

# 1. Executive Summary

## 1.1 Introduction

The context for this review is provided by the setting out of national government policy in relation to health and social care services in *Future Health - A Strategic Framework for Reform of the Health Service 2012 – 2015*. This required a process to ensure that health delivery structures were appropriate to achieve national policy objectives. The fundamental requirement is to deliver better, more integrated and responsive services to people in the most appropriate setting. In February 2013, “*The Establishment of Hospital Groups as a transition to Independent Hospital Trusts*” report dealt with the arrangements for acute hospital services.

In this context, the Director General Tony O’Brien commissioned Pat Healy, National Director Social Care, to lead a review of the organisation of community based services. A project team was appointed to undertake this review (terms of reference and project scope are provided in Appendix A). In summary, the key deliverables were to recommend:

- The number, scale and geographical boundaries of Community Healthcare Organisations as successors to Integrated Service Areas (ISAs) and the transitioning arrangements.
- The appropriate governance and management arrangements to apply.

The project team’s approach included:

- Consultation with consumers of services, representative organisations and interest groups, clinicians and service providers.
- A review of evolving historical arrangements.
- A review of international experience in developing integrated care.

This report recommends the establishment of nine Community Healthcare Organisations and the associated governance and management arrangements. While acknowledging the large range of variables which are unresolved, the report recommends that the nine Organisational Areas are fit for purpose regardless of the finalised detailed approach in regard to commissioning, etc. The report highlights the importance of the transitional arrangements that are required to maintain the safety and integrity of the service delivery system. The establishment of the Directorate and the Divisional structures provide the framework for this transitional phase.

This approach will position primary care at the centre of delivering services through around 90 local Primary Care Networks with average populations of 50,000 with better, more integrated access to specialised services in social care, mental health and health and wellbeing.

Arising from the entire process there is a clear consensus that future Community Healthcare Organisations must:

- Enable and support integrated care
  - within community services
  - between the community and hospital services
  - with wider public service organisations – local authorities, Child & Family Agency, education, local voluntary organisations, etc.
- Deliver the model of service envisaged in *Future Health* operating in a Universal Health Insurance environment with a Healthcare Commissioning Agency.

The foundation steps to achieve this will be to:

- Position primary care in a central role of providing care to local communities.
- Develop identifiable “local community scale” networks averaging 50,000 to:
  - support groups of Primary Care Teams and
  - enable integration of all services for a local population.
- Reform social care, mental health and health and wellbeing to better serve local communities;
  - through standardising models and pathways of care while delivering equitable, high quality services
  - supporting primary care through delivery of rapid access to secondary care and specialised services.

## 1.2 Delivering Future Health

The need for organisational change to deliver on *Future Health* is evident. In this context, a phased approach to the necessary organisational change is appropriate. In the first year, the focus will concentrate on developing primary care services, while at the same time developing and implementing standardised pathways and models of care within each of the specialised community services i.e. social care and mental health. Key to this will be a stronger emphasis on prevention, early detection and health promotion and improvement. This will also enable more effective integration within the networks; between primary care and the acute hospital system generally, and deliver a continuum of care consistently across geographic areas.

Each subsequent year a further phase of the change programme will be progressed, building on the learning from the previous phase. This phased approach will achieve significant benefits for patients and service users, not only in primary care, but in accessing specialised community based services and will lay the foundation for the delivery of fully integrated care over a number of years. Significant collaboration is already taking place across all Divisions i.e. acute services, primary care, social care, mental health, etc. to support implementation of the fully integrated model of care envisaged in *Future Health*. The completion of this report is a further step in progressing this programme of change.

## 1.3 Primary Care Networks

Ownership and responsibility for the provision of health and social care services, through the life cycle is best placed within the communities that people live. In future, it is recommended that the fundamental unit of organisation for the delivery of services will be the Primary Care Network, serving an average population of 50,000 people. The network will support and resource the primary care teams with an identifiable responsible manager in each network. A GP Lead will also be identified to support the network and to act as a GP leader. Consequently every large town and its hinterland, and district of a city, will have a network with an identifiable manager. These positions will be developed through the reorganisation / reassignment of existing resources.

