

7. Governance and Management Arrangements for Community Healthcare Service Delivery Organisations

7.1 Introduction and Context

Chapter 6 addressed the options regarding the number, scale and boundaries of successor Healthcare Organisations to the existing Integrated Service Areas (ISAs) and recommended nine successor structures as outlined in 2A of Chapter 6. This chapter outlines the recommendations on the governance and management arrangements to apply.

In 2012, the Minister for Health published *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015*. This framework, based on commitments in the *Programme for Government*, outlines the main healthcare reforms that will be introduced in the coming years with a focus on the four pillars of reform: Structural, Financial, Service, and Health and Wellbeing.

Future Health outlined the principles and approach to the structural reform of the health service which would be undertaken on a phased basis which is summarised at 7.1.1 below.

7.1.1 Future Health Structural Reform – A Phased Transition

Phase 1

- Establish New Directorate – As governing body.
- New Management and Governance Structure.
- Hospital Groups on Administrative Basis.
- Review ISAs to inform successor structures, executive management and governance.
- Child and Family Agency established.
- Moving to the “post HSE” era – in effect Healthcare Commissioning Agency in shadow form.

Phase 2

- Development of a formal purchaser / provider split.
- Commissioning Model.
- Healthcare Commissioning Agency formally established.
- Legislative Framework.

Phase 3

- UHI

Any recommendations on the governance and management arrangements for Community Healthcare Organisations must be considered within this overall context.

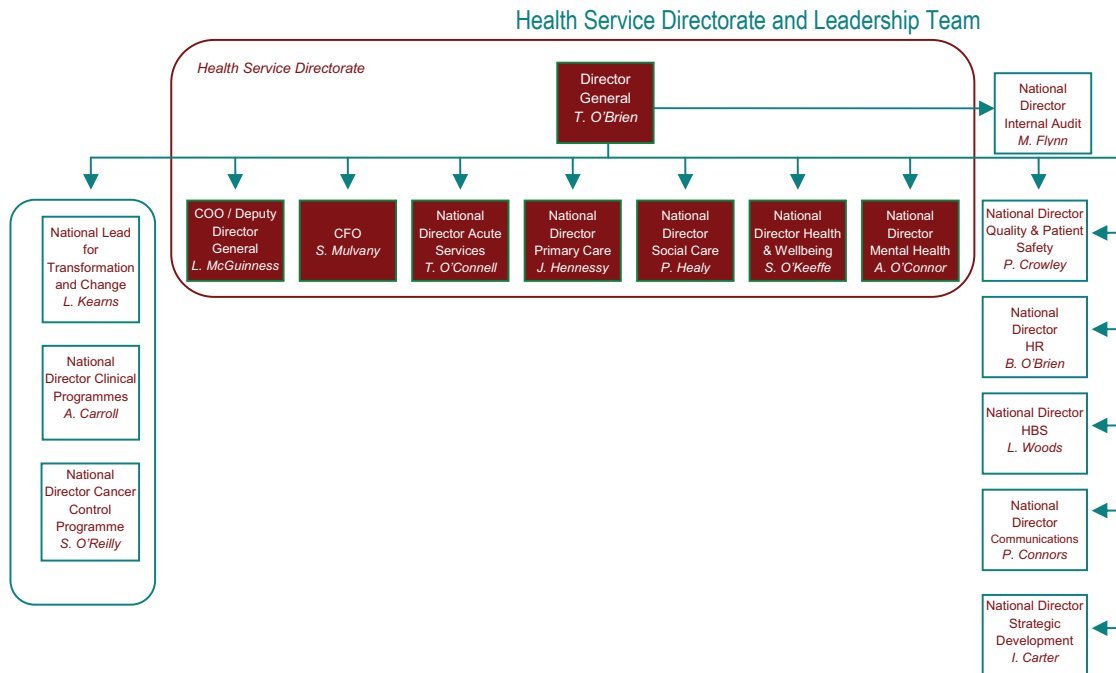
7.1.2 Delivery of Phase 1 - Future Health Structural Reform

Delivery of the first phase of the reform of health structures has already commenced with the establishment of the Health Service Directorate in July 2013, as the precursor to the Healthcare Commissioning Agency. Services are now organised into Divisions covering acute hospitals, primary care, social care, mental health, and health and wellbeing services. In addition the Childcare Agency has been established and we are moving into the “post HSE” era.

The enactment of the *Health Service Executive (Governance) Act 2013* has strengthened the accountability arrangements between the Health Service and the Minister for Health. In this context, a Directorate has been established as the governing body for the Health Service. The Director General, as Chair, and seven Directors have been appointed. A formal scheme of delegations is also in place which clearly defines the line of accountability for each service area.

A formal governance framework is also in place to manage the funding relationship with the non-statutory sector. All funded agencies are required to enter into and sign formal and comprehensive service agreements or grant aid agreements.

These new national governance and accountability arrangements are illustrated in the diagram below:



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 through which the new Community Healthcare Organisations will be enabled to deliver services more efficiently and eliminate the unnecessary duplication inherent in previous systems.

The project team, in considering the governance and management arrangements for Community Healthcare Organisations, had full regard to these new national structures.

An important priority for the Health Service Directorate is to drive forward the implementation of Phase 1 of the Reform Programme as outlined in *Future Health* and to work with the DoH in planning for Phase 2.

The Reform Programme envisages a move from the current centralised management model for health services to a model that will see greater autonomy for front line services through the establishment of hospital groups and the organisation and management of primary care and community services within identified geographic areas. The changes to be introduced will;

- Provide direct line accountability between the individual National Directors for services and the managers responsible for hospitals and primary care and community services as a precursor to moving to a purchaser provider split and commissioning model.
- Ensure the foundation for greater autonomy at service level is in place and provide the stepping stone to independent trusts on the hospital side and effective Community Healthcare Organisational Structures on the Community side.
- Primary care, social care, mental health and health and wellbeing services will be delivered and managed through an integrated management structure within geographic areas, which will be identified in this review. This will include HSE funded agencies in these service areas.
- There is a clear commitment to provide Primary Care and Community Services with governance and management arrangements of equal weight and esteem to those that are now envisaged for the Acute Hospital services. At the same time it is acknowledged that the

detail of the respective structures may differ, reflective of the different models and range of service provision across hospital and earlier.

