6. Options for Community Healthcare Organisations

6.1 Introduction

This chapter outlines a range of options in relation to the number, scale and boundaries of successor Community Healthcare Organisations to the existing ISAs. These options are based on the terms of reference, the output from the consultation process, the learning from the literature and research review and related work. The project team has also drawn on the experience from previous work undertaken in reforming the health service, in particular the previous spatial mapping project which focussed in particular on maximising primary / secondary care pathways.

The focus of the project team has been to develop a design blueprint for the "best fit" local organisational arrangements (both governance and service catchment perspectives) for primary and community care services. This will:

- Deliver excellent health outcomes for the population by driving the delivery of integrated care
- Support the strategy of shifting balance of activity towards prevention and community based care and away from hospital based care;
- Ensure more efficient use of resources;
- Have a clear line of accountability from top to bottom;
- Ensure services are organised around the population based service delivery model;
- Streamline and reduce the management layers and numbers bringing decision making as close as possible to service delivery;
- Develop clinical leadership;
- Supporting the implementation of the *Future Health* and *Healthy Ireland* strategies.

Influencing factors to apply to decisions around service catchments include:

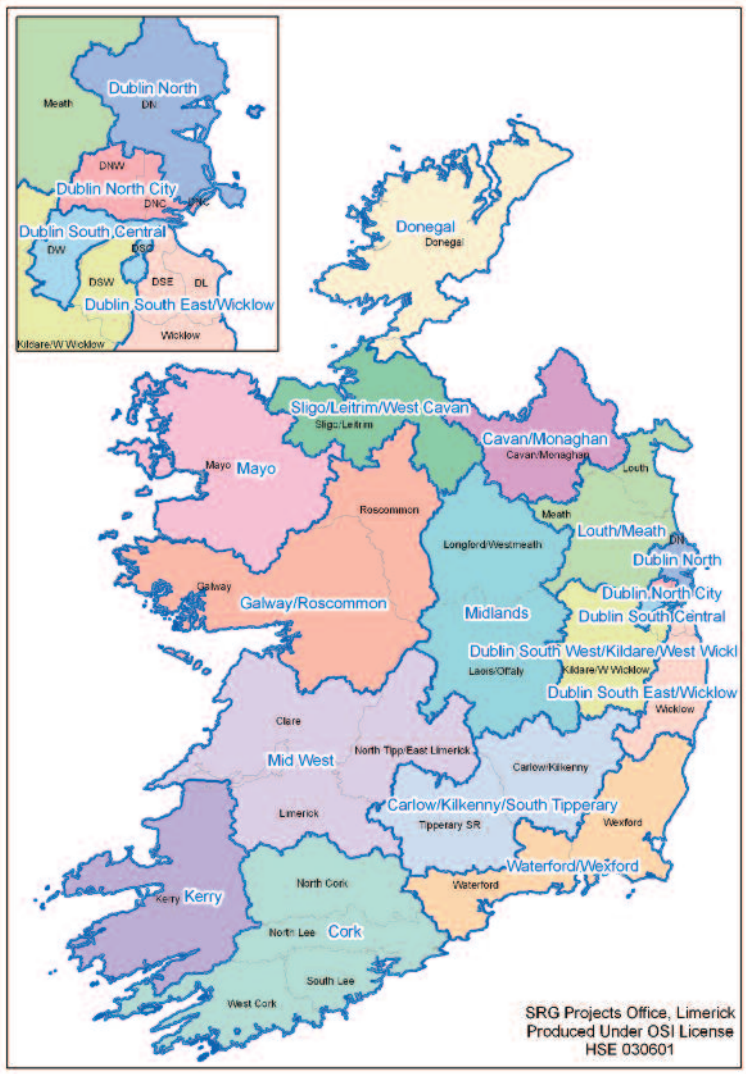
- Catchment areas for new Hospital Groups;
- Community connectivity / affiliations and social and cultural links;
- Composition of current Primary Care Teams and Network spatial units;
- Service catchments of key services such as local authorities, education and social protection that influence the determinants of health;
- Spatial strategy and travel patterns of the public for general services;
- Existing ISA catchments;
- Supports the funding and commissioning model envisaged in *Future Health* and the development of resource allocation models for the Health service.

