

# Audit of Structures and Functions in the Health System

on behalf of the Department of Health and Children

2003



**Quality and Fairness  
A Health System for You  
Action 114**

BAILE ÁTHA CLIATH  
ARNA FHOILSIÚ AG OIFIG AN tSOLÁTHAIR  
Le ceannach díreach ón  
OIFIG DHÍOLTA FOILSEACHÁN RIALTAIS,  
TEACH SUN ALLIANCE, SRÁID THEACH LAIGHEAN, BAILE ÁTHA CLIATH 2,  
nó tríd an bpost ó  
FOILSEACHÁIN RIALTAIS, AN RANNÓG POST-TRÁCHTA,  
51 FAICHE STIABHNA, BAILE ÁTHA CLIATH 2,  
(Teil: 01 - 6476834/35/36/37; Fax: 01 - 6476843)  
nó trí aon díoltóir leabhar.

---

DUBLIN  
PUBLISHED BY THE STATIONERY OFFICE  
To be purchased directly from the  
GOVERNMENT PUBLICATIONS SALE OFFICE,  
SUN ALLIANCE HOUSE, MOLESWORTH STREET, DUBLIN 2,  
or by mail order from  
GOVERNMENT PUBLICATIONS, POSTAL TRADE SECTION,  
51 ST. STEPHEN'S GREEN, DUBLIN 2,  
(Tel: 01 - 6476834/35/36/37; Fax: 01 - 6476843)  
or through any bookseller.

---

ISBN 0-7557-1578-0

# Table of contents

	<b>Page</b>
<b>Executive summary</b>	9
<b>Part 1: Introduction</b>	
Chapter 1: Background and report overview	27
Chapter 2: Context	33
<b>Part 2: Analysis</b>	
Chapter 3: Audit of healthcare agencies	45
Chapter 4: Audit of governance and accountability arrangements	59
Chapter 5: Analysis of supporting processes	63
Chapter 6: The need for system-wide structural reform	70
<b>Part 3: Recommendations</b>	
Chapter 7: Creating a consolidated structure	77
Chapter 8: Developing supporting processes	100
Chapter 9: Strengthening governance and accountability across the system	112
Chapter 10: The reconfiguration of audited agencies in line with the consolidated structure	121
<b>Part 4: Transition</b>	
Chapter 11: Planning the Transition	133
<b>Appendices</b>	
Bound in a separate document	
<b>Appendix 1:</b> Specification of requirements for the Audit of Structures and Functions in the Health System (DoHC)	
<b>Appendix 2:</b> List of agencies audited	
<b>Appendix 3:</b> Description of major functional groupings	
<b>Appendix 4:</b> List of documentation received from agencies audited	
<b>Appendix 5:</b> List of references in main report	
<b>Appendix 6:</b> Table 1 — Relevance, Overlaps and Interdependencies: Analysis of the Individual Agencies reviewed	
<b>Appendix 7:</b> Table 2 — Governance: Analysis of the Individual Agencies reviewed	
<b>Appendix 8:</b> Analysis of International Healthcare Structural Reform	
<b>Appendix 9:</b> Overview of the major system initiatives underway	
<b>Appendix 10:</b> Details on wider public sector management reform	
<b>Appendix 11:</b> Incremental development of agencies audited	
<b>Appendix 12:</b> The Prospectus/Watson Wyatt team members	

# List of abbreviations

---

C&AG	Comptroller and Auditor General
CEO	Chief Executive Officer
DoHC	Department of Health & Children
EHSS	Eastern Health Shared Services
ERHA	Eastern Regional Health Authority
ESRI	Economic and Social Research Institute
EU	European Union
GMS Payments Board	General Medical Services Payments Board
G.P.s	General Practitioners
HeBE	Health Boards Executive
HIQA	Health Information and Quality Authority
HR	Human Resources
HRB	Health Research Board
HSE	Health Services Executive
HSEA	Health Service Employers Agency
HSNPF	Health Services National Partnership Forum
ICT	Information Communications Technology
IHSAB	Irish Health Services Accreditation Board
IR	Industrial relations
IT	Information technology
LHO	Local Health Office
MHB	Midland Health Board
MWHB	Mid-Western Health Board
NCO	National Children's Office
NEHB	North Eastern Health Board
NDP	National Development Plan
NHA	National Hospitals Agency

NHMBWG	National Health Ministers' Benchmarking Working Group
NHO	National Hospitals Office
NHS	National Health Service (UK)
NSWQB	National Social Work Qualifications Board
NSSC	National Shared Services Centre
NWHB	North Western Health Board
OD	Organisational Development
OECD	Organisation for Economic Co-operation and Development
OHM	Office for Health Management
PPARS	Payroll Personnel and Related Systems
PCTs	Primary Care Teams
PMDS	Performance Management and Development System
RHO	Regional Health Office
SEHB	South Eastern Health Board
SHB	Southern Health Board
SMI	Strategic Management Initiative
SSI	Social Services Inspectorate
SSC	Shared Services Centre
UK	United Kingdom
VFM	Value for Money
WHB	Western Health Board

# List of figures

---

	Page
<b>Figure 2.1:</b> Structural overview of the Irish health system in context	34
<b>Figure 2.2:</b> Major initiatives aimed at improving system performance	40
<b>Figure 3.1:</b> Potential overlaps between the functions of HIQA and existing agencies	49
<b>Figure 3.2:</b> Potential overlaps between the functions of the NHA and existing agencies	50
<b>Figure 7.1:</b> Overview of the principal elements of the consolidated structure	78
<b>Figure 7.2:</b> Examples of shared services and processing functions	94
<b>Figure 9.1:</b> Governance arrangements in consolidated structure	113
<b>Figure 10.1:</b> Redistribution of principal functions	123
<b>Figure 10.2:</b> Consolidated structure — revised configuration of audited agencies	130
<b>Figure 11.1:</b> High-level implementation plan for the proposed consolidated structure	137
<b>Figure 11.2:</b> Proposed National Reform Programme	139

---

# Executive Summary

---





# Executive Summary

---

## Overview

The central theme of this report is the need to consolidate fragmented structures and functions to enable the health system deliver sustained value for money and a high quality of service for consumers. The question posed at the outset of the Audit was the extent to which the structures and functions of the health system are organised to deliver on the ambitions of the health strategy *Quality and Fairness (2001)*. Our findings indicate that extensive reforms are required, that go beyond the structures in the health system, to encompass areas such as supporting processes and legislative change. As well as dealing with fragmentation there is a need to modernise the current structures and functions to lay the foundations for the future development of the system.

The purpose of the Audit is to make recommendations which will ensure clear lines of accountability between each part of the system, remove overlaps or duplication between organisations, and align the structure as a whole with the vision outlined in *Quality and Fairness*. The structures and functions should in turn build on existing strengths, release the potential for innovation and help healthcareers to achieve the maximum impact from their work. Most importantly, a better planned and managed health system should deliver measurably improved healthcare to all its patients and consumers.

### The outcomes we seek to achieve are as follows:

- Structures and functions that support the delivery of national priorities for healthcare and the implementation of *Quality and Fairness*;
- A service which combines the best of service organisation values with public sector responsibilities;
- Structures and functions that deliver real value from ongoing investment in healthcare;
- A health system that responds more effectively to the expectations of its stakeholders and achieves a much greater impact to the benefit of the consumer;
- Structures and functions that help to create a high performing health system and build on the existing talents and knowledge of staff.

The present system has been in place, largely unchanged, for over thirty years. It faces significant difficulties in coping with current levels of demand, despite a marked increase in levels of investment. Recent years have seen increasing levels of throughput, rising consumer expectations and major shifts in demographics. Among patients, staff and the general public, there is growing belief that there are more effective ways to organise our health service for the twenty-first century. This report presents a blueprint for the future development of the structures and functions of the health system.

### We propose four major reforms:

- The creation of a consolidated healthcare structure — putting in place a single national Health Services Executive (HSE) to replace the 10 existing health boards and ERHA;

- The development of supporting processes — a major strengthening of processes and capabilities to deliver value for money and manage ongoing change;
- The strengthening of governance and accountability across the system legislation — simpler governance and greater levels of accountability;
- A reorganisation of existing agencies and their functions — a reduction in the number of stand-alone agencies by over a half and direct reports to the Department of Health and Children (DoHC) by almost two-thirds.

The challenges associated with undertaking such a large-scale reform of the structures and functions of the health system are considerable. Sustained leadership from the highest levels and coordinated effort from all agencies involved will be required to effect the changes required. However, the consequences of not moving towards the new model and not tackling the overlaps and system deficiencies outlined in this report, need to be spelt out:

- To continue in the current direction of development of structures and functions will lead to even greater fragmentation of critical functions, potentially resulting in an ever increasing dilution of the cost-effectiveness, performance and manageability of healthcare services in Ireland;
- The continuation of blurred accountabilities, unwieldy governance and lack of clarity of roles will lead to a service which is less responsive to customer needs, has greater difficulty in the delivery of national strategies and finds the challenge of delivering value for money becoming increasingly onerous;
- Sustaining the current structure, or even modifying it to some degree, is inconsistent with the level of effort required to fundamentally reorganise and reform the acute sector on a national scale and prepare for the implementation of the Primary Care Strategy.

There are endless variations on the potential future model for the Irish health system and as many different views as there are interested parties. We believe that the proposed consolidated structure will position the health system to deliver the aims and objectives of *Quality and Fairness*.

## Terms of reference

The Audit of Structures and Functions in the Health System was commissioned by the DoHC in June 2002 and was conducted between July 2002 and January 2003. The primary objective of the Audit as set out in the terms of reference was:

*... to establish the organisational improvements needed to strengthen the capacity of the health system to meet the challenges of implementing the programme of development and reform set out in the Health Strategy document Quality and Fairness: A Health System for You.*

## Scope of the Audit

The list of agencies specified for inclusion in the Audit is extensive, 58 in total, covering statutory and non-statutory bodies, health boards, the Eastern Regional Health Authority (ERHA) and the statute-based hospitals (Appendix 1).

As the project developed it became apparent to the Audit team and the Steering Group that there was a need for a sense of direction around a new health system architecture in order to provide a framework for the future, as well as a context for the changes envisaged. This involved more fundamental consideration of the wider health system and the development of a shape for whole-system reform. This latter task then formed a greater part of the work programme within the fixed delivery timescale. As a consequence, under the Steering Group's direction, the depth and breath of the consultation

originally planned for was replaced by a high level consultation on a broader agenda. We address the need for an extensive and inclusive consultation process in our recommendations and implementation plan in Chapter 11.

## Audit methodology

The Audit of agencies was largely addressed through a literature-based review of relevant legislation, policy documents and other corporate reports, e.g. annual reports and strategy statements. This approach was specified in the scoping of the project by the DoHC. Each agency was requested to submit relevant material to the Department so as to facilitate the analysis. This Audit is based on the information received from the agencies involved.

A second strand of analysis was based on a review of previous published commentary on the health system and our experience in the sector. This existing material, in line with the project brief, also supported an examination of governance and accountability arrangements. The final strand of analysis related to an assessment of the capacity of supporting processes in the system. This assessment is based on international best practice data, advice from our international advisory group, our own system knowledge and the views expressed by participants in high-level consultation sessions or in direct representations. The Audit did not seek to review the performance of the individual agencies.

## Scale and complex nature of the Irish health system

In terms of scale, the Irish health system currently accounts for approximately 23% (2003) of total Government funding. This has grown from €3.6 billion in 1997 to a projected €9.2 billion in 2003. The sector is the largest public service employer in the State, with an approved employment ceiling of 96,000<sup>1</sup> employees at the end of 2002, as opposed to 68,000 in 1997. The range of services provided by the health system — from health promotion and disease prevention to acute hospital treatment, and a wide spectrum of social and community services — is particularly broad by international standards. A total of 968,000 people were treated last year as either inpatients or day patients in acute hospitals. Since 1997 the number of patients treated in our acute hospitals has increased by almost a quarter. General practice consultations are estimated at approximately 16 million annually.

The complex nature of healthcare, together with rising consumer expectations, makes it difficult to demonstrate real progress. It is important to recognise the commitment of staff in the delivery of services despite difficulties encountered. The lack of structural reform to match the increased investment levels has constrained the ability of the system to deliver value for money. These factors, together with the desire of all stakeholders to improve the effectiveness of the healthcare system, have led to work being undertaken on a number of fronts which need to be considered together.

## Major system initiatives currently underway

There are a number of other important initiatives underway designed to improve system performance or to address specific service or operational matters. Many of these are not yet finalised. However, the outcomes and the timing of their implementation will have immediate relevance to the successful implementation of *Quality and Fairness*. In many cases, they will also relate directly to organisational structures and functions in the health system. Our challenge is to align our main areas for change with the recommendations of the parallel initiatives.

While these and other initiatives aim to address critical system requirements, there is a significant risk that an incremental response to putting in place the structural and functional supports for their respective recommendations will exacerbate, rather than improve, the complex nature of today's system. This Audit, therefore, needs to take such parallel initiatives into account. Moreover, the future structures need to be based on a defined set of priorities and build on improvements to date.

---

<sup>1</sup> Excludes home help

## Audit findings

### Healthcare agencies (Chapter 3)

- **Complex and fragmented structures — an obstacle to achieving improvements**
  1. The increase in the number of individual agencies creates a number of challenges in managing and resourcing the system
  2. The development of parallel structures has added to the complexity and fragmentation of both policy-making and implementation
  3. The continued involvement of the DoHC in operational matters reduces clarity around organisational accountability
  4. There are a number of difficulties in managing the scope of healthcare services
  5. The existence of the health boards alongside the ERHA model complicates the interface with the DoHC
  6. The legislative framework for the ERHA creates operational difficulties
  7. The functions assigned to specialist agencies overlap with other bodies
  8. The proposed new national agencies have system-wide implications for both structures and functions
- **Scope for the rationalisation of certain agencies**
  9. A number of service delivery agencies can be mainstreamed or merged
  10. There is evidence of a drive to rationalise the number of professional regulatory and training bodies within other national health systems
  11. There is a clear rationale for relocating the functions of Comhairle na nOspidéal in the National Hospitals Office
- **Need for standardisation and coordination across the system**
  12. The traditional health board model evolved over the years in an unstructured manner and has resulted in insufficient coordination and standardisation
  13. There is no single strategic HR function to coordinate or lead system-wide activities
  14. There is a lack of standardisation in the structures and functions supporting professional registration, regulation and development
  15. There is a need for centralised and standard approaches in relation to quality assurance functions
  16. Challenges remain in coordinating the national health Research and Development agenda and in making health research available to policy-makers and service deliverers
  17. System-wide health information coordination is inadequate
- **Underdeveloped system functions in a number of areas**
  18. Shared services are underdeveloped in the health sector
  19. The planned expansion in the number of regulated professions requires a coordinated approach

## Governance and accountability (Chapter 4)

20. Boundaries of accountability are not always clearly defined
21. Accountability for non-financial performance is not clearly embedded in legislation
22. Basis for Board appointments needs clarification
23. There is inconsistency between leading practice guidelines and current Board size
24. There is inadequate evaluation of Board performance
25. There is a lack of consistency in legislative requirements for formal reporting or production of strategic plans
26. Tensions between local representation, decision-making and the delivery of national and regional strategic objectives hinder decision-making
27. A set of guidelines is required for governance and accountability in the health system
28. The development of clinical governance mechanisms is required

## Supporting processes (Chapter 5)

29. Service planning at national, regional and local level needs to be strengthened and aligned to new structures
30. There is a lack of alignment of resource allocation with planning cycles
31. Service evaluation needs further development and better definition
32. Service evaluation needs to become an integral part of overall health planning
33. There is an absence of a consistent focus on the consumer
34. Stakeholder participation needs clearer focus at each level in the system
35. Poor integration of services is a recurring theme
36. There are many non-structural factors which contribute to poor integration
37. There is a need to strengthen capability to manage and lead significant change
38. A formal performance management framework to link individual and team performance to strategic objectives is required

## The need for system-wide structural reform

An important structural problem is evident in the way in which agencies have been established as a 'part-solution' rather than a more radical 'full-solution' which would address the interrelated nature of the system. This often leads to a dilution of the effectiveness of system critical functions, hidden and poorly used pockets of expertise and an inappropriate location of functions. Our findings reflect the need for comprehensive structural reform.

In our view, a fundamental shift in thinking is required which moves from fragmentation to consolidation and integration. It is necessary therefore to develop a broader vision for the future shape of the health system, through the development of a consolidated structure. This vision is about defining the structural direction for the next critical phase of the development of our health services. It will provide a framework for the continuing development of the service on a more coherent basis.

## Priorities to be addressed by a consolidated structure

In our consultations with the Minister for Health and Children, the Audit Steering Group, the DoHC and representatives of a variety of stakeholders in response to our initial findings, the following priorities to be addressed by future structures emerged:

- **Ensure clear accountability lines throughout the system**

Clear accountability lines will be critical to drive performance and to establish a more streamlined and focused system within which healthcare staff can deliver improved service levels.

- **Provide a national focus for integrating service delivery**

National integration should facilitate effective decision-making at specific points in the system and should allow for national management of resources.

- **Allow the Primary Care model to develop and grow**

The Primary Care Strategy has emerged as an important building block in the drive to shift the balance from care to prevention. This objective is in its infancy and a mechanism is required to allow this model to grow.

- **Develop structures to facilitate the reconfiguration of the hospital system**

Despite its critical contribution to the health service as a whole, there is as yet no formal policy for the acute sector. This combined with the need to deliver significant extra capacity, while simultaneously reorganising to ensure quality and safety for patients, means the hospital service in itself requires a sustained and formal programme of reform over the coming years.

- **Support continuous quality improvement and increased external appraisal**

There is a need for more external and authoritative appraisal of all aspects of health system performance. This external perspective then has to be fed into internal funding decisions and performance standards. It is most important that the correct balance is struck between external checking and internal continuous quality improvement approaches, which deliver effective and sustained results. Common quality standards are required to ensure that leading practice is diffused equally throughout the service and that evaluation is objective and consistent, whenever the user comes in contact within the system.

- **Put in place robust information gathering and analysis capability**

Quality standard-setting, measurement and evaluation is inextricably linked with information collation and its analysis. Developing information gathering and analysis capacity in the system is vital to both of these processes.

- **Consolidate the current system to make it more manageable**

- **Tightly-managed vertical integration**

To assist coordination of activities there is a need to develop local structures, close enough to the customer so as to provide a responsive, patient-centred service which is supported by strong policy guidance and executive oversight functions.

- **Avoiding a one-dimensional approach**

Care must be taken that a one-dimensional approach to developing the system is not adopted, such as simply creating another new agency without regard to the wider structural impact.

- **Strong leadership**

Implementation of the system priorities together with the structural changes specified in this report will demand conviction and a real determination to make critical choices and engage in real reform. Leadership

must be clear, firm and sustained. Taking a less difficult route may ultimately dilute the desired result and perpetuate the fragmentation of critical functions.

- **Preserve and build on the strengths of the current architecture**

In terms of people management and leadership development, the reform approach should also reinforce and build on the efforts to date in creating a more transformational and participative working culture in the health services.

These priorities are strongly supported by our Audit findings. They established the need and rationale for moving to a consolidated structure. They also point to the main benefits which will accrue as a result of the reforms proposed.

## Proposals for reform

### Reform Proposal 1: Create a consolidated healthcare structure

#### **Recommendation 1.1: Establish a separate national HSE and restructure the DoHC**

Actions:

- Establish a HSE on a statutory basis as a corporate body with a governing Board;
- Transfer all executive functions from the DoHC to the HSE;
- Make legislative provisions to remove existing health board and ERHA governance structures, with these functions being assigned to the HSE;
- Develop legislation to ensure accountability by the Board of the HSE for the delivery of health and social services;
- Legislate to give the HSE employing authority;
- Restructure the DoHC and reskill staff to support its role in the consolidated model.

#### **Recommendation 1.2: Create two service pillars within the HSE consisting of:**

- **Acute sector, overseen by the National Hospitals Office (NHO)**
- **Primary, Community and Continuing care**

Actions:

- Establish two service pillars within the HSE;
- Provide for the National Hospitals Office within the corporate structure of the HSE;
- Organise all publicly-funded hospital services under the NHO;
- Develop enabling legislation to ensure accountability to the NHO for the reconfiguration of the hospital system, as well as accountability and funding arrangements for the acute services ongoing.

#### **Recommendation 1.3: Put in place four regional management structures and build on the existing community care structures at local level**

Actions:

- Establish a network of 4 Regional Health Offices, supported by the existing Community Care Area structures (Local Health Offices), to deliver primary, continuing, community and other non-acute services;
- Ensure existing community care structures have the capacity and support to undertake appropriate service planning, budgetary and decision-making roles;
- Establish a standard range of services and facilities for each Local Health Office.

**Recommendation 1.4: Develop a National Shared Services Centre (NSSC) within the HSE**

## Actions:

- Establish the National Shared Services Centre with a remit for the provision of corporate services to the HSE and the NHO, and the provision of shared services across the wider health system;
- Develop enabling legislation to require all publicly-funded health agencies to participate in shared services arrangements.

**Recommendation 1.5: Strengthen quality assurance and information through the establishment of the Health Information and Quality Authority (HIQA)**

## Actions:

- Establish HIQA as a matter of urgency in line with recommendations in *Quality and Fairness*;
- Task HIQA with the preparation and publication of an annual report on the performance of the health system overall against key quality indicators.

**Recommendation 1.6: Develop structural mechanisms to increase consumer involvement in decision-making and service delivery**

## Actions:

- Extend the remit of the National Consultative Forum;
- Develop democratic input at regional level;
- Build on local consumer panels and other forms of consultation in each Local Health Office area.

The consolidated structure is built on four elements:

**Strong accountability, prioritisation and direction**

- Setting clear priorities for the system overall
- Holding the delivery system to account
- Strategic planning on a system-wide basis
- Driving system-wide reform

**Centralised performance management and control**

- Implementation of national public health priorities
- Management of the delivery of integrated healthcare
- Service performance and VFM

**Coordinated regional delivery**

- Matching services to identified needs within an overall national plan
- Delivery of integrated services within regions

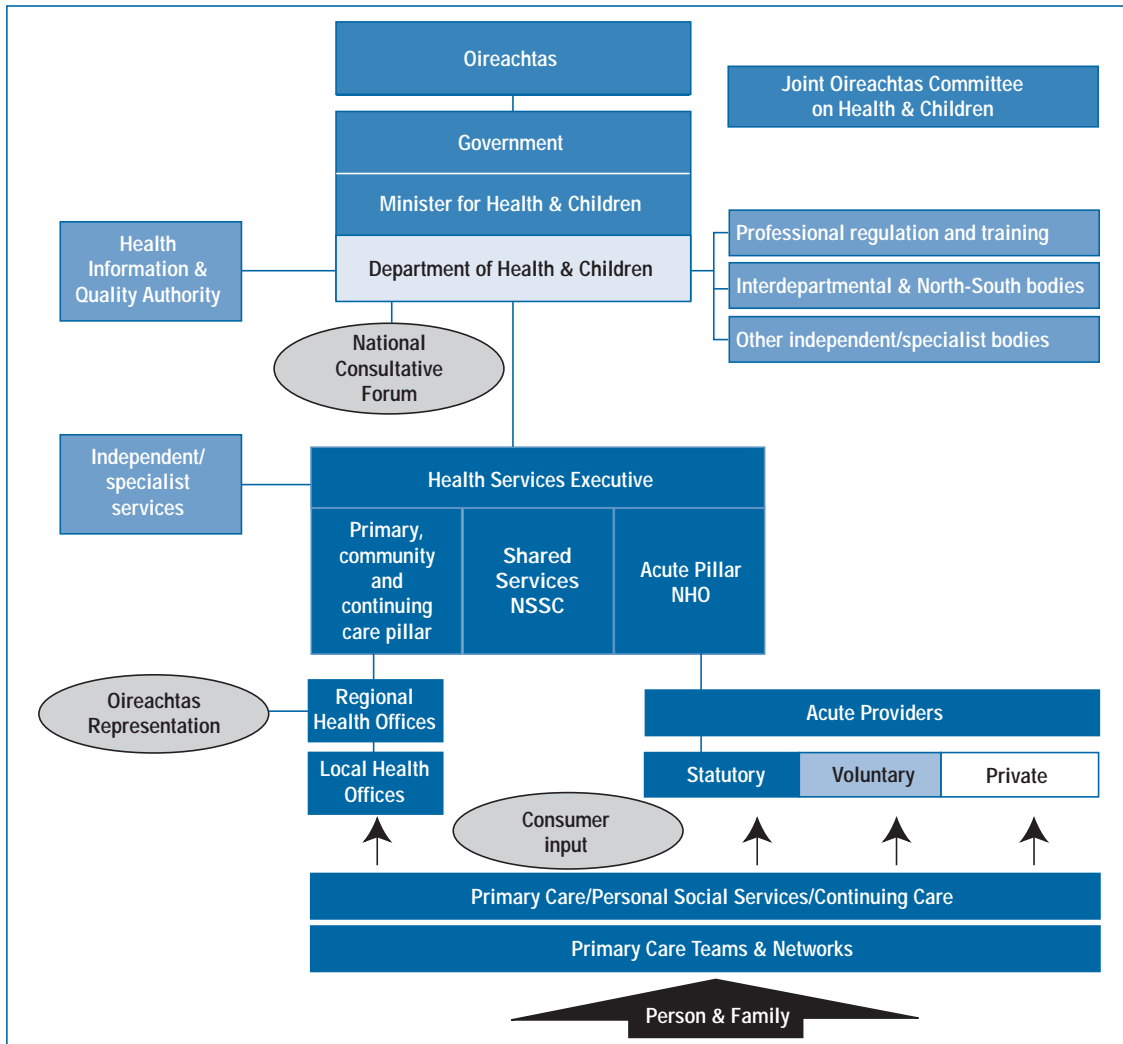
**Patient-centred local services**

- Provision of patient-responsive services customised to local need
- Stakeholder participation
- Integration with wider social and public services



The figure below outlines the key components of the consolidated structure.

Overview of principal elements of the consolidated structure



## **Reform Proposal 2: Strengthen the functioning of the consolidated structure through the development of supporting processes**

### **Recommendation 2.1: Develop strong service planning and funding processes**

Actions:

- Establish processes for the development of a National Service Plan and assign responsibility to the HSE;
- Assign responsibility to the NHO for the development of a service plan for acute services to form part of the National Service Plan;
- Assign responsibility to the RHOs for the development of a service plan for primary, community, continuing and other non-acute services.

### **Recommendation 2.2: Establish strong links between service delivery and evaluation**

Actions:

- Task the DoHC with setting out the framework for performance management of the service as a whole;
- Assign responsibility to the CEO of the HSE for the delivery of the National Service Plan within budget;
- Devolve budgetary responsibility for primary, community and continuing care services to Directors of Regional Health Offices.

### **Recommendation 2.3: Put in place enablers to support integration**

Actions:

- Ensure that the development of supporting processes and infrastructure is designed to promote integration between services;
- Ensure that service planning at all levels supports identification and development of integrated services;
- Ensure that integration with service partners is included as a key standard in the Health Services Accreditation Programme;
- Develop processes and protocols as part of the Primary Care model to ensure leading practice in patient referrals between acute and non-acute services.

### **Recommendation 2.4: Enhance system capability and performance**

Actions:

- Assign responsibility to the strategic HR function of the HSE for the development of leadership capacity, management development, HR effectiveness and organisation development across the health sector;
- Build a revised leadership model and audit existing leadership and change capability within the system;
- Expand the personal development planning process to facilitate stronger role clarity, performance planning and communications between managers and employees;
- Develop an employee engagement process including communications processes as well as national and local partnership structures;
- Conduct an audit of the critical skills and competencies required to deliver system capability and performance and ensure that these are in place within the system;
- Implement a system-wide performance management framework;
- Expand and accelerate the Clinicians in Management programme.

### Reform Proposal 3: Strengthen governance and accountability across the system

#### Recommendation 3.1: Clarify and implement governance and accountability arrangements to support the consolidated structure

Actions:

- DoHC to ensure oversight of governance arrangements and compliance with governance standards of all statutory agencies;
- Establish a Board for the national HSE;
- Revise the Consultant Common Contract to ensure effective accountability for resources used;
- Strengthen the framework for clinical governance.

#### Recommendation 3.2: Develop and implement a set of guidelines for governance and accountability for all health and social service agencies

Actions:

- Assign responsibility to the DoHC to take a lead role in developing a set of governance and accountability guidelines;
- Implement governance guidelines throughout the system.

### Reform Proposal 4: Reorganise existing agencies and their functions in line with the consolidated structure

#### Recommendation 4.1: Significantly reduce the current number of agencies

Actions:

- Mainstream<sup>2</sup> the functions of 27 agencies into the new consolidated structure (establishing sunset clauses<sup>3</sup> where appropriate);
- Merge the structures and functions of 5 agencies.

#### Recommendation 4.2: Change the accountability and funding arrangements for 9 agencies

Action:

- Transfer the accountability and funding arrangements of 9 agencies from the DoHC.

#### Recommendation 4.3: Strengthen and develop a number of agencies

Actions:

- Strengthen and develop 2 agencies to expand their remit and accountability;

<sup>2</sup> Note: The term mainstreaming, as used in this report, indicates the relocation of functions and structures within conventional responsibility and reporting lines for policy and execution (Department of Health and Children, HSE and its offices or HIQA)

<sup>3</sup> Note: The term sunset clause is used to refer to an arrangement whereby the lifespan of an agency is linked to the achievement of specified objectives or a given time span

- Expand the remit of the proposed Health and Social Care Professionals Council to support greater standardisation and cooperation between professions;
- Make changes to proposed governance arrangements of individual agencies.

#### Recommendation 4.4: Retain the structures and functions of 11 agencies

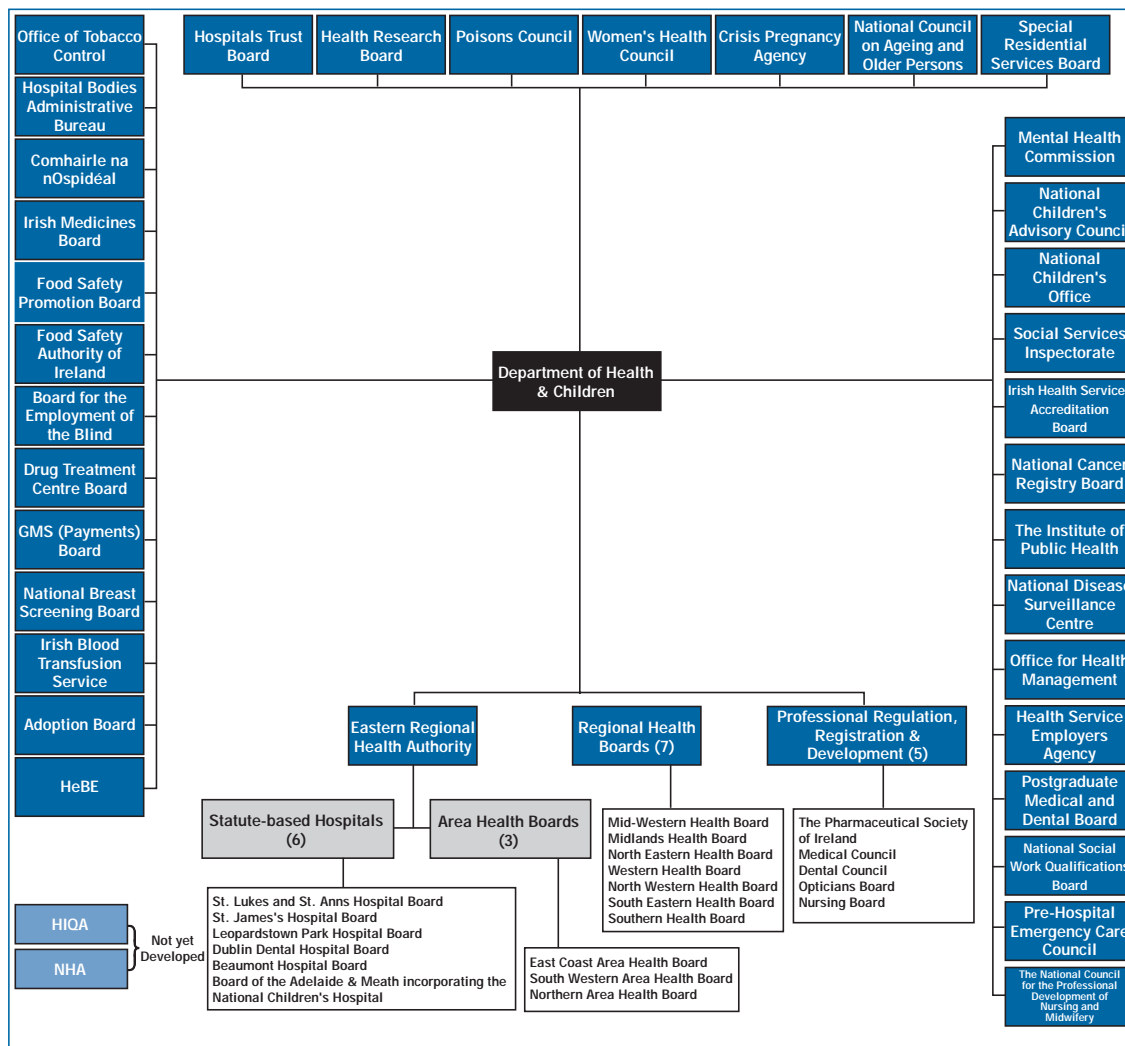
### Summary of combined net effect of reorganisation of agencies

The proposed reconfiguration of agencies and redistribution of functions as outlined above should greatly enhance the manageability of the overall system:

- The overall reduction in the current number of agencies audited will be from 58 to 26 agencies;
- This number will increase to 27 with the establishment of the HSE;
- The number of audited agencies reporting directly to the DoHC will reduce from 49 to 19.

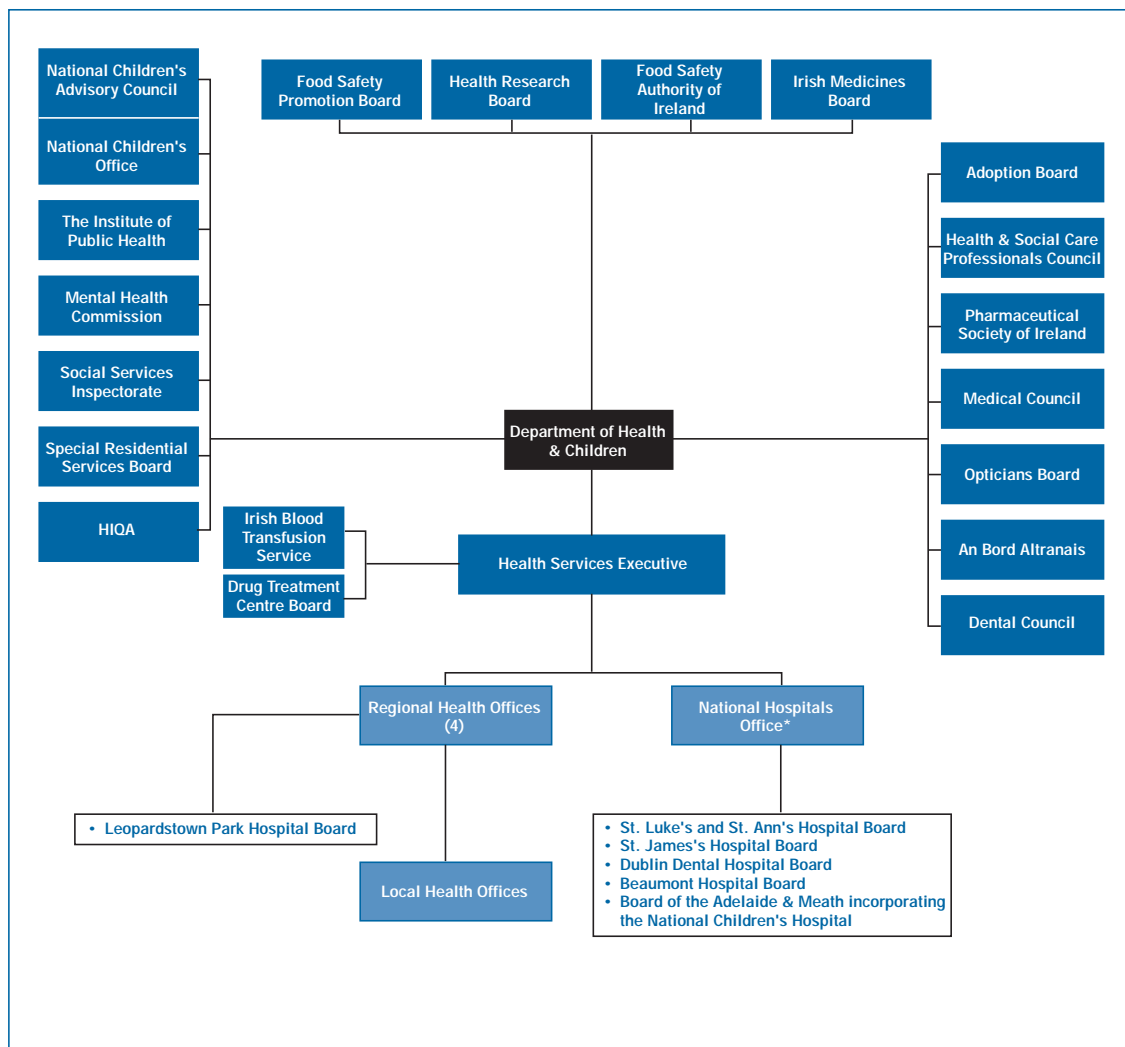
The current configuration of agencies is summarised in the figure below:

Current configuration of audited agencies



The figure below illustrates the revised system map resulting from the proposed changes. (It details only the agencies included within the Audit).