- Move from emphasis on acute care towards preventative, planned and well co-ordinated community based care.
- Primary Care Teams and Social Care Networks provide the foundation for a new model of integrated care.

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.

7.1.3 Planning Phase 2 – Future Health

Future Health noted that it is vital to develop the right organisational structures for our health services so that we can deliver a high quality, responsive and cost effective service to our people. It also recognised that ensuring these structures are appropriate is a complex exercise, which requires that each phase of the transition would be carefully evaluated and inform planning and implementation of the next phase.

Outlined above are the key elements of Phase 1, which are being implemented with the establishment of the Health Service Directorate and these national structures will remain in place throughout Phase 1 of the process and will support implementation of Phase 2.

Planning for Phase 2 is well underway involving work by the DoH and the health service.

Commissioning Framework

Work on the development of an appropriate Commissioning Framework is currently underway under the Leadership of the Chief Operations Officer of the health service in consultation with all stakeholders.

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.

DoH Work on Structures and Related Matters across the Health System

Significant high level work has already been undertaken by the DoH on a wide range of relevant issues, these include not only the development of *Future Health*, but also the ‘*Money Follows the Patient*’ Policy Paper, the white paper on Private Health Insurance, the *Establishment of Hospital Groups as a Transition to Independent Hospital Trusts* Report, the *Framework for Development of Smaller Hospitals*, *Healthy Ireland*, the *E-Health Strategy*, as well as work on the development of a white paper on UHI addressing such issues as the “basket of services” that would be covered under this insurance model, etc. The impact of these separate but related elements of the reform programme will need to be drawn together to ensure cohesion in the overall health system and this work is currently underway within the DoH in collaboration with the Health Service. The output of these deliberations will influence the overall governance and management arrangements.

Legislative Requirements

It should be acknowledged that a significant range of work is required to ensure that an effective legislative framework is put in place to give legislative effect to the reform programme. The DoH

recognises that while a number of these changes will require legislation for their final enactment, it is clear that a great deal of progress can be made through administrative reform within existing structures, ahead of any legislation. This approach will not only help ensure the changes are made in a timely way but will also allow the various changes to be made in a planned and incremental basis, so that the final transition from the current system to the reformed service is as smooth as possible. This overall approach is very much in line with the recommendations of this report based on the consultative process and international research and experience, which emphasises the need for a phased implementation of the change programme towards a fully integrated model of service, road-testing the planned changes and integrating learning as we move from one phase to the next.

The outcome of this work in the planning of Phase 2 of the reform programme, will inform the shape of the final governance and management structures required, particularly at national level, to ensure cohesion in a reformed health system.

7.1.4 Implications for Governance and Management Arrangements for Community Healthcare Organisations

In the context of all of the issues outlined at 7.1.3 above, it is clear that there are a number of important variables which have the potential to impact on the overall national structures and governance arrangement for the system, including Community Healthcare Organisations, which are unresolved at this point and which will take some time yet to work through.

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

Having considered both of the options outlined above and having regard to recommendations in Chapter 6 of this report, the considered view is that the nine boundaries and the associated management and governance arrangements for these structures at local level outlined later in this chapter 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. Our 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.

7.2 Clinical and Corporate Governance

In considering the governance and management arrangements for future Community Healthcare Organisations, the project team also gave full regard to the overview of best practice in clinical and corporate governance referenced in Chapter 5 and outlined in detail in the Reviews of International Experience, Good Governance and Clinical Supervision in Appendices D, E and F. The project team is satisfied that the arrangements recommended, while new in an Irish context, are consistent with evidenced based best practice.

7.3 Transition Arrangements

As referenced above, 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 and 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 9 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 above.

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.

7.4 Recommendations for Governance and Management Arrangements for Community Healthcare Organisations

7.4.1 Management Team of Community Healthcare Organisations Replacing Existing ISAs

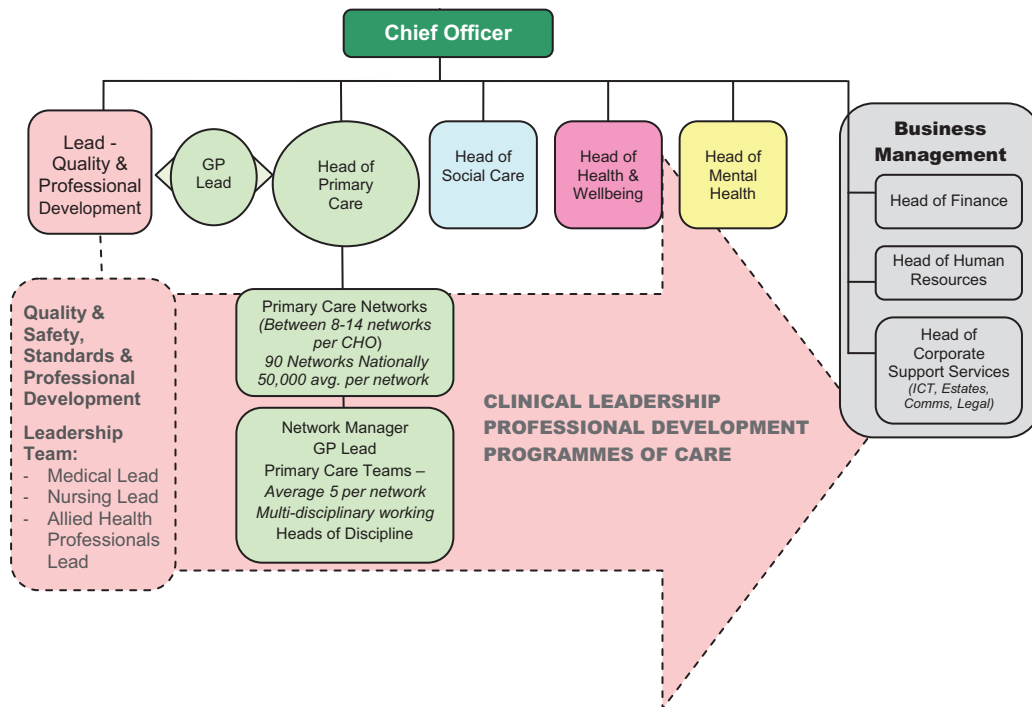
The Chief Officer and Management Team will operate at the highest level of the local community healthcare organisation and will have full authority and responsibility for service delivery. In the transition phase, the Chief Officer will report to the relevant National Director and executive authority and accountability will be derived from the Health Service Directorate. In the long term the governance relationship can be to the Healthcare Commissioning Agency or alternative area, regional, or national structures when established.