6.2 Current Situation

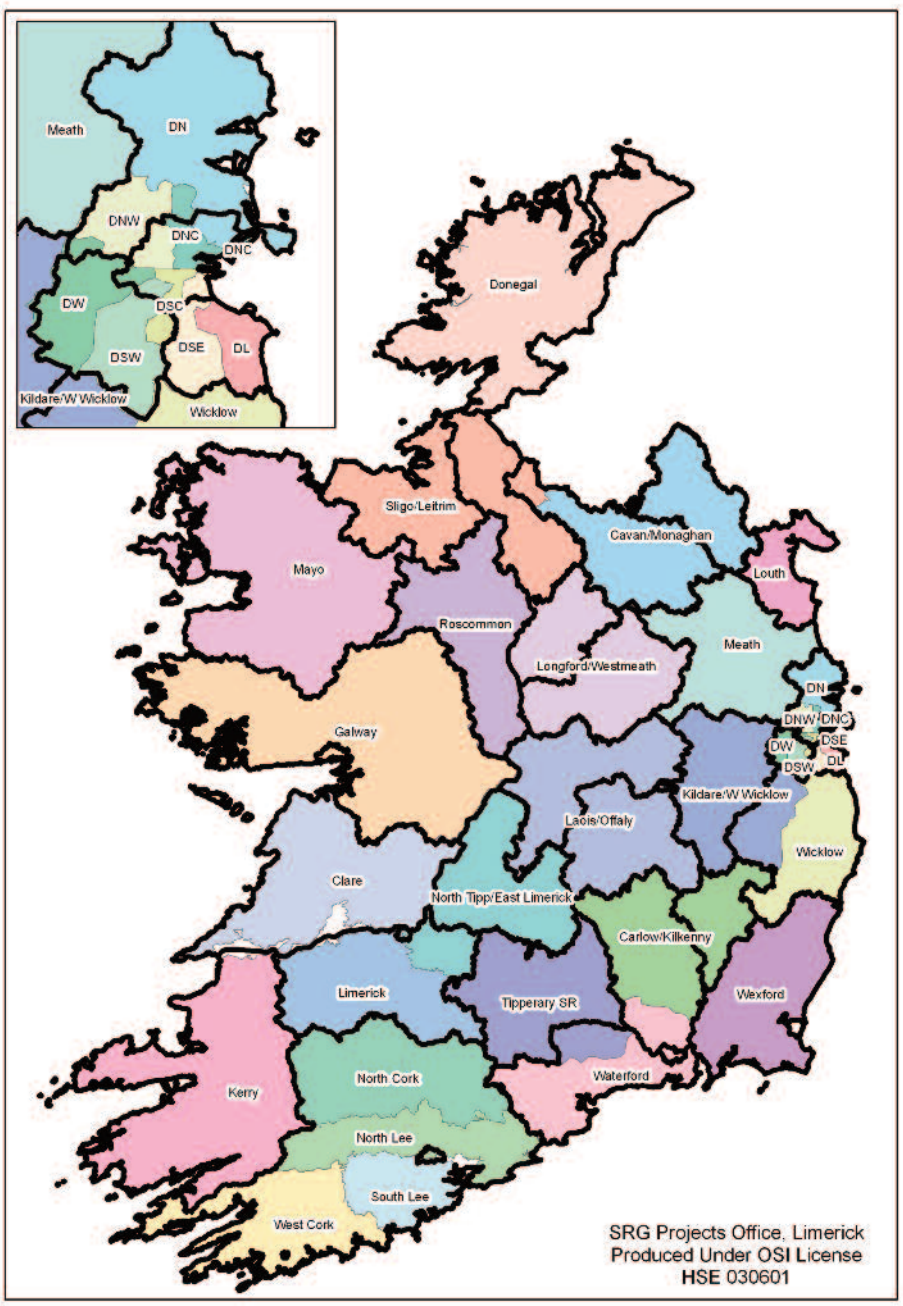
6.2.1 Community Services

As set out in Chapter 3, the Health Boards developed the basis of a community service through a Community Care programme, comprised of thirty-two community care areas, defined geographical areas of service delivery. With the establishment of the HSE, these Community Care Areas became Local Health Offices of which there were thirty-two. 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 and where Local Health Offices were largely grouped around patient flows to local Acute Hospitals in all seventeen possible ISAs, which were mapped. The plan envisaged for the full completion of the ISA structure was impeded by the changed economic circumstances and not fully put into effect.