- 90 primary care networks of 50,000 average population will be developed across the country.
- Leadership of the network will be provided by re-assigning existing senior professional and clinical staff to the new leadership roles as the identifiable and responsible manager of the primary care networks, working with a GP Lead.
- The role of the Heads of Discipline will be redesigned to provide the necessary clinical governance and supervision across all primary care networks.
- Greater participation by GPs at primary care network level, with the establishment of the GP Lead for each network, supporting the Network Manager in developing professional relationships, innovative solutions and multi-disciplinary approaches to challenges within the network.
- The role of Team Leader with protected time will be established for each Primary Care Team.
- A Key Worker will be assigned to support people with complex needs.
- The network will support the maximum provision of primary care services locally, and will ensure appropriate access to specialised services e.g. social care and mental health, etc. for the people living within the network.
- A national process will be put in place to oversee the establishment of the primary care networks as envisaged in this report and to maximise co-terminosity between primary care and specialised services at network level.
- Re-align clerical and administrative supports to ensure effective frontline administrative resource for all primary care networks, to the benefit of primary care teams locally.
- The success of the network over time will depend on how people experience joined-up, integrated care.
- The reorganisation of governance and management arrangements will be delivered from within existing resources.

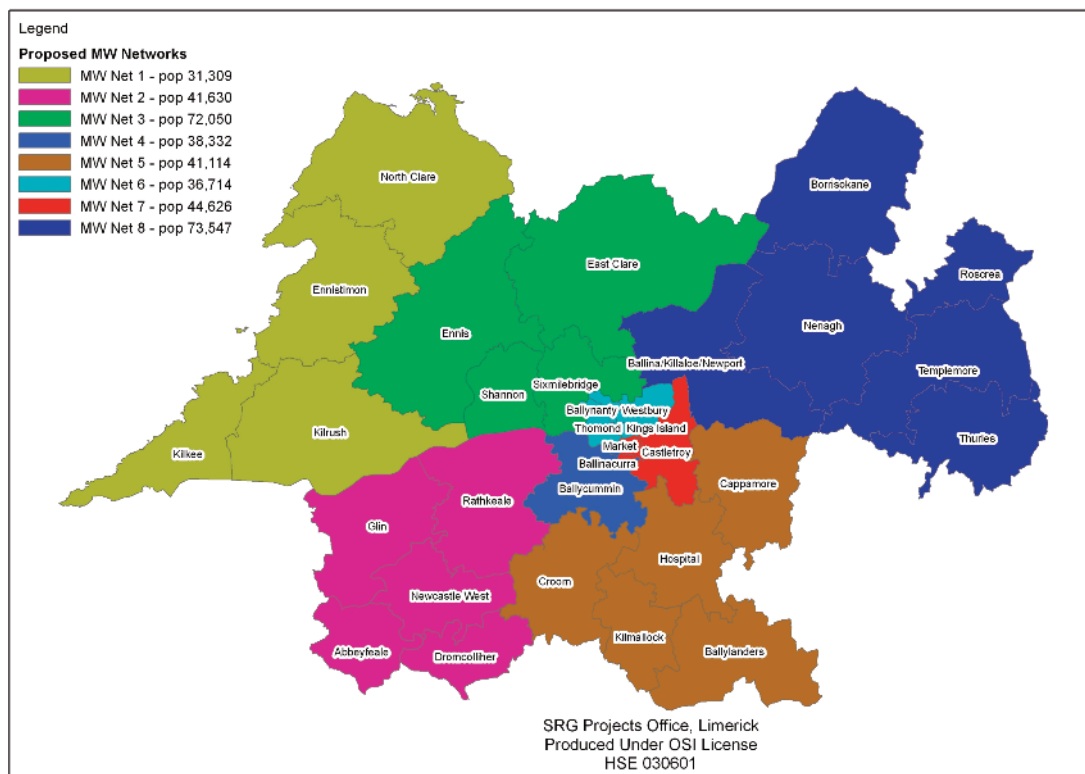
As outlined in *Future Health*, and echoed in this consultation, people should receive the majority of their services, accessed through primary care, within their local community.

People today experience many parts of the service as being very good. However, they experience difficulties in “navigating the system” due to both the complexity and scale of present arrangements. What must be improved is how these parts fit together so that the services are integrated and people can move smoothly through the system.

Staff must be organised in a way that enables joined-up teamwork, responsive to the assessed needs of local people.

In response to these challenges, the creation of accountable networks will pull all of the primary care services together for its population of 50,000, while driving the integration with other specialised services.

This new structure will, for the first time, place an identified, accountable person as responsible for actual service delivery to a defined local population averaging 50,000. This person, working with the GP Lead, will prioritise and manage the delivery of primary care services, while ensuring effective integration of other specialised services e.g. social care, mental health and access to acute hospital provision.