The Management Team will comprise of:

- Chief Officer of Community Healthcare Services, to lead Management Team and accountable for all service delivery within the Community Healthcare Organisations
- Head of Primary Care
- Head of Mental Health
- Head of Social Care
- Head of Health and Wellbeing
- Business Management
 - *Head of Finance*
 - *Head of Human Resources*
 - *Head of Corporate Support*
- Lead Quality and Professional Development

The key role of the Chief Officer and Management Team is to deliver high-quality and safe services to meet the needs of the population. Every effort should be made to progress speedily with the establishment of these management teams so that the momentum of reform is maintained.

The management arrangements are illustrated below in summary form:



7.4.2 Central Role of Primary Care

The *Primary Care Strategy* which set out the policy direction for the future of primary care services in Ireland acknowledged “the central role of primary care in the future development of modern health services”. It proposed the introduction of an inter-disciplinary team based approach through Primary Care Teams and Health and Social Care Networks (HSCNs).

While progress has been made in the implementation of the strategy, and there are some examples of highly effective PCTs, overall implementation of the model and achievement of the outcomes identified in the strategy has not been as comprehensive as originally envisaged. As identified in the HSE Board Report (April 2011) – Update on the Development of Primary Care Teams and their Operational Effectiveness: “it is evident that in some cases that everything is not working in accordance with expectations and there is a need to establish why certain teams are working well and why others are not as good and why some are far more productive than others. Two of the main issues of Teams operation are the competing demands on existing staff with many Teams indicating that they are not adequately resourced to cope with demand and the lack of co-located Team members. Other barriers include lack of administration support, lack of management and governance structures, issues with GP engagement and lack of ICT infrastructure.”

There was a consensus throughout the consultation process that it will be essential to ensure that the new Community Healthcare Organisations are ready to implement the reform agenda as set out in *Future Health* and continue the journey towards ensuring that people experience care that is integrated and allows them to navigate smoothly through the system.

During the consultation phase of this review, the importance of ensuring that there is a robust governance and management model with clear lines of accountability for the PCTs and Networks and the broader organisation was stressed. The most recent guidance document for governance of PCTs and Networks, agreed in February 2012, was referenced throughout the consultation process and while it was acknowledged that significant work had been undertaken and discussions held with staff and unions, etc. the approach had not been successfully implemented. The consultation process identified this as one of the key issues requiring resolution in the establishment of the ISA successor bodies.

The consultation process also emphasised the necessity for more effective engagement with general practice and clarity around roles for GPs and how they can be more effectively engaged in the

process into the future. In addition, it was specifically highlighted by the ICGP in the project team's consultation with them, and in their 2011 review of the effectiveness of PCTs (ICGP report published October 2011). That report highlighted the perspective of GPs on this issue as follows:

- Clinical governance structures are not clear with lack of clarity with regard to final clinical responsibility for team decisions.
- Management of team members does not appear to be optimal – difficult to ascertain who is in charge with team members reporting to multiple managers. This silo effect where team members are reporting to largely hospital based discipline managers is not conducive to team cohesion and productivity.
- Clerical support is essential otherwise team members can spend up to 50% of their clinical time doing administration – appointments etc. rather than seeing patients.

Having considered all of these issues it is clear that there is a real need to reorganise and streamline the existing uni-disciplinary approach to delivery of primary care services in a way which supports the development of professional and clinical leadership within the community, and supports a more inclusive involvement of general practice.

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 new primary care networks, serving a population of average 50,000, 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 in the new Community Healthcare Organisations.
- 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.

The project team has considered the feasibility of implementing these proposals within the existing resources in primary care and are satisfied that this approach can be effectively implemented. There are over 10,500 professional staff working in primary care, many of which have been reconfigured to align with the existing PCTs and networks. To illustrate what can be achieved, it is instructive to consider the position relating to some of the core primary care professions of nursing, physiotherapy, occupational therapy, speech and language therapy, medical services, dietetics and psychology.

There are in excess of 200 Heads of Discipline providing line management as well as clinical governance and supervision to these core professions. The new approach to primary care networks envisaged as part of the development of the new Community Healthcare Organisations will see the reassignment of these existing senior professionals / clinicians as the leaders of the primary care networks (approx. 90 required nationally), working with a GP Lead. It will also see the re-design of the Heads of Discipline role towards leadership of clinical governance and supervision for all networks in the Community Healthcare Organisations (approximately 63 required nationally). The requirement for the revised roles would equate to approximately 153 staff from an existing pool of in excess of 200.

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.

7.4.3 Primary Care Management Arrangements

Primary Care services are provided by multi-disciplinary teams including GPs (Primary Care Teams) to a defined population of 10,000 approx. The Primary Care Team (PCT) has two key roles in relation to its defined population:

- The delivery of front line primary health care services predominantly within the remit of GP, nursing and allied health professionals
- The referral and access to services not delivered at PCT level and the appropriate management of care in conjunction with other services including acute hospitals. The role also includes developing clinical care pathways and shared care models across service provision i.e. primary and social care, and mental health, etc.

Individual team members provide services to individuals through surveillance, advice, assessment, diagnosis, referral, treatment and review. Team members collectively focus on individuals with complex care needs. Collectively team services are focussed on groups within the population for health promotion, early intervention, chronic disease management and access to specialist input.