The HSE currently provides community health services across seventeen ISAs (not all are similar to the seventeen originally mapped). The map below illustrates the location of each ISA. Each ISA is comprised of a number of former Local Health Offices (LHOs) and many of the existing financial systems and reporting systems are based on these. ISAs are illustrated by colour and labelled in blue, with LHO outlines in grey and labelled in grey.

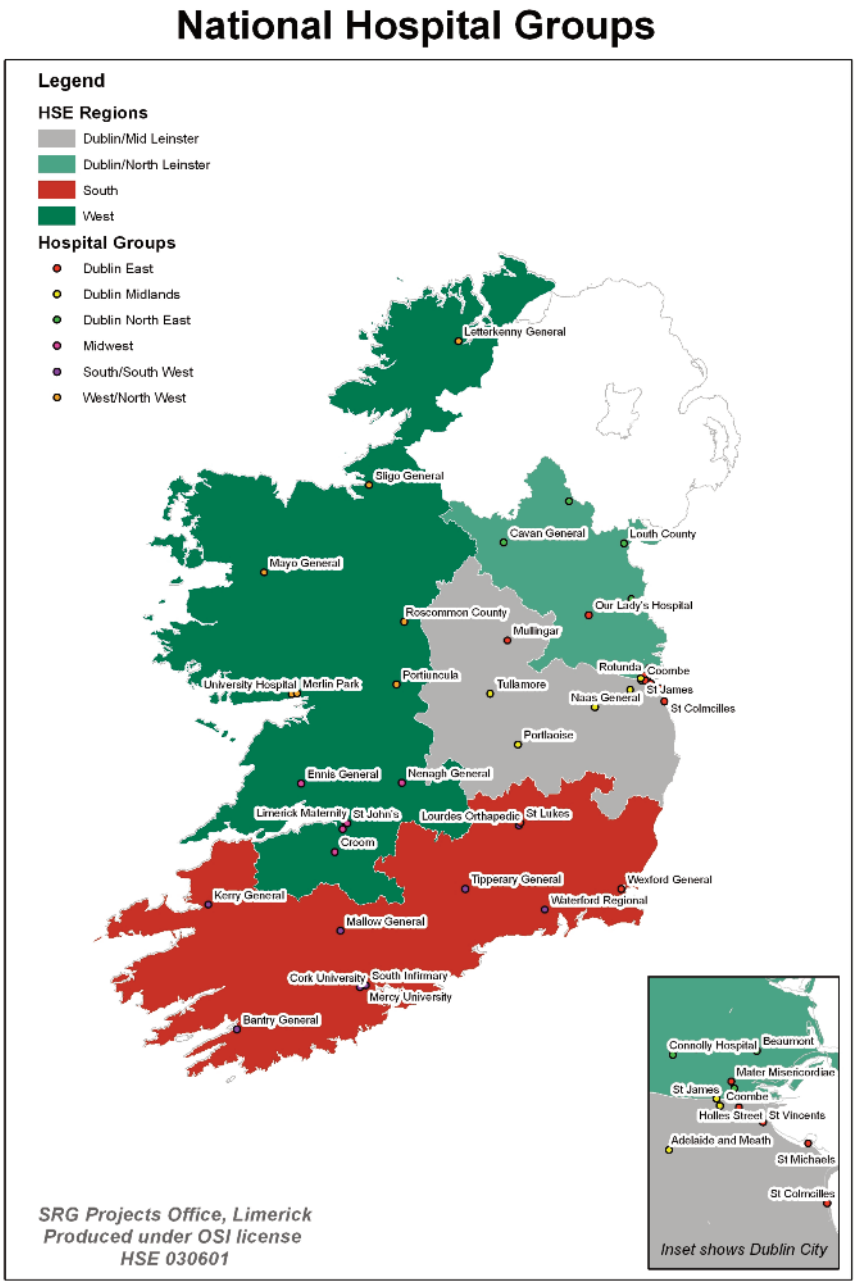


The following map sets out the LHO Boundaries with the local authority boundaries overlaid. It is clearly illustrated that while a number of local authority boundaries are coterminous with the LHO boundaries, this is not the position in respect of all local authorities. Those which are not the same are the LHOs: Sligo Leitrim West Cavan LHO, Tipperary North/East Limerick LHO, Waterford LHO, South Tipperary LHO, Carlow/Kilkenny LHO, Kildare West Wicklow LHO, Wicklow LHO and all 10 Dublin LHOs