*Consolidated structure — revised configuration of audited agencies*



\*Audited agencies only — The hospital pillar (under the NHO) will include existing health board and voluntary acute hospitals.

## Managing the transition

Implementing the consolidated structure involves delivering change on an unprecedented large scale. It is essential that the changes recommended in this Audit are integrated with other current initiatives including medical workforce reforms for the acute sector, the primary care strategy and the recommendations on the reform of financial controls. All these elements need to be coordinated and planned for in an integrated manner.

Existing leaders and managers in the health system will have a major role in achieving the required transition. Securing the early support of leaders throughout the health system will be critical for this programme of change to be accepted and implemented and to maintain performance levels during the period of change.

We envisage three strands in the transition:

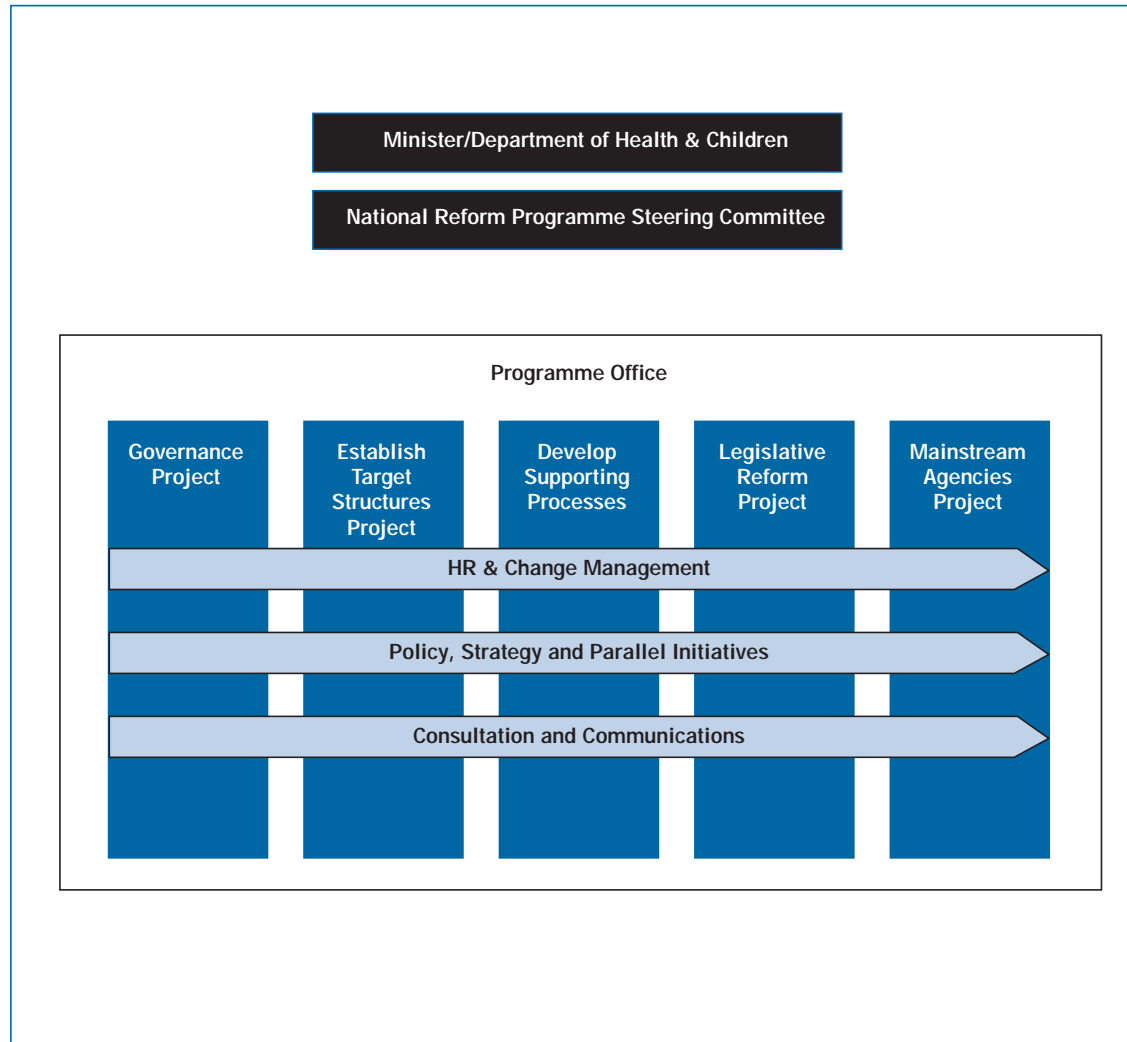
## Strand 1: Communication and consultation

The first step in implementing the proposed structure needs to be the planning and implementation of an extensive programme of communication and dialogue with key stakeholders, to commence in conjunction with the publication of this report.

## Strand 2: Establish a National Reform Programme

The figure below illustrates the major projects and the cross-project support areas.

*Proposed National Reform Programme*



### Strand 3: Implement the proposed consolidated structure

There are a number of distinct but inter-related activities involved in implementing the proposed consolidated structure:

- Developing and implementing the governance framework;
- Establishing the consolidated structure;
- Developing supporting processes;
- Developing and addressing the legislative programme;
- Mainstreaming existing agencies.

One of the first areas for attention in the implementation plan will be to conduct a thorough financial appraisal of the reforms proposed with a view to balancing the up-front investment with the longer term benefits.

We believe that a coordinated modernisation programme which encapsulates a wider reform agenda covering structures, processes, information, governance and legislative/policy reforms has real potential to deliver longer term financial benefits which should offset the initial investment required. Benefits associated with the reform programme should include improved HR management, shared services efficiencies, reductions in health boards overheads and the sale of surplus assets. Costs associated with putting the new structures in place include the establishment of the HSE and its offices (National Hospitals Office; National Shared Services Centre; Regional Health Offices). Implementation should look for synergies between the necessary investment and the support that will be required in any event for other large-scale initiatives. These would include the roll-out of the *Action Plan for People Management* and implementing the major ICT programmes envisaged under the *National Health Information Strategy*

There are two additional actions which would strongly support our proposals for reform:

- Clarification of eligibility and entitlement legislation which sets out the citizen's rights to access services and ensures consistency in the interpretation of legislation and regulations;
- Investment in information technology will form the backbone for integration of services and for capitalising on the potential of HIQA.

### Conclusion

The recommendations presented in this report address many of the underlying difficulties experienced by health professionals in carrying out their work. The reorganised structures and functions must, at a minimum, support all those working in the health system to do their work more effectively. The overall purpose of the reforms proposed is not simply to reduce the number of agencies or to deal with any single issue in isolation. Fundamentally, it is about reducing overall fragmentation of effort, thereby creating real opportunities to release the potential of healthcare workers to deliver enhanced quality services to consumers and value for money to taxpayers.





---

# Part 1

## Introduction

---



## Chapter 1

# Background and Report Overview

---

The Audit of Structures and Functions in the Health System was commissioned by the DoHC in March 2002. It was conducted between July and December 2002. The commissioning of the Audit arose from the National Health Strategy *Quality and Fairness — A Health System for You* which identified organisational development as a key driver in delivering an improved health system. The purpose of the Audit was to make recommendations which would ensure clear lines of accountability and communication between each part of the system, no overlap or duplication between organisations, and a proper alignment of the structure as a whole with the vision and objectives outlined in the Strategy.

This should in turn build on existing strengths, release the potential for innovation in the system and help health carers to achieve the maximum impact from their work. Most importantly, a better planned and managed health system should deliver measurably improved healthcare to all its patients and consumers.

### 1.1 Specification of requirements

The primary objective of the Audit as set out in the specification of requirements (see Appendix 1) was:

*... to establish the organisational improvements needed to strengthen the capacity of the health system to meet the challenges of implementing the programme of development and reform set out in the Health Strategy document Quality and Fairness: A Health System for You.*

The purpose of the project was to determine whether or not the structures in the health system:

- *Are the most appropriate and responsive to meet current and future needs;*
- *Constitute an adequate framework for overall governance of the health system;*
- *Achieve an effective integration of services across all parts of the system;*
- *Adequately represent the views of consumers in the planning and delivery of services;*
- *Focus sufficiently upon the principles of equity, accountability, quality and people-centredness and the national goals of the Health Strategy;*

and to recommend any changes believed to be necessary as a result of the analysis, including an implementation strategy for any changes proposed.

### 1.2 Scope of the Audit

#### 1.2.1 Initial scope

---

The final list of agencies specified for inclusion in the audit is extensive, 58 in total, covering statutory and non-statutory bodies, health boards, the Eastern Regional Health Authority and the statute-based Hospitals (Appendix 2).

The Audit critically examined:

- The number and configuration of existing health organisations (as outlined in Appendix 2);

- Their interactions with one another and with the DoHC;
- The adequacy of governance arrangements;
- The scope for rationalisation.

### 1.2.2 Evolved scope

---

In addition to the bodies included in the original scope, there are many other bodies that play a direct or indirect role in the health system which are not within the direct scope of this review. The most notable of these were the DoHC itself and the major voluntary providers in the acute and non-acute sectors. While the structures and functions of these other agencies were not audited as part of this exercise, they were considered when recommending a future structure for the overall system. It is important that our broader recommendations in the later part of the report take into account all agencies which play a pivotal role in our health system.

In relation to the DoHC specifically, it became clear in the course of the project that significant restructuring of the Department was an intrinsic part of any significant reform and this has been factored into our analysis and recommendations.

As the project developed it became apparent to the Audit team and the Steering Group that there was a need for a sense of direction around a new health system architecture in order to provide a framework for the future, as well as a context for the changes envisaged. This involved more fundamental consideration of the wider health system and the development of a shape for whole-system reform. This latter task then formed a greater part of the work programme within the fixed delivery timescale. As a consequence, under the Steering Group's direction, the depth and breath of the consultation originally planned for was replaced by a high level consultation on a broader agenda. We address the need for an extensive and inclusive consultation process in our recommendations and implementation plan in Chapter 11.

## 1.3 Method of work

### 1.3.1 Project structure

---

Prospectus led the Audit and carried out the project in conjunction with their partners, Watson Wyatt Worldwide. They were assisted in the Audit by a liaison team from within the DoHC, and a Steering Group. They were also supported by an international advisory group consisting of healthcare practitioners and experts from the UK, Canada and Australia.

#### Steering Group

A Steering Group was established to provide guidance and feedback to the Prospectus team. Throughout the Audit, regular meetings were held with the Steering Group. These involved:

- Working sessions in which the Group conducted joint analysis of key issues and provided overall direction to the Prospectus team;
- Review meetings in which the Group provided detailed feedback and signed off on outputs from the process, including the final report.

The Steering Group was chaired by Michael Kelly, Secretary General of the DoHC. The other members of the Steering Group were:

- Frank Ahern, DoHC;
- Elizabeth Canavan, DoHC;

- Frank Cunneen, Irish Business and Employers Confederation;
- Denis Doherty, Health Boards Executive;
- Deirdre Gillane, Adviser to the Minister for Health and Children;
- Eileen Keogh, DoHC<sup>4</sup>;
- Michael Lyons, Eastern Regional Health Authority;
- Joe Mooney, Department of Finance;
- John Murray, University of Dublin, Trinity College;
- John O'Brien, St James's Hospital;
- Michael Scanlon, Department of Finance<sup>5</sup>.

### **DoHC liaison team**

The Department designated a liaison team, headed by Frank Ahern, Assistant Secretary, to arrange for clarification on issues within the Department's remit. Prospectus maintained an on-going reporting relationship with the liaison officer and his team concerning progress on this project. The liaison team also acted as a sounding board for the Audit team in developing its findings and recommendations.

Prospectus would like to take the opportunity to record its appreciation of the considerable commitment and time afforded by both the Departmental liaison team and the Steering Group to the project. Both provided an invaluable source of ongoing advice and expertise throughout the Audit. In addition we would like to record our thanks to all of those who participated so generously in the consultation process.

### **1.3.2 Methodology**

---

The Audit of agencies was largely addressed through a literature-based review of the relevant legislation, policy documents and other corporate reports, e.g. annual reports, strategy statements. This approach was specified in the DoHC's scoping of the project. Each agency was requested to submit relevant material to the Department to facilitate the analysis. This Audit is based on the information received from the agencies involved.

For the purpose of this report the term 'agency' is used to refer to any body or entity included in the Audit Schedule. It does not imply that they have a statutory basis.

On examining the 58 agencies included in the remit of the Audit, a number of major functions were identified:

- Development and implementation of national strategies and policies;
- National advisory and coordinating functions;
- Service planning and delivery (including finance);
- Shared/joint services;
- System-wide HR;
- Professional registration, regulation and development;

---

<sup>4</sup> Attended four Steering Group meetings in the absence of E Canavan

<sup>5</sup> Attended one Steering Group meeting in absence of J Mooney

- Monitoring and inspection (including quality assurance);
- Research and development;
- Health information.

Agencies were classified under each function on the basis of information supplied by them or set out in their terms of establishment. In certain cases, it was unclear whether or not an agency had a primary function. To avoid arbitrary or misleading assignment of primary functions, some agencies appear in our analysis in more than one functional area. A detailed analysis of agency functions, including overlaps, interdependencies and inter-relationships was carried out. See Appendix 3 for descriptions of major functional groupings.

A second strand of analysis was based on a review of previous published commentary on the health system and our experience in the sector. This existing material, in line with the project brief, also supported an examination of governance and accountability arrangements.

The Audit did not seek to review the performance of the individual agencies.

The final strand of analysis related to an assessment of the capacity of supporting processes in the system. This assessment is based on international best practice data, advice from our international advisory group, our own system knowledge and the views expressed by participants in high-level consultation sessions or in direct representations.

Based on the overall conclusions from the Audit and the need to deliver on a number of priorities for the health system in the longer term, we concluded that there was a need to consider system-wide reform. It was judged important to ensure that improvements to the overall structure of the system, as well as improvements to individual agencies and functions, be made in a broader strategic context. It was agreed with the Steering Group that we should advance proposals for a future organisational direction for the Irish health system. Therefore, the development of the Audit recommendations for change were focused on:

- (i) Achieving system-wide structural reform;
- (ii) Improving overall system functioning capacity and governance;
- (iii) Ensuring the most appropriate distribution and location of functions within the system.

## 1.4 The structure of this report

To assist the reader's overall navigation through this report, the following structure is used:

### Part 1: Introduction

#### Chapter 1: Background and report overview

Chapter 1 describes the background to the commissioning of the Audit. It outlines the terms of reference, the scope of the project and the method of work employed during the project.

#### Chapter 2: Context

Chapter 2 provides contextual information on the structures and functions of the health system. It outlines the changes in structures and system functioning in recent years. It considers briefly other relevant reviews of the health system. It also refers to inter-related reports/reviews of the health system which are pending at the time of drafting of this report.

## Part 2: Analysis

### Chapter 3: **Audit of healthcare agencies**

Chapter 3 outlines the findings from the detailed analysis of agencies, including an overview of system-wide findings and the findings in relation to individual agencies.

### Chapter 4: **Audit of governance and accountability arrangements**

Chapter 4 outlines findings in relation to governance and accountability. These findings are based on the detailed analysis included in Appendix 4 which benchmarked current arrangements against leading practice.

### Chapter 5: **Analysis of supporting processes**

Chapter 5 contains analysis of the capacity of supporting processes. A variety of sources were used to develop these findings. These included views expressed by participants in consultation sessions (including both the Steering Group and individuals of agencies audited) and our own experience and knowledge of the healthcare system.

### Chapter 6: **The need for system-wide structural reform**

Chapter 6 outlines the need for system-wide reform which forms the basis of our recommendations in part 3.

## Part 3: Recommendations

### Chapter 7: **Creating a consolidated structure**

Chapter 7 describes a future model for the health system. The model is based on the need for system-wide reform and other emerging priorities identified in the analysis in Parts 1 and 2.

### Chapter 8: **Developing supporting processes**

Chapter 8 makes recommendations in relation to the development and strengthening of supporting processes to ensure that the system has the capacity to respond to the change agenda expressed in both *Quality and Fairness* and this report.

### Chapter 9: **Strengthening governance and accountability across the system**

Chapter 9 describes principles of best practice governance and makes recommendations in relation to the improvement of existing governance arrangements and the development of a framework for governance in the system.

### Chapter 10: **The reconfiguration of audited agencies in line with the consolidated structure**

Chapter 10 makes recommendations regarding the reconfiguration of existing agencies and functions within the new model for the health system set out in Chapter 7.

## Part 4: Transition

### Chapter 11: Planning the transition

Chapter 11 describes the impact of change of this scale and outlines an approach to transitional planning in order to successfully effect the recommendations contained in this report. This Chapter also contains indicative information on the financial implications of the changes proposed.

Given the large numbers of agencies involved and the nature of the analysis, much of the detail is contained in the Appendices:

<b>Appendix 1:</b>	Specification of requirements for the Audit of Structures and Functions in the Health System (DoHC)
<b>Appendix 2:</b>	List of agencies audited
<b>Appendix 3:</b>	Description of major functional groupings
<b>Appendix 4:</b>	List of documentation received from agencies audited
<b>Appendix 5:</b>	List of references in main report
<b>Appendix 6:</b>	Table 1 — Relevance, Overlaps and Interdependencies: Analysis of the Individual Agencies reviewed
<b>Appendix 7:</b>	Table 2 — Governance: Analysis of the Individual Agencies reviewed
<b>Appendix 8:</b>	Analysis of International Healthcare Structural Reform
<b>Appendix 9:</b>	Overview of the major system initiatives underway
<b>Appendix 10:</b>	Details on wider public sector management reform
<b>Appendix 11:</b>	Incremental development of agencies audited
<b>Appendix 12:</b>	The Prospectus/Watson Wyatt team members



## Chapter 2

# Context

---

To give context to this Audit, an understanding is required of a number of elements which impact directly on the current system and the design of future structures and functions.

- The health system — structures, scale, evolution
- The growing complexity of health service delivery
- Previous reviews of the current structures
- Recent developments in system functioning
- Service delivery developments
- Other major system initiatives

## 2.1 The health system

### 2.1.1 Structures

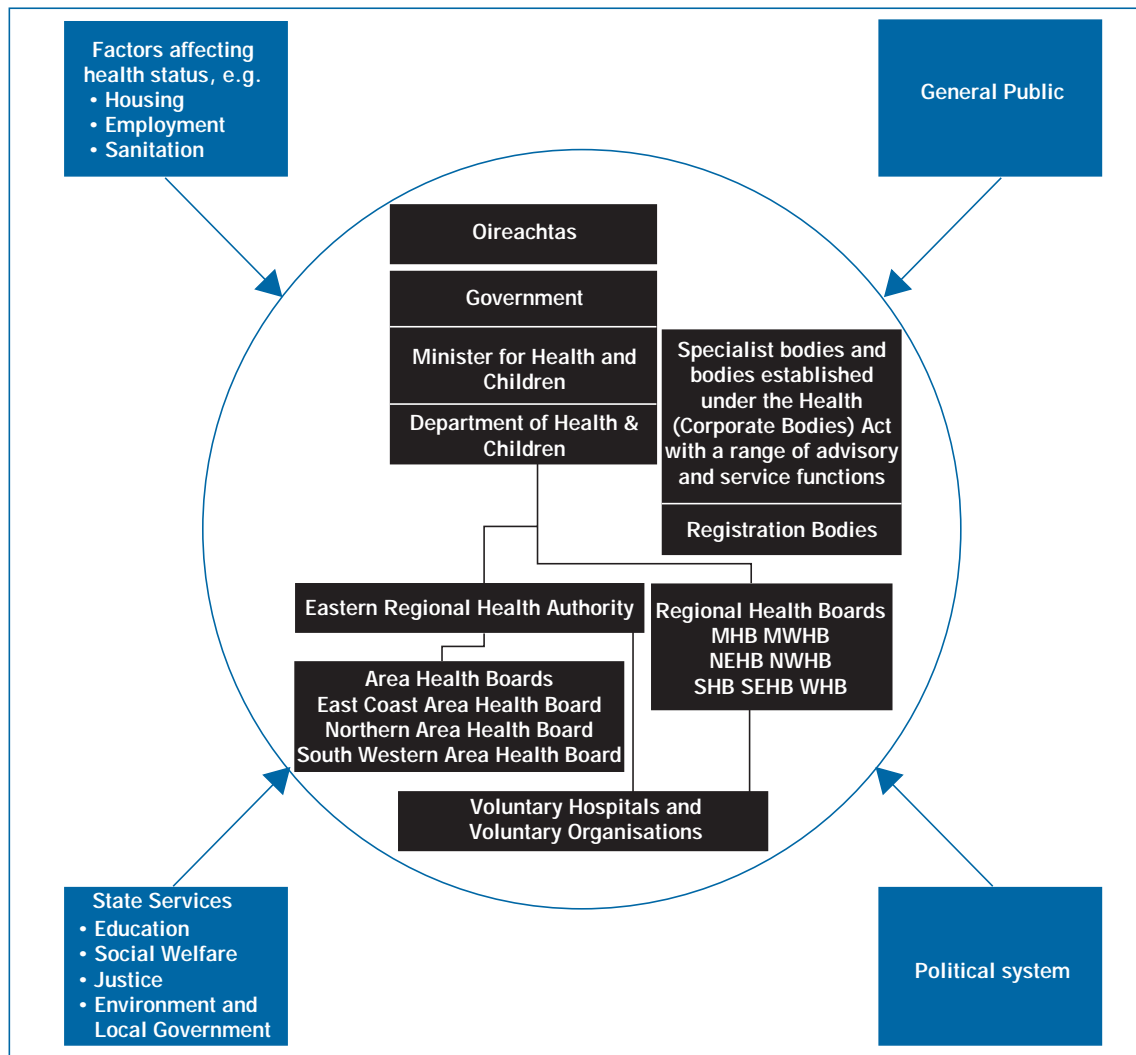
---

The major structures in the Irish health system remain largely recognisable as those set up over thirty years ago with the 1970 Health Act and the establishment of the health boards. The Government, the Minister for Health and Children and the Department are at the head of health service provision in Ireland. The Department's primary role is to support the Minister in the formulation and evaluation of policies for the health services. It also has a role in the strategic planning of health services in consultation with health boards, the voluntary sector, other Government departments and other interests. The Department has a leadership role in areas such as equity, quality, accountability and value for money.

The health boards, established under the Health Act, 1970, are the statutory bodies responsible for the delivery of health and personal social services in their functional areas. They are also the main providers of health and personal social care at regional level. Health boards are composed of elected local representatives, ministerial nominees and representatives of health professions employed by the board. Each health board has a Chief Executive Officer (CEO) who has responsibility for day-to-day administration and is answerable to the Board. The Health (Amendment) (No. 3) Act, 1996 clarified the respective roles of health boards and their CEOs. It made Boards responsible for certain reserved functions relating to policy matters and major financial decisions and CEOs responsible for executive matters.

In addition to this basic architecture, many other advisory, executive agencies and voluntary organisations have a vital role to play in service delivery and development in the health system. Figure 2.1 below illustrates the current structure of the Irish health system and its wider environment.

Figure 2.1. Structural overview of the Irish health system in context



Adapted from Figure 3.1, Quality and Fairness

## 2.1.2 Scale of the system

The scale of the Irish health system can be illustrated by the following:

- The provision of public healthcare currently accounts for approximately 23% (2003) of total Government funding. This has grown from €3.6 billion in 1997 to a projected €9.2 billion in 2003;
- The sector is the largest public service employer in the state, with an approved employment ceiling of 96,000<sup>6</sup> employees at the end of 2002, as opposed to 68,000 in 1997;

<sup>6</sup> Excluding home help

- The range of services provided by the health system, from health promotion and prevention of illness to acute hospital treatment, and a wide spectrum of social and community services, is particularly broad by international standards;
- A total of 968,000 people were treated last year as either inpatients or day patients in acute hospitals. Since 1997 the number of patients treated in our acute hospitals has increased by 23%;
- Since 1997 day cases carried out in Irish hospitals have increased by 44%;
- General practice consultations are estimated at up to 16 million per annum.

### 2.1.3 Evolution of the current structures

---

The evolution of the health board model has been minimal in international terms, and has primarily addressed organisational challenges relating to certain geographic areas, most notably the Eastern Region but also, to a lesser degree, Cork city.

The Eastern Regional Health Authority was established under the Health (Eastern Regional Health Authority) Act, 1999. The establishment of the new body was preceded by a number of appraisals of the former organisational arrangements under the Eastern Health Board. This produced proposals to meet the problems identified, before settling on the reforms introduced in the Act. The new structures set out to address<sup>7</sup>:

- The absence of a single authority with responsibility for planning the delivery and coordination of services for the region;
- Over-centralised decision-making within the health board and the lack of an appropriate management structure at district level, given the increase in population over the past 25 years;
- The need for better communication and co-operation between the voluntary sector and the health board.

A different model has developed within the Southern Health Board area. This has led to a direct funding link between the Board and a number of hospitals in the Cork region whereby funding for the voluntary hospitals is routed through the health board.

## 2.2 The growing complexity of health service delivery

In healthcare, there is no such luxury as a 'steady state' analysis. There are a number of dynamics in the health system which need to be taken into account in considering the current structures. Our health service remains largely Exchequer-funded and, as a consequence, interest is focused particularly on how the publicly owned and operated health service performs. A second consequence of this is that there is a direct link between Exchequer-determined budgetary policy and resourcing of most of the health service. We have taken these factors into account in our Audit and in our proposals.

The service realities include a number of other factors to which our health system, like most others, is exposed:

- The continuous and accelerating growth in the cost and range of technologies (both medical and non-medical) available to the system;
- The trend towards specialisation and sub-specialisation;
- The dependence on human interaction to deliver results;

---

<sup>7</sup> *Interim Report of the Task Force on the Eastern Regional Health Authority, June 1997*

- An increasing supply of services, leading to increasing demand;
- The fact that successful treatment of acute illnesses increases the demands on the system for continuing care;
- The long lead-times for measuring outcomes;
- The fact that, very often, the consumer does not possess full information on services, to allow for informed choice.

These factors are exacerbated by the growing demands being placed upon the service as a whole as our society grows wealthier and expects greater levels of service from the health system. It should be stressed that until very recently levels of investment in health in Ireland were below the OECD average, although we are now slightly above average. Very significant reductions in capacity in the late 1980s, followed by a number of years of budgetary constraints, forced the service to ensure maximum impact from the resources available or to ration care in the face of growing demand.

## 2.3 Previous reviews of the current structures

Health systems by their nature are constantly evolving and developing to respond to these complexities and the inevitable growth in demand. This is not the first time that a review of the health system has been completed and it is worth considering the findings of some earlier reviews in relation to system structure and functioning. We have not attempted to rework this analysis. On the contrary, these reviews are useful in framing what the priority elements of an agenda for structural improvement might be.

### 2.3.1 Commission on Health Funding (1989)

---

As far back as 1989 the Commission on Health Funding engaged in a wide diagnosis of the strengths and weaknesses of the health service. The report made recommendations going beyond funding issues to look at organisational structure and functions. In particular, the Commission advocated:

- The transfer of responsibility for the overall management of health services to an executive authority;
- The freeing up of the health boards from their executive functions, and their renaming as Health Councils (to underline their representative role).

### 2.3.2 Critique of *Shaping a Healthier Future: A strategy for effective healthcare in the 1990s* (2001)

---

The 1994 Health Strategy *Shaping a Healthier Future* identified system weaknesses which it was designed to address. In the development of *Quality and Fairness*, the 2001 strategy, the DoHC commissioned the Economic and Social Research Institute to evaluate the 1994 Health Strategy. It produced a report critiquing its overall approach and impact (ESRI, 2001). Two core findings of this report highlighted the absence of strategy implementation mechanisms and of a process for ongoing evaluation of the impact of the strategy.

### 2.3.3 Value for Money Audit of the Irish Health System (2001)

---

There is also evidence that relates to particular dimensions of the health system's operations. The most recent and extensive of these is the *Value for Money Audit of the Irish Health System*, published in 2001. Like previously cited studies, this report considered in some depth the extent to which the structures and functions of the system were linked, and the degree to which they supported specific policy objectives, in this case the attainment of value for money (VFM). The VFM report helped to shape some of the organisational reform actions contained in *Quality and Fairness*, including the need to advance system development from a non-financial governance and accountability perspective.

### 2.3.4 Quality and Fairness (2001)

---

The need for fundamental change in the current Irish health system is recognised in *Quality and Fairness*, which states:

*“The aim is to have a consistent, national approach to the planning and delivery of services based on clear and agreed national objectives. Improving coordination and integration also means reviewing the roles of existing executive and advisory agencies to maximise efficiency and reduce overlaps”.*

*Quality and Fairness* included a comprehensive diagnostic synthesising the lessons from earlier studies. It was also based on a very extensive consultation process including a wide range of stakeholders. The feedback from all levels of the consultation process was used to produce a listing of the system strengths, in particular its skilled and committed workforce, but also its limitations and shortfalls. In relation to organisational issues specifically, limitations listed were cited as:

- Over-complex decision-making structures;
- Lack of clarity about appropriate level of decision-making;
- Imbalance between national and local concerns and priorities;
- Patchy strategic planning and resistance to evidence-based approaches, particularly in sectors such as acute hospital services;
- Competition between health boards and inconsistencies in service standards and development across the boards;
- Unclear regional identity at board level and persistent county loyalties.

In support of this, *Quality and Fairness* has included organisational reform as one of its six frameworks for change. It included an Action recommending the independent audit of functions and structures — the outcome of which forms the basis of this report. In advance of this Audit, *Quality and Fairness* made a number of specific structural provisions:

- “The establishment of two new agencies: the Health Information and Quality Authority (HIQA) and the National Hospitals Agency (NHA). (These two new agencies will have specific implications for existing structures such as the ERHA and Comhairle na nOspidéal);
- The strengthening of the Health Boards Executive (HeBE) as a key instrument in the change agenda;
- The expansion of the role of the Office for Health Management;
- The development of a new model for primary care as outlined in the accompanying Primary Care Strategy” — (see Appendix 9 for further details).

### 2.3.5 Estimates Review Committee (2002)

---

The recently published *Report of the Independent Estimates Review Committee* (December 2002) makes a number of specific recommendations on the structure and delivery of the health services in the context of an examination of the pre-Budget Estimates for 2003. The following observation is particularly relevant:

*We believe there is a growing recognition that shortage of funding may no longer be the key issue in the health services. There is insufficient relationship between increased funding and actual delivery of services. Fundamental structural changes are required to promote greater efficiency in delivering services. In particular, we have serious doubts about the efficacy of the existing health board structures. We consider that:*

- *there should be a greater focus on the management of scarce resources and on prioritisation at all levels of the health services;*

- the system of large block grants to health boards inhibits monitoring, control and performance assessment;
- the DoHC needs to focus more on existing core spending than on annual incremental additions;
- the work already underway in the Commission on Financial Management and Control, the National Task Force on Medical Structures, and the Audit of Structures and Functions needs to be brought to a conclusion and implemented.

The report concludes that:

- Structural changes are required to promote greater efficiency in delivering health services;
- The first priority is to improve delivery of the existing health services before new programmes/activities are introduced.

## 2.4 Recent developments in system functioning

We realised that in considering major reforms to structures, functions or other supporting processes it is necessary to take account of work already completed in response to *Quality and Fairness* and other reports on the health system. Programmes for Government of recent years have set a continuous improvement agenda to advance modernisation in the public service.

These developments in system functioning, in particular, provide the basis for further development of governance and other processes to support improved system capability. In devising a model to support the advancement of the system, we considered it imperative to take account of the strengths already present in the system and to take advantage of initiatives that provide the building blocks for further development.

### 2.4.1 Strategic and service planning

---

Under the Health (Amendment)(No.3) Act, 1996, health boards are required to submit an annual service plan to the Minister for Health and Children. The plan must set out what a health board will deliver in terms of health services within its financial allocation in a given year. The Health (Amendment)(No.3) Act, 1996 was put in place to improve accountability and the resultant service planning framework has led to significant benefits in the management of health service delivery.

The introduction of the service-planning framework has provided an opportunity to enhance the way in which the health services are planned so as to address changing needs and ensure that the best possible quality of care is provided for within available resources. The need to clearly plan activity in advance for each year and have the plan approved by the members of health boards means that there is better understanding and joint ownership of the strategic management process throughout the health board system. Management of all the major health service employers are actively engaged in using the partnership process to ensure staff participation in strategic and service planning in the system.

While recognising the scope for improvement, the *Value for Money Audit of the Irish Health System* viewed service planning as a major advancement in the Irish health system, linked as it is to statutory accountability. The report identified service planning as a mechanism to assist with bringing value for money to the centre of the health system. The importance of this work was reiterated in *Quality and Fairness*, which emphasised the necessity for service planning and delivery to be based on high quality, reliable and timely information.

For the 2002 service plans, performance indicators were agreed. These are being used to help assess and evaluate service plan delivery. Enhancements to performance indicators are continuing and a project to streamline planning and reporting processes between health boards and the Department is currently underway as a joint HeBE/Department

project. These are positive developments and represent an ongoing process, based on an acknowledgement that more needs to be done in this area.

## 2.4.2 Human resource management

---

The development of a modern approach to human resources has been a focus for health boards in recent years. This has culminated in the development and publication of the *Action Plan for People Management* published in October 2002. Apart from the development of this integrated strategic plan for HRM, a number of agencies are introducing a common personnel information management system (PPARS). Personal development and other training opportunities for staff have also become a key focus for health service employers. Greater capacity and diversity of training opportunities has been a feature in the approach of health boards to developing HRM.

## 2.4.3 Workplace partnership

---

Partnership in the health sector is being advanced by the Health Services National Partnership Forum (HSNPF) which has been in place since 1999. The development and deepening of partnership in the health services is considered to be well advanced compared to other parts of the public sector. In 2002, the Forum published a new Strategic Action Plan for 2002-2005. This plan recognised that the activities of the HSNPF were largely confined to individual projects up to that point. The Forum has now begun to contribute towards the management of change in a more significant way. The Forum executive are now working closely with other change agents within the system to provide an integrated approach to deepening partnership and facilitating change management in the context of the implementation of the National Health Strategy.

## 2.4.4 Shared services and joint initiatives

---

Two recent developments to promote more efficient working in the health service are:

- The establishment of Eastern Health Shared Services;
- The joint working of health board CEOs under the Health Boards Executive (HeBE).

Both of these bodies have significant responsibility for coordinating major cross-system activities. As such they represent an important mechanism for improving services overall and delivering value for money. These joint actions are positive but taken in isolation may find it difficult to deliver their full potential.

## 2.5 Service delivery developments

Recent developments in system processes need to be viewed alongside measures to address service capacity problems identified in *Quality and Fairness*. We list a number of key deliverables in the non-acute and acute sectors below.

### 2.5.1 Acute hospital service delivery improvements

---

An additional €65m was provided in 2002 to begin the first phase in the provision of 3,000 additional acute beds by 2011 and 520 beds were funded to the end of 2002.

The Strategy also placed a new focus on waiting times. €43.8m has been made available for the waiting list initiative over the last three years and again in 2003. The National Treatment Purchase Fund was established in April 2002. The ultimate spend on the fund in 2002 was €10m for acute hospital treatment and €5m for orthodontic treatment. The Fund is used to purchase treatment for public patients from private hospitals in Ireland or from international providers where it is not

possible to treat them within a reasonable period in Ireland. Over 1,900 patients were treated in 2002. In 2003 the throughput has been estimated at 400 patients monthly in Ireland and 200 monthly in the UK.

### 2.5.2 Non-acute service delivery improvements

Additional funding of €88m was made available in 2002 for the further development of services for older people including the enhancement of the Nursing Home Subvention Scheme, provision of additional home helps and improving community based services. Additional revenue funding of more than €17m has been announced for 2003 for these older people and for palliative care services.

For services in Intellectual Disability and Autism, an additional €38m was provided in 2002 and €13.3m in 2003. Service developments in 2002 included over 100 new residential places, 75 new respite places, 600 new day places and the continuation of the programme to transfer persons with an intellectual disability or autism from psychiatric hospitals and other inappropriate placements.

Service developments provided for people with physical disabilities in 2002 included enhancement of home support services, up to 100 additional posts, as recommended in the sector's service audit, 500 rehabilitative training places and additional guidance/assessment staff for therapy services in the health boards in the area of rehabilitative training.

In 2002, €0.25m was allocated for the development of a mental health advocacy service. Capital funding of €190m is being provided over the lifetime of the National Development Plan for mental health services. A significant part of this will go towards the development of acute psychiatric units linked to general hospitals as a replacement of services previously provided in psychiatric hospitals. Ten units are at varying stages of development.

## 2.6 Other major system initiatives

In addition to the system functioning and service developments referred to above, there are a number of other important initiatives designed to improve system performance or to address specific service or operational matters underway. Many of these are not yet finalised. However, the outcomes and the timing of their implementation will have immediate relevance to the successful implementation of *Quality and Fairness*. In many cases, they will also relate directly to the organisational structures and functions in the health system. The challenge is to align our main areas for change and the recommendations supporting the parallel initiatives. The principal initiatives that need aligning are outlined in Figure 2.2 below. A description of the terms of reference for each of the initiatives is contained in Appendix 9.

Figure 2.2 Major initiatives aimed at improving system performance

<i>Initiative</i>	<i>Estimated completion/publication date</i>
Development of a new model for Primary Care	On-going (Task Force)
National Task Force on Medical Staffing (Chaired by Mr David Hanly)	Mid-2003 (interim report)
Commission on Financial Management and Control of the Health Services (Chaired by Professor Niamh Brennan)	Early-2003
Review of Medical Practitioners Act (DoHC)	2003
Action Plan for People Management (DoHC/HSEA)	Published October 2002
National Health Information Strategy (DoHC)	2003
Restructuring of the DoHC	2003



## 2.7 Conclusion

The current health system is large in scale and increasing in complexity. The case for greatly increasing capacity has been acknowledged and quantified in *Quality and Fairness*. Despite investment and other measurable improvements in system functioning in recent years there are continuing threats to the system's ability to respond in full to the agenda set out in *Quality and Fairness*.