Primary Care Teams primarily consist of:

- General Practice (GP)¹
- Public Health Nurse (PHN)
- Registered General Nurse (RGN)
- Speech and Language Therapist
- Occupational Therapist
- Physiotherapist
- Administrative Support

In order to put in place an appropriate management structure for the delivery of primary care services the following roles and functions must be put in place. The project team assessed the overall resource available within the system at community level and is satisfied that these posts can be put in place through reassignments from existing resources:

- Primary Care Key Worker
- Primary Care Team Leader
- Primary Care Network Manager
- GP Lead
- Head of Primary Care.

¹ General Practice staff may include GPs, practice nurses, practice managers etc.

Primary Care Key Worker

The Key Worker can be any healthcare professional on the Primary Care Team who has a significant role to play with the service user. The role of the Key Worker is defined as someone who *“takes a key role in coordinating the patient’s care and promoting continuity, ensuring the patient knows who to access for information and advice”* (NICE 2004)

The Primary Care Key Worker will:

- assess the service users’ needs and their care plan
- liaise with the other team members involved in the person’s care and agree the care plan with the service user
- ensure that the findings from the assessment and care plans are communicated to the others involved in the care of the user on an ongoing basis
- contribute to discussions about the user’s care
- be the nominated member of the team to communicate issues and coordinate care for the user
- be accessible to the user and ensure there is a continuity of the role by another team member in the Key Worker’s absence
- provide any relevant information to the user and, where appropriate, to his/her family or carer
- ensure the user’s pathway is coordinated as they move across various services such as acute hospital, mental health, social care, etc.
- Ensure user’s pathway and/or careplan is focused on health improvement, self care, self management, in addition to treating illness

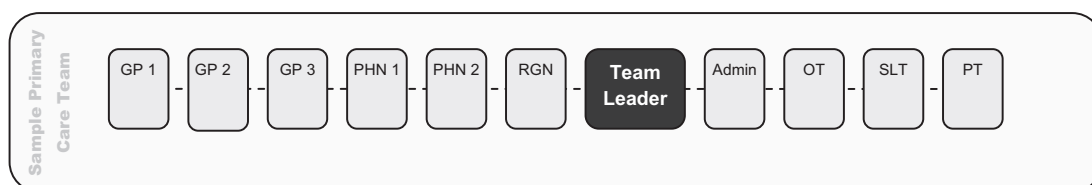
Primary Care Team Leader

Each PCT will have a Team Leader, who is a member of the team, with protected time to co-ordinate daily working arrangements. The role of the Team Leader is central in co-ordinating the self-managed work of the individuals who make up the team and is not a line management role.

The Primary Care Team Leader will:

- ensure that a Key Worker is assigned to people with complex care needs and that appropriate care plans are developed, implemented and reviewed by the team
- co-ordinate the provision of performance and activity related information on behalf of his/her colleagues on the team
- ensure that appropriate common case notes are maintained as required
- ensure that clinical meetings are held and undertaken appropriately
- support the maintenance of a good professional relationship including the GPs on the team
- ensure that there is appropriate liaison and communication with other professionals outside the team, in other divisions and at other levels of service provision.

PCT Leader



The roles of Key Worker and Team Leader are important developments in supporting effective collaboration among primary care frontline staff in the delivery of services. These roles will bring a sense of identity to the teams and establish important points of contact for service users, GPs and other professionals. They will support the achievement of the goal of Primary Care Teams operating as the key access point from the community and will be enablers of integration, particularly in the development of clinical care pathways.

Primary Care Network Manager

The Network concept was originally created for the specific purpose of service organisation and delivery in relation to its defined population. While previous mapping in the development of networks identified a population range of 30,000 – 50,000, the structure referred to in this document is specifically at an average of 50,000 and with a range of 35,000 to 70,000. This approach will ensure the development of a Primary Care Network in each large town and its surrounding hinterland, or for a district of a city. The specific purposes of defining a network are:

- To provide management of the PCTs within the Network.
- To manage and organise the Primary Care Network services shared across the PCTs.
- To liaise on behalf of the PCTs and the population as the key point of management integration with all other health and personal social care services.

By defining Network Management in terms of population size of 50,000 approx. there is an opportunity to develop very specific assessment of needs for each network population. This will support the targeting of resource and service provision to defined areas e.g. high levels of social deprivation, specific demographics, etc. This will in turn support the development of a commissioning model for service provision across each of the divisions and bundles of care under the proposed UHI funding model.

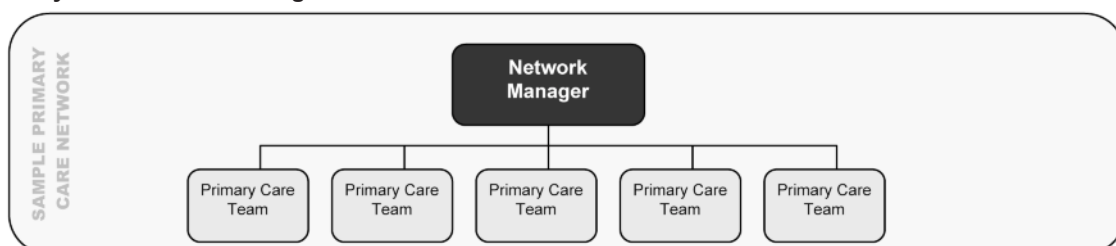
The Primary Care Network Manager is the accountable and responsible person for ensuring the delivery of primary care services to the population within the defined network area. The role of Network Manager will be developed so as to provide a high level of autonomy and decision making in relation to frontline services. It will also be the integrator of other services provided to the network area and will “champion” the needs and requirements of the population. The Network Manager will have full responsibility and accountability for managing the Primary Care Teams within the network. This will see a move away from uni-disciplinary management of Primary Care Teams through the current Head of Discipline system to a management structure where:

- the Network Manager provides the day to day operational line management function
- the Heads of Discipline will provide the clinical assurance, governance and supervision regarding the practice of each professional in the Primary Care Teams. This is elaborated further in the section below.