#### 1.4 Reforming Social Care, Mental Health and Health & Wellbeing

From the analysis of the project team and the feedback from the consultation and research it is clear that significant work remains to be done to develop standardised models and pathways of care within each of the individual care groups that make up “community services” i.e. primary care, mental health, social care and health and wellbeing. These models and pathways of care must encompass the necessary clinical procedures and protocols, business processes and performance measures necessary to deliver comprehensive and effective outcomes to their service users and patients.

Only when this work has been sufficiently developed can the services encompassed by each of these “care groups” effectively integrate with each other in a way which maximises the experience and outcomes for service users. Similarly, the development of such standardised processes will support effective integration between all aspects of community services with the hospital system and external partners, e.g. local authority, education, etc.

*Healthy Ireland* highlights the importance of intersectoral relationships in promoting the health agenda. At a national level and at a policy level the Health and Wellbeing Division will support the Health and Wellbeing Programme in the Department of Health in the co-ordination of the ‘development of models and supports to promote and foster advocates for health and wellbeing in all sectors of society and develop key partnerships with voluntary and other organisations, which can favourably influence health and wellbeing.’

*Healthy Ireland* also refers to the importance of local operational intersectoral engagement as follows: ‘Local health partners will engage with local authorities in their work to address local and community development, with the aim of co-ordinating actions and improving information-sharing for improved

health and wellbeing.’ And ‘It is important to identify local structures for implementation and how these can be supported through this Framework to work on common agendas. It is at this level that individuals, community and voluntary groups and projects, sporting partnerships, local schools, businesses, primary care teams, community Gardai, etc can interact to work together.

While the Health and Wellbeing Division will lead on intersectoral collaboration at national level - enhancing, developing and supporting effective intersectoral linkages as a key support to all Divisions and CHOs, at the CHO level intersectoral collaboration will be led by the local operational health services – Primary Care and Community Services. This will ensure effective intersectoral engagement both nationally and locally

While it will take time to fully standardise and integrate the specialised services i.e. social care and mental health, the intention is that each year we will progressively increase the levels of standardisation and consistency achieved. These annual improvements will be demonstrated by the achievement of identified and measurable targets and outcomes, delivering significant benefits to patients and service users, as services proceed through a journey to fully integrated care.

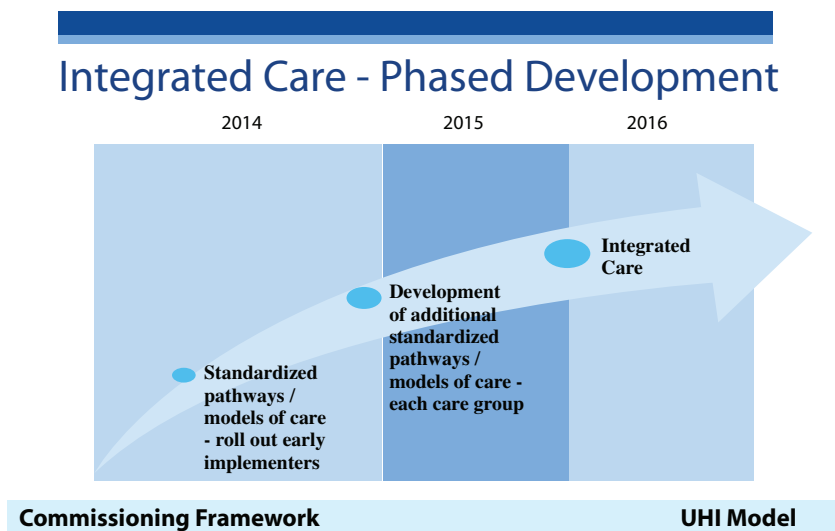
Community healthcare organisations are committed to the implementation of the clinical effectiveness agenda as a key component of patient safety and quality. Clinical effectiveness underpins the proposed standardised models of care for each care group. Quality assured national clinical guidelines and national clinical audit linked to key performance indicators are quality improvement processes which are critical elements of the clinical effectiveness agenda. A clinical effectiveness approach incorporating national and international best available evidence will promote the delivery of integrated care in the community that is current, effective and consistent.

This process of reform will also prepare the way for the implementation of a commissioning model and the purchaser / provider split envisaged in *Future Health* which are currently under development. The programme of care group reform must be guided by the objective of fuller integration and responsive delivery to people locally at primary care network level.

### 1.5 Integrated Care

The delivery of integrated care, treating people and service users at the lowest level of complexity that is safe, timely, efficient and as close to home as possible, is a fundamental objective of the Irish health service.