We have deliberately highlighted a number of very positive developments in the health system over recent years, relating to service developments and enhancement of management processes. The progress to date provides an important foundation on which to move forward. The developments and the initiatives described above aim to address critical system requirements. However, there is a real risk that an incremental response to putting in place the structural and functional supports for their respective recommendations will increase, rather than improve, the complex nature of today's system. This Audit, therefore, needs to take these parallel initiatives into account. Moreover, the future structures need to be based on a defined set of priorities for the healthcare system.



---

# Part 2

## Analysis

---



## Chapter 3

# Audit of healthcare agencies

---

A central objective of the Audit is to identify areas for improvement in the current structures and functions of the Irish health system. A detailed analysis of our findings in relation to the configuration of individual agencies and the distribution of functions across these agencies is contained in Appendix 6. There is extensive material in the Appendices which form much of the evidence-base for our findings in this chapter. These findings are summarised below, under four main headings:

- Complex and fragmented structures — an obstacle to achieving improvements;
- Scope for the rationalisation of certain agencies;
- Lack of standardisation and coordination across the system;
- Underdeveloped system functions in a number of areas.

### 3.1 Complex and fragmented structures — an obstacle to achieving improvements

#### 3.1.1 The increase in the number of individual agencies creates a number of challenges in managing and resourcing the system

---

While the major components of the current system have remained largely unchanged for over three decades, the number of individual agencies has increased significantly in this period. It is striking that, of the 58 agencies included in our review, almost half have been established in the past 10 years. This is a doubling of the number of agencies established in the preceding 45 years (Appendix 11). There are also plans to establish a number of new statutory health agencies in the immediate future (for example the Health and Social Professional Council). It is the case that during this period some significant rationalisation has been undertaken e.g. The Adelaide and Meath Hospital, Dublin incorporating The National Children's Hospital Board replacing three former hospital boards; St Lukes and St Annes Board replacing two former hospital boards; also, the reorganisation of structures in the Eastern region in 1999 followed an in-depth review of management and structural requirements for the Eastern region at that time). Nevertheless, the rapid and incremental development, which has taken place largely without overall review, has resulted in a complex and fragmented architecture that places significant pressures on the system.

It should be recognised that some of these agencies were new, statutory, versions of pre-existing organisations (e.g. the Drug Treatment Centre Board Establishment Order, 1988 replaces the National Drug Advisory and Treatment Board established in 1969). However, there appears to be a pattern whereby a system deficit in specialist knowledge (women's health, care of the elderly etc.) is addressed by setting up a new external body. The concern this raises relates not only to the actual number of bodies involved, which calls into question the adequacy of oversight which the Minister or his Department can exercise. A second more pertinent concern lies in the fact that the work of some agencies has extended beyond their original remit, which has led to duplication and a lack of pooling of experience and know-how. Most critically, it has also led to an almost unmanageable mix of agenda-setting institutions with a strong individual focus but often lacking a broad policy context.

The reality is that there are factors, sometimes beyond the control of DoHC, which encourage the proliferation of such agencies. For example, additional areas of responsibility have been added to the Department's brief, for political and social reasons. Funding and employment control mechanisms have made it more practical on occasion to locate functions outside the Department/health board mainstream in an effort to deliver on policy service objectives. It is also the case that, as a good number of these new agencies are designed to perform executive functions — at least in part — it is quite appropriate to locate them outside the Department. Problems then arise from their isolation from the executive mainstream and the duplication of overhead costs. But in the absence of a centralised executive function to receive them, decision-makers were arguably limited in the options open to them with regard to their location.

### **3.1.2 The development of parallel structures has added to the complexity and fragmentation of both policy-making and implementation**

---

The basis for the establishment of many of these additional agencies (as outlined in Appendix 3) is to be found in the recommendations of expert groups reviewing a particular policy or service gap. They often represent a system response to a particular crisis or pressing public concern. Typically agencies are established on a permanent basis as ongoing operations. However, the proliferation of these agencies in recent years may be symptomatic of other factors:

- The development of stand-alone agencies may be symptomatic of the desire and the appropriateness of shifting responsibility for executive functions outside the DoHC. It may also implicitly question the capacity or expertise base of mainstream policy-making and delivery structures to respond adequately to an ever expanding set of needs;
- It may indicate insufficient consideration of existing expertise and capacity when establishing agencies to support new strategies;
- There may be an advantage in establishing a new agency despite the overhead involved, because of the higher public profile accorded to a particular policy priority at a point in time.

### **3.1.3 The continued involvement of the DoHC in operational matters reduces clarity around organisational accountability**

---

The DoHC has a significant involvement in the day-to-day operations of the health system. Our analysis shows that 49 out of the 58 agencies audited have a direct link to the DoHC (the three area health boards report directly into the ERHA as do the six statutory hospitals. The latter, however, retain certain direct reporting lines which pre-date the ERHA). While it has transferred a number of executive functions in recent times, for example the funding of voluntary acute hospitals and agencies in the mental health and intellectual disability sectors, the DoHC still retains a significant number of executive functions which absorb considerable resources and detract from its core objectives. Some of the services which could be devolved include:

- Consultation with national voluntary agencies on service issues (nursing home owners, agencies for homeless etc.);
- Involvement in HR matters such as the determination of terms and conditions for employees;
- Employment equality issues — consistent application of legislation in health agencies;
- Voluntary Hospital Superannuation Scheme;
- Responsibility for the casemix model used to set acute hospital budgets;
- National media campaigns for Health Promotion;
- Hospital planning services.

The Department's own business plan provides many more examples of such executive functions which are currently part of its day-to-day operations.

### 3.1.4 There are a number of difficulties in managing the scope of healthcare services

---

There are large sectors of healthcare provision outside the planning scope of publicly-funded health services, such as the acute private sector and some of the activities of the larger voluntary providers. Yet these have a significant impact on the overall system. The public/private mix has been adopted as a basic funding model in Ireland. This means that non-Exchequer funded services operate alongside and are intertwined with publicly funded services. Attempts to plan, deliver and evaluate public services are complicated by this mix at a number of levels. This has been particularly evident in the acute hospital sector but also in the GP service and dental care. At present, for example, anyone can establish a private hospital anywhere, subject to planning permission, and may even receive tax incentives to do so. The presence of another hospital will have a direct impact on the publicly-funded system in respect of staffing, patient flows, pre and post- acute care, diagnostic and other back-up services. The complementarity of the public and private systems referred to in the Health Strategy needs to be taken into account so as to facilitate opportunities for joint planning and, where appropriate, shared delivery of particular services or facilities.

Similarly, a number of voluntary agencies concerned with providing services to certain groups (e.g. physical disability) or dealing with specific issues (e.g. suicide) are organised on a national basis. As service providers their national interface is with the state delivery system. As a consequence, they may find themselves obliged to deal with up to 11 different funders or service delivery partners nationally on service planning and operational matters.

Finally, the system of resource allocation which is:

- Incremental, almost in its entirety;
- Sectoral, with each programme or service being considered individually;
- Developmental, focused on 'new money'.

often compounds the fragmentation of service planning from the top of the system all the way through to the patient. This reflects the pattern whereby programme-funding developments are negotiated sectorally between the health board managers and their DoHC equivalents, reinforcing a compartmentalised approach to sector-based funding and new resources.

### 3.1.5 The existence of the health boards alongside the ERHA model complicates the interface with the DoHC

---

The Eastern Regional Health Authority, established in 1999 under the Health (ERHA) Act, replaces the former Eastern Health Board and provides for a central Authority and three area health boards. An additional 36 voluntary agencies have a direct relationship with the ERHA, including the major voluntary hospitals in the region. The ERHA differs from the traditional health boards in that it does not directly provide services, but is responsible for the planning, commissioning, monitoring and evaluation of services in the Eastern region, through the three area health boards and the 36 other agencies.

The creation of a different regional construct in the East has gone some way towards addressing the particular problems of the Eastern region in areas such as coordination, A&E services, tackling hospital waiting lists, child care services and developing continuing care for the elderly. It has also strengthened regional needs assessment and provides a strategic approach to the planning, commissioning and evaluation of services. In addition, it acts as an interface between the DoHC and the service delivery system.

However, the existence of two quite different organisational models (ERHA and the traditional health boards) has further complicated the already intricate links between the DoHC and the delivery system as a whole. In dealing with the ERHA, the Department officials are relating to an organisation which commissions but does not deliver care and which has a specific mandate to commission on needs-based assessment and evaluation. In contrast health boards provide care directly and negotiate directly with the DoHC in their overall funding and by individual care programmes. The Department's internal structures do not match either model closely, thereby adding to the complexity of the situation.

### 3.1.6 The legislative framework for the ERHA creates operational difficulties

---

On examining the desk-based evidence available, it would appear that there are a number of difficulties in the ERHA model itself. In particular, the supporting legislative framework creates a challenging web of relationships and accountabilities. Among the issues we have identified are the following:

- The Authority is required to delegate its reserved functions for service provision in the former Eastern Health Board areas to the appropriate area board, and the CEO must delegate the related executive function. This raises a question about where absolute legal responsibility for service planning and budgeting as set out in the 1996 Health (Amendment) (no.3) Act resides — with the Chief Executive Officer of the ERHA or with the CEOs of the area health boards. While it may be possible to remedy this situation by direction under section 16 of the 1996 Act, which we understand has been done, it would be preferable to see a stronger legislative base with accountability clearly outlined;
- The Authority has the duty to plan for the region. The area health boards have the duty to plan for their own areas, which would appear to result in unclear boundaries between local and regional planning. The Authority may not delegate the making of arrangements for service provision with certain service providers (the voluntary hospitals, the learning disability organisations and a small number of others). This presents particular challenges in relation to these Schedule II Agencies (who have a direct funding relationship with the Authority) whose operations may not feature adequately in the area health board plans;
- There is a requirement under the Health (Amendment) (No. 3) Act, 1996, for the Authority to submit its service plan within 42 days. Given the timescale from the date of issue of the Letter of Determination (from the DoHC), typically in December in the preceding year, the 42-day timescale which is followed by 21 days in which the Minister can accept or alter the Service Plan, appears to mean that, technically, it can be mid to late February before the plan takes legal effect. This timescale difficulty is exacerbated by the subsequent need for the Authority to then finalise the 39 individual Provider Plans with each of the Agencies;
- While the Eastern Regional Health Authority has a statutory obligation to produce a service plan within a specific timeframe, there is not as clear a statutory obligation on Schedule II providers to conclude a service agreement with the ERHA. This in effect means that the Authority is responsible for the delivery of services but is not in a position to require Service Providers to come to a conclusion on the Annual Provider Plan, in order to allow it, in turn, to deliver on its formal commitment to the Department under the terms of its Annual Service Plan;
- There are no formal sanctions open to the Authority in situations where the service providers are 'out of agreement'. Equally, the legislation is silent in terms of accountability obligations on parties with whom the Authority interacts;
- Equally, the voluntary sector agencies outside of the Eastern Region do not have any specific requirement to agree a Service Plan or agreement with their funding agency within a specific timescale and within a specific allocation.



### 3.1.7 The functions assigned to specialist agencies overlap with other bodies

The functions of certain specialist agencies have a significant impact on other agencies, including those:

- Involved in research;
- Involved in planning services;
- Charged with implementing key elements of individual strategies.

Specific responsibilities assigned to individual agencies overlap with the functions of others. For example, the functions of the Office of Tobacco Control have the potential to overlap with the Health Promotion Unit within the DoHC, and the health promotion units in each of the health boards/area health boards. Similarly, the research function of the National Council for Ageing and Older Persons overlaps with the relevant DoHC division and with the Health Research Board. Appendix 6 outlines the overlaps identified for other agencies in this grouping.

### 3.1.8 The proposed new national agencies have system-wide implications for both structures and functions

*Quality and Fairness* provides for the creation of two new agencies — the Health Information and Quality Authority (HIQA) and the National Hospitals Agency (NHA) — to strengthen system capacity and performance in a number of critical areas:

- Policy and planning for the acute hospitals sector on a system-wide basis (NHA);
- Ensuring system-wide quality and information (HIQA);
- Health technology assessment (HIQA).

While neither of these bodies has been formally established, details of their proposed roles have been set out in *Quality and Fairness*. In addition we have consulted with the DoHC on the state of play of current thinking in relation to their design.

#### Health Information and Quality Authority

The multi-purpose nature proposed for HIQA, its role as commissioner and provider of information, as a standard setter for information and also as an evaluator of quality (including quality of functions), means that there are a number of potential overlaps between it and existing agencies:

Figure 3.1: Potential overlaps between the functions of HIQA and existing agencies

<i>HIQA function</i>	<i>Potential overlap</i>
Reviewing and reporting on a selected set of services each year	<ul style="list-style-type: none"> <li>• Statutory responsibility of ERHA to monitor and evaluate services</li> <li>• Informal responsibility of other service providers</li> </ul>
Promoting and implementing structured programmes of quality assurance	<ul style="list-style-type: none"> <li>• Irish Health Services Accreditation Board</li> <li>• Professional regulatory agencies</li> </ul>
Overseeing accreditation and developing health technology assessment	<ul style="list-style-type: none"> <li>• Irish Health Services Accreditation Body (on accreditation)</li> </ul>

There will also be a need in the establishing legislation for HIQA to balance a degree of independence vis-à-vis the Department in relation to the Authority's quality assurance role with the necessary alignment of its work programme to match the Department's national policy objectives.

### National Hospitals Agency

It is not clear what role the NHA as currently envisaged will play, if any, in the following areas:

- Policy on, and development of, shared services between hospitals
  - Advice on the organisation and development of specialist or non-acute hospitals
  - Involvement in services which span acute and non-acute sector, e.g. psychiatric, maternity
  - Paediatric services etc.

Our Audit points to a number of overlaps between the current distribution of functions among certain agencies and those functions planned for the NHA:

Figure 3.2: Potential overlaps between the functions of the National Hospitals Agency and existing agencies

<i>NHA function</i>	<i>Potential overlap</i>
Advising on organisation and development of all hospital services  Liaising with regulatory and professional bodies on matters affecting acute hospitals	<ul style="list-style-type: none"> <li>• Current role of Secondary Care Division and Hospital Planning Office of the DoHC</li> <li>• Current role of ERHA in coordinating and planning hospital services across the Eastern region</li> <li>• Current role of Comhairle na nOspidéal in advising the Minister on matters relating to the organisation and operation of hospital services</li> </ul>
Advising on specialist services	<ul style="list-style-type: none"> <li>• Current role of Comhairle na nOspidéal in regulating the number and type of appointments of consultant medical staff and other relevant staff in prescribed hospitals</li> <li>• Current role of ERHA in commissioning acute services from national specialist units in major hospitals</li> </ul>
Developing strategic relationship with private hospital sector	<ul style="list-style-type: none"> <li>• Existing relationships between health boards and private hospitals</li> <li>• Existing relationships between statutory and voluntary hospitals and private hospitals</li> </ul>
Managing new waiting list database	<ul style="list-style-type: none"> <li>• Role of the National Treatment Purchase team</li> </ul>

## 3.2 Scope for the rationalisation of certain agencies

### 3.2.1 A number of service delivery agencies can be mainstreamed or merged

The Hospitals Trust Board was established to distribute funds raised through the hospital sweepstakes, which are no longer in operation. The staff of the sweepstakes has since been made redundant.

The Hospital Bodies Administrative Bureau was established to provide administrative, analytical, clerical and ancillary services for Comhairle na nOspidéal and Regional Hospital Boards. As the Regional Hospital Boards ceased to function in 1977, the functions of the Bureau have related solely to Comhairle na nOspidéal since that time.

Another agency whose functions could be mainstreamed<sup>8</sup> is the Poisons Council. The sole function of the Council is to provide advice to the Minister for Health and Children or the Minister for Agriculture on matters in relation to poisons, their manufacture, storage, transport, distribution and sale. The DoHC records indicate that the Council has met 3 times in the past 10 years. It appears inappropriate to continue to have a dedicated 'agency' for this function.

### 3.2.2 There is evidence of a drive to rationalise the number of professional, regulatory and training bodies within other national health systems

At present, five professions are subject to statutory registration: doctors, nurses, pharmacists, opticians and dentists. As part of the drive for quality assurance and to promote efficiencies, a number of countries are reviewing their arrangements for the regulation of medical, nursing and other health professionals. Trends driving those reviews include the following:

- Increasing public and system scrutiny of the medical profession;
- The requirement in the EU for national systems of regulation and recognition of professional qualifications to give due weight to qualifications obtained in other member states.
- Support for unification or at least the coordination of health professionals under a single or much reduced number of regulatory bodies due to:
  - The move towards closer multi-disciplinary-based delivery of health services;
  - Perceptions of double standards (different treatment of breaches of standards by different regulators)
  - Cost and efficiency grounds.

### 3.2.3 There is a clear rationale for relocating the functions of Comhairle na nOspidéal in the National Hospitals Agency

The Audit of the individual agencies points to extensive overlaps between the current distribution of functions of Comhairle na nOspidéal and those functions planned for the National Hospitals Agency (NHA). This is recognised by *Quality and Fairness* in Action 80.

*"These arrangements will have implications for Comhairle na nOspidéal, many of whose existing functions will be carried out by the National Hospitals Agency on its establishment. These implications will now be examined carefully as part of the independent audit of functions and structures of the health system, discussed later in this Chapter, and arrangements will be made for transferring the relevant functions of Comhairle accordingly".*

An examination of the individual functions for both bodies, identifies a number of overlaps which are included in figure 3.2 above. Principally these concern Comhairle na nOspidéal's current role in relation to:

- Advising the Minister on matters relating to the organisation and operation of hospital services;
- Regulating the number and type of appointments of consultant medical staff.

Full details of Comhairle na nOspidéal's existing role and functions are set out in appendix 6

<sup>8</sup> Note: The term mainstreaming, as used in this report, indicates the relocation of functions and structures within conventional responsibility and reporting lines for policy and execution

### 3.3 Need for standardisation and coordination across the system

In an attempt to meet the diversity of patient needs and respond to local consumer and political involvement a number of structures and functions have been duplicated or executed in different ways. While the intention is often to meet the needs of multiple stakeholders, this extends the decision-to-action chain and creates widely differing processes. The end result is poor integration of services and multiple contact points for patients. In addition, VFM and quality care are at risk due to the desire to provide all services at all locations, as opposed to taking a system-wide view. The prolonged debates in relation to the location of radiotherapy facilities or breast cancer units are cases in point.

#### 3.3.1 The traditional health board model evolved over the years in an unstructured manner and has resulted in insufficient coordination and standardisation

---

Since the 1970 Health Act the scope and level of activities mandated for health boards has increased. In this period, individual health boards have evolved at different paces, resulting in a considerable variation in their organisational structures and practices. National strategies and policies have also added a number of additional functions to individual health boards, e.g. population health, social inclusion, etc. From available evidence, most of the health boards are developing organisational structures based on a mix of care group and programme functions. The different structural approaches taken in response to their expanding functions increases the likelihood of variable performance between health boards.

It is recognised, however, that as some of the largest organisations in the country, it would be impractical to expect identical structures across the boards, particularly given the variances in geographic and demographic profiles, as well as varying service needs between each board. Notwithstanding this, the different pace of evolution and the current structural differences both within and between health boards leads to practical difficulties in a number of areas, for example:

- Ensuring a standardised approach to the preparation and implementation of national strategies;
- Working on a conjoint basis on individual service or policy matters (an example of this is where health boards have officers at different grades fulfilling the same responsibilities).

An additional issue exists in relation to the current legislative framework for health boards. In reviewing this framework, there is no clear, overarching, broad statement of the functions and related duties of the boards, or of their duties/functions in relation to each other. Only the specific administrative functions in relation to the provision of services are evident in the various pieces of legislation.

The Health (Amendment) (No. 3) Act, 1996, introduced a number of additional accountability provisions for health boards, including the requirement for annual service plans within the budget determination provided by the Minister. We have made the following observations in relation to health board legislation overall:

- Monitoring and evaluating services, measuring outputs and standards in assessing need and matching those to funding are not explicit requirements in the legislation;
- The 1996 Health Act and C&AG (1993) Act both require efficiency with regard to financial expenditure but there is no corresponding evidence to suggest that effectiveness of service delivery is measured;
- There is no requirement to measure quality of output;
- There is no requirement for the boards to consult with the general public in relation to their activities.

Cooperation and coordination between health boards has in the past been underdeveloped. While the *Value for Money Audit* acknowledged the work that has been done to date, it saw the culture between health boards as still one of

competition rather than cooperation, sharing and learning. The establishment of HeBE, therefore, is a significant turning point, recognising the need for concrete measures to support conjoint working and thus improve integrated service delivery nationally. HeBE will also be instrumental in linking service providers outside of the traditional health board structure. The ability and willingness of individual health boards to coordinate and cooperate on a conjoint basis will be pivotal to the impact of this agency. This move by the health boards themselves, and similar initiatives such as the establishment of BreastCheck, reflect the acknowledgment that the current organisational structure does not readily support joint operations.

One of the potential limitations of the contribution of HeBE to the promotion of conjoint working is its statutory base. Currently, the members of HeBE (Chief Executive Officers of the health boards) and the Minister have statutory responsibility for directing the activities of HeBE. The body itself currently has no statutory authority to require or ensure participation of individual health boards in any identified functions.

### **3.3.2 There is no single strategic HR function to coordinate or lead system-wide activities**

---

Our Audit findings point to the need for a single, centralised approach to strategic HR, combined with devolved HR management at local level. This strong centre should support the ongoing development of progressive, devolved HR management throughout the health system, as local HR units respond to ever-changing people issues.

While advances have been made in recent times, much needs to be done. There are considerable deficiencies in terms of strategic HR focus as well as HR capability and overall capacity. A major contributing factor to this has been insufficient investment in HR and the concentration of the function on transactional activities such as personnel administration, IR and recruitment.

The framework for developing Human Resources in *Quality and Fairness* assigns joint responsibility to a number of agencies involved in the area of HR and people management. While a lead role is allocated to the DoHC for certain aspects of the framework (e.g. workforce planning) centralised ownership for the implementation of other critical elements, (e.g. the *Action Plan for People Management*) is less clear. There is also the added dimension of the role of the Department of Finance in relation to oversight of payment and personnel policies in the public sector which directly or indirectly affect the majority of health employers. This situation is further complicated by the fact that there are two agencies currently involved in system-wide HR functions, namely the Health Services Employers Agency and the Office for Health Management, each of which deals for the most part with different elements of the HR agenda but with overlap in the area of change management.

While certain activities have been carried out on a system-wide basis (for example the recent Payroll Personnel and Related Systems (PPARS) project now coordinated by HeBE), and an OHM initiative bringing together the HR Directors of all health boards to discuss a common HR agenda, the need to involve a wide number of agencies in these initiatives further points to the challenges posed by the lack of a single centralised function.

There is a real risk of duplication at best, or at worst, two separate approaches to managing change. The activities of these agencies have, in turn, to be considered against the backdrop of the National Centre for Partnership and Performance and the Health Service National Partnership Forum. In addition, interaction by the wider health system with these HR agencies is largely on a collaborative and discretionary basis, which clearly limits their mandate and impact.

### **3.3.3 There is a lack of standardisation in the structures and functions supporting professional registration, regulation and development**

---

Currently, there are ten statutory agencies involved specifically in the registration, regulation and/or continuing development of health and social care professionals, covering eight different professions. Each of these agencies has

been established at different times and with different purposes, some are involved primarily in maintaining a register and others involved in conducting fitness to practice hearings.

There are a number of overlaps evident. For example the Postgraduate Medical and Dental Board overlap with the roles of the Medical Council and Dental Council who are involved in the promotion of, and setting of, standards for professional education for doctors and dentists respectively.

In addition, common functions are carried out by a number of different agencies. For example An Bord Altranais (the Nursing Board) and the National Council for the Professional Development of Nursing and Midwifery fulfil some similar roles in relation to educational and training standards for nurses:

- An Bord Altranais has responsibility for the promotion and setting of educational and training standards for nurses at entry level and post-registration level;
- The National Council for the Professional Development of Nursing and Midwifery has responsibility for post-registration education and training;
- Both agencies work on aspects of standards for professional practice.

### **3.3.4 There is a need for centralised and standard approaches in relation to quality assurance functions**

---

While there are a number of agencies involved in the inspection of specific areas of the current health system, there is no single authority responsible for a whole-system approach to quality. This presents the following challenges:

- Ensuring quality review of whole-system functions;
- Ensuring standardised approaches to inspection;
- Avoiding duplication of expertise in different agencies;
- Avoiding overlap between inspectorate approaches and continuous quality improvement mechanisms.

The quality 'agenda' draws on a wide range of techniques and approaches which need to be deployed in a planned and systematic manner. In healthcare, this range includes clinical audit, risk management, accreditation programmes, inspectorates, adverse incident reporting systems and programme or service reviews. All of these elements are present to some degree, but are not coordinated and driven through a central point. In addition to external quality assurance mechanisms, there is the even more important requirement for internalised, continuous quality improvement at all levels in the system. This requires leadership, training and adequate technical support. The value of isolated quality initiatives is severely limited by the lack of a national framework to support them. We comment specifically on the need to develop clinical governance mechanisms at Chapter 4.

### 3.3.5 Challenges remain in coordinating the national health Research and Development agenda and in making health research available to policy-makers and service deliverers

---

The Audit points to the myriad agencies involved in research and development, reflecting the wide and highly specialised range of needs embraced by the Irish health system. The research and application of new technologies and therapies is essential as a means to protect health and combat disease. The Government has also identified research as critical to the next phase of the future economic and social development of Ireland and investment in research has increased over the past number of years. The implementation of the Belfast Agreement provides an opportunity to build on successful research initiatives on both sides of the Border, e.g. the co-development of cancer research.

*Making Knowledge Work for Health* (2001), the national health research strategy, identified four reasons why health research is a critical function:

- *“Research is a key factor in promoting health, combating disease, reducing disability and improving quality of care;*
- *Research is vital if the health services are to become more efficient and effective;*
- *Opportunities for high-quality research are a key factor if we are to persuade Irish health professionals to undertake their postgraduate training and subsequent careers in Ireland;*
- *More health research can help achieve other Government objectives such as implanting the healthcare industry in Ireland”.*

*Quality and Fairness* under action 73 commits to the implementation of the national health research strategy. The development of an evidence-based approach is relevant to all of its national goals.

Considerable work has been done in the past year to amend the Health Research Board’s statutory base and bring it into line with the objectives of *Making Knowledge Work for Health*. Funding to the Health Research Board from the DoHC has also been increased. The ERHA has commissioned a wide range of research work since its establishment and a number of health boards have moved to appoint Research Officers.

While the Health Research Board plays a pivotal role in the area of health research, from promotion of research to development of standards, there is no assigned responsibility at a national level for disseminating and embedding research outcomes in the work of health agencies. This need was recognised in *Making Knowledge Work for Health* and addressed by a proposal to establish a forum for Health and Social Care research to advise and agree a research agenda that would focus on the main objectives of the health service. The commitment to a National Health Information Strategy and to the establishment of HIQA provides a clear opportunity for the Health Research Board, in particular, to integrate its functions and broad role in this field more effectively with the health system overall. Other challenges in relation to the health research and development function include:

- The need to establish clear pathways between identification of research needs and the use of research to support evidence-based decision-making within the system;
- The need to ensure that the agencies involved in various strategic planning processes for the development of health research are working in an integrated way;
- The need to ensure that the DoHC has explicit responsibility for guiding the national research agenda and appropriate oversight and control over research priorities.

### 3.3.6 System-wide health information coordination is inadequate

---

A lack of system-wide coordination has led to a number of difficulties in relation to using evidence-based information to inform policy, service planning and delivery. The Value for Money Audit of the Irish Health System report highlighted the following areas in particular:

- A piecemeal approach to implementing information systems and the non-standardisation of data within and between agencies mitigate against benchmarking, the comparability of data and the sharing of information between various stakeholders and agencies;
- Interfaces between the public and private sectors are unclear due to the absence of systematic information sharing between the sectors.

Additional findings from our Audit point to gaps in collection or dissemination of information in relation to major diseases, e.g. the continued absence of a single national Cardiac Register and the lack of a structured approach to exploiting existing data sets such as the GMS Payments Board data in support of the national disease-based strategies and other purposes.

The transfer of knowledge and skills across care group structures is impeded by the lack of access to information systems. For example, treatments available for people with disabilities which would be appropriate for use in the care of the elderly are not being exploited due to the lack of available information to service providers or patients. A fundamental consequence of the information deficit is the inability of the health system to demonstrate the benefits of investment to date and to argue the case for resources in the future.

A National Health Information Strategy has been in preparation for some time. The lead role envisaged for HIQA in driving this strategy forward is critical. The feasibility of this task will be determined to a considerable degree by the extent to which other structural reforms reduce the multiplicity of agencies with which HIQA will have to engage.

## 3.4 Underdeveloped system functions in a number of areas

### 3.4.1 Shared services are underdeveloped in the health sector

---

The business logic for shared services includes the following:

- Elimination of duplicate activities across different departments and sites;
- Creation of economies of scale and the achievement of subsequent reductions in headcount, with associated cost reductions on effective implementation;
- Greater leveraging of technology, management and specialist resources;
- Standardisation of processes, practices and application of leading practice to improve the quality and overall consistency of services provided.

International leading practice is comprehensive on the subject of shared services as a model to enhance operational efficiencies. Shared service initiatives in healthcare are underway in the UK, Victoria, Australia and a number of Canadian provincial healthcare systems. Further details are set out in Appendix 8.

#### Shared services in the Eastern region

Currently, the provision of shared services in the Irish health system is the exception rather than the norm. Eastern Health Shared Services (EHSS) is an example of how shared services could be provided to improve operational efficiencies and



has operated in a sense, as a pilot site for this initiative. However, the EHSS was established 'overnight' with the dismantlement of the former Eastern Health Board and branded as shared services, but effectively took on the old central services model with many services/functions inherited from this organisation. Significant progress has been made in implementing the EHSS mandate. Lessons can however, be learned from the approach taken to the EHSS establishment where there was minimal investment, planning, or change management during initial transition from Central Services to Shared Services and when operational skills were lost from the EHSS during the initial transition.

### **National shared services**

The GMS Payments Board is currently the only shared service provided on a national basis across all health boards, and is principally responsible for the processing and payment of a wide range of claims under the GMS scheme. From our agency Audit and consultations with the DoHC, the following issues are of particular relevance to the GMS Payments Board:

- Ensuring that the wealth of information gathered by the board is exploited by the wider system;
- Clarifying the adequacy of accountability arrangements and operational links between the GMS Payments Board and individual health boards.

The structure and governance arrangements of the GMS Payments Board are currently the focus of an independent review, running in parallel with this Audit.

### **Working on a joint basis**

In relation to the delivery of services on a joint basis the National Breast Screening Programme could be viewed as a pilot programme across a number of health boards sharing the benefits of joint service delivery. The BreastCheck programme was established through the vehicle of a specialist agency because of the absence of any other joint service delivery platform. An obvious issue here is the need to create a specialist vehicle for services of this type. A second disadvantage, however, is the additional effort required now to integrate BreastCheck's operations with the overall cancer strategy implementation programme.

We are aware that the further development of information services is being progressed through HeBE, through the implementation of standard Hospital Information Systems, Finance Systems and Human Resource Systems throughout the agencies. The continued development of financial systems could allow further efficiencies through a national shared service approach for financial, HR and procurement processing. It is particularly important that the design of these important systems should reflect the shared services approach at an early stage.

## **3.4.2 The planned expansion in the number of regulated professions requires a coordinated approach**

---

The Government is committed to strengthening existing legislation regarding registration of certain professions, such as doctors, nurses and pharmacists. In addition, new legislation will be introduced for the registration of health and social care professionals including physiotherapists, occupational therapists, social workers, childcare workers and others. Review and drafting work on legislation in this area has been underway for a considerable time now. In a broader context the Competition Authority is also currently reviewing a number of these professions.

The legislation for professionals already registered, and for health and social care professionals being registered for the first time, will provide for consumer representation on the relevant statutory registration bodies to ensure that the views of service users are presented. The legislation will also enable registration boards to provide for a system requiring re-accreditation of professionals at regular intervals, based on a structured approach to continuing education and training.

Current proposals include the development of a Health and Social Care Professionals Council to ensure that members of the public are protected and informed in relation to the activities of professionals not currently subject to registration.

Ensuring standardisation, sharing of good practices and learning between professional regulators should be a priority, especially with the proposal to increase their number. The role of the DoHC in overseeing the regulators and the location of authority for external auditing of regulatory practice may also need consideration. This is particularly relevant given the growth in the number and type of professionals and the effect of free movement under EU Directives, a factor which is likely to grow over the years in the context of EU enlargement.

## Chapter 4

# Audit of governance and accountability arrangements

---

One of the key tasks undertaken during the Audit was a review of the current governance arrangements of the 58 individual agencies reviewed. This Chapter should be read in conjunction with the detailed analysis in Appendix 7, which outlines the governance and accountability arrangements for each agency and benchmarks each agency against leading practice.

### 4.1 Audit findings

There are nine findings which suggest a number of deficiencies in relation to governance and accountability in the health system.

#### 4.1.1 Boundaries of accountability are not always clearly defined

---

Legislative provisions for the individual organisations audited do not always differentiate between the role of the Board (reserved functions) and the executive functions of its officers. In particular, it is sometimes difficult to distinguish between the role of the Board and the role of the CEO of the organisation.

Despite the clarification of executive and reserved functions in respect of health boards the Health (Amendment) (No. 3) Act, 1996, particular issues still arise. One such example is the reporting relationship of the Chief Executive Officer and the Board and the status of directions issued by the Minister vis-à-vis the statutory role of the Board and the Chief Executive Officer.

Where bodies are established to carry out shared services, or services on a joint basis, it is important to ensure clarity of accountability and respective boundaries. The GMS Payments Board, for example, is clearly responsible for the calculation and processing of payments under the GMS scheme on behalf of the health boards. From the Audit it was unclear as to where formal accountability for the levels of spending under the GMS Payments Scheme lay. We have referred already to the fact that bodies such as the Office for Health Management and the Health Boards Executive, which have responsibility for system-wide support, have no formal authority in the exercise of their functions but must rely on cooperation and collaboration.

#### 4.1.2 Accountability for non-financial performance is not clearly embedded in legislation

---

Governance arrangements of the audited agencies indicated that the majority of agencies focus almost exclusively on financial performance objectives. In relation to the health boards, the reserved functions of the Boards (the governance entity) relate to specific duties such as the approval of service plans and annual financial statements. There is no explicit governance function in relation to quality, equity or meeting service needs. Boards are required to supervise the implementation of service plans (Health (Amendment) (No. 3) Act, 1996) but this is to ensure that the activity stays within budget. The only exceptions are ERHA legislation which charges the Authority with responsibility for monitoring and

evaluating the provision of services (section 8 (3)). However, in a general provision under the Comptroller and Auditor General (Amendment) Act, 1993, the C&AG is entitled to examine the economic and efficient use of resources and the effectiveness of systems, procedures and promotions applied by the board.

#### 4.1.3 Basis for Board appointments needs clarification

---

The Audit indicates that the Minister for Health and Children generally makes Board appointments on the advice of sectoral interests. As these parties are likely to have particular interests in relation to the decision-making of its Board, the role of the proposed appointees may be open to a perceived lack of independence.

An example of how open and non-specific the criteria for board appointments can be, even in the case of specialist agencies, is illustrated by the legislation of the Food Safety Authority of Ireland. The legislation providing for its establishment simply states:

*“The Minister, when appointing an ordinary member of the Board, shall fix such member’s period of membership which shall not exceed 5 years and, subject to this section, membership shall be on such terms as the Minister determines. Four of the ordinary members of the Board appointed under subsection (2) shall hold office for a period not exceeding three years from the date of their appointment as determined by the Minister”.*

A further example of what might be considered an imbalanced approach to board nomination and appointment processes is the statutory guarantee that the ERHA Board will include at least three representatives from the Intellectual Disability sector, but only three from all other voluntary agencies, whatever sector they operate in. The fact that it is also possible for an individual to simultaneously be a member of the Authority, a member of the area health board and Chief Executive Officer of a major service provider to the Authority raises questions about clarity of role and lines of accountability in the ERHA arrangements. There are over 300 different grades of staff in healthcare and it would be clearly impossible to have a representative system based on professions which is workable. Existing professional members are in reality only capable of being elected if supported by their staff association. Equally, they can be expected to examine issues from the perspective of their profession rather than that of the broader community.

#### 4.1.4 There is inconsistency between leading practice guidelines and current Board size

---

Appendix 7 indicates considerable variances in Board size, ranging from 9 (e.g. the Adoption Board and the Irish Medicines Board) to 55 board members (the ERHA). The Boards of ‘advisory/consultative’ organisations tend to be larger to support representation from across the voluntary and statutory sector. With 25 out of the 58 organisations having more than 15 members, the size of these Boards would run counter to leading practice principles outlined in our recommendations. Current Board sizes are likely to foster poor Board performance and slow decision-making and encourage representational behaviour rather than the best interest of the patient or client.

#### 4.1.5 There is inadequate evaluation of Board performance

---

While most agencies reviewed are obliged to produce annual reports, the Irish Medicines Board is the only organisation audited where there is statutory provision for self-assessment of the performance of its board. No external assessment or oversight of the board was apparent in the literature provided for any of the agencies audited.

#### 4.1.6 There is a lack of consistency in legislative requirements for formal reporting or production of strategic plans

The format and requirements for annual reporting vary significantly across the 58 organisations audited. The Adoption Board is the only organisation which has clearly stated requirements for inclusion in its annual reporting. However, it does not have to publish annual accounts in this report format (Adoption Act, 1952).