The Network Manager will:

- manage the Primary Care Teams and ensure that the services are delivered in accordance with the service plan. This includes full accountability and budget responsibility for the primary care resources within the network area
- act as an integrator with other service providers e.g. acute, mental health, social care, etc. so that appropriate care pathways can be accessed and maintained
- ensure that the outcomes and key performance indicators of the individual Primary Care Team members and their collective responsibilities are achieved
- provide day to day management of Primary Care Team members (HSE staff) and collaborate with Heads of Discipline on clinical or professional issues on an individual or collective basis
- liaise and manage the relationship with the respective GPs and their practices through a performance framework and based on key performance indicators in relation to outcomes. It is also envisaged that this role will include a performance management function in relation to pharmacy services in each network
- co-ordinate the health and social care needs assessments for the population
- collaborate with Heads of Discipline on key performance related issues as well as the roll out of initiatives and best practice models and staff development.

Primary Care Network Manager



Primary Care Network GP Lead:

A key component of building an appropriate primary care management structure is the development of an appropriate relationship between GP practices and PCTs/Networks. While the contractual arrangements for GPs will be managed at a more central level, a performance management framework will be implemented at network level. In order to support this process and also to facilitate the roll out of clinical programmes, there is a requirement to develop a "GP Lead" role for each network which is essentially a practitioner with protected time to undertake this role.

The GP Lead role will include:

- providing leadership in relation to quality improvement initiatives
- contributing to operations, planning and performance management
- supporting the Network Manager in the implementation of clinical programmes in such areas as diabetes, asthma, heart failure, stroke, etc. by liaising with other GPs and professionals in the Network
- the implementation of agreed protocols within the network including referral procedures and integrated care pathways across the primary care teams, including GP practices
- supporting the Network Manager in developing professional relationships, innovative solutions and multi-disciplinary approaches to challenges within the network.

Head of Primary Care

There will be a Head of Primary Care with full accountability for the provision of primary care services in each of the new Community Healthcare Organisations managing the services across Networks and Primary Care Teams. The Head of Primary Care will ultimately be responsible for the operational performance and leadership of all Primary Care services (including Social Inclusion Services) across the Community Healthcare Organisation area. 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.

The Head of Primary Care will:

- be the accountable person and budget holder and provide leadership and direction for primary care services in the Community Healthcare Organisation area
- be responsible and accountable for the efficient, effective and safe delivery of these services for patients and clients for a defined population, within national frameworks and for the resources allocated
- be a member of the Community Healthcare Organisation Management Team
- provide line management of the Network Managers and Heads of Discipline of Primary Care Services and ensure that there is collaboration in approach across the service provision and supervision of clinical care (this will be elaborated further in the following section)
- manage and organise those services which are shared across multiple Networks e.g. oral health, audiology, ophthalmology, etc.
- lead the development of effective relationships and structures across all services
- be the leader and promoter of integrated care with other divisional managers across all care settings
- be the leader and promoter of external integration with local authorities, Gardaí, education, etc. giving due regard to county and other geographic boundaries. In addition, coordinating communication with public representatives, media and other community interest groups in relation to all service provision within a specified geographic area.

The position of the Head of Primary Care in the Community Healthcare Organisation, with the supporting structure of Network Managers, Heads of Discipline and PCT Leaders, ensures that there will be a strong spine of accountability and governance in place with clarity of roles and responsibilities. Dependent on the population, size and geography of the new Community Healthcare Organisations, there will be a need to provide the necessary supports to the Head of Primary Care. In addition, as we transition to a commissioning model, the Head of Primary Care will be required to support innovation and local commissioning including incentivising good practice. The Head of Primary Care will ensure that there is a needs assessment undertaken for the respective populations of the networks and will support the Network Managers to do so.

Needs Assessment

A key element of health service planning and delivery will be effective needs assessment. In each CHO, needs assessment and health intelligence will be coordinated by the Head of Health and Wellbeing in partnership with the other Heads of Service. Key features of this will be the involvement of key operational staff in this process e.g. Primary Care Team professionals, Social Care and Mental Health professionals as well as Community Development Workers, the involvement of service users in needs assessment, engagement and cross reference with other services involved in needs assessment and the coordination of existing needs assessments that have been undertaken to date.

7.4.4 Primary Care Clinical Governance and Supervision

Currently the Heads of Discipline of the various professions within primary care provide both line management and governance to their staff. Clinical governance will continue to be provided by the Heads of Discipline with the Network Manager assuming responsibility for day to day line management of staff and general management of the Network. This will allow for the development of the role and function of the Heads of Discipline in providing a structured programme of clinical governance and supervision. Similar to the Network Manager, the Heads of Discipline will report to the Head of Primary Care.

The Heads of Discipline will provide the clinical assurance and governance regarding the practice of each professional in the Primary Care Team. The specific role of the Head of Discipline is to:

- provide clinical leadership and ensure that models of care, including clinical pathways, are implemented
- implement systematic clinical supervision processes including peer supervision, mentoring, self-directed learning, etc.
- provide direct clinical supervision when required of nominated individuals to facilitate reflection on clinical practice, encourage professional growth and provide direction on clinical issues as required
- undertake, and make arrangements for the auditing of individual clinical performance and practice
- support staff rotation to meet service and professional development requirements in conjunction with Network Managers
- support and advise Network Managers on the deployment of staff across and within networks or to specific roles as required
- ensure that information is disseminated on clinical issues and that there is a sharing of evidence based practice across the profession
- collaborate with Network Managers on policy and guideline development and update
- maintain education and training records for their respective disciplines
- facilitate the implementation of professional competency maintained schemes as required by professional regulators
- identify the overall requirements for professional development and make provision for specialist competencies
- collaborate with Network Managers in ensuring compliance and implementation of quality and patient safety frameworks and HIQA standards

Both the role of Network Manager and Head of Discipline are critical to the safe and effective provision of service at PCT level. The network manager position is the key role within the overall operational management and delivery system taking ownership of the integration of services within the network, and with other service providers relevant to the network. The Heads of Discipline (with support from senior therapists and Assistant Directors of Public Health Nursing [ADPHNs]) is the key role in providing clinical assurance and quality and patient safety.