In the context of the international experience, and informed by the consultation process, a phased approach will be taken to the development of a comprehensive integrated care system as diagrammatically represented below:



The overall objective of *Future Health* is the provision of an integrated model of care. The phased approach recommended in this report is based on an appreciation of the complexity involved in achieving this.

The Irish and international experience to date shows that the implementation of comprehensive integrated care takes time and must be implemented in a phased manner with clear milestones and goals which enables safe transition (ref. Chapter 5).

International research on integrated care shows a number of things very clearly:

- It can make a real difference to the quality of care received by patients and service users: The danger of a fragmented delivery system is that individuals' needs will not be fully met, substantially reducing patient outcomes.
- The introduction of integrated care takes a significant period of time to implement. Even countries recognised as having made significant advances in the area have been working on the concept for two decades or longer.
- One size and approach to integrated care does not fit all circumstances and it is important to be cognisant of the local challenges in any approach. More importantly, it is neither possible nor advisable to attempt to introduce integrated care across all areas in one step, and a number of countries have adopted a pilot type approach introducing integrated care in pockets of service with a view to expansion
- It is very difficult to turn the concept of integrated care into a cost effective operational reality. One of the main challenges is to target the right individuals and conditions. For instance, it is clear that case management must be a crucial part of integrated care. However, because case management is a labour intensive activity it is unlikely to be cost effective unless it is targeted effectively.
- There are many ways to implement integrated care: Crucially organisational integration is not necessarily required. The key requirement is clinical and service level integration, supported by an appropriate incentives system.

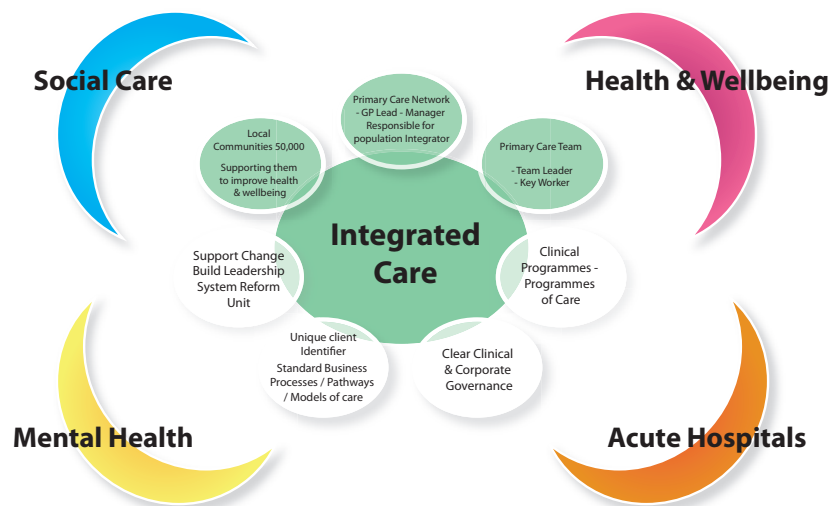
Achieving integrated care means that services must be planned and delivered with the patients' needs and wishes as the organising principle.

It will be necessary to identify early successes where it will be possible to roll out "early implementers" of this integrated care model and new ways of working. This will require a body of work by each care group to bring their services to a level where integrated care is achieved.

Examples of the type of practical benefits that will be delivered from this approach are:

- Home Care and Community Support Services – Realignment of the model of care to enable older persons to live independently in their own homes for as long as possible, with a service improvement programme to ensure standardised delivery of home help and home care packages and supporting self-care.
- Disability Services for Children and Young People (0 - 18s) – A national unified approach to delivering a clear pathway to services regardless of where a child lives, the school attended or the nature of the disability or delay.
- Diabetes – Integrated management of diabetes, alignment of existing primary diabetes care initiatives to nationally agreed model of care.
- Chronic Obstructive Pulmonary Disease (COPD) - A model of care including guidelines for the management of COPD including spirometry in the primary care setting.
- An over-arching model of care in Mental Health Services to provide a relatively standard level of basic services regardless of location, focused on recovery and enhancing clinical excellence.
- Integrated community services management of healthcare associated infections with processes for access to specialist expertise as required.

The end phase of a fully integrated Health and Social Care model would contain all of the elements in the diagram below:



## 1.6 Recommendations for Community Healthcare Organisations – Number, Scale and Geographical Boundaries

Organisational arrangements are required to support and enable the delivery of services. In order to best support the ultimate objective of fully integrated services, and the foundation steps of development of primary care networks, together with the reform of specialised services and enable the ultimate objective of fully integrated services, it is necessary to develop a number of community organisations to replace the existing ISAs and to outline appropriate transitioning arrangements. These community organisations will be known as “Community Healthcare Organisations”.