*“13 (1) The Board shall, after the expiration of each year, publish a report giving the following information in relation to that year—*

- the number of applications for adoption and the decisions of the Board thereon*
- the names of the registered societies concerned in the applications*
- the number of applications for registration of societies and the decisions of the Board thereon*
- the name and address of each society which is registered or the registration of which is cancelled during the year.*

*(2) The Board shall present a copy of the report to the Minister who shall cause it to be laid before each House of the Oireachtas*

*19 (1) The Board shall cause to be published in Iris Oifigiúil a notice in the prescribed form of the making of every adoption order and of every registration and cancellation of registration in the Adoption Societies Register.”*

As outlined in Appendix 6, legislation for other agencies is less specific, e.g. ‘The Board shall in each year, not later than such day as the Minister shall direct, make a report to the Minister of its activities during the preceding year’ (*The Drug Treatment Centre Board Establishment Order 1988*).

An increasingly common requirement for agencies in the wider public sector is the production of a strategic plan. Government Departments are now required to produce a formal Statement of Strategy, for example. Apart from the practical benefits of such an approach it also serves as a useful mechanism for the overseeing authority, most likely the DoHC in this case, to monitor the agency’s overall direction in a formal manner.

#### 4.1.7 Tensions between local representation, decision-making and the delivery of national and regional strategic objectives hinder decision-making

Currently the health boards, the Eastern Regional Health Authority and the area health boards operate under a legislative requirement that public representation on the boards shall exceed the total number of other members on the board. This ensures that elected representatives form the board majority grouping and that all areas covered by the board are adequately represented through a formal democratic process. However, some of the negative effects of this arrangement which have been identified are:

- Predominance of local area concerns over regional interest;
- Competition between representatives on the basis of locality or professional background rather than objective need;
- Reluctance to accept evidence-based information or recommendation where it is locally unpopular, e.g. location of acute services;
- Focus on operational and short-term issues over strategic issues.

The *Value for Money Audit of the Irish Health System* comments that ‘the political nature of the health boards constrains the delivery of VFM health services and can make a nonsense of some elements of decision-making within the regions’. In addition, *The Commission for Health Funding* (1989) found there was inadequate effective representation of the

interests of individual patients and clients and that *'the decision-making process is not underpinned by management information or process/system evaluation'*.

We found no evidence in reviewing individual governance arrangements that the preceding issues have been addressed.

#### **4.1.8 A set of guidelines is required for governance and accountability in the health system**

In 1992, the Department of Finance issued a set of guidelines for the governance of State Bodies. In 2002 these guidelines were updated to take into account 'recommendations made in subsequent reports and publications'. However, the updated Code of Practice for Governance of State Bodies has a distinctly commercial focus. In our view it does not fully address the particular requirements of the health system in relation to governance and accountability.

#### **4.1.9 The development of clinical governance mechanisms is required**

Consideration of accountability and performance measurement in the healthcare context has to take account of the clinical dimensions of care. The topic of accountability for the quality of clinical care has been the subject of growing debate and research in recent years under the general heading of clinical governance. Clinical governance has been defined in the following terms<sup>9</sup>

*"A framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".*

Clinical governance is a 'whole system' process and includes all disciplines involved in patient care (medical, nursing, clinical support, professional and management). It has a number of features:

- Patient centred care — this means that patients are kept well informed and are given the opportunity to participate in their care;
- Good information about the quality of services is available to those providing the services as well as to the patients and the public;
- Variations in the process, outcomes and access to healthcare are greatly reduced;
- Risks and hazards to patients are reduced to as low a level as possible, creating a safety culture throughout the health service.

To date in Ireland the mechanisms that are central to effective clinical governance have generally been patchy in their development, as commented on earlier in section 3.3.4. The role to be played by HIQA and the hospitals accreditation programme in progressing this agenda will be critical. So too will programmes being put in place by the professional regulation and training bodies to ensure ongoing review of competence of their members. Acknowledgement and credit must be given to those who have worked in Ireland on individual initiatives which will play a role in the broader clinical governance agenda as we move forward. Substantial progress has been made in involving clinicians in management and governance functions at a number of hospital sites, e.g. Cork University Hospital, St James's Hospital, Coombe Women's Hospital. But structural reform and improved information on the processes and effects of treatment will be of limited value unless they are underpinned by a coherent policy and legal framework. This should allow for evidence to be fed back effectively into day-to-day operations and ensure continuous quality improvement. While respecting the importance of the patient/doctor relationship for quality control and broader governance reasons, it is essential that clinicians be within the direct accountability line.

<sup>9</sup> G.Scally and L.J.Donaldson, "Clinical governance and the drive for quality improvement in the new NHS in England" BMJ (4 July 1998): 61-65

## Chapter 5

# Analysis of supporting processes

---

Findings in relation to current governance arrangements as outlined in Chapter 4 clearly impact on the functioning of the overall system. The Audit also reveals features that warrant commentary in the context of good functioning of the health system as a whole. We have set out our findings relating to these issues grouped under the following headings:

- Service planning and funding;
- Evaluation and service delivery;
- Consumer involvement and stakeholder representation;
- Integration of services;
- Capability and performance.

Our Audit was conducted from literature submitted by the individual agencies relating to their own structures and functions. This was less relevant as a source of qualitative analysis of system-wide issues relating to planning, resourcing, performance, evaluation and capability. These findings, therefore, are developed predominantly from our review of international leading practice, previously published analysis and our own experience in healthcare.

### 5.1 Service planning and funding

Currently, each of the health boards and the ERHA agree Service Plans with the DoHC on an annual basis in line with their funding as notified in the Letter of Determination. This funding, in turn, is derived from the Department's annual Vote from Dáil Éireann to cover the expenditure of the Department itself and the health services generally. This process and the respective accountability responsibilities of the Minister, the Secretary General, the health boards and the Health Board Chief Executive Officers are set out in legislation.

As indicated in Chapter 2, the *Commission on Financial Management and Control in the Health Services* has as its objective *to consider the various financial management systems and control procedures currently operated in the DoHC and by the main spending and service areas of the health sector*. It is clear from its terms of reference that the Commission was mandated to consider key aspects of current financial management and control processes that have a direct impact on the functioning of the health system. While this area is outside of the explicit scope of our own Audit, we consider it relevant to outline a number of general findings relating to service planning and funding from a financial perspective.

#### 5.1.1 Service planning at national, regional and local level needs to be strengthened and aligned to new structures

---

*Quality and Fairness* recognises the need for strengthening service planning in health boards by building on the provisions of the 1996 accountability legislation. Two actions in the Strategy specify how service planning will be strengthened:

- Action 70 — Accountability will be strengthened through further development of the service planning process;
- Action 110 — Health boards will be responsible for driving change, including a stronger focus on accountability linked to service plans, outputs and quality standards.

The DoHC will also have a stronger focus on monitoring the achievement of deliverables outlined in the service plans.

*“Ultimately, it will provide for greater consistency between health boards, and in the context of the development of the HeBE, the opportunity for maximum cross-fertilisation of leading practice initiatives, expertise and knowledge. Standard formats and performance indicators for service plans will be agreed as part of this process”.*

We have referred to the important developments in the service planning process and its ongoing evolution. Our own consultation with stakeholder agencies leads us to fully subscribe to the objectives set out above and to conclude that structural reform which is not underpinned by a robust and streamlined service planning process will have limited effect. There is also a need for recognition that the more sophisticated service planning becomes, the more it makes explicit the limits of activity that can be provided within budgets. This has the potential to cause difficulty in a system which has to balance demand-led services with fixed global budgets. Clear policy and prioritisation, as well as good measurement of real need, will be required to meet this challenge.

### 5.1.2 There is a lack of alignment of resource allocation with planning cycles

---

A number of deficiencies in relation to the alignment of resourcing and planning cycles were identified during a review of previous system commentaries. These have a significant impact on how well the system works. They include limitations and shortfalls in relation to funding processes, as outlined in the Strategy, which recognises the need to link funding and service planning more closely.

In support of the objective of allocating funding on the basis of implementing sound strategic plans, where the funding relates clearly to service outcomes, *Quality and Fairness* has identified two actions:

- Action 95 — Multi-annual budgeting will be introduced for selected programmes;
- Action 98 — Annual statements of funding processes and allocations will be published.

The Government decision to retain an Exchequer-funded, global budget funding mechanism for the public health system was based, in part, on the opportunity it gave to ensure cross-system coherence in planning and delivery of care. The focus is now on identifying the optimal resource allocation and financial management processes to support this model — and the *Commission on Financial Management and Control in the Health Services* will report in 2003 on its findings in this regard. Our Audit has identified a number of factors which are fundamental to ensuring that financial management and control processes support coherent planning:

- The need to inject strategic coherence and evidence-based analysis into the funding process;
- The need to ensure that both strategic and operational planning functions are present within the health system;
- The need to incentivise behaviour in support of system priorities, with funding seen as an important mechanism to achieve this aim;
- The need to quantify and measure more clearly exactly what outcomes are anticipated from the totality of resources available.

## 5.2 Evaluation and service delivery

### 5.2.1 Service evaluation needs further development and better definition

---

As indicated in Chapter 2, one of the core findings of the ERSI critique of the 1994 health strategy was the absence of a process of ongoing evaluation of the impact of the strategy. This gap in evaluation at a strategic level feeds down through the system and is evident in an uncoordinated approach to evaluation at service level.



The service planning and monitoring process has been considerably strengthened in recent years to ensure greater accountability, and to provide some performance indicators for the year in question. However, in the majority of agencies reviewed the focus is on reporting activity and accounting for financial expenditure at the year end. This needs to be broadened to include reporting on outcomes such as quality, value for money, etc.

In relation to health boards, the reserved functions of the boards relate clearly to specific duties such as the approval of service plans and annual financial statements. There is no explicit requirement for monitoring and evaluation of services, measuring outputs and standards relating to quality, equity or meeting service needs. Boards are required to supervise the implementation of service plans, with the primary focus on compliance with limits of the annual budgets.

The formal requirement in the ERHA's legislation that it monitor and evaluate services it funds is the exception, and not the norm. The other delivery agencies do increasingly undertake service evaluations and are moving individually to develop their capacity in this area. The challenge faced by individual health agencies in conducting service evaluation is that, high-level performance indicators apart, technical resources, standardised approaches and benchmarking data are not widely available to support this vital work. More recently advances have been made in the use of performance indicators which should build over time into an effective component of service review.

### 5.2.2 Service evaluation needs to become an integral part of overall health planning

---

It is noteworthy that, even where an individual agency assesses and reports well in relation to evaluation and review of its own operations (for example in its annual report), there is limited comparability possible. At present there is no drawing together of such material to produce a coherent national picture of performance or to allow an agency to benchmark its own performance. Nor is there an established mechanism for authoritative and ongoing independent review of entire programmes using evidence-based analysis. The early establishment of the Health Information and Quality Authority represents a real opportunity to meet these deficits.

## 5.3 Consumer involvement and stakeholder representation

There is explicit recognition in *Quality and Fairness* of the need for a more people-centred health system:

*"The health system must become more people-centred with the interests of the public, patients and clients being given greater prominence and influence in decision-making at all levels".*

Work on these elements is ongoing under Actions 48-52 which provide for the following:

- A national standardised approach to the measurement of patient satisfaction will be introduced (Action 48);
- Leading practice models of customer care will include a statutory system of complaint handling (with an extension in the role of the existing Ombudsman to deal with complaints in relation to the health system proposed) (Action 49);
- Individuals and families will be supported and encouraged to be involved in the management of their own healthcare (Action 50);
- An integrated approach to care planning for individuals will become a consistent feature of the system (Action 51);
- Provision will be made for the participation of the community in decisions about the delivery of health and personal social services (Action 52).

The Strategy acknowledges the established partnerships with community and voluntary organisations, and sees these partnership arrangements as a key strength of the system. The importance of partnerships with the staff of the health system is also underlined as an essential feature of the successful operation of the system.

### 5.3.1 There is an absence of a consistent focus on the consumer

---

Clear and visible accountability to the user of health services is underdeveloped. Some health agency governance structures, especially those established more recently, make provision for consumer representation; most do not. For example, there are no direct means for local communities to find out what is being planned for their local health service and no consistent mechanisms for service users to feedback their views so as to influence planning decisions. Similarly, there is very little in the way of user-friendly performance information, which could help patients, prospective patients or their carers to make choices about the services they wish to use. A very welcome development in recent years has been the national patient satisfaction survey in Irish hospitals by the Irish Society for Quality in Healthcare, in collaboration with the hospitals themselves. These standardised surveys provide vital information about patient experience of the health service and are an example of a strength that could be built on effectively within a more consolidated health system.

### 5.3.2 Stakeholder participation needs clearer focus at each level in the system

---

The current legislative framework provides that the interests of individuals and communities are reflected through the participation of elected local representatives in the governance of health boards, ERHA and the health authorities. In addition, some health professionals have access to health board representation, e.g. medical professionals, nursing; others do not. However, several questions have been raised in the Audit about the effectiveness of those governance structures, and by extension, about the capacity of public (and other) representation in governance.

The Audit highlights the need for a coherent, system-wide infrastructure for stakeholder partnerships which will link stakeholders into the health system in a meaningful way. The development of these linkages will require the formalisation and extension of the elements of good practice that are now in place. Some relevant examples of positive initiatives in this area which we have identified are:

- Sunbeam House  
Introducing a Service Quality System in an organisation caring for adults with intellectual disability. Staff and service users combining to assess and adapt organisational practices
- North Western Health Board  
Consultation with 100 adolescents in Donegal on child and adolescent mental health with a view to designing better services
- Eastern Regional Health Authority/South Western Area Health Board  
'Community Planning for Better Health': work with community in Clondalkin through a multi-disciplinary group. Designed to transfer skills to allow citizens participate in 'bottom-up' health planning.

In addition, there has been extensive development in recent years of local and community-based partnership and participation structures and other inter-agency/inter-departmental structures. The extent to which these structures exist will be important in assessing the health-specific mechanisms to be used in each locality.

## 5.4 Integration of services

One of the principal findings in Chapter 3 relates to the extent of fragmentation in the current structures and functions. This directly affects the ability to plan or deliver integrated health services to the consumer. As already noted, the complexities of healthcare, the numbers and type of staff involved and the range of specialist institutions often make for a difficult journey for an individual patient or consumer across the system's component parts.

### 5.4.1 Poor integration of services is a recurring theme

---

Poor integration of services is a recurring theme in external reviews as far back as the *Commission on Health Funding* (1989). It was also a major theme emerging from the consultation process which preceded *Quality and Fairness* and was confirmed in our own findings. Many of the major health agencies have undertaken initiatives in this area, designed to overcome the difficulties. Examples include the establishment in the Southern Health Board of Age Care Evaluation teams based at Cork University Hospital and the pilot shared diabetes programme between the Northern Area Health Board and Beaumont Hospital. However, the fact that our Audit identifies overlaps and duplication in the role and function of agencies suggests strongly that integration will remain a challenge unless it is placed within a context of organisational reform. We are aware that this issue goes well beyond structures to include a wide range of other factors which inhibit integration.

### 5.4.2 There are many non-structural factors which contribute to poor integration

---

Our health system has an integrated health and personal social services remit. This is considered to be a key strength in the Irish health service compared to others. It provides the potential for holistic care to the individual, the family and the community. Too often, however, the integration happens in only a limited number of cases and cannot be sustained across the service as a whole.

The Primary Care Strategy refers to the need for a new approach:

*“Investment and effort needs to be focused on the parts of the service that are best placed to provide maximum return, to grow to serve unmet need and to deliver the kind of person-centred, holistic and locally accessible range of services that are required if the Health Strategy is to make a real difference”.*

Among the non-structural factors that we identify as working against integration are the following:

- Lack of common standards and records;
- Funding which is compartmentalised;
- No measure of integration incorporated into performance assessment;
- Fragmented management structures;
- Institutional competition;
- Restrictive work practices.

Poor integration is common in health services worldwide. There are also examples in Ireland of intra-sectoral initiatives that are working extremely well to cross service boundaries and deliver seamless care e.g. the ‘Home First Project’, linking the community with the acute service sector under the aegis of the Northern Area Health Board and Beaumont Hospital. The proposed organisational reforms will need to be complemented by progress in these other non-structural areas in order to ensure improvements in the patients’ interests.

## 5.5 Capability and performance

### 5.5.1 There is a need to strengthen capability to manage and lead significant change

---

Health service leaders face significant challenges in managing day-to-day services. They operate in a fragmented system and are required to meet the ever-changing needs and demands of consumers, new technologies and new regulations within allocated resources.

The ability to lead and manage change at a system level is central to the delivery of *Quality and Fairness*. The strategy identifies a key role in particular for the DoHC and the health boards in managing this change. Indeed, the DoHC has acknowledged this, recognising that it will *'require strengthening if it is to provide credible and authoritative leadership during the period of major transformation ahead.'* (*Quality and Fairness — Action 109*). A primary role is also identified for the health boards in Action 110, where they are assigned responsibility for change management in implementing the strategy.

There has been considerable debate about the impact of the increasing numbers of 'managers and administrators' in the health system, on the level and quality of services. There is a perception that despite additional management resources the management capability of the system has not improved. While this issue was not central to this Audit it emerged as a recurring theme during our high-level consultation. Senior management in the health system have repeatedly pointed out that over 70% of the new staff approved since 1999, and categorised as Clerical/Administrative staff, are in fact involved in front-line service delivery. This serves to highlight the point that simply adding more people to the existing organisation may not in itself solve the difficulties presenting. Measures need to be taken to ensure maximum value from additional resources.

In the absence of independent empirical information, our sense is that:

- The current complexity and fragmentation of the system make it extremely difficult to manage at all levels. In effect, individual managers often find themselves managing 'in spite of the system';
- There is a need to further develop modern management and leadership skills broadly across the health system, both in general management and in clinical disciplines.

The requirement to further develop organisational competence in the management of change is evidenced in the expanded remit assigned in *Quality and Fairness* to the Office for Health Management to include organisational development as well as its traditional role in management development.

The development of two national health strategies in the past eight years has clearly demonstrated the capacity of the system to devise a blueprint for the service overall and a sense of direction for moving forward, albeit on a periodic basis. However, existing structures and functions do not facilitate on-going and regular strategic planning, and rely, all too often, on parallel arrangements for the coordination and review of most individual strategies. The development of the 1994 and 2001 national health strategies, for example, depended on creating temporary coordination mechanisms to ensure appropriate system-wide consultation and strategic planning.

Experience in health system reform internationally shows that clear accountability for effecting change needs to be assigned at a system, organisational and individual level. In other health services specialist agencies to drive change at a system-wide level have been established e.g. the Modernisation Agency in the UK. At a minimum, leadership development and carefully structured incentives through performance management frameworks need to be linked in any change programme underpinning the implementation of *Quality and Fairness*.

### **5.5.2 A formal performance management framework to link individual and team performance to strategic objectives is required**

All experience and research suggests that managing and monitoring performance at a system wide level (through improved planning evaluation and auditing) will not be enough to deliver a high performance health system. Strong performance at a system-wide level, particularly in a knowledge-based sector like the health service, will only be delivered through effective performance management and measurement at an organisational, team and individual level.

*The Action Plan for People Management* (October 2002) outlines the development of performance management as one of its key themes. It advocates the introduction of a system of performance measurement and feedback to improve performance. The Government's Strategic Management Initiative to develop better government also identified the need to devise and implement a formal performance management framework across Government departments.

While the scope of this Audit did not extend to evaluating performance management practices it is recognised as a key dependency for improving effectiveness. Despite recent progress in people management practices there is as yet no formal performance management framework in place across the health system. In our view this significantly reduces the system's ability to monitor the quality and effectiveness of its outcomes, to manage performance against its objectives and to engage with staff on a one to one basis on the key aspects of their role.

## Chapter 6

# The need for system-wide structural reform

---

This Chapter brings together the findings contained in Chapters 3, 4 and 5 and sets the priorities to be addressed by structural reform. Our analysis has concluded that the Irish healthcare system is characterised by the fragmentation of its structures and functions. This represents a serious structural obstacle in attempting to deliver the longer-term priorities for healthcare, most recently identified in *Quality and Fairness*.

These difficulties have been compounded by the addition of new roles within healthcare such as childcare, and food safety and control. In theory the system has operated an integrated model for the past 30 years, based on devolved responsibility to local health boards managing both acute and non-acute healthcare services. In reality this model has allowed a fragmentation of structures and functions which has made the job of integration more, rather than less, difficult.

An important structural problem is the way in which agencies have been established as a 'part-solution' rather than a more radical 'full-solution' which would address the interrelated nature of the system. This often leads to a dilution of the effectiveness of system critical functions, hidden and poorly used pockets of expertise and an inappropriate location of functions. Our findings reflect the need for comprehensive structural reform.

## 6.1 Summary of findings

### Healthcare agencies (Chapter 3)

- **Complex and fragmented structures — an obstacle to achieving improvements**
  1. The increase in the number of individual agencies creates a number of challenges in managing and resourcing the system
  2. The development of parallel structures has added to the complexity and fragmentation of both policy-making and implementation
  3. The continued involvement of the DoHC in operational matters reduces clarity around organisational accountability
  4. There are a number of difficulties in managing the scope of healthcare services
  5. The existence of the health boards alongside the ERHA model complicates the interface with the DoHC
  6. The legislative framework for the ERHA creates operational difficulties
  7. The functions assigned to specialist agencies overlap with other bodies
  8. The proposed new national agencies have system-wide implications for both structures and functions
- **Scope for the rationalisation of certain agencies**
  9. A number of service delivery agencies can be mainstreamed or merged

10. There is evidence of a drive to rationalise the number of professional, regulatory and training bodies within other national health systems
11. There is a clear rationale for relocating the functions of Comhairle na nOspidéal in the National Hospitals Agency

- **Need for standardisation and coordination across the system**

12. The traditional health board model evolved over the years in an unstructured manner and has resulted in insufficient coordination and standardisation
13. There is no single strategic HR function to coordinate or lead system-wide activities
14. There is a lack of standardisation in the structures and functions supporting professional registration, regulation and development
15. There is a need for centralised and standard approaches in relation to quality assurance functions
16. Challenges remain in coordinating the national health research and development agenda and in making health research available to policy-makers and service deliverers
17. System-wide health information coordination is inadequate

- **Underdeveloped system functions in a number of areas**

18. Shared services are underdeveloped in the health sector
19. The planned expansion in the number of regulated professions requires a coordinated approach

## **Governance and accountability (Chapter 4)**

20. Boundaries of accountability are not always clearly defined
21. Accountability for non-financial performance is not clearly embedded in legislation
22. Basis for Board appointments needs clarification
23. There is inconsistency between leading practice guidelines and current Board size
24. There is inadequate evaluation of Board performance
25. There is a lack of consistency in legislative requirements for formal reporting or production of strategic plans
26. Tensions between local representation, decision-making and the delivery of national and regional strategic objectives hinders decision-making
27. A set of guidelines is required for governance and accountability in the health system
28. The development of clinical governance mechanisms is required

## **Supporting processes (Chapter 5)**

29. Service planning at national, regional and local level needs to be strengthened and aligned to new structures
30. There is a lack of alignment of resource allocation with planning cycles
31. Service evaluation needs further development and better definition

32. Service evaluation needs to become an integral part of overall health planning
33. There is an absence of a consistent focus on the consumer
34. Stakeholder participation needs clearer focus at each level in the system
35. Poor integration of services is a recurring theme
36. There are many non-structural factors which contribute to poor integration
37. There is a need to strengthen capability to manage and lead significant change
38. A formal performance management framework to link individual and team performance to strategic objectives is required

## 6.2 Priorities to be addressed by the consolidated structure

In our consultations with the Minister for Health and Children, the Audit Steering Group, the DoHC and representatives of a variety of stakeholders in response to our initial findings, the following priorities to be addressed by future structures emerged. They are strongly supported by our Audit findings as outlined in Chapters 3-5. These major system priorities established the need and rationale for moving to a consolidated structure. They also point to the main benefits which will accrue as a result of the reforms we propose:

- **Ensure clear accountability lines throughout the system**

Our review, together with the views expressed by stakeholders, has highlighted the need for clarity of accountability in the system. The lack of clear accountability is exacerbated by the blurring of policy and executive roles and by the number of agencies performing similar or overlapping functions as outlined in Chapter 2. As a result, there are real difficulties for the system in demonstrating the VFM case for the sustained levels of investment that will be required to develop services to the required levels. Clear accountability lines will be critical to drive performance and to establish a more streamlined and focused system within which healthcare staff can deliver improved service levels.

- **Provide a national focus for integrating service delivery**

A fundamental requirement of the future structure is to provide a national focus for integrating service delivery. Unless integration is planned and monitored at a national level, it is unrealistic to expect that integration will happen at a regional or local level. National integration should facilitate effective decision-making at specific points in the system and should allow for national management of resources, resulting in a more efficient and streamlined health system within which healthcare professionals can deliver.

- **Allow the Primary Care Model to develop and grow**

The Primary Care Strategy has emerged as an important building block in the drive to shift the balance from care to prevention. This objective is in its infancy and will require sustained support in the coming years. A mechanism is required to allow this model to grow. While there is a Primary Care Task Force charged with its implementation, primary care needs to be at the core of the health service delivery structures in order to manage these services in an effective manner.

- **Develop structures to facilitate the reconfiguration of the hospital system**

Acute sector reform is one of the two service areas targeted as a 'Framework for Change' in *Quality and Fairness*. Despite its critical contribution to the health service as a whole, there is as yet no formal policy for the sector. This combined with the need to deliver significant extra capacity, while simultaneously reorganising to ensure quality



and safety for patients, means the hospital service in itself requires a sustained and formal programme of reform over the coming years. Implementation of the report of the National Task Force on Medical Staffing will also have major implications for the reform agenda in the hospital sector.

- **Support continuous quality improvement and increased external appraisal**

Formal quality assurance is relatively undeveloped in the health system at present. Examples of work which has been done include the recent establishment of the hospital accreditation programme on a statutory basis, the development of the Social Services Inspectorate, the appointment of risk managers in a number health boards and hospitals, and the development of service evaluation programmes in the ERHA, in particular. The National Disability Authority is currently completing production of a set of national standards for disability services, to provide a benchmark for ensuring that all services reach an agreed level of performance. A number of health boards have drawn up high-level strategies on quality and have appointed officers with responsibility for quality issues generally. The Irish Society for Quality and Safety in Healthcare has done extensive work promoting and supporting the quality agenda. The Medical Council and the Royal Colleges have been to the fore in recent years in setting standards for their members and introducing competency assurance programmes. However, quality initiatives are often stand-alone and remain largely in-house.

There is a need for more external and authoritative appraisal of all aspects of health system performance. This external perspective then has to be fed into internal funding decisions and performance standards. It is most important that the correct balance is struck between external checking and internal continuous quality improvement approaches, which deliver effective and sustained results. Common quality standards are required to ensure that leading practice is diffused equally throughout the service and that evaluation is objective and consistent, whenever the user comes in contact within the system.

- **Put in place robust information gathering and analysis capability**

Evidence-based decision-making can only happen if evidence is available through:

- Needs assessment;
- Research;
- Sound and standard information systems.

Quality standard-setting, measurement and evaluation is inextricably linked with information collation and its analysis. Developing information gathering and analysis capacity in the system is vital to both of these processes.

- **Consolidate the current system to make it more manageable**

Managing a system with fragmentation is a matter of constantly balancing the need to consolidate and integrate with the need for building sectoral policy and execution. In our view the following is required:

- **Tightly-managed vertical integration**  
To assist coordination of activities there is a need to develop local structures, close enough to the customer so as to provide a responsive, patient-centred service which is supported by strong policy guidance and executive oversight functions. The ability of local care teams and services to respond quickly and well to the needs of patients is directly related to the efficiency and quality of support they get from the system as a whole
- **Avoiding a one-dimensional approach**  
Care must be taken that a one-dimensional approach to developing the system is not adopted, such as simply creating another new agency without regard to the wider structural impact. A coordinated approach

is required which specifies the priorities for the system and accordingly applies structures and functions to allow the priority areas to be addressed

- **Strong leadership**  
To provide assurance around the future performance of the healthcare system and to deliver value for money, tight discipline regarding the systems structures and functions will be required. Implementation of the system priorities together with the structural changes specified in this report will demand conviction and a real determination to make critical choices and engage in real reform. Leadership must be clear, firm and sustained. Taking a less difficult route may ultimately dilute the desired result and perpetuate the fragmentation of critical functions

- **Preserve and build on the strengths of the current architecture**

The reform approach has to be developmental, not destructive. In designing a new architecture and implementing it we need to build on the many positive aspects of the existing system. In particular there is a need to capitalise on the key functions of operations such as HeBE, the Irish Health Services Accreditation Board, OHM and the planning and monitoring capacity in the ERHA and the health boards. It also needs to recognise the very extensive role played by the voluntary sector in providing a wide range of services such as care for the intellectually disabled, childcare, physical disability service and acute hospitals. These providers, who bring their own ethos and innovative contributions to the health service overall, must be supported within a national framework that requires consistent standards of performance and accountability for all.

In terms of people management and leadership development, the reform approach should also reinforce and build on the efforts to date in creating a more transformational and participative working culture in the health services.

## 6.3 Creating a consolidated structure

Building on the need for system-wide structural reform, the overall goal of our proposals is to develop a consolidated structure which will deliver on the priorities outlined above. In our view, there needs to be a fundamental shift in thinking which moves from fragmentation to consolidation and integration.

It is necessary, therefore, to develop a broader vision for the shape of the future health system, through the development of a consolidated structure. This vision is about defining the structural direction for the next critical phase of the development of our health services and will provide a framework for the continuing development of the service on a more coherent basis.

To achieve this system-wide structural reform, we make four major proposals for reform:

1. Create a consolidated healthcare structure	Chapter 7
2. Develop supporting processes	Chapter 8
3. Strengthen governance and accountability arrangements across the health system	Chapter 9
4. Reorganise existing agencies and their functions within the consolidated structure	Chapter 10

Chapters 7, 8, 9 and 10 develop these four reform proposals, and their supporting recommendations and actions.

---

# **Part 3**

## **Recommendations**

---



## Chapter 7

# Creating a consolidated structure

---

### Reform proposal 1: Create a consolidated healthcare structure

We have set out in the preceding chapter the priorities for the health system overall which a new structure must support. In the pages that follow in this chapter we describe the principal components of the consolidated structure we propose and their roles.

To create a consolidated healthcare structure, the following recommendations are proposed:

#### Recommendation 1.1

- Establish a separate national Health Services Executive (HSE) and restructure the Department of Health and Children (DoHC)

#### Recommendation 1.2

- Create two service pillars within the HSE consisting of:
  - Acute sector, overseen by the National Hospitals Office (NHO);
  - Primary, Community and Continuing care sector.

#### Recommendation 1.3

- Put in place four regional management structures and build on the existing community care structures at local level

#### Recommendation 1.4

- Develop a National Shared Services Centre (NSSC) within the HSE

#### Recommendation 1.5

- Strengthen quality assurance and information through the establishment of the Health Information and Quality Authority (HIQA)

#### Recommendation 1.6

- Develop structural mechanisms to increase consumer involvement in decision-making and service delivery

To adequately implement the priorities outlined in Chapter 6 in a way that moves clearly and directly from policy to patient care, we envisage a model built upon four elements:

#### **Strong accountability, prioritisation and direction**

- Setting clear priorities for the system overall
- Holding the delivery system to account
- Strategic planning on a system-wide basis
- Driving system-wide reform

### Centralised performance management and control

- Implementation of national public health priorities
- Management of the delivery of integrated healthcare
- Service performance and VFM

### Coordinated regional delivery

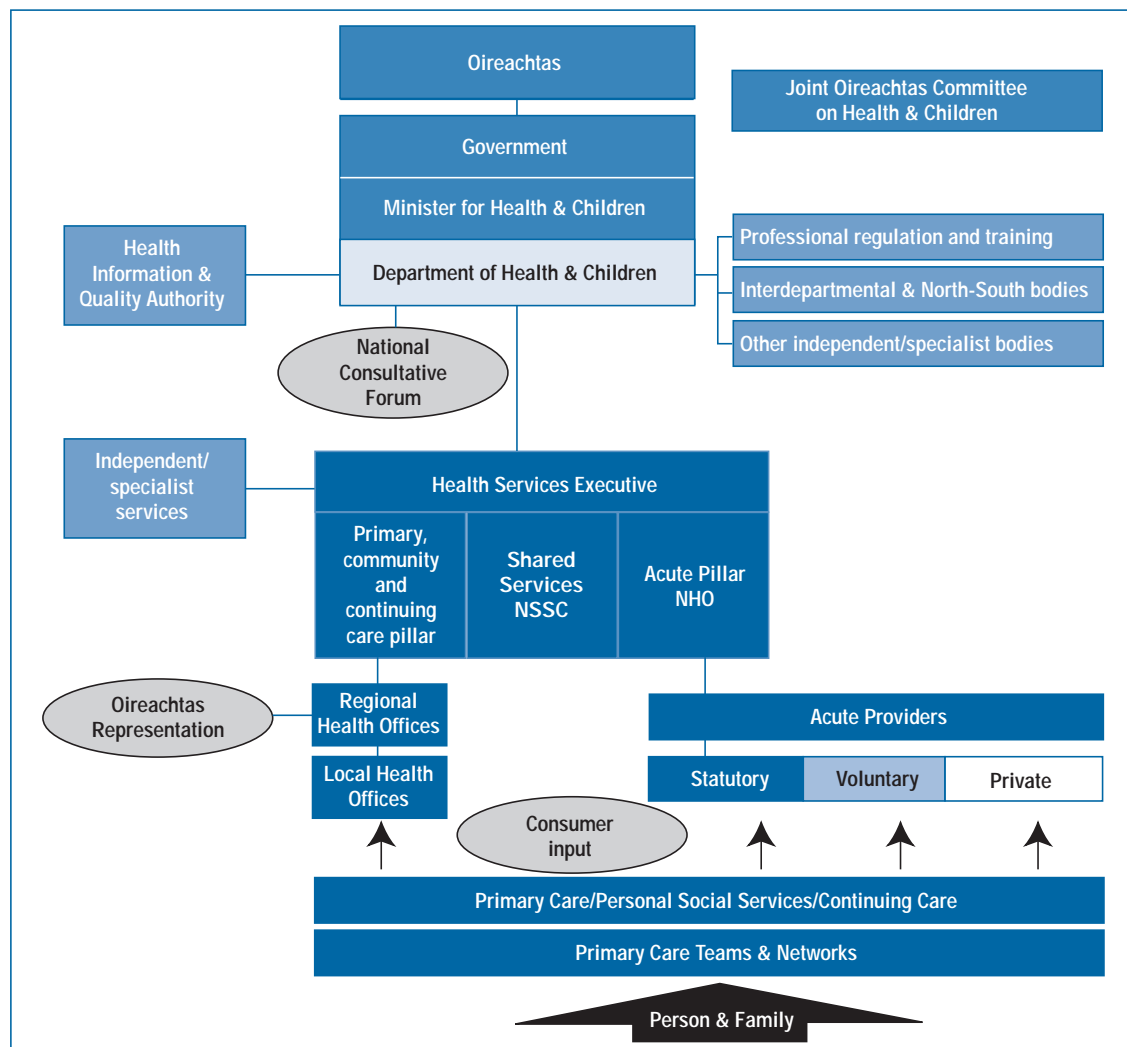
- Matching services to identified needs within an overall national plan
- Delivery of integrated services within regions

### Patient-centred local services

- Provision of patient-responsive services customised to local need
- Stakeholder participation
- Integration with wider social and public services

An illustration of the consolidated structure is contained in figure 7.1 below.

Figure 7.1: Overview of the principal elements of the consolidated structure



## Recommendation 1.1: Establish a separate national HSE and restructure the DoHC

### Actions:

- Establish a HSE on a statutory basis as a corporate body with a governing Board;
- Transfer all executive functions from the DoHC to the HSE;
- Make legislative provisions to remove existing health board and ERHA governance structures, with these functions being assigned to the HSE;
- Develop legislation to ensure accountability by the Board of the HSE for the delivery of health and social services;
- Legislate to give the HSE employing authority;
- Restructure the DoHC and reskill staff to support its role in the consolidated model.

### Rationale:

---

#### Why a HSE?

- **The separation of policy and executive functions**

The transfer of executive functions from the DoHC to the HSE will clearly separate the policy from the executive role in the health system. This will allow both functions to operate more effectively. Confusion around these functions has led to gaps in critical policy areas and to blurring around executive responsibility. All too often those gaps result in the Department being pulled into 'fire-fighting' or operational issues. Similarly, existing executive agencies find their role is being subverted or confused. Clear definition and separateness will allow the Department to exercise a number of important roles which we have listed as absent or underdeveloped in the current system. This will also enable it to take a bottom-up evaluation approach to the totality of spending, rather than focusing on the issues around development funding in the annual Estimates (typically 2% or 3% of current total spend).

- **Accountability for all operational matters within the public health delivery system channelled through one body**

Taken together our findings suggest strongly that the division of executive responsibility across a wide number of agencies is limiting the system's ability to perform efficiently and effectively and leads to a diffusion of responsibility and accountability. The emergence of HeBE as a vehicle for joint executive action in recent years points up the existing structural deficiencies and reflects an acknowledgment at senior levels within the health system of the need for stronger coherence and system-wide action.

- **Enabling legislation**

Enabling legislation for the HSE will need to specifically address the deficiencies in the Health Acts with regard to obligations in areas of monitoring and evaluation of services, consultation and measurement of outputs.

#### Why locate the HSE outside of the DoHC?

We considered two structural options in constituting the HSE:

- A separation of the internal structures of the Department to reflect policy and executive functions in discrete internal units;
- The creation of an external organisation with its own governance structure.