It is vital that the respective roles of network manager and head of discipline are collaborative in nature while being clear about their respective functions so that there is no ambiguity, duplication of purpose or confusion of responsibilities.

The number of frontline staff that would be reporting directly on day to day matters to a Network Manager is significant (25 – 35 wte approx) and not in line with management best practice. To address this, the position of ADPHN will provide both line management and clinical oversight to nursing on behalf of the Network Manager and Director of Public Health Nursing respectively. This is

appropriate as nursing (PHN and RGN) generally represents up to 60% of the current staffing of PCTs. The ADPHN will report directly to the Network Manager and will report to the DPHN for clinical supervision.

All therapies will report directly to the Network Manager as outlined, and senior therapists working in the Primary Care Teams will support basic grades by providing clinical supervision, supporting skill development, and giving clinical oversight in conjunction with the Heads of Discipline.

7.4.5 Mental Health Management Arrangements

Mental Health services are a secondary service with referral from primary care. In keeping with the ethos of primary care it is the objective that people with mental health needs would be supported in as much as possible, at primary care team level. This is generally provided by GP practices but in some areas there are mental health liaison nurses who provide an additional support. Where it is not possible to fully support the person with mental health needs at primary care level, a referral will be made to mental health services for diagnosis, treatment and support. There will also be circumstances where “shared care” arrangements across primary care and mental health services will be appropriate.

The structure for the organisation and management of the mental health services has evolved since the publication of the national policy *Vision for Change (2006)*. The organisation is specified up to the level of *Vision for Change* area management team which in original design was to be managed by an Executive Clinical Director (ECD), and in practice has developed with the ECD currently working alongside a senior manager in many areas.

Community Mental Health Teams

The direction of travel within mental health is that services will be delivered to a population of on average 50,000 with Community Mental Health Teams (CMHTs) and the Child and Adolescent Mental Health Services (CAMHS) being provided at that level. While this approach is not yet fully implemented, significant progress is being made. There is an opportunity to enable integrative working by having the Primary Care Networks co-terminus with these mental health sectors. This will be important from the service users’ perspective as the GP, PCT and the specialist multi-disciplinary services (CMHTs) will work to the same population base and geography. Therefore their relationships and working arrangements in the area of communication, patient pathways, etc. can be optimised. A number of specialised teams e.g. Psychiatry of Age, Rehabilitation will be provided to populations of 100,000 or more, and these will align, or be co-terminous with a number of primary care networks.

Mental Health Management Team

Each Community Healthcare Organisation will have a Mental Health Management Team. It is acknowledged that currently there are management teams in place which will need to be reconfigured on an area basis within the new successor bodies. There will be a Head of Mental Health services for each Community Healthcare Organisation who will lead the Mental Health Management Team and will also be a member of the Management Team.

The proposed membership of the Mental Health Management Team is broadly in line with *Vision for Change* and includes:

- Executive Clinical Director (ECD)
- Director of Nursing
- Heads of Discipline for Psychology, Social Work and Occupational Therapy
- Operations Manager
- Service User

Vision for Change envisaged that the role of Head of Mental Health services would be a senior clinician and currently this is a role that is in development within the services. Therefore there may be a transitional stage whereby the Head of Mental Health will be either the Senior Operations Manager or the ECD on an interim basis until the clinical role and leadership function is fully developed.

The Mental Health Management Team will manage all of the services at the various levels of the future Community Healthcare organisations both in terms of day to day duties and clinical governance arrangements. Their duties will include:

- Delivering a recovery focussed clinically excellent mental health service that involves service users in the design and delivery of their services.
- Ensure there are appropriate structures in place to facilitate consultation and involvement of service users, carers and family members in the design and delivery of their mental health service.
- Ensuring that CMHTs in all specialties are delivering on agreed service levels and in accordance with mental health clinical programmes.
- Being accountable for the delivery of all mental health services safely
- Ensuring that there is a commitment and process in place to deliver these services based on quality standards and the regulations inspected by the Mental Health Commission.
- Managing the services within the available resources.
- Reorganising current services to a community based model and reducing the requirement for residential care.
- Progressing the implementation of the recommendations of *Vision for Change* across the Community Healthcare Organisation area.

Reorganisation of Mental Health Management Arrangements

It is important in the development of new governance and management structures that the progress made to date in mental health services can be sustained and developed in line with the policy direction of *Vision for Change*. To this end, and taking account of the feedback from the consultation process as well as submissions made by the National Mental Health Division, the following actions are required:

- each mental health catchment area will be aligned to the geography of the new Community Healthcare Organisations, and should not cross their boundaries. There will be a requirement to review the current 16 mental health super catchment areas to comply with this arrangement i.e. the Midlands and Kildare
- the 16 *Vision for Change* Service Areas will be reviewed to combine them where possible in terms of scale (geography and population) so that there would be one single mental health service area co-terminus with the Community Healthcare Organisation.
- While there will be one Mental Health Management Team in each of the new Community Healthcare Organisations, there will in some cases be a need to put in place appropriate sub-structures where geography and population merit this. These sub-structures will particularly seek to enable greater local ownership around clinical governance and service improvement
- there will be one Mental Health Management Team and where there are two mental health service areas, a supporting sub-structure will be put in place
- Mental Health Sectors will be aligned to Primary Care Networks for the provision of services and to optimise integrated care.
- Certain services may require to be managed as national services within mental health. One possible example of this is the Forensic Mental Health Service.

Conclusion

In the context of all of the above, it would be premature to seek to specify the detail of a number of the structural issues, including:

- Any potential sub-structures.
- What, if any services, may be operated nationally.

Consideration of these issues will take some time to address and will be determined by the Mental Health Division in consultation with the relevant stakeholders during 2014.