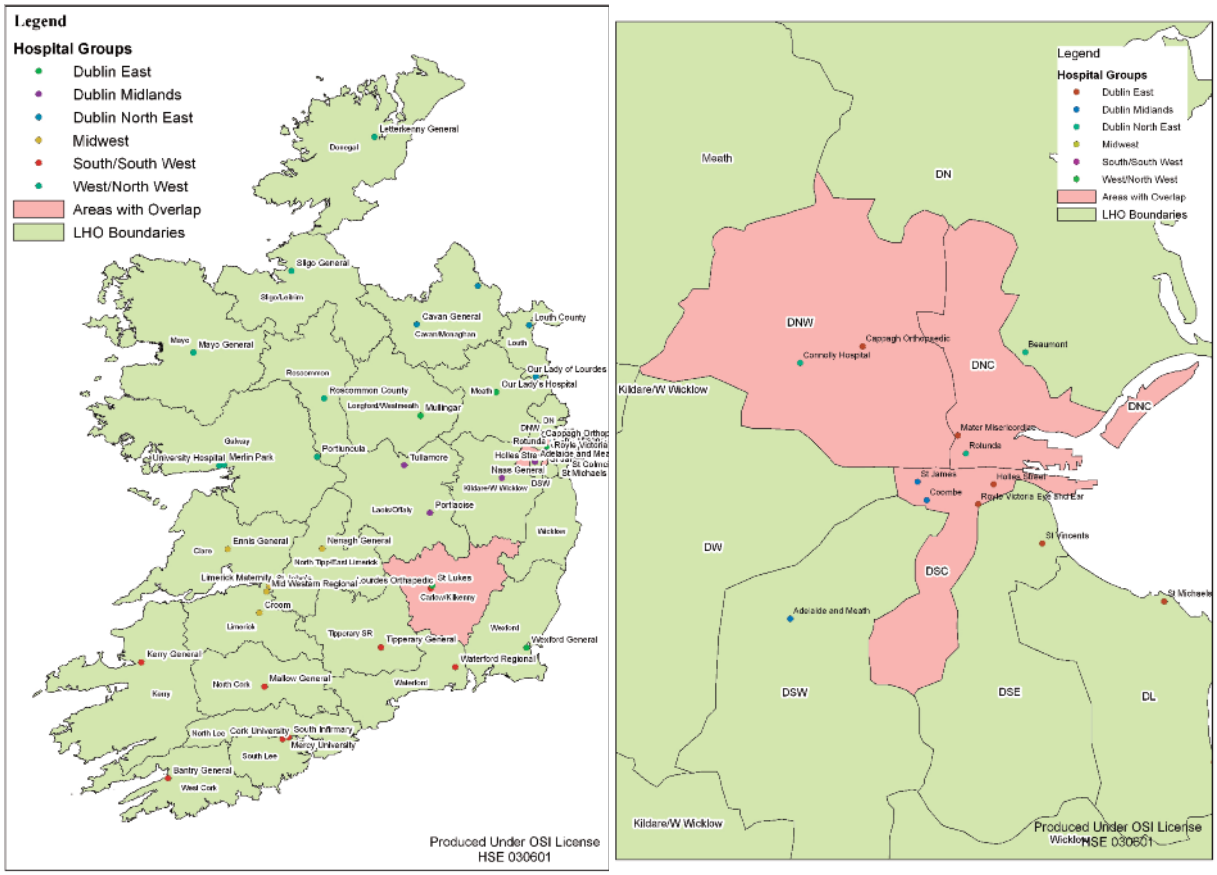
6.2.2 Proposed Hospital Groups

The following map sets out the location of the acute hospitals. Each proposed new Hospital Group is colour coded as described in the map legend. Appendix H.4 sets out a table of this information.