While the first option had the advantage of working within existing structural arrangements, it would not, in our view, meet the system priorities set out in Chapter 7. The decisive factors are the following:

- A separate entity with its own governance structures will have the duty and authority to deliver the annual service plan and demonstrate 'arms-length' accountability;
- In turn this will require the Department to be explicit about its priority setting, policy frameworks and the delivery targets it sets for the Executive;
- The skill sets and competencies required to discharge a policy-making role in a Department of State are of a different order to those needed for a national executive agency;
- The organisational culture for the Executive will need to be distinctly focused on delivery within a strong managerial and performance ethos;
- A separate Executive is more likely to be able to draw upon the widest range of senior management talent, from inside and outside the public sector, which will be required to achieve the restructuring objectives;
- The establishment of a separate Executive with its own governance, high-calibre management and a clear accountability for service delivery will send a very strong signal to both patients and staff on the purpose of the reform package.

### Benefits of a separate HSE

A separate Executive and restructured DoHC has the following benefits. It will:

- Represent a move from a system of boards (health boards) to one National Executive Board;
- Bring together the service planning, funding and delivery mechanisms for the entire health system to ensure unified accountability structures. For the first time it will be possible to monitor service delivery from a single unit which has effective control over all delivery mechanisms;
- Provide for comprehensive and integrated reporting on a timely basis to the DoHC regarding emerging financial/service pressures;
- Provide focus and resources for functions that are currently without a national presence e.g. VFM, HR, cross-system IT, system-wide implementation and coordination of national strategies (*Quality and Fairness*, cancer and cardiac);
- Establish a framework for the development of shared services that are currently fragmented (payroll, HR administration, procurement, estate management), ensuring that efficiencies and value for money are achieved across the system;
- Support a single interpretation of policy, legislation, regulations and entitlements etc, and help eliminate variability in this area to the benefit of both patients and staff. This provides an opportunity to address some of the criticisms of the current system by ensuring a consistent standard of service across the country for all citizens. It also represents an opportunity to ensure equity of provision for people, irrespective of geography, and a means of ensuring quality by integrating diverse strategies into a single service plan for the entire system;
- Ensure a whole-system approach in a number of critical areas:
  - As the single employer, disseminate HR best practice and ensure consistency of application across the service;
  - Standardisation e.g. development of common systems and processes which yield efficiency gains and consistency of service;
  - Collaboration among fewer Regional Health Offices on supra-regional issues;



- Integration from the top between acute and primary, continuing, community and other non-acute services;
- Dedicated resources for the development and implementation of joint services;
- Provide a platform for a reduction in the level of inappropriate executive functions retained within the DoHC, freeing up capacity to allow it perform its redesigned role.

## **DoHC — Role in the consolidated structure**

---

The DoHC will retain ultimate responsibility for holding the delivery system to account by drawing on the evidence-base to be provided by HIQA but also by re-skilling its own staff and strengthening its technical resources.

It will increase its ability to focus on strategic and policy issues by reducing its involvement in operational matters, through:

- Transferring all remaining executive functions to external agencies;
- Reducing the number of direct interfaces with the wider health system;
- Taking charge of a number of policy functions and levels of expertise currently residing outside of the Department;
- Sponsoring the programme of organisational reform which flows from this report and the other major reviews currently underway.

Specifically the DoHC will be responsible for:

### **1. Serving the democratic process**

- Supporting the Minister in the formation and evaluation of policy for health services.
- Supporting the democratic process by giving advice and support to the Minister, Oireachtas Committees and other Dáil business.
- Representation of the State on health-related matters in the European Union and internationally.

### **2. Monitoring and evaluation**

- Ensuring value for money through effective resource allocation and evaluation of outcomes.
- Setting financial, activity and quality targets and performance measures for the HSE and the wider system and assessing their impact with the assistance of HIQA.
- Agreeing the National Service Plan with the HSE.
- Setting governance and accountability standards across the system and measuring their effectiveness.
- Control of overall numbers employed in the health system and ensuring adherence to national pay policy.
- Oversight and funding of national specialist agencies.

### **3. Developing policy**

- Develop public health policy.
- Priority-setting for health and social services.
- Overall human resource and organisational development policy.

- Workforce policy and liaison with education sector.
- Providing leadership in the development of the research agenda.
- Strategic management, e.g. disease-based and population health strategies.

#### **4. Operational responsibility**

- Acquisition of resources from Government.
- Establishing necessary legislative frameworks for the health system.
- Liaison with relevant professional, regulatory and training bodies.
- Liaison with other Government Departments and agencies, national, cross-border and international.

In support of this role, the availability of a range of specialist skills will be particularly important, and these should include:

- Strategic management;
- Population health analysis;
- Health economics;
- HR and workforce policy analysis;
- Organisational development.

#### **HSE — Role in the consolidated structure**

---

The HSE should comprise the following discrete components:

- The HSE corporate;
- The National Hospitals Office;
- The National Shared Services Centre;
- Four Regional Health Offices.

Each of these components should operate within a single governance structure under the Board of the HSE.

Specifically the HSE will be responsible for:

#### **Coordination and implementation of national priorities/strategies**

- Delivering the National Service Plan on time and within budget. Its performance will be measured against targets set by the Department in relation to activity levels, quality and impact.
- Ensuring national policies and strategies are implemented. e.g. Primary Care Strategy, disease-based Strategies, Traveller's Health, etc.
- Assuming the executive functions of the DoHC which remain to be devolved as specified in our findings in Chapter 3.

- Assuming the executive functions of a number of existing stand-alone agencies as specified in Chapter 10.
- Contributing to the work of the DoHC in its policy formulation and strategic planning and management role by providing advice on operational and service matters.
- Delivering organisational reform. The DoHC will be expected to prioritise certain sectors or services for reform or development and will require the HSE to take the necessary steps to deliver change in line with these priorities.

### Funding, commissioning and oversight of services

- Funding, commissioning and overseeing the delivery of integrated health and social services including:
  - Primary, community, continuing and personal social services, coordinated on a regional basis through the Regional Health Offices;
  - Acute services, coordinated on a national basis through the National Hospitals Office located within the HSE;
  - Shared services, provided for the entire system through a separate platform (National Shared Services Centre);
  - National specialist services, delivered through independent structures;
  - Co-ordination of joint services, facilitated by the HSE on a pilot basis and then providing for roll-out as required.
- Adopting an integral role in the planning, funding and delivery of all healthcare services. Specifically:
  - Funding acute hospital services via the National Hospitals Office;
  - Funding primary, continuing, community and other non-acute services via the Regional Health Offices for either direct delivery or by arrangement with voluntary or other providers;
  - Ensuring delivery of an integrated service to all users.

We consider that the HSE corporate, excluding the NSSC and RHOs, should be kept as compact as possible. Its ultimate size will depend upon decisions in relation to the totality of our recommendations such as the realignment of agencies and the extent to which the DoHC migrates executive functions to the HSE.

In support of the roles set out above, the HSE will require the following corporate functions:

- Human resources
  - Participate in national union negotiations (including pay)
  - Implement the *Action Plan for People Management* (to include development and oversight of performance management frameworks, etc)
  - Identify and disseminate best HR practice throughout the system; take responsibility for control and data collection of total employment numbers
  - Be the major employer of health service staff
  - Ensure consistency of application in terms and conditions of national programmes of employment
  - Assess workforce planning needs, fund training and manage the recruitment of staff
  - Implement national pay policy
- Organisation development
  - Promote change management and roll-out of best practice in relation to organisation and people development
- Service planning and evaluation
  - Coordinate service planning activity and evaluation function

- Shared services
  - Arrange for delivery of shared services via national shared services platform
- Professional advisors
  - Provide medical, nursing and allied professional expertise
- Finance
  - Carry out internal audits and VFM reviews
  - Follow-up on external reviews
  - Comptroller and Auditor General reports
  - Ombudsman reports, etc
- Management Information Systems
  - Develop management information infrastructure across the system. Policy on information sets to be developed by HIQA

### **Recommendation 1.2: Create two service pillars within the HSE consisting of:**

- **Acute sector, overseen by the National Hospitals Office**
- **Primary, Community and Continuing care sector**

#### **Actions:**

- Establish two service pillars within the HSE;
- Provide for National Hospitals Office within the corporate structure of the HSE;
- Organise all publicly-funded hospital services under the National Hospitals Office;
- Develop enabling legislation to ensure accountability to the NHO for the reconfiguration of the hospital system, as well as accountability and funding arrangements for the acute services ongoing.

#### **Rationale:**

---

*Quality and Fairness* identified two health service sectors in particular — primary care and the acute hospitals sector as critical elements in the *Frameworks for Change*. In our view the consolidated structure must take account of these priorities and support their development.

A sectoral approach supports a clear understanding of the relative funding of the individual sectors, which to date has not changed, despite declared policy to do so. The Primary Care Strategy seeks to redress this balance by outlining a clear vision for the provision of all but the most complex and acute healthcare in the primary care setting, based on a framework of primary care networks and teams offering front-line services to local populations.

The major reforms identified under each pillar are quite different in nature, operating to separate timescales and requiring separate approaches. The principal challenge in the non-acute sector will be to build the Primary Care Teams and Networks. This is developmental work and is at an early stage, building up from the primary care components which are in place. The HSE should provide a strong executive focus at national level on progressing this work.

The acute sector reforms are equally challenging but of a different nature. *Quality and Fairness* charged the proposed National Hospitals Agency with a wide range of responsibilities relating to the performance of the entire acute sector. It is described in the Strategy as being 'established on a statutory basis under the aegis of the Department'. Issues such

as bed shortages, waiting lists, Accident & Emergency, roles of individual hospitals and locations of national specialties are all clearly set out as requiring urgent attention and coming under the remit of the new agency.

We have included these assigned functions in our recommendations, but have also proposed a more comprehensive executive role for the NHO within the consolidated structure. While the decision to establish the NHO signals the clear intent of the Department to undertake a major programme of sectoral reform, we are strongly of the view that the organisation shaping this reform must be linked as tightly as possible with the totality of the services covered by the HSE. Thus we see the NHO as operating within the overall Executive but with a clear remit — and resources — to discharge its specific tasks. The priority given to driving change in the acute sector and the extensive range of responsibilities identified for the NHO show the need for an authoritative and effective mechanism to deliver large-scale reform. We propose that in the consolidated structure all public funding (revenue and capital) for acute services will come under the auspices of the NHO within the HSE.

This separation of primary and other non-acute care from the acute sector pillar is designed to allow appropriate focus on these critical service areas. As has been stated earlier, the health board model, which in structural terms appears to be fully integrated, has arguably failed to deliver adequately on integration. This is evidenced by customer experience and the need to create parallel structures to implement 'joined-up' programmes as envisaged under the Cancer and Cardiac strategies. In our view, poorly organised or underdeveloped individual sectors are a real impediment to delivering seamless care. We believe that integration is about more than organisational structures. The objective, in this case, is to ensure that individual sectors are strengthened within themselves. It is only with strong individual sectors that supporting processes and incentives for integrated working will be effective. The priority therefore must be to ensure that critical interfaces work while the separate elements of the system are reconfigured and strengthened.

The arrangements proposed with two service pillars under a single Executive have the following benefits. They:

- put a structural mechanism in place which reflects the declared priorities of strengthening primary care and reforming the acute hospital sector;
- allow recognition of the different management demands made of each sector in terms of scale, technology, organisation type and delivery mechanisms;
- focus on addressing the specific challenges of integration and re-organisation within the hospital system itself;
- support integrated priority-setting, service planning and evaluation within a National Service Plan at the level of the HSE;
- ensure that the skills in areas such as financial management, planning, HR, audit, project management, and clinical expertise which are required at the top of the national executive structure are pulled together and used efficiently and effectively;
- provide transparency in relation to the proportion of funding allocated to the acute sector. The increased transparency in funding should also encourage a focus on the most effective forms of service provision (in-patient versus non-acute care), as well as greater measurement of VFM.

One option we considered was a stand-alone NHO reporting directly to the DoHC. We consider this incompatible with our overall approach as it:

- fragments the overall executive function and authority of the HSE;
- produces 'lop-sided' acute and non-acute systems with one sector being managed internally by the DoHC and the other areas on a devolved executive basis by HSE;
- produces a similar skewing inside the DoHC in relation to its own policy/executive split;

- raises significant integration problems, from policy-making and resource allocation down to service delivery;
- draws detailed operational decision-making and reactions to its implementation back into the DoHC and the political arena;
- inhibits the DoHC from engaging with its appropriate core role.

We recommend that the NHO be established as an Office of the HSE, be located within the physical structure of the HSE, with its Director reporting directly to the Chief Executive Officer of the HSE and sitting on its management team.

The Office should be staffed with high-calibre and authoritative personnel who can engage directly with the acute system and with the professional bodies. It should draw upon the existing skill base and technical knowledge of the DoHC, Comhairle na nOspidéal, and the ERHA among others but is likely to need strengthening, given the breadth of its mandate and the absolute requirement for a strong knowledge base to deliver it. The NHO should also avail of the services provided by the HSE (e.g. workforce planning) and the NSSC (e.g. capital project development).

### National Hospitals Office — Role in consolidated structure

---

While the policy decision in relation to the *National Task Force on Medical Staffing* recommendations will rest with the DoHC, it has already determined that a key function of the NHO will be to advise on the organisation, planning and coordination of acute hospital services, including the location and configuration of particular services or specialties. Decisions on workforce levels, consultant appointments and the location of specialties clearly have a direct link with the physical and organisational structure of the wider hospital system.

*The National Task Force on Medical Staffing* will make recommendations in relation to the re-organisation and grouping of hospital services. The overall objective will be to ensure an appropriate range of acute services at a local level, backed up by specialist services at a central location. In order to ensure a unitary approach to the re-organisation of the acute sector, we recommend the following arrangement of acute services in the consolidated structure:

- All funding (capital and revenue) for acute services be allocated through the NHO;
- Existing major health board hospitals be brought under the remit of the NHO, with their own legal identity and governance structures. The objective will be to ensure an integrated management structure for the hospital sector and clear governance arrangements between the NHO and the hospitals. There are a number of governance models already in existence. Consideration should also be given to alternatives which are in accordance with our recommendations on governance generally and the statutory establishment of the HSE;
- Hospitals should have employing authority in their own right;
- Funding for all acute hospitals be based on contracts incorporating service agreements. Strengthened legislative provisions will be required to ensure parity of accountability standards across all acute providers and the ability of the NHO to require compliance;
- Regional hospital groupings, or combinations thereof, be aligned with the areas of responsibility of the RHO so as to reinforce integrated planning and service delivery across the sectors within each region. As the NHO develops a reformed organisation structure for hospitals, there may be a need, on a transitional basis, to put in place dedicated management resources to project manage the changes required and to form the necessary liaison and formal working relationships with the Directors of the RHOs.

Specifically the NHO will be responsible for:

- Planning, commissioning and funding all acute hospital services;

- Managing the acute capital programme and providing technical and professional services currently within the Hospital Planning Office in the DoHC, in conjunction with the NSSC;
- Managing national waiting-lists and the current activities of the National Treatment Purchase Fund;
- Approving consultant posts in publicly funded hospitals;
- Contributing to the national acute policy framework of the DoHC;
- Ensuring hospital services are integrated within the wider health system;
- Managing the interface with private acute providers;
- Ensuring acute sector delivery on national health strategies (Cancer, Cardiac, etc).

### **Recommendation 1.3: Put in place four regional management structures and build on the existing community care structures at local level**

#### **Actions:**

- Establish a network of 4 Regional Health Offices, supported by the existing Community Care Area structures (Local Health Offices), to deliver primary, continuing, community and other non-acute services
- Ensure existing community care structures have the capacity and support to undertake appropriate service planning, budgetary and decision-making roles
- Establish a standard range of services and facilities for each Local Health Office

#### **Rationale:**

---

##### **Ensure appropriate regional structures within the system**

Under current arrangements the health boards play a central role in delivering services at regional and local level. Since their inception they have had to adapt to a much increased range and scope of services delivered on a regional and local basis — this often in the absence of sufficient coordination and support at a national level.

Our earlier findings in relation to the structure, role and legal framework surrounding the health boards and ERHA lead us to propose a move towards one national HSE with its own Board. In developing our proposals we address the question of whether there is a role for regional management units in the context of the new consolidated structure and, if so, how they add value to the delivery system overall. A further question then arises as to how many such units are required.

There has been considerable simplistic and selective comment in the media and elsewhere on the issue of health board numbers. Our research has confirmed firstly that it is extremely difficult to compare health service organisational structures in a meaningful way. Secondly, that an international analysis of management units/governance structures by population base turns up extremely wide-ranging variations and point to no simple formula by which to calculate an optimal configuration or number.

Furthermore, when reviewing the varying bases used by other public sector agencies in Ireland to organise at local, regional and national level, it quickly becomes clear that there is no national best fit for these structures. We looked for patterns in the broader public sector, in particular, which might precisely map across to the health system. These included:

- Counties;
- Aggregated health board regions;
- IDA regions;

- FÁS regions;
- Local Authority maps, the eight regional authority areas;
- Revised regional arrangements for structural funding which reduced the eight regions into two: the Border, Midland and Western Region (BMW) and the Southern and Eastern Region (S&E Region);
- Recommendations for local education offices.

In our view, while there are some elements in these arrangements which matched in part the requirements of a reformed health structure, none of them offered a full solution or adequately matched the criteria outlined above.

Looked at in the context of the proposed consolidated structure, it is apparent that the current ten health boards/area health boards and the ERHA, as regional management units, would no longer be appropriate. The establishment of the HSE is designed to substitute for many of the higher executive functions now duplicated across the system. The reallocation of responsibility for the acute sector to the NHO removes a significant element of the workload traditionally borne by the health boards. On top of this, putting in place the NSSC should logically reduce the requirement for multiple regional centres providing the same logistical and other supports to the delivery system. Finally, Primary Care Teams and Networks are now being developed as the principal point of patient interface with the health system. A significant opportunity exists, in our view, to reconfigure existing health board functional areas and governance structures so as to reduce overheads and improve accountability lines overall.

In assessing the desirability of regional management units our starting point was the context set by the consolidated structure. We then considered the following:

- What organisational arrangement would ensure a reasonable span of control and responsibility over the Local Health Office groupings proposed, given their functions and state of development;
- How to create an effective planning, commissioning and budgetary link between local areas and the centre, without compromising the integrated nature of the new delivery system;
- The value in maintaining regional structures to help deliver change while at the same time ensuring continuity of service delivery;
- The need for regional access for input from stakeholders;
- The need for a regional focus for democratic input (meetings with regional members of Oireachtas, for example);
- The degree of potential fit with other regional 'maps', political or public service;
- The need to achieve an approximate balance of population size within the component parts of the new organisation;
- The need for the structures to recognise geographic and demographic variations;
- The requirement to support the principle of regional self-sufficiency in health services;
- The need to cluster certain services which are not appropriate for either local or national delivery for reasons of scale, cost or geography, e.g. laboratory, public health services, emergency planning;
- The potential of regional structures to match the scale of other health service features:
  - Adequate base for regional population health planning;
  - Fit with major service blocks such as a University hospital group or groups;
  - Fit with configuration of voluntary and private service providers;
- The extent to which the overhead cost of a regional management structure could be justified by its benefits.



Based on these requirements, it is our view that regional structures will be needed in the consolidated structure. Our recommendation is that four RHOs best meet the balance of the requirements set out above. It may be that, over time and as management and supporting infrastructure develops, this issue can be reconsidered including the continued need for regional structures in the long-term. A more detailed analysis will be necessary to work out the exact boundaries of the regions.

In a final decision on the geographical split for these structures there may be opportunities to support an integrated approach at Government level to match the evolution to RHOs with the outcomes of the National Spatial Strategy and any further Public Service decentralisation programme. Account will also need to be taken of the variable extent of existing health service infrastructure and specific features such as the clustering of stand-alone specialist and national speciality hospitals in the Dublin regions.

### **The development of Local Health Offices to deliver services close to the consumer**

In recent years General Manager positions have been put in place at Community Care Area level across the country. The consolidated structure envisages a network of between 6-10 Local Health Offices within each region, which will be based on these existing Community Care areas, catering for population bases of circa 120,000 to 150,000 each. This will take advantage of the existing infrastructure and networks to ensure a bridge between the small-population groupings covered by the primary care teams (7,000) and networks now in development and the much larger population bases to be covered by the region as a whole.

The management and organisational structures already in place at Community Care Area level provide the basis for effective joint working between managerial and clinical professionals. This in turn allows for real multi-disciplinary team working to deliver packages of care to the patient. Our proposal to use existing organisation and general management structures is based on the belief that it:

- Supports the devolution of decision-making to front-line services, as far as possible;
- Ensures that accountability and responsibility is clear at a local level;
- Builds on existing Community Care Area structures and avoids creation of a new tier of management;
- Limits the extent of change at the service point closest to the client;
- Provides an opportunity to develop one-stop-shop arrangements;
- Supports the establishment of Primary Care Teams and Networks by providing operational and managerial support at a local level;
- Broadly matches local authority boundaries and will assist in cross-sectoral links;
- Supports the development of Primary Care Teams and Networks on a local basis by providing a managerial framework within which they can operate.

### **Regional Health Offices (RHOs) — Role in consolidated structure**

---

The services under the primary, continuing, community and other non-acute sectoral pillar should be delivered (on a population basis) through a network of 4 RHOs supported by the existing Community Care Area structures (Local Health Offices).

The four RHOs in the consolidated structure should act as regional offices of the HSE, and should therefore come under the same accountability structures as the Executive. Each RHO will be headed by a Regional Director, and should report directly to the Chief Executive Officer of the HSE. The Regional Directors of each RHO will participate on the management team of the HSE.

The RHOs should be responsible for the assessing and planning for needs at a regional level; managing delivery of primary, community, continuing and other non-acute services; managing the relationship with acute hospitals within the region; and accountability for resources and outputs at a regional level. They should also be responsible for the delivery of services best provided on a regional basis.

Lead responsibility should be allocated to individual RHOs by the HSE for new services as they are being developed. Individual RHOs would cooperate on cross-regional issues on a bilateral basis or through mechanisms developed and facilitated by the HSE.

Specifically the RHO should be responsible for planning, commissioning and funding all non-acute services within the region, supporting a population health focus through:

- Incorporating these services in the overall Regional Plan;
- Supporting active involvement in planning of services by the LHO, e.g. personnel administration, payroll, training and development, financial management and reporting, IT support, where these are not available from the NSSC.

The Regional Director of the RHO should have ultimate responsibility for the production of an integrated regional service plan covering all services in this functional area.

As reform of the acute sector structures is being undertaken the NHO will decide what form of regional management structures will be required to discharge its remit. This could include, for example, a managerial function at regional level with the specific objective of establishing the necessary liaison and working relationships to ensure integrated delivery of service on at least a transitional basis. This function within the NHO should have a key role at regional level in collaborating with the Director of the RHO, who would be explicitly mandated to ensure that all necessary mechanisms to support seamless services between the acute and non-acute sectors are incorporated in the RHO plan.

The RHO should be involved in both direct and indirect provision of services. Its role would be to:

- Direct the management and delivery of statutory services on a regional basis, e.g. emergency planning, provision of specialist non-acute care such as rehabilitation, etc. This will require supporting organisational and management structures to be located within the RHO;
- Develop the primary care model within its region. It will carry out needs assessments to identify the coverage, composition and number of primary care teams for funding from the HSE on an on-going basis;
- Provide services at a local level through the LHOs in its region;
- Monitor and evaluate all services in the region against the regional service plan in association with the NHO for acute services;
- Collate and analyse regional data to support population health approaches.

As well as the significant patient flows between the acute and non-acute sectors, a number of specific services have been identified which are organised and delivered on a cross-sectoral basis. These include psychiatric services, rehabilitation, social work services in hospital settings, etc. The development of separate sectoral pillars for acute and other services will require:

- A decision in terms of the pillar under which these cross-sectoral services should be funded and commissioned. In our view the non-acute pillar should be the preferred commissioning authority unless there are strong arguments to the contrary;
- Appropriate mechanisms to ensure the seamless transfer of patients across these services;

- Leading and directing local service planning through a planning forum where all LHOs come together to plan a particular service in the region. Other service providers, e.g. voluntary or private providers should also attend such a forum. This would ensure that there was no unnecessary duplication of effort across the LHOs. It would also involve other service providers in the planning of services, again avoiding duplication of effort and supporting seamless service delivery across an entire region. The basis on which this is done would be a matter for regional and local management to decide.

### Local Health Offices (LHOs) — Role in consolidated structure

---

In the consolidated structure, the Community Care Areas and their existing General Management structures will operate as LHOs. Their role would include the following:

- Responsibility for the provision of one-stop-shop arrangements as a point of access to and a source of information on all health and personal social services;
- Accountability for local budgets, with authority to make service decisions within the parameters of the regional Service Plan;
- Responsibility for participation in regional service planning;
- Responsibility for the development of new services within their locality;
- Responsibility for the provision of secretariat and other supports to local consumer panels and for participation in their work;
- Authority to plan joint services with other LHOs (subject to regional policy and parameters).

While LHOs will be supported and encouraged to ensure a flexible and customised service to their local users, the development and provision of these services will be guided at all times by standards and processes provided by their RHO. The LHOs are local offices of the regional management structures.

Specifically the LHO will be responsible for the following:

- **Service planning and commissioning within agreed regional parameters**

Each LHO will be responsible for developing a service plan for its locality, including the provision of primary care services through the Primary Care Networks and Teams in its area. The development of these local plans, within regional parameters, will be facilitated by the RHO through the provision of advisory and coordinating support. Each of the local plans in an RHO area will be incorporated into the overall Regional Service Plan.

- **Service delivery**

The LHO will provide the full range of health and social services deemed necessary in its local area (either directly or through voluntary or private providers operating on formal service agreements). The provision of these services, while customised to meet local needs, will reflect overall regional and national priorities.

LHOs within each region will be responsible for the delivery of statutory and other services to local populations, through a number of channels:

- Primary care networks (funded, supported and overseen by the LHO) will provide primary care — in line with the model outlined in the Primary Care Strategy. The LHO will be a key instrument in ensuring the establishment and development of Primary Care Teams, as agreed by its RHO. These teams are only gradually being put in place and will need sustained support if they are to develop to their full potential. The LHO will support the

establishment of Primary Care Teams and Networks in its area, from a staffing and accommodation perspective, and will also play an on-going role in resourcing the Primary Care Teams and Networks, providing back-office support, etc. Other health or personal social services which are not currently organised to match Community Care Areas will need to be realigned in time to fit this new structure;

- Non-acute voluntary and private service provision will be commissioned by the LHO in line with regional direction;
- LHOs will provide a number of statutory services directly where appropriate, e.g. personal social services, environmental health, community welfare, etc, and will build on the one-stop-shop concept through the use of ICT for the dissemination of up-to-date/online information on behalf of all health service providers. The LHO will also link with other service providers in the area to provide integrated services at a local level (including health and wider public services).

## **Recommendation 1.4: Develop a National Shared Services Centre**

### **Actions:**

- Establish the NSSC with a remit for the provision of corporate services to the HSE and the NHO, and the provision of shared services across the wider health system;
- Develop enabling legislation to require all publicly funded health agencies to participate in shared services arrangements.

### **Rationale:**

---

#### **Authority to develop and implement shared services across the system**

In managing the healthcare delivery system, one of the major objectives of the HSE will be to ensure maximum efficiencies and value for money. The development of a National Shared Services Centre is designed to do two things: to instil a 'shared services philosophy' and to provide a mechanism for delivery of this objective.

The concept of a Shared Service Centre has become an essential element of many leading-edge commercial and service organisations, contributing significantly to cost reduction, improved customer service and organisational performance. Many public sector organisations now recognise the benefits SSCs can bring to their business and are considering adopting or have developed SSCs. Indeed the work of the EHSS in the Eastern Region and HeBE in this area are evidence of the acknowledged potential of such a centre in a modern health service. Benefits from the NSSC would include:

- VFM — reduction in general and administrative costs by bringing duplicated effort together (see Chapter 11 for indicative levels of saving);
- Better service quality, accuracy and timeliness by creating real process expertise;
- Improved management and standardisation of business processes, with end-to-end redesign to make effective use of enabling technology;
- Freeing up resources that can be used elsewhere in the system.

Establishing the NSSC under the aegis of the HSE will ensure it has the mandate to require the full use of shared service potential by healthcare providers through the medium of the National Service Plan. This will address our earlier findings in relation to the underdeveloped state of shared services practice overall. Service Level Agreements should underpin all services offered so as to ensure that there is a rigorous business case behind any expansion of the shared services role and to maintain standards for clients of the service.

A shared services centre can be provided in more than one location. Neither does it require to be provided within existing organisational arrangements. The potential benefits of outsourcing back office processes to third party providers warrants consideration within the shared services context. Scoping the extent of this potential should be considered as part of the overall business case for the National Shared Services Centre.

Where there are clear efficiency gains, the HSE should be able, through service agreements, to oblige voluntary providers, who are publicly funded, to avail of NSSC services.

### **National Shared Services Centre (NSSC) — Role in consolidated structure**

---

The National Shared Services Centre should provide shared services for the entire health system, where such a function can offer efficiency, economy and quality gains. The Centre should display the following characteristics in particular:

- Value for money based on strong financial and operational management;
- High performance organisation with the primary focus on service excellence, cost control, continuous improvement (service and cost);
- Low cost infrastructure with standardised and highly integrated technology platforms;
- Service management through Service Level Agreements, key performance indicators and performance reporting;
- Service responsibility shared between the SSC and clients as stated in the Service Level Agreements;
- Multiple channels of customer contact management including contact centre staffed with customer service representatives, contact management software and client relationship managers;
- Common management of business processes, with end-to-end processes redesigned to make effective use of enabling technology.

Customers of the NSSC should include the two service pillars, and agencies in the wider system. The use of shared services identified for national provision will generally be on a mandatory basis and will be tied into funding agreements with providers as required. Services to be provided by the NSSC can be divided into three distinct categories:

- **Corporate Shared Services for the HSE**

A range of support services could be provided by the NSSC to HSE Corporate, enabling it to maintain a lean structure. The following services could be provided in this way:

- HR: recruitment processes, personnel administration, etc;
- Accounting processes;
- IT processes and support;
- Facilities management;
- Customer services.

- **The provision of core processing functions and other shared services for the system as a whole**

The NSSC would also provide a range of processing functions and shared services to the wider system. Examples of these are included in Figure 7.2 (see over):

Figure 7.2: Examples of shared services and processing functions

Processing functions	Shared services
<ul style="list-style-type: none"> <li>• Payroll administration</li> <li>• Pensions administration</li> <li>• Accounts payable</li> <li>• GMS payments services, etc</li> <li>• Administration of community drugs schemes</li> <li>• Administration of nursing home subventions</li> <li>• Maintenance of registers, e.g. Tobacco Control</li> </ul>	<ul style="list-style-type: none"> <li>• Estate and facilities management</li> <li>• Specialist expertise — legal, audit, etc</li> <li>• IT</li> <li>• Central procurement</li> <li>• HR administration, including recruitment</li> <li>• Accounting</li> <li>• Call centres for patient information and services</li> <li>• Capital projects office (equivalent to role currently played by Hospitals Planning Office in the DoHC)</li> </ul>

These functions would be provided either on a statutory basis (e.g. GMS payments), or commissioned by the HSE or other executive bodies in the case of new services.

- **The development and roll-out of new systems**

In addition, the NSSC would be responsible for the development of new services on a shared basis, e.g. eHealth initiatives. These developments could be carried out on an independent basis, or developed jointly with sponsoring agencies such as the DoHC and HIQA.

### **Recommendation 1.5: Strengthen quality assurance and information through the establishment of the Health Information and Quality Authority**

**Actions:**

- Establish HIQA as a matter of urgency in line with recommendations in *Quality and Fairness*;
- Task HIQA with the preparation and publication of an annual report on the performance of the health system overall against key quality indicators.

**Rationale:**

The establishment of HIQA is proposed in *Quality and Fairness* to promote the twin aims of:

- Delivering high-quality service;
- Basing the service on evidence-supported best practice.

Under this proposal, HIQA has been assigned three distinct but related functions:

- Developing health information systems;
- Promoting and implementing quality assurance programmes;
- Developing health technology assessment.

While we endorse the proposed combination of functions, it does present some difficulties as well as opportunities. The principal challenge lies in the fact that HIQA, in reviewing the performance of the delivery system in relation to the production and use of health information, may be called on to critique the performance of elements of its own operations

in adequately defining data sets, etc. That said, there are strong efficiency and effectiveness arguments for pooling these three functions in the manner proposed. It also allows the opportunity to drive the roll-out of a high performance national health information service by giving a single budget holder (HIQA) the commissioning role for major ICT developments required to support the National Health Information Strategy.

A second challenge lies in the need to balance HIQA's role as an authoritative resource for the Department with its value as an independent reviewer of quality and performance. Establishing legislation will need to be carefully framed to encompass both of these roles.

Our Audit findings confirm the lack of system-wide coordination in collecting or using health information. This has serious consequences for the planning and evaluation of services. Equally it impedes the dissemination of best practice and the access of consumers to information about services or treatments. Finally, it limits the ability of the health service to demonstrate VFM and the investment case for ongoing or new services.

In our view it is essential that HIQA be established at an early date to provide a sound information and quality platform for the new Executive. HIQA's analysis, to be effective, must feed into the service planning, funding and evaluation relationships between the DoHC, the HSE and other agencies. We also recommend that HIQA be mandated under its terms of establishment to produce an annual whole-system report on the health services for the Minister.

### HIQA — Role in consolidated structure

---

The development of HIQA provides an opportunity to reinforce internal quality assurance practices at all levels within the delivery system and at the same time to bring external quality assurance to bear in an objective manner. Given its independent oversight role, the Authority should be set up as a statutory agency with its own governance structures and be funded by the DoHC.

HIQA should be responsible for the following:

- **Developing health information**

- Providing the lead on information development and the commissioning of major ICT initiatives and other information systems
- Setting the system standards and the framework to be used in the implementation of clinical and operational support systems through the development of electronic health records
- Developing information standards, definitions and data dictionaries
- Developing and agreeing minimum datasets
- Quality-assuring data and information
- Assessing proposed information development relating to data and technical standards
- Promoting education, training and skills development for information staff
- Promoting and coordinating national research and development on eHealth
- Developing a national e-library to guide decision-making
- Promoting a common approach to security, privacy and confidentiality
- Developing and agreeing guidelines governing access to information from health agencies

- **Promoting quality nationally**

- Developing and disseminating agreed standards and guidelines/models of best practice
- Introducing and overseeing accreditation processes across the health system

- Promoting formal health impact assessment programmes
- Promoting and advising national initiatives on patient safety
- Liaising with new Irish Clinical Negligence Claims Agency on risk management.

- **Developing an annual programme of service reviews**

- Publishing a report assessing national performance in relation to each service area examined, against specified national standards
- Producing an annual whole-system report on the health services for the Minister for Health and Children and the Joint Oireachtas Committee for Health and Children.

- **Overseeing health technology assessment**

- Overseeing the development of health technology assessment and promoting its use to inform vital policy decisions, from initial evaluation to implementation, monitoring and review of outcomes
- Drawing upon health technology assessment work carried out in other countries.

The existence of HIQA does not substitute for information and analytical functions within the Department or the HSE. Parallel skills will be required within the HSE to implement policy and within the Department to undertake policy analysis. HIQA does, however, have a complementary and objective role to play in assisting the policy and executive arms to discharge their responsibilities effectively.

Finally HIQA represents a significant new opportunity for the clinical professional bodies to shape the way in which Irish healthcare is planned and delivered. HIQA should directly employ senior clinical staff but also draw on expert panels and other advisory mechanisms in order to carry out its work. Its links with the professional bodies will be critical to successfully fulfilling its role.

## **Recommendation 1.6: Develop structural mechanisms to increase consumer involvement in decision-making and service delivery**

Actions:

- Extend the remit of the National Consultative Forum;
- Develop democratic input at regional level;
- Build on local consumer panels and other forms of consultation in each Local Health Office area.

### **Rationale:**

#### **The need for structural mechanisms for consumer involvement and stakeholder participation**

Stakeholder partnership, and in particular the participation of individuals and communities in the health system, should not be an 'add-on' to service delivery but an essential means of engaging people as partners with service providers to improve population health. While interaction between individual consumers and health professionals is critical for the support and encouragement of individuals and families in the management of their own healthcare, a number of additional structural requirements will be necessary to support enhanced involvement and representation in processes such as evaluation and service delivery (see section 6.2). By proposing mechanisms for this engagement, the consolidated structure aims to facilitate a core objective of *Quality and Fairness*.

We recognise that one of the challenges for the consolidated structure is to strike an appropriate balance between direct participation by citizens and consumers and their representation through their democratically elected representatives. A



further challenge is to reconcile stakeholder influence with the influence and authority of management at all levels. It is our view that user and citizen participation can play an extremely powerful role in transforming our health system. We believe, in particular, that evidence of responsiveness and openness in this area should be seen as an important factor in assessing managerial and service unit performance under the new structures.

The forms of participation should include:

- Health information and health service information design, delivery and provision to individuals and families;
- Active engagement in community health programmes;
- Feedback mechanisms, complaints procedures and advocacy programmes;
- Opportunities for input into evaluation and monitoring of services;
- Participation in needs identification and service planning at local and regional level;
- Inputs to policy development.

### **Extend the remit of the National Consultative Forum to foster increased stakeholder representation and participation in policy-making**

The National Consultative Forum was set up to allow the DoHC to draw directly on the expertise of a wide range of partners in the health system in the preparation of the National Health Strategy. The Forum has continued to operate as a mechanism for giving those partners an ongoing opportunity to support the implementation of the Strategy, and to be informed about progress. In line with our findings in Chapter 5 that strategic planning and management should not be seen as an ad-hoc function exercised at lengthy intervals, we propose that the National Consultative Forum could serve as a structure through which stakeholders can influence national planning and policy-making on an ongoing basis.