The project team developed key criteria to guide the decision making process on the number, scale and geography of these organisations. The criteria and process are outlined in Chapter 6 of this report. Informed by the literature and research, and from experience, an important consideration centred on striking the right balance between two considerations:

- sufficiently small scale to provide the local responsiveness required to deliver effective integrated care and
- sufficiently large scale to justify the necessary organisational architecture, business and service capability

In determining the appropriate geographical configurations for the community organisations a range of criteria were developed and applied. These criteria take account of the output from the consultation process, representative organisations and interest groups, clinicians and service providers and the previous spatial mapping exercise.

The main criteria used are outlined below in summary form:

### Internal Integration Criteria

- Maximise co-terminosity with new six hospital groups;
- Recognition of the clear relationship between primary and secondary care;
- The primary care teams must be the building blocks for any new spatial units as their determination followed a robust decision process which took cognisance of a wide range of relevant criteria to form areas which maintained natural community integrity, captured GP populations and followed patient flows;
- Cognisance needs to be taken of the establishment of mental health areas in the context of “*Vision for Change*” and that any new areas should minimise the impact on the work already established;

- Take consideration of existing and historical linkage across former Local Health Offices (LHOs) and ISAs, where service relationships and arrangements have built up;
- Minimise change for change sake, given the extent of change still happening following previous transformation initiatives e.g. ISAs.

### Demographics/Deprivation

Populations are not evenly distributed and a balance must be found between spatial factors, community integrity, deprivation levels and a justifiable population size to support service levels. Key considerations include:

- Population size and density;
- Deprivation levels;
- Demographics;
- Cultural diversity.

### **Self Sustaining / Manageability Factors**

- Viability i.e. each area identified must have a critical mass of population which is sufficient for an area to be self-sustaining in terms of service delivery;
- Manageability i.e. the area should be of a size that its senior manager can balance focus on both integration matters and managing accountability;
- Facilitate clustering of services without too many tiers of management;
- The new organisations must be capable of facilitating strategic direction as articulated in *Future Health*.

### **Geographical/Physical/Cultural**

- Relatability i.e. there must be a simplicity of service arrangements where people can relate to the community organisations and there is an ability to drive integrated responses with local communities and agencies;
- Area contiguity i.e. the whole catchment area must be physically joined (The law of contiguity states that things which occur in proximity to each other are readily associated);
- Issues such as road infrastructure and avoidance of traffic congestion are important in terms of equitable access. This includes an area being well served by public transport for

those on lower income but also connects to natural tendencies and directions of communities and populations and local cultural links;

- Geography needs to be seen to have relevance beyond size to what can be described by people as “making sense” and deciding what forms “natural communities”.

### **External Integration Issues**

There is a requirement on the wider public services environment to develop new ways of tackling complex societal goals. In many reports the adoption of county boundaries or groupings of them is recommended as a key initiative.

There are a number of key external boundaries that the project considered to maximise co-terminosity but the team recognised the fact that some natural community affiliations and historical client flow sometimes work across such boundaries and would work against the benefits for integration with clients.

The following were considered:

- Local authority boundaries;
- Existing and proposed local authority Regional Assemblies;
- Gardaí catchment areas;
- Cross border connectivity with Northern Health Authorities

In applying the criteria, a total of seven options were identified for consideration and all of these options are outlined in detail in Chapter 6. These options were then subjected to further appraisal based not only on the above criteria, but also having regard to the prioritised considerations which are summarised below:

- Emphasis on Community and Integration
- Local Authorities
- Child Care Services
- Efficiency of Scale
- Design of Governance and Management Structures at Area and Sub-area Level
- Supporting UHI Environment

The project team also gave particular regard to the issue of connectivity with the Hospital Groups, particularly the primary / secondary care interface.

The recommended option below meets more fully the broad range of criteria referred to and the development of nine community organisations, with each responsible for the geographic areas as outlined in the recommended option.





## 1.7 Recommendations for Community Healthcare Organisations – Governance & Management Arrangements

### National Context

The approach to the governance and management arrangements must be informed by the structural reform which has already occurred involving the establishment of the Health Service Directorate. The Directorate is responsible for implementing the strategic policy direction of *Future Health* and the development of standard national service frameworks. The Directorate will also provide leadership and direction on shared service platforms, new financial systems, the development of a commissioning framework, procurement and other business supports which are currently underway.