7.4.6 Social Care Management Arrangements

Social Care services include older person services and services for people with disabilities. The Social care Division provides its services in line with the *Healthy Ireland* strategy by encouraging and supporting older people to keep healthy, remain at home and stay out of hospital for as long as possible. Similarly in relation to people with disabilities, the aim is to facilitate people to live lives of their own choosing and to support their independence. To achieve these principles, services need to be provided through a person centred model of care and in a collaborative way, with shared responsibility between the person, their families and carers, health and social care professionals, a multiplicity of agencies and society as a whole. This requires further reorganisation of existing services within an environment of a higher level of demand and a diminishing resource. There is also a need to address the opportunities and challenges of people living longer and healthier lives, developing models to suit individualised budgeting where people have increased control of their own resources and have choices in relation to their care. This requires clear and comparable information and advice available to service users to make good decisions about their services.

Social Care services have traditionally been provided by two separate care group structures i.e. older people and disability services. In this context, each of these care groups had its own distinct structure and as with primary care and mental health, the structure has tended to vary from one ISA area to another. Both models of service delivery and management had the requirement to work closely, particularly with primary care services, and the high level of integration of service provision that is required between social care and primary care specifically, remains paramount.

In general, the majority of disability services are provided by Voluntary Agencies and local organisations which are funded by the Health Service through Section 38 and 39 of the Health Act. Disability services vary significantly in scale and complexity and those which are funded under Section 38 tend in the main to be large residential care providers. However, both Section 38 and 39 funded agencies provide a range of multi-disciplinary, day and residential services and have significant linkages with education services, local authorities and other statutory agencies in order to provide a wide range of services to users.

With regard to services for older people, long stay residential care is provided by public, private and voluntary providers and is funded under the nationally managed Nursing Home Support Scheme (NHSS). Short stay residential services e.g. rehabilitation is provided in the main in public units.

The current management structure of both care groups at ISA level features both Service Managers of disability and older people services.

- In disability services, the structure also features professional Case Managers (for organising and coordinating services for people with complex care needs) and Assessment of Need Officers (related to the Disability Act legislative requirements).
- In older people services, the current management structure also features Home Help Coordinators, Home Care Package / Home Support Service Managers, Directors of Nursing / Service Managers for Residential Care and Day Care Centres.
- Individual areas have other supporting roles in both care groups, particularly in relation to the development and oversight required for service level agreements, multi-disciplinary disability teams, discharge coordinators / acute hospital liaison staff, etc. A range of staff also work in the area of community work and community development which is provided across all divisions of service.

As referenced in *Future Health*, international research suggests strongly, that the most effective way to meet the needs of individuals in the social care domain is through an integrated system, where there is a common funding source as part of a purchaser / provider split, a single care assessment framework, a robust governance and accountability framework, a greater emphasis on individualised budgeting all of which would be underpinned by appropriate quality assurance and regulatory frameworks.

The sustainability of social and continuing care provision, particularly in light of the current budgetary climate and the changing demographic profile, means that increasingly scarce resources must be efficiently managed, targeted at areas of greatest need and delivered at the point of lowest complexity.

Work has commenced on the development of a commissioning framework, under the leadership of the COO, however, the detailed arrangements to apply will only be settled during 2014. At the same time, within social care, the Fair Deal scheme already encompasses many of the elements of the

Money follows the Patient approach, and work will commence in expanding this model by developing a similar approach in respect of other services in 2014, including home care and short stay residential provision for older people.

While the significant role of voluntary agencies in delivering services is acknowledged, it is clear that their role will have to evolve to meet the new approach as outlined above. In respect of the disability sector, 2014 will represent a step change in the pace of implementation of the recommendations of the *VfM Report & Policy Review*, which is intended to deliver transformational change in the model of service delivery, moving away from the traditional and often institutionally based service to a more person centred model, with a community focus. Service level arrangements will be revised and re-drawn to reflect a more rigorous emphasis on budgeting and monitoring in preparation for eventual changes to the procurement or commissioning of individual based services.

In this overall context it would be premature at this point to specify the detailed management arrangements required to support this evolving service model. The Social Care Division nationally will, in 2014, review the existing arrangements, drawing on much of the work undertaken as part of this review and elsewhere, to develop a blueprint for more appropriate management arrangements for social care. This review will be undertaken in consultation with all stakeholders in line with the Public Service Stability Agreement (Haddington Road Agreement).

The Head of Social Care will lead the management of the services and the implementation of the reforms at Community Healthcare Organisation level.

7.4.7 Health and Wellbeing Management Arrangements

Improved Health and Wellbeing is one of four pillars of reform outlined in *Future Health*. This pillar of reform demarcates a shift in policy, service design and practice away from treating sick people to keeping people healthy. This underlying principle informs many of the other reforms in *Future Health*, including service, financial and structural reforms. Many areas of the health service already successfully deliver prevention, early detection and self-care programmes, e.g. immunisation, screening and tobacco cessation support. However, leading clinicians, other healthcare professionals and healthcare managers have identified the need to redesign healthcare services and practice to improve the quality of care and to close the gap between what is known to improve outcomes, and what is practiced.

The Health and Wellbeing Division has operational responsibility for all aspects of delivery of a range of services including:

- Public Health, Child Health and Health Protection including the work of the Directors of Public Health, National Immunisation Office and the Health Protection Surveillance Centre
- Health Promotion and Improvement including the work of the Crisis Pregnancy Programme
- Environmental Health Services
- Emergency Management
- Health Intelligence
- National Screening Programmes
- Development of national service strategies and strategic commissioning frameworks for 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.

Healthy Ireland

The Department of Health is leading a new, whole-of-Government, whole-of-society, approach to health improvement, *Healthy Ireland*. The publication of *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013 - 2025* is a major milestone for the future provision of health and social care in Ireland. It provides the structure to enable service providers to influence major change in the development, implementation and delivery of health and social care for future generations. It emphasises the need for a collaborative approach between the health sector and other areas of Government and public services to work together, to affect improvements in social protection, food safety, education, housing, transport and the environment. These are the key factors which influence health and social outcomes for the entire population. Tackling health inequalities, introducing preventative health measures and health promotion activities, to be delivered in the community, were the key messages in the consultative process which informed the publication of *Healthy Ireland*. It is widely recognised that these factors are economically more prudent than costly acute care and treating increasingly costly long-term chronic diseases.

Intersectoral Collaboration

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 gardaí, 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 lead by the local operational health services – Primary Care and Community Services. This will ensure effective intersectoral engagement both nationally and locally.