The Forum will continue to include representatives of patients and clients of the health service, staff, employers, the regulatory bodies and specialist health agencies. The Forum's composition will be at the discretion of the Minister for Health and Children.

The role of the National Consultative Forum as envisaged in the consolidated structure is not intended to interfere in any way with the clear executive role of the HSE and its relationship with the DoHC. It is proposed that a Memorandum of Understanding be drawn up, describing the linkages and relationships between the Forum, the DoHC and the HSE.

### **National Consultative Forum — Role in consolidated structure**

---

The National Consultative Forum should continue to perform the role it was assigned during the development of the National Health Strategy, but with a broader remit to include influencing all national health policy. The Forum will be convened and supported by the DoHC.

Specifically the National Consultative Forum will be:

- A means through which stakeholders can put matters on the national 'agenda' in consultation with the DoHC;
- A forum for formal consultation between the DoHC and other stakeholders on national policy matters;
- A location for dialogue among all stakeholders concerning health issues at national level;
- A resource from which HIQA can draw consumer and other inputs into the design of evaluation and monitoring systems;

- A mechanism from which HIQA can draw consumer and other inputs into the national dialogue about best practice models for stakeholder partnerships.

### **Develop alternative channel for democratic input at regional level**

Democratic input at regional level should focus on the delivery of national priorities. As we have an Exchequer-funded health service with centrally determined resourcing decisions, Oireachtas members have a responsibility to ensure that there is a match between funding of services and national priorities. We have highlighted the need to improve the decision-to-action-chain. This requires effective arrangements for direct public representative input at appropriate levels without unduly limiting the ability and responsibility of managers to act in a speedy and responsive manner. In our opinion, democratic input is best represented at regional level through twice yearly meetings between Oireachtas members in their respective regions, and the Director of the RHO and his/her senior management team, together with other members of the HSE or its offices as appropriate. This mechanism is designed to complement and reinforce the role of the Joint Oireachtas Committee on Health and Children in reflecting the views of public representatives in the ongoing oversight of the health system.

### **Regional consultation — Role in consolidated structure**

---

The Directors and management team of the Regional Health Office, together with a representative of the National Hospitals Office, should meet the group of Oireachtas members for the regions at least twice yearly. These meetings should allow the elected members to:

- Review current and proposed activities of the RHO;
- Discuss issues relating to regional service delivery in the context of national policy objectives;
- Communicate with RHO and the NHO, as appropriate, on public perception of regional health service delivery;
- Consult with planners and managers on health service issues of regional and national importance.

The framework described above will not take the place or reduce the role of several other important consultative processes that exist at the moment at regional level. For example the value of the Advisory Panels/Regional Coordinating Committees for learning disability services and physical and sensory disability services is widely acknowledged, and there is a commitment to extend this model to other areas, such as services for older people. Some of these consultative processes include direct representation from the population group involved. The RHOs should take responsibility for integrating the work of these groups.

### **Develop consumer input at local level**

Genuine partnership must go well beyond consultation processes, to directly engage citizens and their representatives in needs identification, planning and decision-making at appropriate levels. Extremely useful work in the principles and practice of stakeholder participation has been documented in two recent reports: Community Participation Guidelines (HeBE 2002) and Public and Patient Participation in Healthcare (OHM Discussion Paper, 2002). The latter document in reviewing Irish and international experience stresses ‘*..the emphasis on process as much as outcome. Participation and partnership are not “achieved” per se but are developed through time*’. Clear principles are also set out, based on national and international experience, to inform consultation and participation approaches. The Irish Patients Association and other representative groups, specialist and general, are increasingly not just working with planners and service providers, but disseminating best practice on participation processes, all of which can be drawn on in developing these critical mechanisms.

## Local consultation — Role in consolidated structure

---

At local level, we propose that the LHO as one of its central responsibilities, has the task of promoting citizen and community participation in its area, through the application of consultation tools such as consumer panels. In supporting consumer involvement the LHOs will provide:

- Designated personnel to hold this responsibility in the Local Health Office team;
- Support for the participation mechanisms and initiatives.

Within the acute sector consultation and participation processes are equally important. This is illustrated by the approach of the new hospital accreditation programme which includes this dimension of a hospital's performance as one of the elements specifically measured when a hospital, or hospital group, is seeking accreditation. This will be an important driver for responsiveness and engagement between hospitals and their patients. Again, it is our view that service plans and performance management systems must give real weight to this dimension of performance and reflect it accordingly in resourcing decisions.

We do not think it appropriate to prescribe set structures at local level to promote user involvement and stakeholder representation but feel it is more effective to build on guiding principles and practices already developed which can be reflected in the varying needs of individual communities.

## Chapter 8

# Developing supporting processes

---

### Reform proposal 2: Strengthen the functioning of the consolidated structure through the development of supporting processes

How the consolidated structure works is best described by examining the main supporting processes. Chapter 7 outlined our findings in relation to these areas. The actions we propose to develop the supporting processes are as follows:

#### Recommendation 2.1

- Develop strong service planning and funding processes

#### Recommendation 2.2

- Establish strong links between service delivery and evaluation

#### Recommendation 2.3

- Put in place enablers to support integration

#### Recommendation 2.4

- Enhance system capability and performance

### Recommendation 2.1: Develop strong service planning and funding processes

Actions:

- Establish processes for the development of a National Service Plan and assign responsibility to HSE;
- Assign responsibility to the NHO for the development of a service plan for acute services to form part of the National Service Plan;
- Assign responsibility to the RHOs for the development of a service plan for primary, community, continuing and non-acute services.

The current planning and funding processes will be streamlined in the consolidated model by the reduction in the number of reporting routes and delivery agencies. In particular, we recommend that the DoHC engage in a 3-year planning cycle for *Quality and Fairness* implementation, linking performance against the national strategy targets with annual service plans.

It is envisaged that the service planning and funding processes will work in the following way at national, regional and local level:

## National level

---

### Development of a single National Service Plan

Under the reformed structures a single integrated National Service Plan for the entire publicly-funded health service will be agreed each year between the HSE and the Department. The Plan will cover both revenue and capital spending. It will have to reflect the formal policy objectives of Government generally and, in particular, health policy priorities as set out in the Department's own Strategy Statement. Under the terms of the Public Service Management Act, 1997, Section 5, the Strategy Statement '*...shall comprise the key objectives, outputs and related strategies (including use of resources) of the Department*'.

The Department will, therefore, set the strategic context and priorities against which the annual Service Plan should deliver. This will require the Department in its own operations to be explicit about policy priority-setting. The objectives of leading and supporting change also require explicit expression in the Department's formal contracts with the executive and delivery services. Equally, the internal structure of the Department will have to reflect the need to relate to the delivery system in a new way. Apart from the statement of priorities in contracts, the key messages from the political level to the HSE and vice versa will need to be conveyed through well organised and supported liaison between the Department and the HSE on an on-going basis. This form of continuing communication and joint monitoring of key performance indicators will be an essential feature in ensuring that the new structures deliver the desired impact.

In summary, the type of service planning that is envisaged, working from national level to local management, is far more developed and multi-dimensional than is currently the case. This needs to be led from the top to ensure its adoption at all levels.

### The process for National Service Planning

The preparation of the annual National Service Plan will be a rolling process, feeding into the Estimates cycle for agreement by Government and the Dáil on the proportion of national resources which will be devoted to the health and personal social services coming under the aegis of the Department. The need for the process between the DoHC and the HSE to be constant and 'live' (reviewing the current year and preparing the next year's plans in parallel) is underscored by the tight calendar for the existing estimates cycle. Formal strategic planning by the Department in its direction to the HSE will have added value to the extent that it is possible to agree on a multi-annual budgeting cycle for the DoHC.

In agreeing the annual National Service Plan with the HSE, the Department will also be required to reflect the findings of service evaluations and quality reviews conducted by the Health Information and Quality Authority. The quality assurance dimension these reports will bring to funding decisions, investment prioritisation and performance review will again help link resourcing to strategic objectives.

In allocating funds, the HSE and the NHO will need to be in a position to ensure that the contractual obligations with the voluntary agencies (non acute or acute) receiving public money are no less onerous than those applying to State agencies. It has been noted earlier that the ERHA under current legislation cannot apply the same service planning requirements to voluntary providers as it is subject to itself. Legislation may be required to underpin the Terms of Engagement by which the HSE, or its offices, contract with voluntary providers.

Finally, the availability of a properly established Health Technology Assessment capacity within the health system (HIQA) will support informed decision-making at a national level on the desirability and effectiveness of investment in new therapies, drugs or equipment, or indeed on the rationale for continuing with existing practices. At present, Ireland is one of the few developed countries with no mechanism in place to evaluate the impact of these developments, which are of enormous importance in terms of both potential benefit and potential cost.

The HSE will prepare the National Service Plan. This will consolidate the individual regional plans but the HSE will ensure that, when combined with appropriate elements in relation to centralised functions under HSE control such as Shared Services and IT development, they are in line with the requirements of the system overall. Responsibility for reconciling system priorities with individual regional demands will rest with the Executive, which will be expected to apply the same population health and policy priority tests to these demands as those used by the DoHC.

The potential to leverage shared services and other centralised functions at planning and funding decision-making points is significant. Nationally prescribed and supported programmes in the areas of IT infrastructure or estate management, for example, can be factored straight into the Service Plan agreed with the Department and given immediate operational shape in the regional service plans.

Similarly, national strategies in the patient services area such as the Cardiovascular Health Strategy, which is very clear in its targets and objectives but faces significant challenges in implementation because of the multiplicity of structures it has to engage with, can be given real expression in a plan for delivery through the HSE and its regional arms. Responsibility for delivery will rest with the HSE, the Department will set the performance management framework to measure this delivery and external review will be provided by HIQA, in particular, at its own initiative or at the request of the DoHC.

### **Sectoral funding**

We also propose that in agreeing the annual Service Plan with the HSE, the Department should distinguish clearly between the budget for the NHO and other service funding. The Director of the NHO, who will be accountable to the Chief Executive Officer of the HSE, should separately manage this discrete budget.

The separation is designed to do a number of things. Firstly, it will highlight the current resource commitment to the acute hospital sector, which has remained largely constant as a proportion of overall resources over several decades. Secondly, this earmarking of funding could be used as the basis for an agreed staged shift of priority in allocating resources over time in line with best practice of linking funding explicitly with strategic objectives. Thirdly, it is consistent with the logic of the restructuring proposals, which are designed to focus on reform of the acute hospital sector as a major system priority.

The policy backdrop to restructuring of the hospital system is not yet available, but we anticipate that the report of the National Task Force on Medical Staffing will be at its core. If accepted by the Department, and approved by Government, it is likely to form the blueprint for the work of the acute hospital pillar of the HSE i.e. the operations of the NHO. The Primary Care Strategy is notably explicit about the detailed funding which will be required for implementation of its various components (including capital, IT, etc) and a similar approach will be required in the acute sector when the blueprint for reorganisation has been agreed.

Service planning for the hospital sector at national level will form part of the overall remit of the National Hospitals Office to drive through the reorganisation of acute services. Service plans and funding for the acute sector will have to be aligned with proposals by the NHO, approved by the Department as being in line with national policy. These plans will have to reflect NHO decisions on issues such as the location of national specialties, reconfiguration of services within the acute sector, capital developments, staffing levels, training and workforce planning. Funding levels within the acute hospital sector will continue to be based, at least in part, on the casemix budgeting system, which it is proposed to refine and expand.

A critical function proposed for the hospitals agency under *Quality and Fairness* was the approval of new consultant posts; their number, location and qualification requirements. The NHO will need to collaborate closely with the medical training and regulatory authorities in discharging this role. The fact that it will ultimately be responsible for approving the number and type of posts should help ensure the best objectives match between service needs, medical workforce staffing and available resources.

The NHO will ensure that the national programme of acute sector reform is reflected overall within regional service plans in a balanced manner. We recognise that many major hospitals play multiple roles: local, regional, supra-regional and national (in some cases). Part of the NHO's remit will be to bring clarity to these distinctions and have this reflected in regional planning and operations. In cases, for example, where the region does not have an existing provider but needs a particular acute service, the NHO would organise to provide the regional service in line with the national plan.

We anticipate that hospital services will increasingly be organised in hospital groups or clusters with their own overall governance and management structures, where this is not already the case. At regional level the NHO will have a role in putting those groups in place and ensuring they operate effectively. This will require different approaches depending on the region involved. In the Eastern region the existence of major academic teaching hospitals with a range of specialty roles alongside a number of stand-alone specialist hospitals, some of which also have national specialty status, presents a complex set of policy, organisational and managerial challenges. Elsewhere in the country, the need to reconfigure existing hospital roles, to meet local and regional demands, or to align with best practice in treatment and professional training presents other equally challenging difficulties.

In its assigned role to manage the national waiting list database the NHO can also ensure that planning reflects the need to match supply and demand for long-waiters for acute hospital services and bring real focus to solving problems such as this or relieving pressures on the A&E services. The provision of a direct reporting line in relation to the acute sector from the regions to the NHO should facilitate the necessary match between system-wide reorganisation objectives and the specific circumstances of each region.

### Regional and local level

---

As set out in Chapter 7 above it is proposed that the Regional Directors of the HSE have overall responsibility for preparing and delivering their own Regional Service Plan within budget, which will then be integrated with the national plan by the HSE. Again, they will prepare this plan using population health analysis and prioritising competing demands at regional and local level within the national policy context. Plans will cover the full spectrum of services currently provided directly by the health boards themselves or on their behalf through the voluntary and private sectors.

There are likely to be a number of functions and services that are planned largely at regional level for reasons of efficiency of scale, as is often currently the case. Each region might make its own decision in relation to these service matters. However, a unified national executive structure will offer an opportunity to harmonise the different approaches which have developed across health boards in relation to defining client groups around whom services should be planned and delivered.

In developing regional plans there will be extensive support available from the centralised skills in the HSE to avoid unnecessary duplication of scarce analytical and other capability. However, regions will need their own planning and evaluation functions to keep these critical elements to the fore right down through the service. In addition, the development of partnership structures, regional coordinating committees and local consultation mechanisms which include the community and voluntary sector offers real potential for developing a broader scope for regional health and social services planning than has traditionally been the case.

It is proposed that voluntary providers and professional groups will feed into the planning process via regional planning fora. This will help integration of services across LHOs throughout the region. Voluntary providers will be part of the service planning process from the outset. They will be briefed on the national priorities for the coming year and be able to feed into local and regional needs assessment, drawing on their own specialist background as well as indicating the level and type of services that they are in a position to supply.

The principle that has been set out definitively in the Primary Care Strategy is that the Primary Care Teams now being put in place are ultimately to be the first point of access to the system for the vast majority of patients needing healthcare. In addition, it is envisaged that, in time, they will play the key role in ongoing management of the patient's needs. In line with this objective, the Director of the RHO, under whose remit primary care falls, will have overall responsibility for the preparation of the Regional Service Plan, for its coherence and for negotiation within HSE in relation to its content.

The funding for acute hospitals, coming directly from the NHO, will be linked to service agreements with the hospitals which contain explicit provisions in relation not just to hospital activity outputs but also to measures of integration and responsiveness with the wider health system e.g. services to GPs and Primary Care Teams, links between acute and community psychiatric care, pathways from the hospital to sub-acute care and long-stay care.

Local service plans will be developed by the Local Health Offices and feed into the overall regional planning process. As the Primary Care Networks grow in scale and skills it can be anticipated that they will play an increasing role in the development of local service plans, as well as delivering them. As indicated earlier, we also envisage that at local level focus groups, consumer panels and other participative mechanisms should play a much stronger role in helping to plan care as close as possible to where it is actually delivered. This is not an easy task, particularly with the more dispersed client groups and 'packages' of care required in the community sector. The range of providers of care is mixed between statutory, voluntary and private, some with State funding for a large part, others essentially charitable or privately resourced. Our reform proposals are designed to give health planners and managers the opportunity to develop these structures at local level and to quickly share best practice in doing so.

Another dimension that is particularly relevant in the acute hospital sector is the significant presence of major teaching hospitals (both statutory and voluntary). The voluntary hospitals are, in effect, private institutions whose functions extend beyond the contracts for service provision which are the subject of direct funding by the State. The extended role of the major teaching hospitals covers areas such as medical training and research and development. These broader functions can make a significant contribution to the acute sector and the wider health system. The NHO will play a critical role in integrating these issues with the overall strategy for developing a high performance hospital sector.

## **Recommendation 2.2: Establish strong links between service delivery and evaluation**

Actions:

- Task the DoHC with setting out the framework for performance management of the service as a whole;
- Assign responsibility to the CEO of the HSE for the delivery of the National Service Plan within budget;
- Devolve budgetary responsibility to Directors of Regional Health Offices.

### **National level**

---

Under the consolidated structure, the Department will have no role in direct service delivery. But it will have the decisive role in setting out the framework for performance management of the service as a whole and in calling the system to account. This framework will move beyond financial control in the narrow sense to measures of service quality, impact and value for money (see Chapter 5, 5.2). Good governance relates to all aspects of an organisation's operations and judging the performance of the health system in terms of value will clearly require that the service can demonstrate not just efficiency but also quality and responsiveness, for example. The Department will need to lead with explicit measures for these aspects of performance which should form part of the annual National Service Plan it approves. In turn, the DoHC should insist on the HSE putting in place suitable measures for the services it funds.

The Chief Executive Officer of the HSE will have direct responsibility for the overall delivery of the National Service Plan within budget and other performance parameters, including overall employment control ceilings. He/she will be



responsible to the Board of the HSE and will appear before the Public Accounts Committee or other Dáil Committees, in line with existing Health Act accountability requirements for health board CEOs. As well as integrating the regional service plan he/she will play a particular role in ensuring that the shared services function at the heart of the HSE is exploited to full effect by the Regional Directors and the head of the NHO. The performance of the HSE itself in this respect will be overseen by the DoHC.

The legislative provisions setting out the responsibilities of the CEO of the HSE should also provide for the possibility of devolved authority to regional level and beyond, to allow for the reporting and management structures to evolve over time and drive decision-making down through the system. The ultimate logic of the Primary Care Strategy proposals is to have as much decision-making as possible located close to the patients and mediated by the Primary Care Teams.

A strong role is envisaged for the Health Information and Quality Authority in reviewing the performance of the health service overall, by programme or by sector. HIQA will carry out or commission service reviews on its own initiative, or at the request of the Department, and will publish its reports and recommendations. It will make its reports directly to the DoHC, as well as providing an annual system-wide report for the Minister and the Dáil Joint Committee on Health and Children. It will be essential that HIQA standards (in areas such as information sets or best practice in services) and HIQA findings (in areas such as assessment of the effectiveness and VFM of new technologies) shape the service delivery and evaluation process from policy level down to patient experience.

While performance parameters for the delivery system will be set down by the Department, supported by HIQA at a national level, the cascading of performance measures through the national delivery system and the establishment of a performance culture within it will need to be driven by the HSE.

## Regional and local level

---

The Regional Health Offices will be directly responsible for arranging delivery of all non-acute health and personal social services in line with the National Plan. The regional Director will have devolved budgetary responsibility for his/her area and, ideally, employment control authority also. He/she will be the key link with other State agencies who can contribute to promoting better health status for inhabitants of the region and also for liaison with colleague regional Directors in relation to cross-regional issues.

The regional Director will not have direct budgetary responsibility for acute hospitals within the region, which will be centrally allocated by the NHO, but will be required to put in place a protocol with the relevant acute hospital network(s) which will cover planned activity outputs for the regional population and performance standards in relation to issues such as access and integration of acute care with other sectors. Monitoring of key performance indicators, and reviews of service quality will be expected to assess the impact of service delivery at both regional and local level and to feed this analysis back into the planning cycle.

The NHO will be responsible at regional level for coordinating acute care and will look to both public and private providers for services. Their role will have to be fully integrated in regional structures built around client needs. The resolution of any conflicts around competing demands on particular hospital networks will be the responsibility of the NHO.

Within regions there will be a need to cascade critical performance measures across the system down to local levels and ensure delivery against these. As described in the preceding section on service planning and funding, it will be the role of managers of LHOs in the first instance to deliver within these performance measures. Once developed, the evolving primary care structures will be subject to the same business disciplines as the LHOs.

## Recommendation 2.3: Put in place enablers to support integration

Actions:

- Ensure that the development of supporting processes and infrastructure is designed to promote integration between services;
- Ensure that service planning at all levels supports identification and development of integrated services;
- Ensure that integration with service partners is included as a key standard in the Health Services Accreditation Programme;
- Develop processes and protocols as part of the Primary Care model to ensure leading practice in patient referrals between acute and non-acute services.

### Integration in the consolidated structure

---

The solution to the difficulties described earlier in Chapter 7 in relation to fragmentation in the health system is often described as providing an integrated, or 'seamless', service. The sectoral approach taken in our consolidated structure is designed to recognise the considerable differences between the acute and non-acute sectors, not just in terms of management requirements and the nature of the services provided, but also their state of development. Achieving an integrated service for patients and other users is something which organisational structures in themselves can go some way to support, but in no way guarantee. Many of the elements which will support integrated working and a seamless customer experience are to do with process or infrastructure. They include the following:

- Modern information technology systems;
- Availability of unique patient identifier number;
- A performance management and development system for health staff which measures and encourages integrated working;
- Harnessing customer feedback and participation;
- External accreditation programmes which assess and promote integrated working within and between services;
- Customer service centres which link information and service points to the customer;
- Agreement on flexible out-of-hours working.

These elements are real integrating forces which will make organisational structures largely invisible or irrelevant to the patient. Achieving effective integration of services is ultimately a managerial function, in many instances combined with effective team working and inter-professional relationships. There are already some models in existence within the Irish health system which could be built on to make the service effectively seamless to the patient. These models, some of which have been cited earlier, have been developed within health boards and also between stand alone voluntary providers and other parts of the service.

### National level

---

It is difficult, if not impossible, for those at the frontline to offer integrated services if this approach is not adopted from the very top of the system. Traditionally this has not been the case. The health service suffers doubly in that the actions of other Departments of State often have a major influence on health status, but are rarely coordinated at the decision-making level. Some steps have been taken to redress this, notably in the establishment of the Cabinet Committee on the Health Strategy.

In the consolidated structure, the restructuring of the DoHC will need to ensure that policy-making and priority-setting functions within the Department itself support integration across sectors. The establishment of the HSE at national level, and the development of a single National Service Plan will help to ensure that appropriate integration and cross-sectoral working is in place for the delivery of the overall priorities of the health system. The location of the National Hospitals Office within the HSE will also support integrated planning within the hospital sector, and between acute and other services.

Integrated working will require a mixture of imperatives and incentives. The system at a national level needs to ensure that accountability and funding arrangements at individual, sectoral and organisational level support integration — through the inclusion of integrated working as a measure of performance, for example. As health services accreditation is strengthened and rolled-out, it should continue to include integration within and between sectors as a necessary standard to achieve accreditation. This approach has been adopted internationally and can evolve, for example, into whole-system or whole-region accreditation which has the provision of seamless care as one of its main measures of performance.

### Regional and local level

---

To safeguard and build integration during the transition period in particular, the NHO will need to agree appropriate arrangements at regional level for its interfaces with the RHOs. In some cases this may take the form of transitional posts to manage regional acute care issues. This will support integrated working between the two sectors at a critical point in the delivery system, particularly in relation to regional planning and evaluation. Integration performance targets will be used to incentivise management behaviour on this important issue. These arrangements will be supported by the regional coordinating committees and other mechanisms already in place to support coordination between the statutory and voluntary providers and other stakeholders.

In addition, the advent of new approaches to delivering medical care such as Managed Clinical Networks offers real potential. This concept is still relatively recent but it involves supporting teams of doctors, nurses and other health professionals in working together across different facilities and boundaries, be they geographical or organisational, to provide the best care for patients delivered from the most suitable location. The acute sector in the NHS in Scotland, which has many similarities to Ireland in terms of population, demographics and the challenges of a dispersed client base, is to the fore in developing this way of working. Hospital services in Northern Ireland, which are currently under review for reform purposes, are also looking to the possibility of using the managed clinical networks model to overcome organisational and geographic barriers that are similar to our own.

At local level, it will be the development of the Primary Care model which will provide the driving force for the provision of seamless services to patients. This integration can be made real on the ground through the development of formal protocols and processes by which patients are referred to and from primary care or continuing care services into and out of the acute sector, for example. These enabling mechanisms will need to be shaped and promoted nationally but delivered locally. They will require a sustained degree of inter-disciplinary co-operation in order to develop and deliver. This work will have to be supported and incentivised if it is to be achieved in a system with acknowledged capacity and funding pressures.

## Recommendation 2.4: Enhance system capability and performance

Actions:

- Assign responsibility to the strategic HR function of the HSE for the development of leadership capacity, management development, HR effectiveness and organisation development across the health sector;
- Build a revised leadership model and audit existing leadership and change capability within the system;
- Expand the personal development planning process to facilitate stronger role clarity, performance planning and communications between managers and employees;
- Develop an employee engagement process including communications processes as well as national and local partnership structures;
- Conduct an audit of the critical skills and competencies required to deliver system capability and performance and ensure that these are in place within the system;
- Implement a system-wide performance management framework;
- Expand and accelerate the Clinicians in Management programme.

Over 70% of the cost of the health service is payroll related and the service itself is delivered by and through people. This demonstrates the importance of developing and managing capabilities to achieve sustainable performance.

### **Assign responsibility to the strategic HR function of the HSE for the development of leadership capacity, management development, HR effectiveness and organisation development across the health sector**

The strategic HR function in the HSE should be assigned specific responsibility for developing leadership capacity, HR effectiveness, management development and organisation development across the health sector. Specific responsibility for implementation at local level should be assigned at senior management level in all health sector agencies and resulting initiatives led by HR Directors and Managers. The need for professional HR functions to be in place and functioning effectively is critical not only for the transition process but also for the ongoing development and maintenance of services throughout the system. The strategic HR function in the HSE will play a critical role in the development and support of local HR, as follows:

- The role of Head of HR in the HSE is that of Change Driver and the skills, energy, personal drive and commitment required to deliver this role should not be underestimated;
- A comprehensive HR strategy articulating the people management vision, objectives and practices of this significant employer needs to be developed. It should incorporate and build on the HR commitments made in *Quality and Fairness* and elements of the *Action Plan for People Management*. It should also incorporate the accountabilities and strategic objectives currently discharged by the Office for Health Management and the Health Services Employers Agency;
- The Head of HR for the HSE will need to ensure that best practice skills assessment, selection and recruitment practices are deployed in appointing staff to new roles under the new arrangements. It is critical that staff across the health system accept that there is equality of opportunity for all in the new structure;
- The HSE HR function will need to ensure that the key managers selected for the new agencies possess not only the required skills and competencies but also the managerial skills and style to create and support a facilitative and transformational organisational culture and ethos;
- The Head of HR for HSE should be accountable for consistency in implementation of the HR strategy, practices and policies;
- HR function heads need to be capable of playing a critical role in managing the transition of staff from existing agencies to new/redefined agencies.

The Head of HR should also play a lead role in engaging the health system workforce in the strategic objectives of the health system by strengthening a communications and employee engagement infrastructure. This should build on existing service planning and partnership activities and managing the deployment and effectiveness of the personal development planning process. Overall, the HR function should lead and support local HR management towards:

- Making the health services a progressive employer of choice;
- Engaging with staff at all levels in the achievement of organisational objectives and the highest quality service;
- Offering an opportunity to staff to be part of structures that are dedicated to the provision of a high performance healthcare system;
- Improving the overall development and effectiveness of human resource management in the health system.

### **Build a revised leadership model and audit existing leadership and change capacity within the system**

One of the first tasks of the strategic HR function in the HSE should be to establish a revised leadership model based on the skills and competencies required to roll out the change programme involved under the new strategy for the health services. In developing this model, the transformational role of leaders, particularly in engaging staff in a participative and empowered working culture, should be recognised. This work would involve an audit of the existing leadership capability and capacity within the system and the integration of the leadership model in future recruitment, selection and development processes.

We advise a review of the remuneration strategy for health sector leaders, taking into account the recommendations of Report No 37 of the Review Body on Higher Remuneration in the Public Sector (commonly known as the Buckley Report). The review body made a number of recommendations in relation to the extension or introduction of performance-related pay for higher level roles within the public sector including CEOs of health boards. These recommendations will need to be taken into account for roles within the future health system at a similar level and implemented in conjunction with a proper performance management system. The delivery of the change programme for the health services and ongoing service delivery should be aligned with remuneration policy, particularly at senior levels where incentive pay already exists within the public sector.

### **Expand the personal development planning process to facilitate stronger role clarity, performance planning and communications between managers and employees**

To support the working of the reformed structures the roll-out of a personal development planning process across the health system is required. This has been already suggested in *Quality and Fairness* and in the *Action Plan for People Management*. The action plan is explicit about activities and implementation responsibilities. In the new structure the primary role on the management side will be led by the HR function of the HSE. Specific benefits of this initiative, in our view, will be:

- The provision of a critical communication channel between managers and staff as the health system enters a period of change and organisational disruption;
- A forum for employees to discuss career and development objectives with their current role and into the future;
- A process to ensure role clarity and enhanced focus on critical elements of the job;
- Greater alignment between the new performance management framework at system level and day-to-day priorities at team and individual level.

### **Develop an employee engagement process including communications processes as well as national and local partnership structures**

The benefits of the new strategy for health sector employees are significant — making the health services ‘a better place to work’ is a clear objective of the recommendations in this report, of the *Action Plan for People Management* and of *Quality and Fairness* itself. The role that staff have played and continue to play under pressure in the day-to-day delivery of service to patients and customers needs to be recognised as do the legitimate concerns that staff will inevitably have as they face into a period of organisational change. It is also clear that without the engagement and commitment of staff, the speed and effectiveness of the change programme will be adversely affected.

It is important that the partnership model continues to be developed particularly at local level where it can be used effectively to communicate change and solve specific issues at agency level. This process should be supplemented with other communication and feedback tools, e.g. using web-based technology, employee surveys, newsletters, etc to ensure that staff are kept up to date and engaged and that their concerns are heard and acted upon.

### **Deploy the personal development planning process to facilitate stronger employee engagement, career and skills planning and communications between managers and staff**

The continued deployment of the personal development planning processes, already in place in some agencies, would also support the management of change in the short term. This provides a one-to-one communication mechanism between management and staff, an opportunity to discuss skills development and career opportunities and to provide clarity in times of change. For the longer term it will also support the development of a more inclusive and participative management culture.

### **Conduct an audit of the critical skills and competencies required to deliver system capability and performance and ensure that these are in place within the system**

This Audit has identified some of the key skills and competencies that will be required to enable capability and performance. These include strategic health planning, health economics, workforce planning and performance measurement. We recommend that the strategic HR function of the HSE conduct an audit of these skills in conjunction with HIQA and that acquisition and development of these skills are prioritised in future selection and development plans.

### **Implement a system-wide performance management framework**

A performance management framework operating at system, organisational and individual level needs to be established. Key measures for monitoring and measuring the effectiveness of the health system should be identified. Measures such as customer satisfaction, internal process/system efficiency, financial management and people management effectiveness should be included. The framework should look to balance the variety of often competing demands on staff, e.g. integration, service quality, efficiency, team working etc.

Once the framework for managing performance at a system level has been developed it will need to be cascaded down to individual organisations. In particular, performance measures for service delivery in the acute and non-acute sectors should be identified, and the information required to monitor and report on these measures gathered on an ongoing basis.

Any performance management framework implemented should build on the experience gained throughout the public sector to date and the development planning processes already in place in the health sector and should be owned jointly by staff and management within the system.

### **Expand and accelerate the Clinicians in Management Programme**

Currently the Clinicians in Management Programme appears to fall within the remit of the Office for Health Management, under the direction of the Personnel Management and Development Unit of the DoHC. The Programme now needs to be extended, resourced and aligned with the *Action Plan for People Management*. Responsibility for the Programme should transfer to the HSE on establishment. We will discuss the critical need to align the Consultants Common Contract with the extension of this programme in Chapter 9.

## Chapter 9

# Strengthening governance and accountability across the system

---

### Reform proposal 3: Strengthen governance and accountability across the system

Our findings from the Audit in relation to current governance arrangements (Chapter 4) establish a clear need to improve governance and accountability across and within the Irish health system. Two major recommendations are proposed:

#### Recommendation 3.1

- Clarify and implement governance and accountability arrangements to support the consolidated structure

#### Recommendation 3.2

- Develop and implement a set of guidelines for governance and accountability for all health and social service agencies

#### Recommendation 3.1: Clarify and implement governance and accountability arrangements to support the consolidated structure

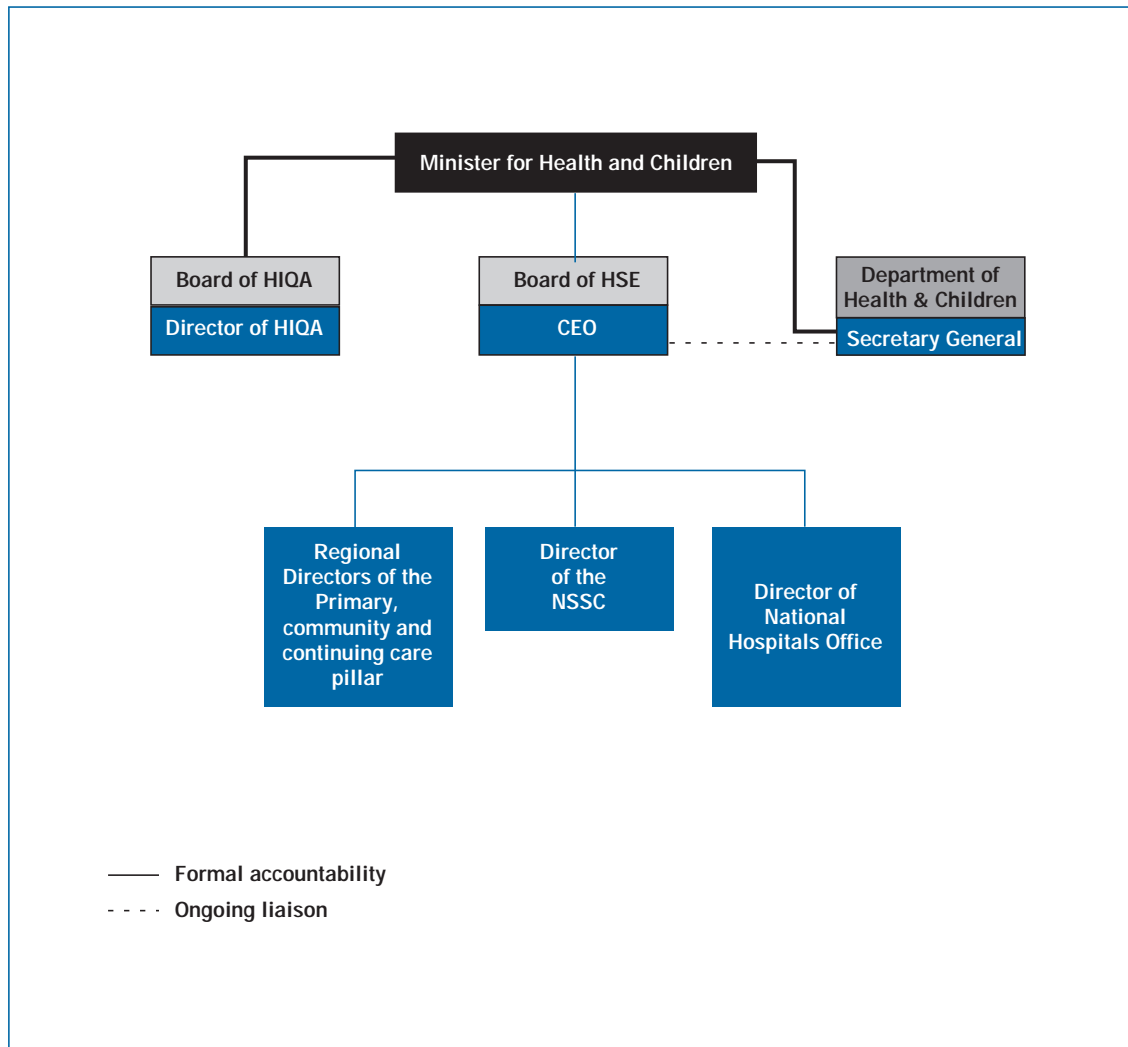
Actions:

- DoHC to ensure oversight of governance arrangements and compliance with governance standards of all statutory agencies;
- Establish a Board for the national HSE;
- Revise the Consultant Common Contract to ensure effective accountability for resources used;
- Strengthen the framework for clinical governance.

Figure 9.1 outlines the governance and accountability lines in the consolidated structure. It reflects the Audit findings in Chapter 4 relating to the clarification of boundaries of authority and accountability. Clearly these structures will need to be provided for in legislation. This should also underpin the structural changes with other reforms identified, such as the need to legislate as strongly for non-financial as for financial performance. The major thrust of the revised governance arrangements revolves around putting in place a Board for the HSE which effectively replaces the ten health boards/area health boards and the ERHA currently in operation. The Board will provide governance for the two service pillars and the shared services function of the HSE.



Figure 9.1: Governance arrangements in consolidated structure



## DoHC

The Secretary General of the Department will continue to be accountable to the Minister for Health and Children for the functioning of the Department, but also for holding the delivery system to account under the terms of the Public Service Management Act, 1997.

While the formal accountability relationship will be directly from the Board of the HSE to the Minister, in practice, key functions in this regard will be assigned by the Minister to the Secretary General and the Department. To effectively discharge its role of holding the HSE to account, the Department will need to be equipped, resourced and organised to maintain an on-going liaison role with the HSE as well as to exercise its policy leadership and planning roles.