It is the intention of the Health Service to gradually transition to a commissioning model on an administrative basis, as both provider and commissioner capabilities strengthen, with the clear aim of achieving the greatest progress possible on a commissioner / provider split prior to the introduction of the statutory functions. This will reduce the risk at the point of statutory transition.

During 2014 progress will be made on the development of a phased implementation of the commissioning function and the development of a robust commissioning and provider framework, which allows for the purchasing of services and which provides assurance that the services are provided at the level and quality required. This important work will commence on the design and development of the formal contractual arrangements to support the commissioning framework.

An important outcome from this reorganisation of service is to devolve greater autonomy and decision making to frontline services at local level through the establishment of the Hospital Groups on the one hand, and the new Community Healthcare Organisations on the other. This earned autonomy, will support the development of leadership capacity and innovation locally. However, there is a critical balance to be achieved with this independence on the one hand and the necessity for clear accountability and the standardisation and delivery of services locally in a consistent and equitable manner in line with national frameworks. Striking the right balance in this regard will be an important consideration for the management and governance arrangements to be put in place in respect of the Community Healthcare Organisations to replace the existing ISAs. Other important outcomes from this service reorganisation will include an improved focus on quality and patient safety, an enhanced focus on health and wellbeing and an enhanced ability to plan and deliver integrated care.

### *Consultation with Stakeholders*

Throughout the consultation process it was also fully recognised and communicated that any proposals would need to be considered by the DoH and Government within the overall context of health service reform, including the requirement to ensure a cohesive and integrated structure for the whole health system. Similarly, it was recognised that any reorganisation at local level would need to have regard for the emerging commissioning type model and the associated purchaser/provider split appropriate to the Irish context.

It is fair to say that the expectation of the majority of stakeholders was that the Community Healthcare Organisations to replace the ISAs would become the local service provider of Primary Care and Community Services, working within national frameworks and direction, and accountable to the national system through the Healthcare Commissioning Agency or other national entity, through a performance contract type arrangement.

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.

Following consultation with DoH it is important to note in designing a new organisational structure for the health services we need to be conscious of the number of agencies required. In developing proposals for new organisational structures, a strong emphasis will be placed on streamlining functions, avoiding duplication and having full regard to the *Programme for Government* and *Future Health*.

In this context, consideration should be given to options which range from the nine successor ISAs progressing to individual agency status or being operational divisions within a single national delivery organisation.

*“Best Fit” Community Structures*

The considered view of this report is that the nine boundaries and the associated management and governance arrangements for these structures at local level are the most appropriate to deliver the type of significant reform and responsive service delivery envisaged in *Future Health* and the Programme for Government. These structures are sufficiently robust to deliver the current requirements for service management, while being flexible enough to support the system from the current state through a number of transition phases to the UHI environment. They provide the “best fit” structure to dovetail with whatever final national organisational arrangements emerge.

The primary emphasis of the future Community Healthcare Organisations as outlined in this report is on service delivery within the context of nationally prescribed frameworks. They will concentrate on implementation of the nationally agreed standardised models of care for each care group, bringing a local community focus to service delivery, and ensuring integrated services are provided to their primary care networks serving average populations of 50,000. The primary focus has been to establish the appropriate leadership and management team arrangements that need to be put in place to ensure the new structures are fit for purpose in implementing the challenging reform agenda ahead.

The Community Healthcare Organisations will be responsible for the delivery of primary and community based services within national frameworks responsive to the needs of local communities.

It is essential, to ensure the continued effective management and organisation of the service and to progress implementation of the reform programme, that we move rapidly with the implementation of the recommended nine Community Healthcare Organisations on an administrative basis.