6.2.3 Issues with Hospital Catchment Overlap

The following maps highlight in pink former LHOs which have hospitals in a number of proposed Hospital Groups within them and this does not facilitate the formation of a distinct geographic patch (based on LHO boundaries) for each Hospital Group.



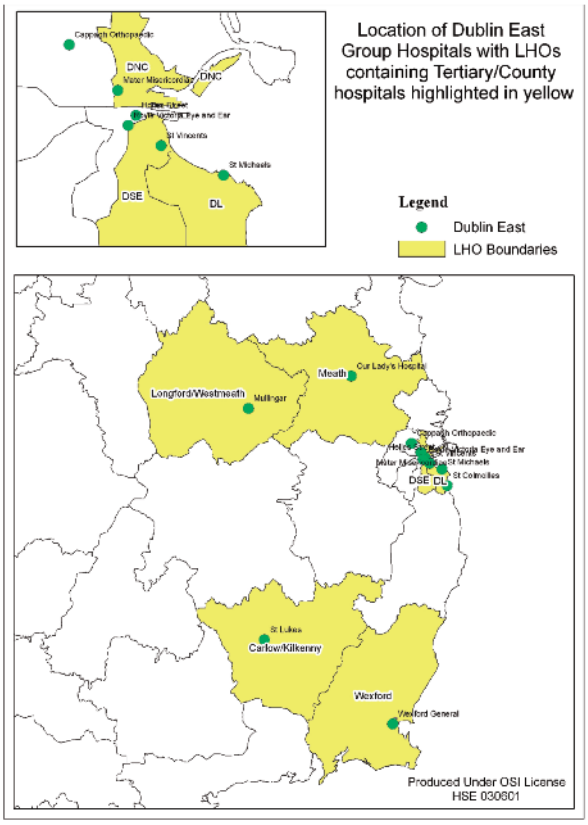
Issues with Current Configuration

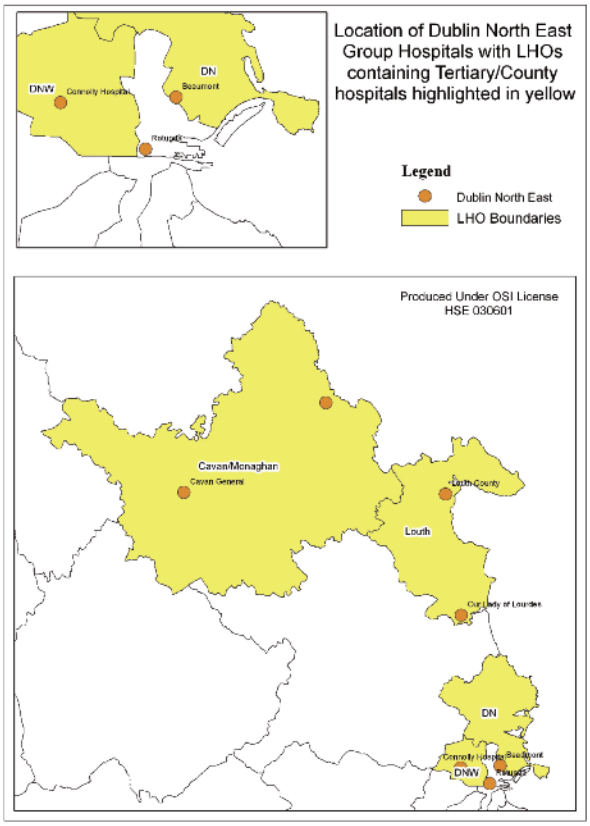
Hospital Catchment overlap

Due to the location of the acute hospitals and the overlap of their catchment areas, it is not possible to assign each hospital a discrete catchment area. The map above illustrates those LHOs which have hospitals from multiple groups within them:

- Carlow Kilkenny LHO – this has Lourdes Orthopaedic Hospital, Kilcreene which is in the South/South West Hospital Group and also St Luke's Hospital, Kilkenny which is in the Dublin East Hospital Group;
- Dublin South City LHO – the National Maternity Hospital, Holles Street and The Royal Victoria Eye and Ear Hospital, which are in the Dublin East Hospital Group and also St James's Hospital and the Coombe Women and Infant Hospital which are in the Dublin Midlands Group;
- Dublin North Central LHO – the Mater Misericordiae University Hospital which is in Dublin East and the Rotunda Hospital which is in Dublin North East Hospital Group;
- Dublin North West LHO – Connolly Hospital which is in Dublin North East Hospital Group and Cappagh National Orthopaedic Hospital which is in Dublin East Hospital Group.