This will require strengthening of the Department in specialist skills in areas such as system level performance evaluation, health planning and policy analysis, health economics, option appraisal and health impact assessment among others. The Department should be in a position to guide, monitor and, where necessary, challenge the actions of the HSE within a context which demands ongoing consistency with overall policy objectives and priorities. It has to be able to exert

positive pressure on the HSE to deliver planned service outputs and results in approved financial, employment and activity (volume and quality) parameters.

## **HSE — Governance and accountability arrangements**

---

The HSE will be established on a statutory basis. It will be operationally responsible for the implementation of national health policy and the overall management of the healthcare system.

The HSE will have its own Board and the Chairperson will be accountable to the Minister for the management of the public health services delivery system.

The Chief Executive Officer will report to the Board of the HSE. He/she will also be required to appear before the Public Accounts Committee or other Dáil Committees, as appropriate. The Board should have 7-10 members, in line with best practice and to address our findings in relation to current Board sizes. The make-up should at a minimum include the following:

- An independent Chairperson;
- A DoHC representative;
- 3-4 other non-executive directors with the range of experience and skills to enable the Board of the HSE to deliver on its mandate;
- 1 service user, non-executive director.

The Chief Executive Officer of the HSE should not be a member of the Board, but should be required to be in attendance. Other members of the HSE, for example the Finance and HR Directors, should attend as required. The Minister for Health and Children should make all appointments to the Board.

The Board of the HSE will have such reserved functions as the Minister prescribes, but should:

- Direct the operations of the HSE;
- Approve the Annual Report and Financial Statements of the HSE;
- Approve the National Service Plan;
- Agree the Key Performance Indicators which should be monitored on a monthly/quarterly/annual basis;
- Appoint the CEO of the HSE;
- Review its own performance on an annual basis.

It will be essential, within this structure that there be close and ongoing liaison between the CEO of the HSE and the Secretary General of the DoHC. This should ensure a common understanding of emerging issues and system priorities.

## **Regional Health Offices — Governance and accountability arrangements**

---

Each Regional Health Office will have a Regional Director, the budget holder directly responsible for the planning and delivery of primary, continuing, community and other non-acute services within his/her region. The Regional Director will be accountable to the CEO of the HSE.

The current Boards of each health board will be replaced by:

- The Board of the HSE for governance of executive functioning of the health and social services delivery system;
- Community participation structures and the National Consultative Forum for consultation, dialogue and advocacy;
- Meetings of RHOs with regional Oireachtas members for democratic input.

This should have a positive impact on the speed of decision-making and the delivery of national and regional strategic objectives.

A regional management team will support the Regional Director, and depending on the internal functions and structures of the RHO, will consist of a number of Assistant Directors with responsibility for the core service lines on which the individual RHO is structured (e.g. programme, care group), and for corporate functions, e.g. Planning, Population Health, etc. We envisage that the RHOs should have direct or indirect access to high-calibre, professional clinical advice on all aspects of their service. Links will need to be developed through the HSE, with the DoHC, HIQA and the professional bodies in this respect.

### Local Health Offices — Governance and accountability arrangements

---

Each Local Health Office will be based around the existing General Management structures in Community Care Areas. The General Manager will be accountable to the Regional Director of the relevant Regional Health Office. The General Manager will be supported by a small, core management team to manage the range of services delivered from that Office. To ensure a truly multi-disciplinary team, as well as to support the involvement of medical and other allied health professionals in management at local level, this management team should include Heads of Discipline (physiotherapy, social work, nursing, etc) where appropriate.

### National Hospitals Office — Governance and accountability arrangements

---

The NHO will have a Director who will be a member of the senior management team of the HSE. The NHO Director will be accountable to the CEO and ultimately the Board of the HSE for delivering planned activity levels (volume and quality) within the approved employment and financial parameters set down for the hospital system.

It will be important for the NHO to include the specialist skills required to execute its wide-ranging and technical brief. Many of these skills may be available from the consolidation of agencies being proposed. Consideration should be given to some new roles which are not currently present in the Irish health system, e.g. a Medical Director, or Director of Clinical Affairs. In every possible instance the NHO will share central functions with the HSE as a whole (project management for capital programmes, analysis/evaluation skills, etc) so as to use resources for maximum efficiency and effect.

### Health Information and Quality Authority — Governance and accountability arrangements

---

The Board and CEO of HIQA will be accountable to the Minister for Health and Children. HIQA will also produce and publish a system-wide annual report for the Minister which would go before the Joint Oireachtas Committee on Health and Children. The annual work programme for HIQA will be negotiated through a service plan between it and the Department. This will balance HIQA's argument for a degree of autonomy in its operations with the need to provide an evidence base to support national health policy objectives.

The Agency will have its own board structures, reflecting in their composition the competencies relating to its remit, and an emphasis on external evaluation. It is not envisaged that the HIQA Board will include representatives of service providers.

## System-wide governance of the health service

---

The governance structures we have described above are constructed to fit the design criteria set out in Chapter 6. As always in health systems, they attempt to balance the tensions between local and national needs, between specialist knowledge and external oversight, between political and managerial imperatives. No such design will ever be perfect or could ever remain so. What is critical is that, once these structures are agreed, they are clearly communicated, implemented and supported. Compliance must then be monitored and managed. Later in this Chapter we outline the steps required to ensure a supporting framework for these governance structures.

Ultimately, governance in the publicly funded health service is reflected through the political system. The direct line of political accountability runs through the Minister for Health and Children and the Government to the Dáil. While the reformed structures we propose are based on a much sharper demarcation of executive responsibility and accountability, organisational redesign alone will not make this distinction effective. Unless political and senior health service leadership require the system to perform as designed and refrain, for example, from direct involvement in operational issues, the risk of pulling executive matters into the centre, or into the political arena, will persist.

The Joint Oireachtas Committee on Health and Children is another key governance mechanism through which political governance is brought to bear on the current work and future planning of the health services. In our view, this committee could be more widely used than at present. Our recommendation in Chapter 7 that HIQA's annual 'whole system' report should go before the Joint Committee could form one basis for this deeper engagement.

In this context, it is worth noting that in the US a national quality report on healthcare delivery has been mandated annually by Congress, beginning in 2003. This review, a *National Quality Report on Health Care Delivery*, has been commissioned to ensure that the required information was gathered on a national basis to allow Congress examine health status and thus determine which aspects of the service are underperforming, and assess whether the quality of care is improving over time. The report format has been developed with a view to allowing both policy-makers and the general public to make year-to-year comparisons and determine where the quality of care diverges from desired levels. The report will cover the complete spectrum of healthcare settings, not just in-patient care. In the future, it is proposed to allow for state or regional level measures, as well as measures that compare the quality of care received by minority populations.

## Clinical governance

---

We have referred in Chapter 4 to the need to develop clinical governance mechanisms. What is involved is demanding: putting in place coordinated mechanisms to assess, assure and promote the quality of all aspects of clinical care. This will include quantitative and qualitative measures of care, assessment of variations in process, outcomes and access to care, rigorous risk management programmes and training in skills such as team working between caregivers. While the Clinicians in Management programme has attempted over a number of years to embrace some of this agenda it is neither widespread nor elaborate enough. The NHS in the UK has developed a range of structural and policy provisions specifically to underpin the clinical governance agenda. A 'duty of quality' for all NHS organisations was put in place under the 1999 NHS Act. This introduced corporate accountability for clinical quality on the same basis as more traditional measures of performance.

A whole-system approach is critically important here. In this regard, we consider that the current arrangements in relation to both GP services and hospital consultant services governed by the Common Contract are in need of review in order to ensure that accountability is as tight as it can be for all aspects of quality patient care. The areas that need to be strengthened in a revised Common Contract for Consultants will include the following:

- Effective accountability for resources used;
- Participation in managed clinical networks;

- Flexible provision of clinical services;
- Co-operation with clinical audit.

In relation to General Practitioners, the following requirements need to be considered:

- Payment for performance rates on immunisation and screening;
- The provision of comprehensive cover to geographic areas including areas of disadvantage and disadvantaged groups;
- Effective involvement of general practice in shared care;
- Co-operation with ICT developments;
- Sharing of morbidity and population health data on their total practice;
- Comprehensive, reliable out-of-hours services.

As well as these contractual amendments, legislative reforms planned under the Medical Practitioners Act, for example, will provide an opportunity to underpin the new organisational structures with a new legal framework for clinical governance.

### **Recommendation 3.2: Develop and implement a set of guidelines for governance and accountability for all health and social service agencies**

Actions:

- Assign responsibility to the DoHC to take a lead role in developing a set of governance and accountability guidelines;
- Implement governance guidelines throughout the system.

One of the key findings of the Audit is the underdeveloped oversight and assurance of the current governance arrangements. The proposed structural developments arising from the implementation of the consolidated model (as outlined under Action 3.1 above) are likely to provide a location for this responsibility. As indicated earlier in Chapter 8, we will see an increased focus on management of system performance by the restructured DoHC. This oversight role should also include system-wide governance.

Independent review of governance of the health system will be enhanced by strengthened external quality assurance through HIQA and the expansion of the current health services accreditation framework, which considers governance as an accreditation standard. We believe that adherence to the set of governance guidelines adopted by the DoHC should be a prerequisite for receipt of State funding.

We do not, however, attempt to prescribe the definitive guidelines for governance and accountability for the Irish health system. Development of the guidelines is a project in itself that will need to be led by a sponsor from within the DoHC. Once the overall direction of the consolidated structure is agreed, this project will need to be conducted within the context of the existing health system while also reflecting the objectives of the consolidated structure. Close consultation with stakeholders during both the design and implementation of the governance guidelines will be critical if it is to be successfully adopted.

This section, therefore, outlines the following:

- 9.1 Guiding principles emerging from international leading practice in relation to governance and accountability
- 9.2 Initial identification of the critical elements of effective governance and accountability guidelines for the Irish health system

## 9.1 Guiding principles emerging from international leading practice in relation to governance and accountability

International research demonstrates that there is no single model of good governance that can be applied across organisations. Many different frameworks and models have been devised for specific systems, none of which is perfect. What is important in the design of the models and processes for governance are the underlying principles and the quality of the education, implementation and compliance of these principles at all levels in the system. Certain principles, listed below, have been articulated by a number of authorities including the OECD (2001), Cadbury Report (1992), Hampel Report (1998) and more recently the *International Federation of Accountants (IFAC) (2001)*.

According to the OECD (2001):

- “A clear and credible set of objectives should be laid down in the organisation’s founding instruments;
- Clear published annual objectives for financial and non-financial performance, contribution to the government’s priorities and standards of management should be in existence for all organisations;
- Organisations should be required to account to government and the general public for their use of public resources against the normal public criteria of economy, efficiency, effectiveness and due process;
- Organisations should disclose all information necessary to assure government and the general public of due propriety in their operations;
- Organisations should disclose any circumstances or events that may impact on the achievement of objectives or the government’s overall performance;
- Organisations should ensure that they make information about their operations available to all stakeholders;
- Clarity of roles and responsibilities of governing bodies and positions is critical for effective governance although it can be difficult to create and maintain. For public sector organisations it is about the central government, boards and management and how they relate to each other in stewardship matters;
- For public sector organisations a whole of government framework is required that recognises the interdependent nature of government agencies in delivering services to the community.”

Appendix 8 (Analysis of International Healthcare Structural Reform) refers to the governance arrangements in the health sector of a number of countries including Australia, Canada and the UK. Each model attempts to incorporate the accepted principles of good governance and has been developed to reflect the specifics of the local health system.

## 9.2 Initial identification of the critical elements of effective governance and accountability guidelines for the Irish health system

Effective governance and accountability guidelines are a critical requirement to ensure that there are common, professional parameters across the health system, designed to deliver accountability, standardisation and value for money. As stated above, it is our view that the DoHC should take a leadership position and adopt a set of guidelines for governance, which address the deficiencies identified in this Audit, and draw on the features identified in our review of international experience. It should then put in place mechanisms to monitor compliance.

The following elements will need to be reflected in any proposed governance guidelines for the Irish health system:

	Critical Element	Requirement
1.	Clarity over stakeholder rights and roles	The identity of all stakeholders together with the scope of their interests, rights, roles and their power/influence will need to be defined in any effective governance framework. The move towards patient-centredness and the involvement of citizens in particular will need to be considered in defining the rights and roles of stakeholders.
2.	Clarity and definition of boundaries	The boundaries of the authority and accountability of organisations at each level in the hierarchy of the Irish health system (central, regional, local, etc) will need to be clearly defined in order for a governance framework to be effective.
3.	Match between authority and accountability	At each level in the system each entity must be empowered to take the decisions for which it will be held accountable. The governance framework needs to be sufficiently clear to ensure those deemed accountable are the decision-makers.
4.	Clarity and scope of roles	Each Board should have clear statements of authority and accountability for itself, chief executives and management teams in the areas of strategy and planning, financial control and oversight, risk management, people management and performance and service delivery. For the public sector the role of Ministers and Boards should also be defined and clearly separated.
5.	Board membership, appointment, training and independence	In line with our Audit findings there should be clear rules for the size and composition of the Board, for criteria of eligibility and for the selection, appointment and training of non-executive Board members. These rules should be standardised as far as possible across the health system. Information regarding appointments and remuneration should be publicly available.
6.	Clarity and integrity of decisions on management appointment or dismissal	Boards should have the authority to appoint and dismiss senior managers, including the chief executive, within agreed guidelines.
7.	Disclosure	Timely and accurate disclosure of all material matters (financial and non-financial) will be a critical element of any effective governance framework for the health system.
8.	Supporting processes, particularly performance monitoring processes	Supporting processes will need to be established to support the effective delivery of governance principles and objectives. These include communications and training but also, critically, regular monitoring of management performance and organisational outcomes. These processes will need to be clearly specified and communicated.
9.	Reporting arrangements	There should be arrangements made for periodic reporting to all stakeholders on management and Board plans, actions, results and general stewardship. These arrangements will need to be clearly specified and communicated.
10.	Internal controls	There needs to be a system established whereby it is a requirement for Board members to periodically conduct a review of the internal controls and risk management mechanisms in their organisations. Such reviews should extend to the operations of the Board itself, as there is little evidence of this practice in our findings. The degree of desired convergence/overlap between these internal control systems and clinical governance mechanisms will need to be considered.
11.	Independent audit	An audit mechanism/function will need to be established and located appropriately in the system to ensure objective assurance of the system's ability to deliver on objectives.

The eleven elements listed above are, we believe, the critical components of the governance guidelines for the Irish health sector. In isolation, however, each will do little to improve the functioning of the Irish health system. All eleven are inter-related and interdependent. In order to really improve the functioning of the Health system each element must be addressed as a sub-component of an overall integrated set of governance guidelines that are consistently applied across the health system and take into account the inter-dependencies of the health sector with other bodies and Government departments.



## Chapter 10

# The reconfiguration of audited agencies in line with the consolidated structure

---

### Reform proposal 4: Reorganise existing agencies and their functions in line with the consolidated structure

The proposed consolidated structure presents a number of opportunities to streamline the current architecture of the Irish health system. Our recommendations are as follows:

#### Recommendation 4.1

- Significantly reduce the current number of agencies

#### Recommendation 4.2

- Change the accountability and funding arrangements of 9 agencies

#### Recommendation 4.3

- Strengthen and develop a number of agencies

#### Recommendation 4.4

- Retain the structures and functions of 11 agencies

### Recommendation 4.1: Significantly reduce the current number of agencies

#### Actions

- Mainstream the functions of 27 agencies into the new consolidated structure (establishing sunset clauses<sup>10</sup> where appropriate)
- Merge the structures and functions of 5 agencies

More detailed analysis on the current remit of each of these agencies is to be found in the appendices to this report (Appendix 6 and 7).

---

<sup>10</sup> Note: The term sunset clause is used to refer to an arrangement whereby the lifespan of an agency is linked to the achievement of specified objectives or a given time span

## Mainstream the functions of 27 agencies into the new consolidated structure

### Rationale for location

---

The consolidated model and its component parts provide significant scope to reduce the number of individual agencies operating in the health system.

Based on our analysis we have identified 27 existing agencies which could be subsumed by the HSE and its offices, HIQA or the restructured DoHC. The agencies identified are as follows:

- **Specialist Agencies:**

- **Crisis Pregnancy Agency, the National Council on Ageing and Older Persons, the Office of Tobacco Control and the Women's Health Council**

While it is fully acknowledged that these agencies have played a key role in developing policies in their respective areas, the proposed restructuring of the DoHC to include a stronger emphasis on its policy development role provides an opportunity to include these agencies in mainstream policy formulation.

We recommend, therefore, that these agencies be transferred with their advisory functions into the body of the Department. It will be essential that the skills and functions residing in each of the agencies to be mainstreamed are retained within the revised structures. Where particular commitments would be threatened by mainstreaming, sunset clauses should be established for relevant agencies (with provisions for review) to protect these.

- **Hospitals Trust Board**

The Hospital Trust Board is no longer operational, so it is proposed that its files be transferred to the DoHC and it be formally disbanded.

- **Comhairle na nOspidéal and Hospital Bodies Administrative Bureau**

There is a direct overlap between Comhairle na nOspidéal's role and the prescribed functions for the NHA, as set out in *Quality and Fairness*. Given the extended role of the National Hospitals Office under the consolidated structure (as outlined in Chapter 7), it is recommended that the functions of Comhairle na nOspidéal be transferred to the National Hospitals Office, within the HSE.

As the Hospital Bodies Administrative Bureau provides administrative support to Comhairle na nOspidéal, which is proposed for amalgamation with the National Hospitals Office, it will be absorbed by the NHO within the transfer of Comhairle na nOspidéal.

- **ERHA, Health Boards and Area Health Boards**

The consolidated structure proposed will have a number of implications for the existing health boards and ERHA (and its area health boards). The rationale behind the changes proposed and their impact on the existing regional delivery structures are set out in full in Chapter 7.

In the consolidated structure, the functions of the ERHA, health boards and area health boards will transfer to the HSE and its Regional and Local Health Offices, the National Hospitals Office or the National Shared Services Centre. Figure 10.1 summarises the redistribution of principal functions.

Figure 10.1: Redistribution of principal functions

Entity	Redistribution
Eastern Regional Health Authority	<ul style="list-style-type: none"> <li>Planning and commissioning functions in relation to hospital services to be transferred to the National Hospitals Office</li> <li>All other commissioning and planning services to be transferred to the relevant RHO or the HSE, as appropriate</li> <li>All monitoring and evaluation functions to be transferred to the HSE</li> <li>Eastern Health Shared Services to be transferred to the NSSC within the HSE</li> </ul>
Area Health Boards/Regional Health Boards	<ul style="list-style-type: none"> <li>Arrangement and delivery of regional services to be transferred to RHOs</li> <li>Delivery of local community-based services to remain with LHOs</li> <li>Certain elements of support services to be transferred to NSSC</li> <li>Planning and commissioning functions in relation to hospital services to be transferred to the NHO</li> <li>Acute service delivery functions to be transferred to new hospital Boards or groups</li> <li>Monitoring and evaluation functions to be transferred to regional offices or HSE as appropriate</li> </ul>

- **Board for the Employment of the Blind**

We propose that the Board for the Employment of the Blind cease to exist in its current form. The service provided is similar to other sheltered employment services and as such we recommend that the Board be disbanded and that the service be provided for and funded by the relevant RHO.

- **GMS Payments Board, HeBE, National Breast Screening Board**

The establishment of a NSSC, and a single HSE, provides a national platform for the location of both shared and joint services. It is proposed that the functions of one agency be located within the NSSC for traditional shared services (GMS Payments Board), and the functions of two others within the HSE Corporate (National Breast Screening Board; HeBE). It should be noted that Eastern Health Shared Services, while not separately audited, is recommended for integration within NSSC.

- **Health Services Employers Agency, Office for Health Management**

With the creation of a central HSE, a focus for the work currently carried out by both the Health Services Employers Agency and the Office for Health Management will be provided by transferring these functions into the mainstream delivery structures of the HSE. The HSE's responsibility for strategic HR and IR will support its role as a direct employer or primary funder within the public health system. These functions will need to be embedded in the new delivery structures to deal with the multiple challenges that the programme of organisational reforms will present.

- **National Disease Surveillance Centre, National Cancer Registry Board and Irish Health Services Accreditation Board**

The development of HIQA as a repository for health information for the whole system also offers the opportunity to bring together the work of some of the specialist information gathering agencies, specifically the National Cancer Registry and the National Disease Surveillance Centre. We consider that these bodies could be reconstituted as divisions within HIQA's overall operation.

We recognise (as noted in Appendix 6) that the NDSC has a significant operational role in respect of disease control, over and above its surveillance activities. This properly belongs to the HSE and should not in our view be assigned to HIQA. There will clearly be a requirement, however, for explicit and well defined linkages between the surveillance and central mechanisms of communicable disease management.

The planned development of HIQA provides a central function with primary responsibility for the development and monitoring of quality standards and the provision of an evidence-base to service planners and providers. Given the proposal to expand the role of the Irish Health Services Accreditation Programme, it is recommended that the IHSAB should, in time, be brought under the corporate structure of HIQA. It has been noted during the Audit that the Board of the IHSAB has been established on a mix of competence and sectoral knowledge basis, while ensuring independence from the system which it will accredit. This structure could be used as a reference model for the governance of HIQA itself on establishment.

## Requirements

---

- Review outstanding commitments of the 27 agencies identified and establish sunset clauses where appropriate
- Agree arrangements to phase out the Boards of agencies being mainstreamed
- Make legislative provision for the changes in the remit and accountability of 'receiving' agencies
- Make legislative provision for transfer of employment of existing staff to new employer
- The reconfiguration of specialist agencies (i.e. Crisis Pregnancy Agency, the National Council on Ageing and Older Persons, the Office of Tobacco Control and the Women's Health Council) is dependent on decisions about the restructuring and strengthening of the DoHC. This would involve the creation of appropriate internal structures and the addition of specialist skills to match incoming advisory functions or policy areas
- The mainstreaming of policy/advisory functions will require strengthening the Department's internal capacity. However, the retention of expert panels or other similar mechanisms, on a non-statutory basis, to ensure continued external advice to the Department is recommended. For example, the National Council on Ageing and Older Persons has access to a wide range of expertise in its area which could continue to be drawn upon. The Department might refer relevant policies and strategies to these panels for advice and appropriate input. Where an agency, set up for a specific purpose, is still regarded as being at an embryonic stage and needs to build further momentum, a specific sunset clause should be fixed.

This should require a positive decision by the Minister at the end of the period if the agency is to be left in place. In the normal course, it would be expected that functions would be mainstreamed once the expected life span of the agency's mission has elapsed.

## Merge the structures and functions of 5 agencies

### Rationale

---

- **National Council for the Professional Development of Nursing and Midwifery, Postgraduate Medical and Dental Board**

At present, five professions are subject to statutory registration: doctors, nurses, pharmacists, opticians and dentists. New legislation will provide for the statutory registration of a number of other health professional groups. We are aware from our Audit analysis that there would be considerable difficulties in amalgamating the organisational structures of the established professional bodies representing dentists, doctors, nurses, opticians

and pharmacists. This is due to a number of factors, including the historic independence of each of these professions, as well as the high degree of specialisation attached to each. Furthermore the functions of these agencies will also be directly affected by proposals currently in preparation in relation to the Medical Practitioners Act, 1978. There is a commitment in *Quality and Fairness* to review all legislation in relation to the accountability of regulatory bodies to the Oireachtas within five years of its introduction. We therefore propose that these agencies continue to operate as is currently the case.

However, it is proposed that where a single profession is represented by more than one statutory agency, these agencies be amalgamated. A number of the above professions have more than one body carrying out these functions:

- The Dental Council and the Postgraduate Medical and Dental Board both operate on behalf of dentists;
- The Medical Council and the Postgraduate Medical and Dental Board operate on behalf of doctors;
- An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery support the nursing profession.

It is therefore recommended that:

- The monitoring and approval of specialist posts in accordance with agreed standards, together with the funding for continuing postgraduate medical and dental education, should transfer to the HSE. The remaining functions of the Postgraduate Medical and Dental Board would move to the relevant organisations, the Medical Council/Dental Council. Other issues of concern related to the proposed consolidation could be dealt with in the review of legislation.
- The monitoring and approval of specialist posts in accordance with agreed standards, together with the funding for continuing nursing education, should transfer to the HSE. Standards should be agreed in relation to the criteria for appointment and approval of posts by the HSE and the advisory panel (which could initially comprise members of the existing Council representing appropriate education and service interests) and an Bord Altranais. The remaining functions of the National Council for the Professional Development of Nursing and Midwifery would move to an Bord Altranais. Other issues of concern related to the proposed consolidation could be dealt with in the review of legislation that will be required to support a restructuring of an Bord Altranais.

- **Pre-Hospital Emergency Care Council, National Social Work Qualifications Board**

The development of a Health and Social Care Professionals Council to establish a system of statutory registration for health and social care professionals has been proposed. As this would result in the HSCPC having responsibility for social workers and professional pre-hospital emergency staff, it is proposed that the Pre-Hospital Emergency Care Council and the National Social Work Qualifications Board be amalgamated with the Health and Social Care Professionals Council.

- **Comhairle na Nimheanna (Poisons Council)**

It is proposed that the functions of the Irish Medicines Board could be expanded to include advice on poisons. The IMB currently deals with both veterinary and human medicine and this expansion into poisons should be relatively undemanding, given that the Poisons Council has only met three times in the last ten years.

## Requirements

---

- Amend legislation for 'receiving' agencies
  - In the case of an Bord Altranais, provision should be made to retain the enhanced public representation as provided for in the establishment of the National Council for the Professional Development of Nursing and Midwifery
- Take legal steps to disband the Boards of the agencies being merged
- The timing of the reconfiguration of professional regulatory agencies as outlined above will be dependent on the development of the Health and Social Care Professionals Council, and on the completion of any specific tasks assigned to newly-established agencies (for example the Pre-Hospital Emergency Care Council).

## Recommendation 4.2: Change the accountability and funding arrangements for 9 agencies

Action:

- Transfer the accountability and funding arrangements of 9 agencies to the HSE.

## Rationale

---

As originally envisaged in *Quality and Fairness* the National Hospitals Agency would be established on a statutory basis under the aegis of the DoHC. Within the proposed consolidated structure, the NHA has been renamed as the National Hospitals Office and will be located within the HSE, rather than reporting separately to the Department.

Six statutory hospitals are included within the Audit. All currently receive their funding from the ERHA. In each case, however, their establishing legislation still includes provision for direct accountability to the Minister for Health and Children in relation to certain issues. We propose that this be amended to reflect an exclusive accountability relationship with their funding authority, either the NHO or the relevant RHO. In the case of the five acute hospitals (Beaumont Hospital, Adelaide and Meath Hospital incorporating the National Children's Hospital, Dublin Dental Hospital, St Luke's and St Ann's Hospital and St James's Hospital) accountability should transfer to the NHO. As Leopardstown Park Hospital is a non-acute service provider it would be more appropriately accountable to the RHO in which it is located.

As the HSE will be responsible for the funding and delivery of the entire range of services within the system, it is proposed that the funding and accountability arrangements for the Irish Blood Transfusion Service should transfer to the HSE in due course. Substantial investment has been made in recent years with the aim of insuring that blood safety in Ireland meets the highest international standards. *Quality and Fairness* specifies that '*the Irish Blood Transfusion Service will continue to be supported in maintaining international standards of safety and quality*'. We recommend that the transfer of accountability arrangements from the DoHC to the HSE be done in a manner and at a time which ensures that public and patient confidence in the IBTS is maintained.

We propose that the current funding and accountability arrangements for the Drug Treatment Centre Board be located with the HSE as the Board is principally a service delivery agency.

## Recommendation 4.3: Strengthen and develop a number of agencies

Actions:

- Strengthen and develop 2 agencies to expand their remit and accountability;
- Expand the remit of the proposed Health and Social Care Professionals Council to support greater standardisation and cooperation between professions;
- Make changes to proposed governance arrangements of individual agencies.

## Strengthen and develop 2 agencies to expand their remit and accountability

### Rationale

---

Health research is a critical function to enable health service planners make informed decisions supported by a solid evidence-base, as well as serving to attract and retain the highest calibre staff and make the health service an employer of choice. A strong research and development function is also a critical spur for innovation in health service operations — a characteristic that is central to all high performance service organisations.

We propose that the Health Research Board will have a strengthened role to include responsibility for the development and maintenance of a register of all Irish based health and social services research to be commissioned and conducted in any given year. The register will be a public domain document, circulated to all agencies. This proposal will provide a further support for the difficult task of ensuring a coordinated approach to research and development. We recognise that this is not a straightforward matter, raising questions as who defines what constitutes research and whether a database is preferable to a register. The Health Research Board will need to work closely with HIQA in the development of this aspect of its functions and in the context of the objectives of the *National Health Information Strategy*. As well as this specific item, we feel there is a need and an opportunity for the HRB to play a lead role in assisting the DoHC to discharge its oversight function in relation to research priorities for the health system overall. Similarly, a lead needs to be taken in ensuring that the various strategic planning processes for health research are integrated and coherent.

In relation to the Social Services Inspectorate, it is recommended that this agency continue to report directly to the DoHC, given its critical function in ensuring that quality standards are met in the provision of social services. Expanding this function to cover inspection of all personal social services, e.g. residential care for older people or Intellectual Disability, would ensure that these standards are in place right across social services. However, in order to support the move to a quality system based on continuous quality improvement, it is recommended that the current inspectorate functions in the system work in close association with HIQA to evolve towards a continuous quality assessment approach which could complement the inspectorate function.

### Requirements

---

- Appropriate authority for the Health Research Board to maintain a register of all Irish-based health and social service research
- Development of supporting information systems to facilitate the registration, access to, and dissemination of research
- Formal legal provision for extension of the remit of the Social Services Inspectorate.

## Expand the remit of the proposed Health and Social Care Professionals Council (HSCPC) to support greater standardisation and cooperation between professions

### Rationale

---

The Government is committed to strengthening existing legislation regarding registration of certain professions, such as doctors, nurses and pharmacists. In addition, new legislation will be introduced for the registration of health and social care professionals including physiotherapists, occupational therapists, social workers and others. Review and drafting work on legislation in this area has been underway for a considerable time now. In a broader context the Competition Authority is also currently reviewing a number of these professions.

The legislation for professionals already registered, and for health and social care professionals being registered for the first time, will provide for consumer representation on the relevant statutory registration bodies, to ensure that the views of service users are presented. The legislation will also enable registration boards to provide for a system requiring re-accreditation of professionals at regular intervals, based on a structured system of continuing education and training. It is understood that current proposals include the development of a *Fitness to Practice Function* to ensure that members of the public are protected and informed.

As the HSCPC will be responsible for the statutory registration of health and social care professionals, it is recommended that the Council also assume responsibilities for the training and education of regulated health and social care professions.

Given that the HSCPC will be the first organisation to represent multiple professions, we also propose that the Council also be charged with developing collaborative mechanisms for all professional groupings — including those already covered by separate statutory professional regulation. Specifically this could involve:

- Acting as a single interface for the professional regulatory and development sector with the wider environment for representational and other duties;
- Supporting and developing joint policy, standards and processes.

While we recognise that this is a challenging task, in particular for a new organisation, these moves would reflect the growing international trend of bringing professional groupings under umbrella structures to support greater multi-disciplinary cooperation.

## Requirements

---

- Ensure that the Health and Social Care Professionals Council has an appropriate mandate in developing collaboration among the professional sector as a whole in matters of common interest
- Ensure that the HSCPC has a range of specialist skills and resources which will allow it to fulfil its proposed functions. In particular, it will be important that the pre-requisite skills for professional regulation, be provided for in addition to professional education and training
- Existing professional agencies to be mandated to work on issues of joint action with the Health and Social Care Professionals Council

## Recommendation 4.4: Retain the structures and functions of 11 agencies

### Rationale

---

- **Irish Medicines Board and Adoption Board**

As the Irish Medicines Board and the Adoption Board both fulfil specific specialist roles, the Irish Medicines Board is a licensing authority and the Adoption Board has a quasi-judicial function; it is not proposed to change the accountability or funding arrangements of these bodies, who will maintain their relationship with the DoHC.

- **Pharmaceutical Society of Ireland**

In line with our recommendation above concerning the five professional bodies, no change in overall status is recommended. However, the inspection functions of the Pharmaceutical Society could be considered for transfer to the Irish Medicines Board who carry out a similar function in relation to the manufacture and wholesale of human medicines.



- **Food Safety Authority of Ireland, National Children's Office, National Children's Advisory Council, Special Residential Services Board, Food Safety Promotion Board, Institute of Public Health**

We examined the diverse and extensive roles of these agencies closely, as set out in Appendix 6. Apart from their core functions, which relate to specific sectors or care groups, two other characteristics emerged:

- A significant role in cross-cutting liaison between Government Departments, other public sector agencies or other providers;
- A specified role in North/South institutional arrangements, with extra-jurisdictional governance links.

Given either of these two characteristics we felt it would be inadvisable to propose any alteration to their existing status.

- **Opticians Board**

No changes are proposed for the Opticians Board, in line with the reasoning cited above in relation to the professional regulatory bodies as a whole.

- **Mental Health Commission**

Given the recent establishment of the Mental Health Commission it is not proposed at this stage to change its current arrangements. The Mental Health Act, 2001, section 75, specifies that the Minister after 5 years will review the operations of the Act and report to both Houses of the Oireachtas. It is our view that this represents an appropriate approach in relation to ongoing evaluation of the role of the Mental Health Commission.

It is important to note, however, that general recommendations in relation to the governance arrangements of agencies in the Irish health system, as outlined in Chapter 9, will apply equally to these agencies as to those whose structures or functions have been recommended for rationalisation or other significant change.

## Summary of combined net effect

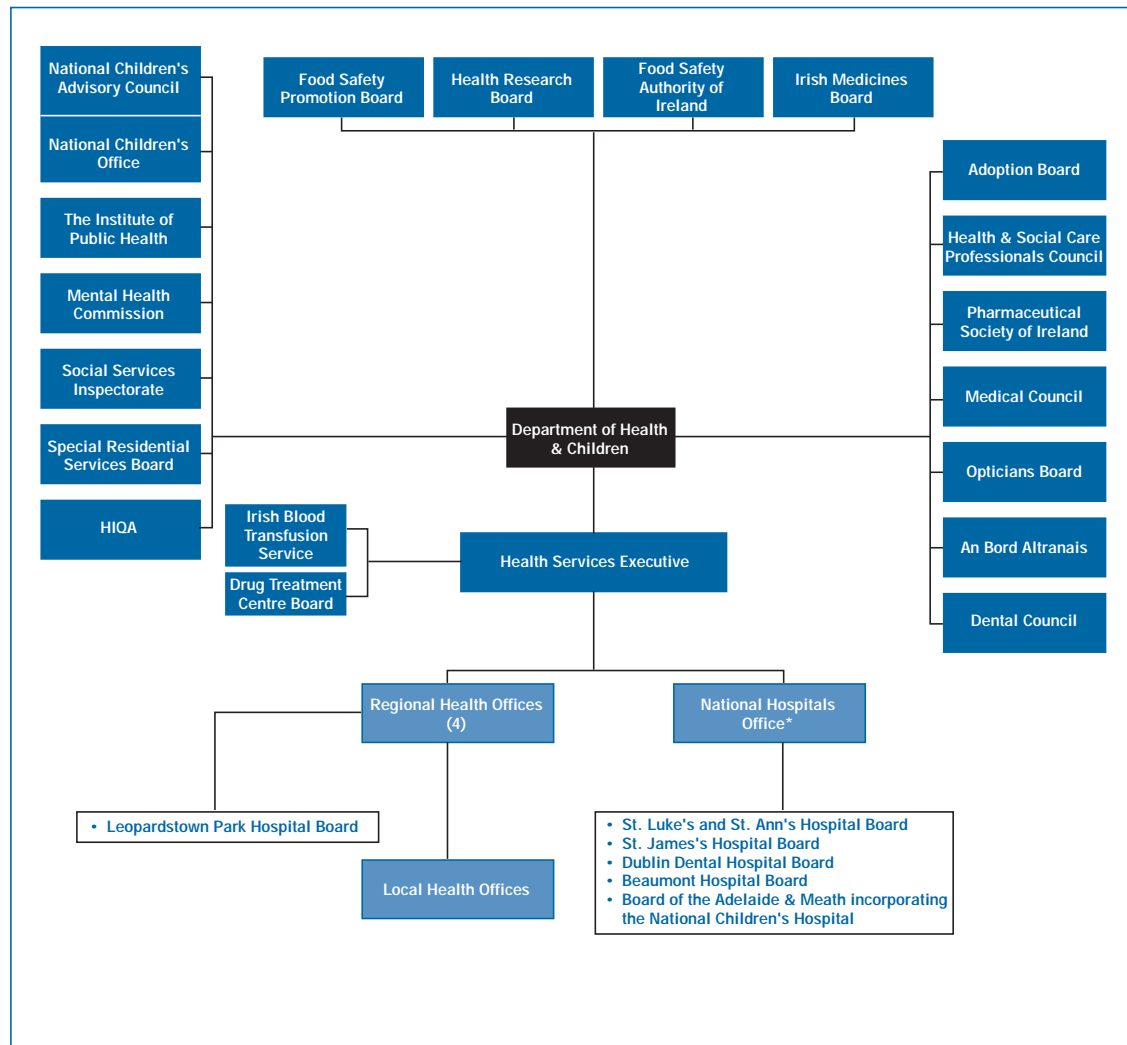
---

The proposed reconfiguration of agencies and redistribution of functions as outlined above should, when completed, greatly enhance the manageability of the overall system:

- The overall reduction in the current number of agencies audited will be from 58 to 26 agencies;
- This number will increase to 27 with the establishment of the HSE;
- The number of audited agencies reporting directly to the DoHC will reduce from 49 to 19.