*Transition Arrangements*

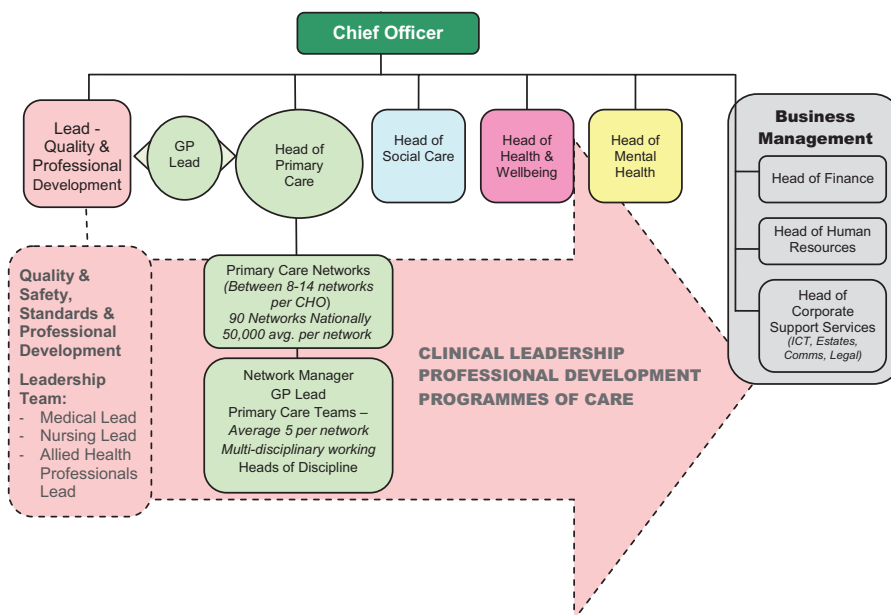
The clear intention is that the reform programme will be implemented on a phased basis as outlined in *Future Health*.

In this first phase, the intention is that from March 2014 the current ISAs will report directly to the National Directors of Primary Care, Social Care, Mental Health and Health & Wellbeing. It is essential, to ensure the continued effective management and organisation of the service and to progress implementation of the reform programme, that we move rapidly with the implementation of the recommended nine Community Healthcare Organisations on an administrative basis. This reorganisation can take place smoothly within the existing governance arrangements of the Health Service Directorate. This approach will allow the new arrangements to bed down at local level while work is continuing in finalising the overall national approach to be taken with regard to the commissioning model and other issues referred to at 7.1.3.

During transition, the appropriate governance at national level will be provided through the National Directors, the Leadership Team and the Health Service Directorate. During this period arrangements will also be put in place to ensure effective integration and performance management across the system.

**Community Healthcare Organisations - Organisational Arrangements**

The management arrangements for the Community Healthcare Organisations are illustrated below in summary form:



## Chief Officer of Community Healthcare Services

The Chief Officer, working in line with nationally agreed frameworks and reporting arrangements, will have full responsibility and accountability for the delivery of all primary, community, social and continuing care services within the catchment area, ensuring the appropriate integration with secondary care services and with all appropriate stakeholders. The Chief Officer will:

- deliver the multi-year strategic plan and the annual service plans
- lead the Management Team in reforming services of care to ensure integrated care for patients and service users
- be accountable for the quality and safety of care provided and support clinical leadership in the management and delivery of services
- represent the future Community Healthcare Organisation in public and representational engagements and ensure motivated staff
- ensure appropriate engagement with communities and public representatives to develop the necessary public confidence in the Health and Social Care services.

## Management / Leadership Team

### • **Head of Primary Care**

The Head of Primary Care will have full responsibility and accountability for service provision across Primary Care Networks and Primary Care Teams. The Head of Primary Care will carry particular responsibilities for developing an effective relationship with General Practitioners, driving the implementation of the primary care approach envisaged in *Future Health*. Similar to the Network Manager role, the Head of Primary Care will be responsible for driving effective integration at Community Healthcare Organisation level. Their relationship with the Head of Health and Wellbeing will be key to ensuring a stronger emphasis on prevention, early detection, health promotion and improvement.

### • **Head of Social Care**

The Head of Social Care will have full responsibility and accountability for service provision for older people and people with a disability, implementing standardised models and pathways of care to support integration. In line with the reform programme, the intention is to introduce a standardised framework to commission services from both public and non-public providers; individualised budgeting to bring about a closer alignment between funding and the outcomes for individuals; and a robust regulatory regime to ensure quality and safety. The Head of Social Care will lead the implementation of these reforms at Community Healthcare Organisation level.

### • **Head of Mental Health**

The Head of Mental Health will have full responsibility and accountability for mental health service provision. The reform programme reaffirms the move from the traditional institutional model of mental health care, towards a recovery focussed, clinically excellent model that involves service users in all aspects of the design and delivery of the service in line with *Vision for Change* policy. The Head of Mental Health will lead the implementation of these reforms at Community Healthcare Organisation Level.