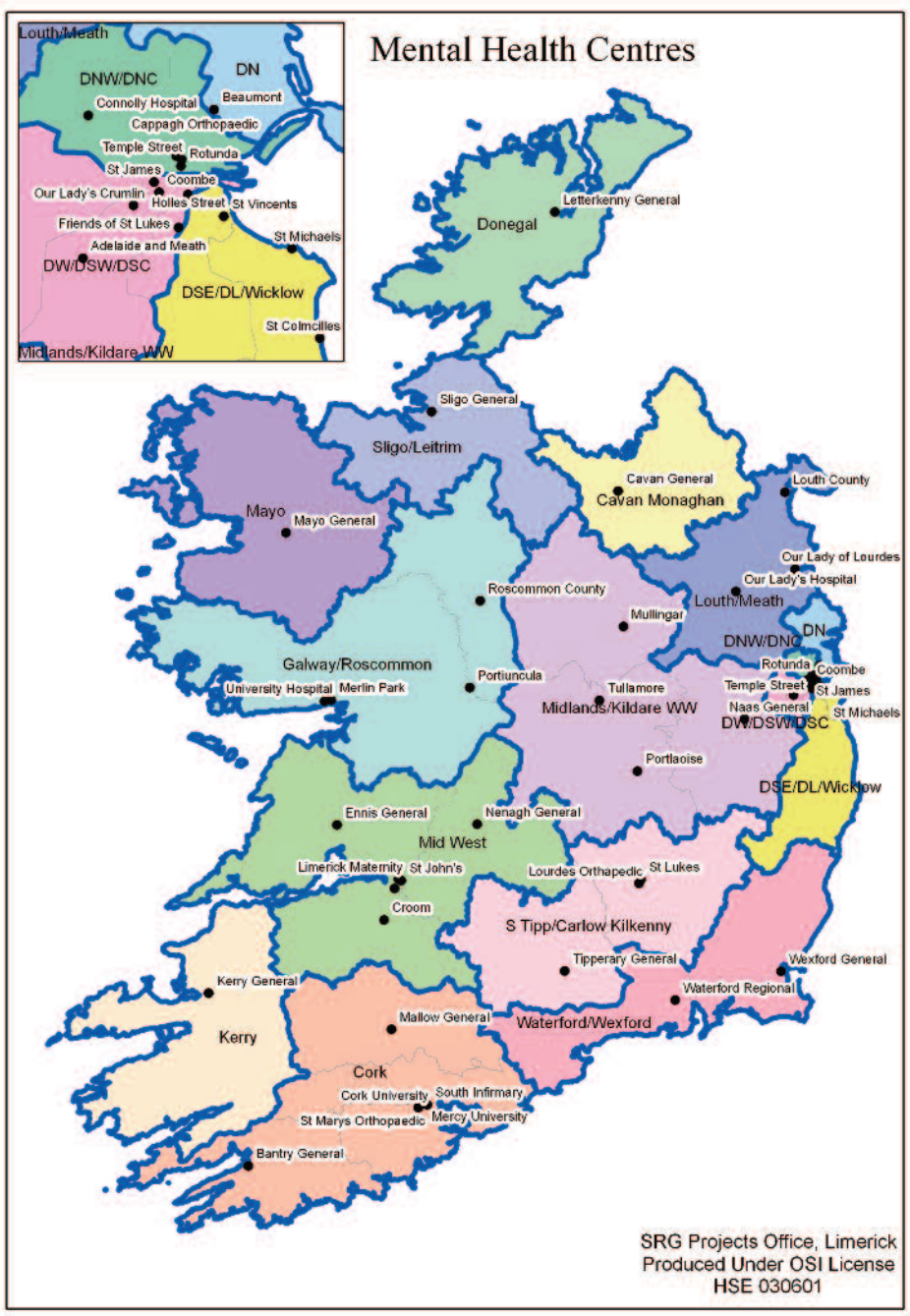
See diagrams below for the Dublin East and Dublin North East Hospital Groups.