Figure 10.2 below illustrates the revised system map resulting from these changes. It details only the agencies included within the Audit.

Figure 10.2: Consolidated structure — revised configuration of audited agencies



\* Audited agencies only — The hospital pillar (under the NHO) will include existing health board and voluntary acute hospitals

---

# Part 4

## Transition

---



## Chapter 11

# Planning the Transition

---

The challenges associated with undertaking such a large-scale reform of the structures and functions of the health system are considerable. However, the consequences of not moving towards the new model and not tackling the overlaps and structural deficiencies outlined in this report, need to be spelled out:

- To continue in the current direction of development of structures and functions will lead to even greater fragmentation of critical functions with consequences for cost effectiveness, performance and ability to manage healthcare services in Ireland;
- The continuation of blurred accountabilities, unwieldy governance and lack of clarity of roles will lead to a service which is less responsive to customer needs, which has greater difficulty in delivery of national strategies and where the challenge of realising value for money becomes increasingly onerous;
- Sustaining the current structures, or even just modifying them to some degree, is inconsistent with the level of effort required to fundamentally reorganise and reform the acute sector on a national scale and prepare for implementation of the Primary Care Strategy.

There are endless variations on the potential future model for the Irish health system and as many different views as there are interested parties. We believe that the proposed consolidated structure will position the health system to deliver the aims and objectives of *Quality and Fairness*. In our view, the direction and change being recommended is building on the strengths of the existing system and is consistent with many of the progressive decisions that have already been committed to, including:

- The move towards standardised practices in both HR and IT, as demonstrated by the PPARS programme and the implementation of SAP Finance across the health system;
- The introduction of coordinated system-wide initiatives through HeBE;
- The development of the *Action Plan for People Management* which advocates the introduction of new managerial skills, the establishment of a performance management ethos and the further development of partnership mechanisms.

This Chapter, therefore, seeks to outline how the proposed consolidated structure could be implemented and the likely costs associated with implementing it. It identifies some of the key transitional issues that will need to be addressed in advance of and during implementation. This Chapter is structured into four main areas:

- Implementing the proposed consolidated structure;
- Implementation approach;
- Potential financial implications;
- Dependencies for the effectiveness of the new structure.

## 11.1 Implementing the proposed consolidated structure

Implementing the consolidated structure involves delivering change on a large scale and on a sustained basis over a number of years. It is critical that the changes recommended in this Audit are integrated with other current initiatives including medical workforce reforms for the acute sector, the Primary Care Strategy and the recommendations on the reform of financial controls. All these elements need to be coordinated and planned for in an integrated manner.

The complexities associated with delivering organisational change are well documented in both general publications and healthcare literature. However, the scale of this proposed change programme is such that some of those complexities warrant specific attention:

### 11.1.1 Engaging stakeholders

---

Any significant transformation needs to secure and maintain the commitment of stakeholders to the proposed change. This is particularly the case when dealing with a complex, system-wide and potentially lengthy transition such as that proposed here. There are a large number of stakeholder groups that will need to be engaged. They include:

- Leaders from within the existing health system;
- Staff and staff representatives from within the existing health system;
- Consumers, professional groups, politicians and the general public.

The concerns of stakeholder groups will need to be identified and a programme of communication and involvement will need to be established and tailored to engage them in the change programme. Outlined below are some early considerations for each of the three groups identified:

- **Engaging leaders — Health Board and Agency CEOs, Senior DoHC officials**

Leaders need to be actively involved from the outset in driving these changes and maintaining stability during the transition. Their role in securing acceptance for and achieving this change must be personally and publicly acknowledged. The opportunity for them in the short term to play a role in creating this new entity and delivering an improved health service must be clearly painted.

A programme of engagement for leaders will need to be undertaken by the Department/Minister ideally in conjunction with the publication of this report. In the longer term the good progress made to date in developing leadership capability within the health system must be maintained and remain a priority throughout the transition in order to ensure that the system continues to build leadership capability for the future.

- **Engaging staff and their representatives**

Organisational transformation research and experience has clearly demonstrated that the engagement of staff and their representatives to support and participate in the implementation of successful organisational change is also critical. For the Irish health system, which already suffers from skills shortage, this is even more crucial if the necessary skills and competencies to deliver health services in the new consolidated health system are to be retained.

As in any significant transition, it is likely that existing staff will have considerable concerns about the security of their jobs, who their future employer is likely to be and their future career prospects in the new model. This lack of certainty, if poorly managed, is likely to result in a drop in performance and morale, a lack of focus and greater difficulties in retaining talented staff during the transition.

A comprehensive staff engagement approach incorporating existing partnership arrangements as well as comprehensive communication initiatives and true involvement of staff in the implementation of the new structure will need to be developed and deployed across the health system.

Deploying an effective engagement during the transition should also serve to establish the basis for creating a health system with a culture of clarity, openness and trust and a deeper awareness of the potential of working in partnership particularly at a local level.

The potential career opportunities in the new model need to be identified as early as possible along with the extent of any plans to locate some of the proposed new organisations in regions as part of the Government's regionalisation strategy. In addition to this it is important that the Department commits to a fair, equitable and transparent selection process for all new roles. The competencies and skills required to create the new agencies, as intended, will need to be defined and potential candidates assessed against them.

- **Engaging consumers, the general public and their representatives**

One of the recommendations of this audit is to increase direct consumer involvement and representation throughout the system. Engaging consumers and the general public, however, is not just a design feature of the future model — it is a necessity for the acceptance and successful implementation of the proposed consolidated structure. International experience has shown that where the general public and consumer representatives support a proposed course of action it can lead to the creation of momentum and demand for change on a scale otherwise unachievable.

The overall agenda set out in *Quality and Fairness* generated a broad degree of public and stakeholder support. The DoHC therefore has an opportunity with the publication of this and other reviews in the coming months to paint a compelling vision for the future of the Irish health system in terms of the reform and modernisation agenda it envisages and to engage the general public in the achievement of this vision.

Development and implementation of a communication and engagement programme for the general public and consumer groups in the proposed programme of structural reform is a must if the recommendation to increase consumer involvement throughout the health system is to be taken seriously.

### 11.1.2 Capability, coordination and resourcing

---

Given the scale of the change, the current capability and resource levels of the system to deliver this transformation is a very real challenge to implementation. Without dedicated and skilled resources committed to delivering the proposed structural changes the effort will struggle to gain the necessary momentum and deliver the results required. Due to the inter-related and complex nature of the proposed changes strong coordination and planning skills will be required, as will resilience to ensure momentum is sustained.

A national reform programme will need to be carefully planned and then effectively resourced with both the requisite staff numbers and skill sets if it is to deliver the intended results. The best people will need to be secured and leading practices in programme management, organisation restructuring and change management techniques will need to be applied. Sufficient resources will need to be assigned not only to designing the detail of the new structures and roles but also to managing leadership and staff engagement, communication and the migration from existing structures into the new environment. The skills, competencies and resources required to deliver this change need to be defined at the earliest opportunity and secured without adversely affecting front-line services.

The scale of the change proposed is such that a full-time reform implementation team alone, regardless of size/staff numbers, will not be sufficient. Change sponsors and champions from across impacted areas of the health system will

need to be secured to support and deliver the change effort on a part-time basis. Existing managers and staff from across the health system will need to participate in steering groups, design workshops and pilot schemes and play a role in communicating with peers and colleagues — where appropriate promoting the proposed changes and feeding back concerns and issues to the implementation team. For agencies being mainstreamed local project managers and project team members may also be required.

While delivering the change programme it is critical that the current levels of service are safeguarded and protected. Any deterioration in the existing levels of service over the course of the change programme will only serve to undermine support for the proposed health system modernisation.

### 11.1.3 Managing the transition

---

There are considerable implications for many of the health system's 96,000 staff. For some it will mean a change of job with new responsibilities. For others the operational aspects of their role may not change but the structures and processes for securing decisions and funding will be considerably different. For many there will be a change of employer.

There is considerable work involved in planning and managing a successful transition from an existing structure to a new entity. To support these changes the implementation team will be dependent on the support of experts within the system to achieve this transition and play a leading role in the transition effort. The transition of people to the consolidated structure will represent challenges — particularly in a system that despite recent progress and improvements still has a largely underdeveloped HR capability and resources. In our view, the Head of HR for the HSE will need to be appointed at the earliest opportunity and the process of improving HR capability in the consolidated structure commenced as soon as possible.

## 11.2 Implementation approach

The change envisaged will demand adherence to certain criteria common to all major transformations. The sequencing of events in particular will require attention in order to create a momentum for change and to manage the interdependencies inherent within the health system. An initial high-level implementation plan is depicted below and described in some detail in this chapter. This will need validation during the planning stage of the implementation.



Figure 11.1: High-level implementation plan for the proposed consolidated structure

High-level implementation plan	Year 1	Year 2	Year 3
<b>Strand 1 - Communication and consultation</b>			
Plan and set up communication and consultation infrastructure			
Conduct communication and consultation programme			
Ongoing engagement of stakeholders			
<b>Strand 2 - Establish Reform Programme</b>			
Establish programme office and core change team			
Establish a programme steering committee			
Developing the business case and plan implementation			
Establish workstreams and secure project resources			
Develop working and advisory groups			
Ongoing implementation and monitoring			
<b>Strand 3 - Implementation Consolidated Structure</b>			
Develop and implement legislative programme			
Develop and implement governance framework			
Establish consolidated structures			
– Set up Health Service Executive with Interim Board			
– Restructure Department of Health and Children			
– Establish Health Information Quality Authority (interim)			
– Set up National Hospitals Office (interim)			
– Establish Health Board Hospitals as independent entities			
– Set up Regional offices of the Health Service Executive (interim)			
– Set up target structures on statutory basis			
– Disband Boards of Health Boards			
– Mainstream existing agencies			
Develop supporting processes			

The plan consists of three strands:

- Strand 1 — Communication and consultation
- Strand 2 — Establish a (National) Reform Programme
- Strand 3 — Implement the (proposed) consolidated structure

Each of these is described in more detail below.

### 11.2.1 Strand 1 — Communication and Consultation

The evolution of this Audit assignment to include the need to develop a 'sense of direction' for the health system architecture (as described in Chapter 1) has meant that there has been only limited engagement with health system staff, potential leaders of the change and the general public in the development of the proposed consolidated structure. Yet it is fully dependent on the support and involvement of these key groups. Accordingly, we strongly recommend that the first

step in implementing the proposed structure needs to be the planning and implementation of an extensive programme of communication and dialogue with key stakeholders to commence in conjunction with the publication of this report.

The communication programme should be viewed as an opportunity to present and discuss the Department's and the Minister's vision for the future of the health system. The objective should be to explain the rationale for the changes proposed and to elicit views on the best pathways to implementation. The possibility of incorporating the results of other related health initiatives due for publication at the same point in time into one overall vision for the future should be considered. The communication programme should include presentation of the audit findings and the key elements of the proposed consolidated model as well as consultation on the draft implementation plans with stakeholders. Leaders from within the existing health system, such as the health board CEOs, should be engaged in advance of the communication process and should be given an active role in engaging broader stakeholder groups in the proposed future model for the health system. Mechanisms such as agency/team briefings, one-to-one meetings, web and phone based 'Question and Answer' databases are established and work alongside existing partnership and local communication mechanisms to ensure dialogue is maintained and accurate information is available throughout the transformation.

While we are proposing a consultation process focused on implementation, rather than defining the desired services, the extensive consultation process that preceded the publication of *Quality and Fairness* set a standard for inclusiveness which needs to be sustained. The consultation and communication infrastructure will need to be established in advance. Engaging with the well-developed partnership structures in the health service will be critical. The National Consultative Forum will provide one very useful collaborative and non-political vehicle for ongoing consultation around the proposed organisational reforms.

We envisage that a process such as that proposed here will take a number of months to complete. This should be conducted in tandem with the next phase — the establishment of a National Programme for the Reform of the Structure and Functions of the Health System.

### 11.2.2 Strand 2 — Establish a National Reform Programme

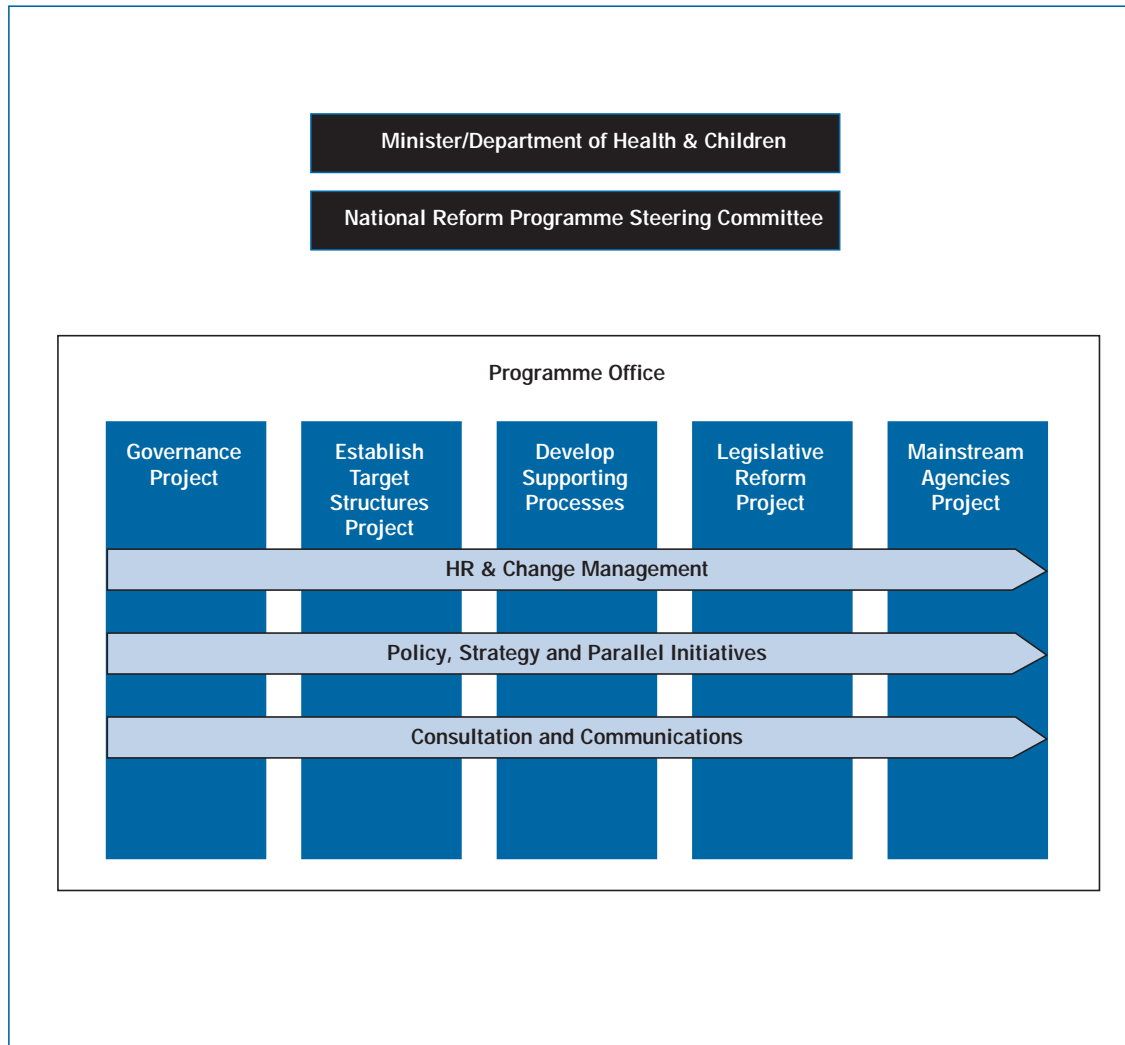
---

The Minister will need to establish a National Programme for the Reform of the Structure and Functions of the Health System with the specific aim of implementing the proposed consolidated structure. This will include:

- Establishing a programme office and core change team;
- Establishing a programme steering committee;
- Developing the business cases and detailed implementation plans;
- Defining workstreams and securing workstream resources;
- Setting up working and advisory groups.

The figure below illustrates the major projects and the cross-project support areas:

Figure 11.2: Proposed National Reform Programme



- **Establishing a programme office and core change team**

A programme office will include the following:

- A full-time Programme Director with the skills and experience to drive through and coordinate this scale of change supported by a skilled Programme Coordinator who will coordinate programme planning, reporting, issue management and escalation;
- A full-time Implementation and Change Manager to manage the effective implementation of the change programme and the engagement of stakeholders;
- A Business Analyst with health planning and healthcare cost benefit analysis skills to lead and support the development and tracking of programme and project business cases.

- **Establishing a programme steering committee**

The Programme Director will report to a steering committee established by the Minister for Health and Children. The role of the steering committee will be to set direction for the programme, make decisions, sign off on the design and business cases for future structures and ensure the objectives of the programme are successfully achieved. The steering committee should include individuals (both academics and practitioners) with considerable experience in driving organisational change in the public and private sector.

The major elements of the reform should be led by an interim Board of the HSE. The appointment of a CEO to lead the change must be a priority. Once some of the system wide elements of the proposed consolidated structure (e.g. HIQA, HSE) have been established, it may be appropriate for some workstreams, such as the legislative programme and the governance framework, to separate from the programme and become the responsibility of the DoHC. In this situation the remainder of the programme (mainstreaming the agencies and developing the supporting processes) would then report directly to the HSE.

- **Developing the business cases and detailed implementation plans**

The first task of the core group will be developing a high-level project plan. The core programme team and workstream project managers will need to conduct detailed programme and workstream planning in advance of any implementation. The approach to implementing the changes and managing the engagement of stakeholders will need to be developed. A significant factor will be the ability to coordinate the various activities and provide transparency of process. A business case for the programme, perhaps representing an aggregation of the business cases for the individual workstreams, will need to be developed, submitted for sign off by the steering committee and communicated to stakeholders. Specific deliverables and timeframes for each of the workstreams should be developed and responsibility assigned to team members and working groups.

- **Defining workstreams and securing resources**

At this stage the programme appears to naturally fall into the five workstreams listed below:

- Developing and implementing a governance framework for the health system;
- Establishing target structures;
- Developing supporting processes;
- Identifying and addressing the necessary legislative changes;
- Mainstreaming the existing agencies.

Each of these workstreams will require a project manager as well as dedicated project resources with the necessary expertise. While the exact scale of resources required cannot be determined at this stage without more detailed planning, our experience in organisational reform indicates that the programme is likely to require at least 20 to 25 dedicated team members. Obviously this figure is dependent on a number of different factors including the experience and skill levels of team members as well as the timeframe for the delivery of the programme.

While we recognise that this proposed approach will place a drain on already scarce skills and resources within the health system it is hard to envisage this level and scale of change being successfully driven through the system without a commitment to dedicated resources. The proposed approach does have the benefit of building a longer term capability within the system to drive and deliver organisational change — something identified as critical in *Quality and Fairness*.

- **Setting up working and advisory groups**

The programme team alone will not be capable of delivering the required level of change in the health system. Working groups made up of representatives with relevant knowledge and expertise from across the health system should be developed to work alongside each of these workstreams and in conjunction with full-time project team members. Consideration might be given to how existing change management and organisational development programmes e.g. Office for Health Management and the work of the Health Services National Partnership Forum can be best utilised. Roles for working group members need definition along with an estimate of the time commitment involved during the programme planning stage.

The establishment of the programme to drive the implementation of the proposed consolidated model is a considerable task in itself. We envisage that it could take in the region of two to three months to plan the implementation, work in tandem with the communication and consultation of Phase 1 and in parallel with the appointment of leaders to the key roles in the consolidated structure.

### 11.2.3 Strand 3 — Implement the proposed consolidated structure

---

There are a number of distinct but inter-related activities involved in implementing the proposed consolidated structure.

- **Developing and implementing the governance framework**

This workstream will be led by a project manager with considerable expertise in effective governance and delivered by team members working in partnership with a governance working party.

A framework for governance across the system will need to be developed by the project team. All proposed organisations in the new structure will need to be assessed against this framework and the necessary steps taken to ensure agencies work in line with the framework and best practice principles. Those changes involving legislation will need to be fed into the legislative programme. Those changes requiring alterations to any agency's defined accountabilities or terms of reference will need to be incorporated into the mainstreaming workstream for action.

- **Establishing the consolidated structure**

The consolidated structure includes the establishment/restructuring of the following:

- DoHC;
- HSE;
- Health Information and Quality Authority;
- Regional Health Offices;
- National Hospitals Office;
- National Shared Service Centre;
- New acute hospital governance structures.

This workstream will be led by a project manager with considerable expertise in organisational design and restructuring.

The mandate for each new structure will need to be defined by the DoHC and a person appointed to head up each new organisation. The project team should initially design the detail of the target structures — building on the proposals in this report. The design stage would involve clearly defining the next level accountabilities and the responsibilities of the future as well as the key roles and responsibilities within each structure and the competencies and skills required.

This design stage will need to be carried out in consultation with a working group comprising representatives from across the health system. As proposed designs for the target structures are identified they will need to be assessed by the governance project team against the governance framework to ensure that they are aligned with leading practice and submitted to the Programme Steering Committee for sign off.

Once the consolidated structures are signed off by the Programme Steering Committee any necessary legislative changes will need to be incorporated into the DoHC legislative programme and a detailed implementation plan developed for each of the consolidated structure.

## HSE

---

The establishment of the HSE will represent the major catalyst for change within the health system. It will drive the DoHC restructuring and the setting up of the sectoral pillars. We therefore recommend the use of an interim board structure to enable the rapid establishment of the HSE.

This will create a momentum for change on three fronts. Firstly, it will send a clear signal for major structural reform. Secondly, it forces the system to engage in the real practicalities of the reform rather than a theoretical debate. Finally, it provides an immediate platform for many of the current functions which are dispersed throughout the system.

To safeguard the quality and integrity of current services, we propose that a two-speed process be adopted in relation to the development of the two service pillars — with more rapid structural change in the acute pillar (e.g. setting up of the National Hospitals Office) and a more paced or evolutionary approach in the primary, community and continuing care pillar. Within the latter, however, it will be important to prioritise the elements of change which precede others. Agreeing the sequencing of this process will form part of the remit of the implementation team.

The major constituencies in the change are health boards and health board-managed hospitals. In the sequencing of the changes it is envisaged that the separation of the health board hospitals would commence after the establishment of the National Hospitals Office.

## The DoHC

---

Restructuring the DoHC must be conducted in conjunction with the establishment of the HSE and the mainstreaming of the agencies. The DoHC, through the National Reform Programme, will be accountable for delivering the future health system structure and providing and driving the system towards the proposed model. Ideally therefore it should be restructured quickly and at an early stage in the programme, to demonstrate the commitment of the Department to the consolidated model and to facilitate the mainstreaming of agencies and the functioning of the structures.

However, the restructuring of the Department is dependent, in part, on the existence of new organisations such as the HSE to take over its delivery accountabilities and executive functions. Therefore the restructuring of the Department will need to be phased. Initially it will need to be strengthened to take on the additional accountabilities such as strategic and medium term planning and health measurement and economics while retaining other accountabilities until the new arrangements are in existence. Then it will need to be streamlined following the transfer of accountabilities to the HSE.

## Health Information and Quality Authority

---

HIQA will have accountability for setting standards across the system for health and social care. Accordingly, it is recommended that HIQA is established at an early stage in the reform programme, again through the creation of an interim board if necessary.

In order to facilitate this, a clear mandate for the organisation will need to be defined by the DoHC. A leader to head up the organisation should be appointed at an early stage. Legislative change required to facilitate the establishment of HIQA will need to be addressed by the legislative project.

The project team, in conjunction with the CEO of HIQA will need to define accountabilities between HIQA, the HSE and the agencies involved in monitoring and inspection. Based on these accountabilities an organisation structure defining the key roles and resources required can be developed and implemented. HIQA will need to commence its role of establishing a system-wide framework for quality and information standards, monitoring and inspection as quickly as possible.

### **Regional Health Offices**

---

The health boards themselves are central to maintaining service levels to customers and as such careful planning of the migration to the envisaged regional structures is required. While it is envisaged that the change from health boards to regional and local structures will be more evolutionary and paced (over two years), the first critical steps on the path to change will be the establishment of the HSE. The driving force for change here will be the replacement of the health board structures with a single board for the HSE.

One way to manage the migration from the existing 10 health boards/area health boards and the Eastern Regional Health Authority is to firstly create the shell of the 4 new RHOs and populate the key roles early. Then the functions and roles of the relevant health boards can be migrated to the new regional offices of the HSE and in time the health boards can be phased out.

### **National Hospitals Office**

---

Funding for all hospitals will ultimately be determined by the National Hospitals Office and accountability lines need to be put in place for existing health board acute hospitals. In the short term, service level agreements would be required for services currently provided to these hospitals through the health boards. Over time, a proportion of these services would be provided from the National Shared Services Centre or NHO.

### **National Shared Service Centre**

---

It is proposed that a National Shared Service Centre should be designed by the project team in conjunction with a working party. Ideally the objective should be to create a greenfield site while using the skills and experience of shared services already in existence in the EHSS. The design adopted will need to be developed in close consultation with other stakeholders such as the PPARS programme, the SAP Finance initiative and IT as well as the future customers of the service centre. The design for the National Shared Service Centre will need to be signed off by the Programme Steering Committee prior to implementation.

Once designed the National Shared Service Centre should be implemented in line with best practice thinking at the earliest possible opportunity on a phased basis. The HSE will need to appoint a leader to head up the Shared Service Centre and will need to provide him/her with a mandate for the Centre that reflects the proposed consolidated model.

Once the centre has been established the operations of the EHSS can be transitioned across, followed by the activities of the GMS Payments board and relevant HeBE activities. Then, as each new entity is established, the National Shared Service Centre can put in place service level agreements and take over the relevant activities from the health boards and health agencies being disbanded or replaced.

- **Develop supporting processes**

This stream of work will address developing the supporting processes described in Chapter 8. It will focus on the following four areas:

- Develop strong service planning and funding processes;

- Establish strong links between service delivery and evaluation;
- Put in place enablers to support integration;
- Enhance system capability and performance.

A project team will need to scope and plan the activity involved in addressing these four areas and identify key individuals from across the health system who will need to be involved in implementing recommendations. Four sub-project teams may need to be established initially, with responsibility for the development of supporting processes passing over to key roles once the target structures are established.

The development of stronger service planning and funding processes will require some new skills and competencies in the HSE and will require definition of effective work practices and processes. The establishment of strong evaluative capacity will require close cooperation between HIQA and the HSE. A liaison group with representatives from senior levels of each organisation may need to be established and regional and local employees from within the HSE may need to be identified to coordinate the links at the regional and local level.

- **Developing and addressing the legislative programme**

Addressing legislative change is an important enabler of the proposed consolidated structure. In the proposed implementation model a project manager and resources with legislative expertise will be responsible for delivering this workstream. They will need to do this in conjunction with a sponsor from within the Department and a working party made up of individuals from relevant areas of the health system.

Changes to legislation required to support the implementation of the proposed consolidated model will firstly need to be identified and planned in conjunction with the legislative calendar and the other Department work cycles. The legal requirements for the new structure will need to be proposed and the legal and staffing implications of this proposed structure considered. Once planned, the legislative programme and proposed legal structure of the new organisations will need to be signed off by the steering committee in advance of implementation. The legislative project team and the working party will then focus on implementing the proposed legislative changes through the normal legislative process.

- **Mainstreaming existing agencies**

It is recommended that the CEO of each affected agency is assigned responsibility for working with the project team to establish the process, timescale and implications of implementing the proposed recommendations for their agency. The performance measures of some agency CEOs may need to be reviewed to support this responsibility. The timescale for the proposed change should to be aligned with the timescale for establishing relevant structures.

It is envisaged that an analysis and planning stage will be conducted by the project team and the CEO and a proposal for implementing the relevant Audit recommendation will be put forward to the Programme Steering Committee. The proposal must define the proposed process, timescale and implications of implementing the recommendation. Where the change represents a merger or involves more than one agency the project team will work in partnership with the CEOs.

## 11.3 Potential financial implications

One of the first areas for attention in the implementation plan will be to conduct a thorough financial appraisal of the reforms proposed with a view to balancing the up-front investment with the longer term benefits. It is extremely difficult to accurately predict the true financial impact of programmes of this scale. This difficulty is likely to be exacerbated by the variability of cost data for certain elements of current expenditure. In preparation of this Audit we sought financial data which might allow for a high-level estimate of costs/benefits in relation to major components of the reform. These



were not readily available, however. Notwithstanding these limitations we have endeavoured to outline the main areas that need to be taken into account in order to develop a robust cost/benefit analysis of the reforms overall. The transition programme as planned provides for the development of business cases for individual components and for the establishment of mechanisms to track both costs and benefits.

Structural reforms of this nature require significant up-front investment to ensure follow through in the changes required. Ongoing experience with reform in the Welsh and Northern Ireland health services is relevant in this regard. A recent study on organisational costs in the health and personal social services sector in Northern Ireland, for example, has highlighted the difficulties in achieving cost savings through structural reform alone. We believe that a coordinated modernisation programme which encapsulates a wider reform agenda covering structures, processes, information, governance and legislative/policy reforms has real potential to deliver longer term financial benefits which should offset the initial investment required.

The costs of healthcare are increasing rapidly year on year. The Irish experience mirrors international trends in this regard. The objective, therefore, should be to ensure that the necessary systems and frameworks are in place to yield maximum value in health terms from the annual investment of public funding in healthcare. A failure to invest the required level in the modernisation programme can only lead to greater cost penalties being carried by the tax paying public at a later stage.

We have identified a number of areas which will warrant attention in developing a thorough cost/benefit analysis:

### 11.3.1 Benefits associated with the reform programme

- **Improved human resource management**

Watson Wyatt research and experience has shown that improvements in management focus, role clarity and team working should contribute to increased productivity from the existing labour base in people-based services, such as healthcare. In our view, a conservative increase of 2.5 % in productivity from the current staff base would not be an unrealistic target to aim for. Based on 2001 total payroll figures this would be worth an extra €140m per annum. While this improvement would take some time to achieve it is an indication of what is possible where these cost factors are actively managed and measured. Enablers to achieve these gains will include management and staff development, performance based management systems and strong HR management.

- **Shared service efficiencies**

Research demonstrates that shared service organisations can be expected to deliver significant savings and productivity improvements across a broad range of functions. Indications of the range of savings across a number of functions are listed below.

<i>Function</i>	<i>Savings/Productivity Gains</i>
General Accounting	55%
Accounts Payables	45%
Human Resource Administration	35%
Purchasing	25%
Receivables	25%

Source: Accenture (2002)

While the ratios provide an indication of the potential associated with a move to a national shared service centre for health, a detailed analysis will be required as part of the business case for the NSSC.

- **Reduction in health board overheads**

The major cost element in the proposed reform relates to the activities of the current health boards and ERHA. For example, DoHC figures for 2001 indicate that the average health board headquarters remuneration costs alone were approximately €8.5m. In moving to the consolidated structure cost improvements are likely to be targeted in this area, as opposed to in the mainstreaming or merging of many of the smaller agencies, where savings may be less significant. These freed-up resources could be utilised to support other elements of the new structure such as the HSE, the NSSC or the NHO, or to meet demand for front-line services. However, it will be necessary to invest in alternative structures and supporting systems to realise the potential savings under this heading.

- **Sales of surplus assets**

Other sources of cost saving should also be considered. If structured appropriately they could be used to fund elements of the transformation programme, e.g. the sale of assets surplus to requirements. It is likely that, on foot of the restructuring, there will be a number of assets, currently in the ownership of public health agencies, which will no longer be required. An immediate task of the HSE would be to identify what assets it has, the property strategy going forward and accordingly what assets should be retained, developed, utilised in other ways or disposed of. Finance could also be raised from the sale and leaseback of properties that do not fit with the HSE's property portfolio strategy.

### 11.3.2 Costs associated with putting in place the new structures

---

A number of significant costs associated with the restructuring programme have been identified during the course of our work. While certain restructuring costs have been described below we have not attempted to calculate the exact costs associated with each item. To attempt to do so at this stage with limited access to accurate data would be misleading.

- **Establishment of the HSE**

While there will be additional costs associated with the establishment of the HSE the ongoing costs of its operations should be to some extent balanced by the reduced costs of running a slimmed down DoHC and a lesser number of health agencies. Executive functions being transferred from the Department or elsewhere to HSE will bring existing resources with the transferring function.

With regard to staff we have proposed that the HSE entity be kept lean. Over time, any additional requirements could be met by redeployment from the DoHC or the wider system. The HSE will have to look outside the healthcare system for certain skills that will be fundamental to building the management capability required to lead the healthcare system that we envisage. It is likely these staff will be at a senior level and sourced from the open market.

- **Establishment of the NSSC**

The NSSC will build on the infrastructure already in place in EHSS with input from HeBE and other shared services initiatives currently underway. The scale of its operations will be determined by the areas prioritised for development. With the possible exception of a small number of specialist and senior management posts, it seems reasonable to assume that any additional staffing required can be found within the consolidation of existing health board functions. However, it is likely that a significant investment will be required to enable and support a comprehensive national shared service strategy. This strategy will ultimately determine the investment required.

- **Establishment of new hospital groups**

The overheads associated with establishing health board hospitals (or hospital groups) on a stand-alone basis represent an additional cost. For the moment it is unclear how many such groups there will be, but in any event the on-cost of new hospital governance structures is likely to be relatively modest. A strengthening of management may be required at hospital level in cases where these hospitals currently rely to a large degree on support from health board headquarters.

- **Establishment of HIQA and NHO**

Two of the structures now being proposed, HIQA and NHO, have already been approved for inclusion in *Quality and Fairness* and its overall costing. Accordingly we have not attempted to recalculate the likely benefits or costs associated with their establishment

### 11.3.3 Reform programme

---

As described earlier in this chapter, a dedicated and well-resourced transformation team will need to be established to implement the proposed consolidated structure. The cost of the team will be dependent on the cost of the planned changes, the sequencing of them, the pace of implementation and whether the resources can be found within the health system itself or not. It is likely that some of the specialist skills required will need to be sourced from external specialists and drawn down only as required.

Assuming a core team of 25 staff with the requisite skills is assembled to support the transformation programme, a minimum cost of €2.5m per annum over the life of the programme would, in our view, be a realistic estimate in respect of direct costs. Clearly there will be synergies between the overall national reform programme and the roll-out of other large-scale initiatives which should allow for efficiencies, if factored into planning. Particular examples of this would be the anticipated investment in implementing the *Action Plan for People Management*, as referred to earlier in discussing transition arrangements, and the support which will be required for delivering and implementing the major ICT programmes envisaged under the *National Health Information Strategy*.

## 11.4 Additional supports for the effectiveness of the new structure

In Chapter 6 we concluded that structural change on its own is unlikely to address the system deficiencies and that other factors such as governance, service planning and support processes are also critical. In conclusion we thought it appropriate to identify two specific areas for action which are not structural but would greatly support the transition to the consolidated structure. They are:

- Eligibility and entitlement legislation;
- Information Technology investment.

### 11.4.1 Eligibility and entitlement legislation

---

The current provisions defining eligibility for services from our health system are highly complex. There is no statutory framework which sets out a citizen's right to access services within a stated timescale or to ensure consistency across the country in the interpretation of legislation or regulations. This is unsatisfactory firstly from the perspective of patients, but also for the carers and managers who have to work within these provisions. We are aware that work is progressing with the DoHC on a package of legislation reforms covering both entitlements and complaints procedures. This is an extremely positive development. The early clarification of the statutory basis for health services would be a powerful force for integration and send a strong signal of the modernising intent behind the overall system reconstruction.

## 11.4.2 Information Technology

---

It has been well established that significant development of information technology is required if the health system is to reach the performance standards expected. This will certainly still be the case in the consolidated structure.

The health board CEOs have argued strongly for a major increase in ICT investment from existing levels, suggesting that industry norms indicate a requirement of 2% to 4% of turnover (€160m-€320m) as against the NDP provision of €25m. We would support the view that there would be real gains in process efficiency (move away from paper, use of bar codes, shared financial systems, etc) and equally important gains in transaction efficiency (better managerial and clinical decision-making, benchmarking against other service providers or best practice standards) from a major increase in current levels of investment. The *National Health Information Strategy*, yet to be published, will provide a framework for ICT development but without significant resourcing it will not deliver the required performance improvements. We would anticipate that the ICT Strategy being prepared by HeBE for the health services will set out in more detail an implementation plan for this area.

Investment will be required at a number of levels:

- **HSE/regional and local level IT investment**

This should deliver process and transaction efficiencies particularly in the area of back office/shared service operations. More importantly though it will enable greater access to data and enable more effective planning, decision-making and monitoring of results. In particular access to reliable data across the health system will enable more effective resource management.

- **Service user level investment**

Investment in IT at the patient level is required to enable the efficient movement of necessary clinical data to clinicians regardless of physical location. Integration of the information across the health system should support consistent and shared views of patient data. This must encompass both resource management and patient/client systems to ensure that activity levels are matched to resources. One effective way to facilitate this integration would be the introduction of a unique patient identifier. While this may be a medium term option for reasons associated with data protection issues it would contribute significantly to the integration of the health system from the patient perspective.

Clearly there is a need for a major acceleration in the pace of development of information systems implementation through the health service. Management of budgeting at individual clinical level demands a high level of sophistication and integration of information systems. Much of the benefit to be derived from more streamlined organisation structures and sharper accountability relationships will depend on relevant and up-to-date information being put in the hands of managers and clinicians at all levels in the health system, to enable them to make reliable decisions in a timely manner. Effective devolution of budgetary accountability to clinical managers at the point of contact with patients is neither reasonable nor possible without adequate data.

To gain the full benefits of restructuring it will be essential that the necessary investment is made in strengthening this and other aspects of management systems in the health services.