### • **Head of Health and Wellbeing**

Given the criticality of health and well-being services to the health of the population and its status as a pillar within the *Future Health* document, the review proposes that a Head of Health and Wellbeing be appointed to the Leadership team of the new Community Healthcare Organisations. As part of the continued development of the Health and Wellbeing Division at national level, a significant programme of work is underway to align, and where relevant, more fully integrate its operational service components. The specification for the role of Head of Health and Wellbeing at CHO level, potentially encompassing responsibility for a range of services hitherto managed discretely will be informed by the output from this programme. Clarity around governance, the 'best-fit' for such a post relative to the current delivery models (spread of national, regional and departmental resources) and its role within a commissioning environment are key here. The pace at which this process can be meaningfully completed, relative to the timeline for the creation of Community Healthcare Organisations, may mean that the role specification, accountabilities and competencies of a Head of Health and Wellbeing will be interim.

- **Lead Quality and Professional Development**

The Lead for Quality and Professional Development will provide assurance that the appropriate clinical governance and related assurance frameworks are in place in respect of all services throughout the Community Healthcare Organisation area.

The post holder will lead a multi-disciplinary team of clinicians to steer and monitor the day to day development of clinical governance, providing staff with the necessary support and leadership.

The post holder will also provide advice to the management team and review progress against specified objectives. The Lead Quality and Professional Development will be a non-executive member of the Management Team.

- **GP Lead – Management Team Level**

The General Practice Lead will be a key influencer on decision making at management team level. In particular, this position will support the development of the Primary Care Networks and the service delivery arrangements in order to ensure responsiveness to the needs at Primary Care Team level.

- **Business Management**

The Heads of the Business Support functions will operate within the context of the national shared services arrangements. These positions will lead their respective functions in support of efficient and effective service delivery. In particular, they will be responsible for achieving the benefits of scale arising from national frameworks in areas such as procurement within the Community Healthcare Organisation area.

The detail of these new arrangements will be implemented in consultation with staff associations and representative bodies in line with the Public Service Stability Agreement (Haddington Road). The development of the GP Lead role and its specifications will be undertaken in collaboration with the ICGP and relevant representative bodies.

## **1.8 Transitioning Arrangements**

The implementation approach and process must be grounded in the objectives of the Health Reform Programme and measured against the objectives of this programme.

### **Challenges**

In embarking on this programme of change, ensuring that integrated care is experienced by people and their families, involving the establishment of Community Healthcare Organisations it is imperative to take on board the learning and experience of other countries to ensure that change is implemented in a timely manner but not at the cost of sustainability.

Both international and Irish experience demonstrates that structural and organisational reform by itself is limited in effecting significant change and impacting positively on the experience of service users. Fundamental cultural and attitudinal change must complement the changed organisational arrangements:

- The values and leadership approach engendered in each Community Healthcare Organisation will be critical to success.
- Direct service providers must work across all traditional boundaries and outside of historical service settings with the service user as the focus of all activity.
- People in senior clinical and management positions must provide the necessary leadership to give effect to the implementation of the fundamental changes that are now required.
- All staff, including those in positions of leadership such as Heads of Discipline and heads of clinical services must combine responsibility for safety and stability of existing services, while transforming their services and their own ways of operating.

The challenges of working in a comprehensive and integrated way are significant and will need to be supported through a comprehensive human resource strategy which will include an appropriate investment in education and training with appropriate mentoring, and development of leadership and management skills.

## Enablers

A number of critical enablers are necessary and these include for example the development of comprehensive ICT systems and a unique patient identifier which will facilitate greater linkages between electronic health record systems and thus ensure better, safer care.

A number of key enablers are already in place which will support the necessary change management process:

- The new Health Service Directorate will bring a national leadership focus in respect of each Division (care group) i.e. primary care, mental health, social care, acute services and health and wellbeing.
- The National Clinical Programmes, developed in collaboration between the health service, the Royal Colleges and with the support of HIQA and the DoH, provides a strong platform to develop and implement the standardised models of care and processes referred to above. The National Clinical Programmes will support the development of a national, strategic and coordinated approach to the design of clinical service improvement, to deliver improved patient care, access and better use of resources. A National Clinical Group Lead is being appointed for each of the Divisions, which will embed clinical and professional leadership within the management structures of the new Divisions, providing the necessary support and advice at national and local level.
- The System Reform Unit will play a key leadership role to support the work of the Divisions in the implementation of their significant change programmes. It will be responsible for the necessary programme and project management.
- The Quality and Patient Safety Division provides strong patient safety and quality improvement support and assurance to each of the service Divisions and throughout the system. This programme of support will be further enhanced with the establishment of the Patient Safety Authority which will be formed and located initially within the Health Service.
- Communications and Stakeholder Engagement is an essential enabler of change. Key stakeholders such as staff, patients and service users, representative and professional bodies and others should feel part of the change, and that their views are listened to. This approach will inform a comprehensive communication effort throughout the change programme.