6.2.4 Mental Health Services

Under *Vision for Change* 16 areas for service provision are set out, the map below sets out these areas based on groupings of former LHOs. The Mental Health Centres are identified on the following map:



6.3 Options Identified

6.3.1 Design Criteria

The design criteria below provided broad direction in relation to the number and size of new Community Healthcare Organisations. However it must be recognised that no one factor of itself is capable of determining the answer as the concept of *Future Health* is rooted in a local integrated approach and in the knowledge that populations are not evenly distributed. A balance had to be found between spatial factors, community integrity, existing patterns of care, justifiable population size to support service levels, manageability issues, etc. Depending on the relative emphasis placed on this criteria the range of options varied.

- **Internal Integration Criteria**
  - Maximise co-terminosity with new 6 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 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 and in time have its own full governance and management structure;
  - Manageability i.e. the area should be of a size that the 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 new Community Healthcare 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 team 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 considering these criteria, there are a number of important points that need to be emphasised as follows:

Report of the Expert Group on Resource Allocation and Financing

On the issue of resourcing the Report of the Expert Group on Resource Allocation and Financing in the Health Sector 2010, recommends that the basis for geographic allocation of resources within the population health model should be areas with a population of at least 250,000 – 300,000 people and that there would be no upper limit to the range where the areas represent integrated geographical units. This size supports budget sustainability, local management capacity and integrated care.

The Importance of Local Authority Boundaries in Public Service Provision

The development of the *Healthy Ireland* policy document seeks to develop a whole of government approach in addressing the health status of the population. This policy document provides a key framework to guide the development and the delivery of health service on a cross sectoral basis into the future. *Healthy Ireland* stressed the importance of identifying local structure for implementation of the strategy and how they can be supported to work on common agendas. It is at this local level that individuals, community and voluntary groups and projects, sporting partnerships, local schools, businesses, primary care teams, community Gardaí, etc can interact to work together. Local authorities already play a critically important role in protecting and promoting health and wellbeing at local level; this is particularly so in areas of disadvantage.

Action 2.5 of *Healthy Ireland* requires that the feasibility of co-terminosity of health service areas with local authority city/county boundaries, as aligning service provision and administrative boundaries has been identified as a significant enabler for implementation of actions, be reviewed.

In arriving at the number and composition of the Community Healthcare Organisations, the importance of alignment with local authorities has been taken into account. However due to the variance in size of the local authorities and the requirement for the Community Healthcare Organisations to be of an appropriate scale this has not been possible in every area. In identifying the composition no existing county boundary has been broken other than in Dublin (due to the population density and primary secondary patient pathways).

In addition, in the long term one of the objectives of *Healthy Ireland* is the publication of health outcomes at county level to facilitate comparison of performance of ISAs and local authorities in achieving the strategic objectives. Therefore it will be important that, insofar as possible, no Primary Care Team or Network crosses county boundaries.

Child and Family Agency

With the establishment of the Child and Family Agency as an independent body from January 2014, the development of a productive relationship between the reformed health service and the Child and Family Agency will be important. Both agencies, in addition to working together, will also need to collaborate with a number of other public sector bodies in particular An Gardaí and local authorities.

6.4 Proposals

There are many potential configurations which could be explored but this study initially identifies four broad areas to explore:

- Co-terminosity with new Hospital Groups;
- Maximising primary and secondary care activity, pathways and relationship;
- Co-terminosity with local authorities including the proposed Regional Assemblies;
- An alternative approach to the Dublin area.

Each option is set out in detail in this chapter and each option has:

- A description of the background to the proposal;
- GIS Map;
- Description and population size of each new area proposed;
- A review of the proposal based on the advantages and disadvantages of same across each criterion identified,
- Estimated resources based on LHO expenditure.

Initially, four options were considered by the project team, however, taking account of the feedback and inputs, etc. variations within the options were developed. This was particularly the case within the context of considering the position in respect of Dublin and concentration of population across four local authorities. In all, when initial options and variations are taken into account, a total of seven options were considered in detail.