A practical example of this is as follows:

In relation to local intersectoral working one of the main alignment reforms the Government has directed is the establishment of new Local Community Development Committees (LCDCs) in each county/city, to have oversight and responsibility for local development and community-related funding in their area. LCDCs will have a key function of achieving a more strategic, joined-up approach to local and community development locally. From the health service perspective locally, the CHO representation on the LCDC will be lead by the local operational health services - Primary Care / Community Services to ensure practical operational engagement at a local level.

The work of the LCDCs will also be underpinned by collaborative Departmental working at central government, to support the streamlining of local development structures, improved programme impact assessment, more targeted resource allocation and sustainable funding/administrative arrangements. In this regard that the Health and Wellbeing Division will engage with the process at the national inter-departmental level which in turn will support the with local engagement lead with LCDCs by the Primary Care / Community Services local operational system.

Reorganisation of Management Arrangements

Management arrangements within this new division are currently being established and it is the view of the project team that it is appropriate that there would be a Head of Health and Wellbeing on the Management Team of each of the Community Healthcare Organisations.

7.5 Clinical Leadership

Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver. It is built on the model of senior managers working in partnership with senior clinicians. A key characteristic of clinical governance is a culture and commitment to agreed service levels and quality of care to be provided.

Over recent years the health service has placed an important emphasis on quality and patient safety by developing an infrastructure for integrated quality, safety and risk management with the aim of achieving excellence in clinical governance.

The Quality and Patient Safety Division is building on this. Formalised governance arrangements ensure that everyone working in the health and personal social service are aware of their responsibilities, authority and accountability and work towards achieving improved patient outcomes. Effective governance recognises the inter-dependencies between corporate and clinical governance across services and integrates them to deliver high quality, safe and reliable healthcare.

Clinical governance helps ensure people receive the care they need in a safe, nurturing, open and just environment arising from corporate accountability for clinical performance. The benefit of clinical governance rests in improved patient experiences and better health outcomes in terms of quality and safety. This has resulted in the clinical governance approach being widely adopted internationally.

Clinical governance is an integral component of governance arrangements, where:

- each individual, as part of a team, knows the purpose and function of leadership and accountability for good clinical and social care;
- each individual, as part of a team, knows their responsibility, level of authority and who they are accountable to;
- each individual, as part of a team, understands how the principles of clinical governance can be applied in their diverse practice;
- a culture of trust, openness, respect and caring is evident among managers, clinicians, staff and patients;
- each individual, as part of a team, consistently demonstrates a commitment to the principles of clinical governance in decision making; and
- clinical governance is embedded within the overall corporate governance arrangement for the statutory and voluntary health and personal social services in realising improved outcomes for patients.

The Health Service has developed a suite of principles to assist in the development of good clinical governance throughout its services – these are outlined below:

- Patient First
- Safety
- Personal responsibility
- Defined authority
- Clear accountability
- Leadership
- Inter-disciplinary working
- Supporting performance
- Open culture
- Continuous quality improvement

To give effect to clinical governance and ensure that practice is developed in line with the principles set out above in a uniform manner, a framework will be embedded in each Community Healthcare Organisation with the appointment of a Lead – Quality and Professional Development, who will be a non-executive member of the Management Team. The Lead – Quality and Professional Development will be supported by a Quality and Safety, Standards and Professional Development Leadership Team comprising of lead clinicians in medicine (including GPs), nursing, therapies and also including expertise in the areas of quality and patient safety, clinical audit, advocacy and education and training and representatives of frontline service provision. The appointment of clinicians to some of these roles will be made on a rotational basis and will be representative of the various services that are provided across the Community Healthcare Organisation. The function of the Quality and Safety, Standards and Professional Development Leadership Team will be to inform the Lead – Quality and Professional Development on a range of processes required to drive effective clinical governance and which will in turn support the Management Team in terms of its overall strategy and responsibilities.

Examples of these processes include:

- Quality and Performance Indicators
- Learning and sharing information
- Patient and public community involvement
- Risk management and patient safety
- Clinical effectiveness and audit
- Staffing and staff management
- Information management
- Capacity and capability

This framework will support the delivery of a range of positive outcomes in the areas of patient care, patient experience, staff experience and service improvement.

Commissioning and Resource Allocation

A priority for the specialised community based services will be to ensure the delivery of appropriate services to the population of the Primary Care Network. This will involve new management arrangements such as memorandums of understanding or service agreements which bring clarity to the type, volume and range of services which are accessible to the network from these specialised services.

7.6 Summary

- The provision of care services in the community will be grounded in Primary Care Teams, serving an average population 7,000 – 10,000 people.
- The Primary Care Team will be supported by the Primary Care Key Worker and Primary Care Team Leader working closely with GPs and other professionals in the delivery of the maximum possible services.
- Groupings of on average five primary care teams will form a Primary Care Network, the total number of networks will be 90 approx.
- A designated Network Manager will be appointed with the responsibility of support for the provision of direct services by the Primary Care Team and ensuring the appropriate integrating linkages with both the specialist community services and the acute hospital services.
- The Community Healthcare Organisation will provide organisational support for an average of ten Networks.
- The considered view 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.
- The Management Team will be led by a Chief Officer of Community Healthcare Services and will be comprised of the Head of Primary Care and the Heads of the specialist community services i.e. Mental Health, Social Care and Health and Wellbeing, as well as the appropriate corporate and clinical support services.
- During transition, the Chief Officer will report to the relevant National Director and executive authority and accountability will be derived from the Health Service Directorate. In the long term the governance relationship can be to the Healthcare Commissioning Agency or alternative area, regional, or national structures when established.

- Achieving improved patient outcomes through ensuring robust quality and safety standards across all services will be a key focus of the Management Team and leadership at all levels.
- The Heads of individual Discipline will provide the clinical assurance and governance of practice standards throughout the services with a reinforced focus on delivering and measuring service performance on the basis of an integrated service response. The change management challenges arising in delivering services across traditional boundaries is recognised and will be the subject of specific training and reinforcement.
- 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.