by the project team in conjunction with the learning from Chapter 4 and a combined summary is set out at the end of Chapter 4.