Interim Report Of

The Task Force

on the

Eastern Regional Health Authority

June 1997

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Appendices

Chapter 1 Introduction

1.1 Establishment and Membership of Task Force

On 27 November 1996 the Minister for Health announced that the Government had agreed to his proposals for the establishment of an Eastern Regional Health Authority which would have responsibility for the funding of all health and personal social services in Dublin, Kildare and Wicklow. The Minister also announced his intention to establish a high level task force to oversee and manage the implementation of his proposals and to work out the detailed organisational and administrative arrangements which would be required for the transition to the new structures.

The Task Force, which held its first meeting on 18 December 1996, is comprised of a Chairman and six members, as follows:
Mr Donal O Shea (Chairman), Chief Executive Officer, North Eastern Health Board
Mr Tony Enright, Assistant Secretary, Department of Health
Mr P.J. Fitzpatrick, Chief Executive Officer, Eastern Health Board
Mr Nicholas Jermyn, Chief Executive Officer, St Vincent's Hospital and Chief Executive Officer, St Luke's and St Anne's Hospital
Sister Catherine Mulligan, Provincial, Daughters of Charity of St. Vincent de Paul
Mr Brian Sweeney, Siemens Group Chairman, Ireland
Ms Muireann Morris, Chief Executive Officer, Sonas Housing Association

The Minister requested the Task Force to produce this Interim Report by 30th June, 1997.

1.2 Approach to our work

We recognised at the outset that all of our deliberations and recommendations should be framed within the context of:

- the Minister's statement of 27 November, 1996 in which he outlined his proposals for a new Eastern Regional Health Authority (see Appendix 1)
  and
- the National Health Strategy "*Shaping a healthier future*" which contains the policy framework on which the Minister's statement was based.

Based on these documents, our proposals for new structures must incorporate the following features:

a) A new Eastern Regional Health Authority to replace the Eastern Health Board and to be responsible for the funding of all health and personal social services, both statutory and voluntary, in Counties Dublin, Kildare and Wicklow;
b) All services, both voluntary and statutory, to be funded by the new Authority, in order to facilitate more integrated planning, delivery and evaluation of health and personal social services in the area;
c) Public representatives to hold the majority on the new Authority, and to be nominated to the Authority by Dublin Corporation and by the County Councils of Fingal, South Dublin, Dun Laoghaire-Rathdown, Kildare and Wicklow;
d) Membership of the Authority to include persons drawn from the voluntary hospitals, mental handicap agencies and other voluntary bodies;
e) The Authority to be managed through three Area Health Councils, whose members will be drawn from the membership of the Authority;
f) Area Chief Executives, reporting to the Regional Chief Executive Officer, to be appointed to correspond with the Area Health Councils;
g) The independent identity of the voluntary agencies to be fully respected under the new structures. Voluntary agencies to retain their operational autonomy but to be accountable to the Authority for the public funds which they receive;
h) The management structure for the Authority to reflect the organisational and service needs of the region. A special emphasis to be placed on providing structures which encourage the development of linkages between statutory and voluntary services;
i) Structures at area level to be designed to achieve the optimal integration of services and to reflect local needs and priorities;
j) Decision making to be assigned to the most appropriate level of the organisation. Decisions which affect patient care to be taken as near to the point of service delivery as possible in order to make the service more responsive to the needs of patients and clients.

1.3 Consultation Process

Having decided on our approach, our next task was to begin a consultation process with all interested parties. It is our intention to engage in ongoing consultation throughout the period of transition to the new arrangements.

Providers in the Eastern region, both statutory and voluntary, were contacted and were invited to make submissions to us on the basis of the two key documents, viz., the Minister's statement of 27 November 1996 and the Health Strategy (see Appendix I). The main staff associations, the universities, other third level institutions and private hospitals were also contacted on the same basis.

We held meetings and discussions with many of the principal parties involved, including the members of the Board and management of the Eastern Health Board, management and owners of voluntary hospitals, voluntary agencies and organisations providing services to persons with a mental handicap and some staff associations.

Some of the major issues raised with us during the consultation process are discussed in Chapter 10 and a list of all organisations who have forwarded submissions to date is set out at Appendix III. We note that some organisations have indicated their intention to make submissions to us at a later date.

1.4 Summary

The Task Force was established by the Minister for Health to oversee and manage the implementation of his proposals for a new Eastern Regional Health Authority, which were announced on 27th November, 1996 (see Appendix 1). The Minister requested the Task Force to produce this Interim Report by 30th June, 1997.

The work of the Task Force is framed within the context of the Minister's statement and the Health Strategy, *"Shaping a healthier future"*.

The Task Force has begun a process of consultation with all interested parties.

Chapter 2 The need for change in the Eastern Region

2.1 Strengths of the services

In this chapter, we necessarily concentrate on the issues in the Eastern region which need to be addressed in the new organisational structures. We are very much aware, however, that there are many positive aspects to the existing services. In general, the staff working in the health services are well trained and highly motivated. The Eastern Health Board has been successful in carrying out its statutory functions and has been innovative in the area of needs assessment. The individual voluntary providers in the region provide a quality service.

It is our view, however, that the high quality of staff and infrastructure available in the region is not being optimised to its full potential at present and that a more effective service could be provided with the same level of resources if the organisational issues in the region were resolved.

2.2 Earlier studies

Structural problems have existed in the Eastern region for many years. They have exercised the minds of several committees and working groups before us. The core problems identified in the Eastern Region by successive reports are:

(a) the absence of a single authority with responsibility for planning the delivery and co-ordination of services for the region;

(b) over centralised decision making within the health board and the lack of an appropriate management structure at district level, given the increase in the population over the last 25 years;

(c) the need for better communication and co-operation between the voluntary sector and the health board.

Below we summarise the main points of relevance from earlier studies.

2.2.1 *Health - the wider dimensions (1986)*
While not dealing specifically with the Eastern region, this report was one of the first to identify the need within the health system for greater accountability, closer integration between the statutory and non-statutory

sectors and a more structured planning cycle to incorporate, *inter alia,* the monitoring of quality of care.

2.2.2 Commission on Health Funding (1989)

Again, this report did not deal exclusively with the Eastern region, but carried out an evaluation of health services generally. It did, however, identify the specific problems in the East. It stated: *"There is now widespread recognition that a cost-effective health service, providing care at the least complex level appropriate to the particular case, requires the integration of responsibility for all levels of service within a particular catchment area. In the absence of this, there are practical difficulties in the co-ordination of hospital services with community-based services in the most efficient and effective manner. This problem is particularly marked in the Eastern Health Board area, where most hospital services are provided by the voluntary sector".* (page 248)

2.2.3 Hospital Efficiency Review Group (1990)

This group, chaired by Mr Noel Fox, focussed mainly on the internal management arrangements of acute hospitals to determine whether greater efficiencies could be achieved. It concluded that acute hospital services could be delivered more efficiently if mechanisms could be developed to *"better co-ordinate services, more intensively use facilities and improve resource management".* (Summary of Recommendations, page 1)

2.2.4 Dublin Hospital Initiative Group (1990)

This group, chaired by Mr. David Kennedy, was critical of the existing organisational structure for delivery of health services in the Eastern region. It put forward the view that the present fragmented arrangements should be replaced with *"an integrated and comprehensive health service, based on a systematic evaluation of patients' needs, with decision-making located as close as possible to the point of delivery of service, and with a continuation and development of the voluntary contribution to health care in the region."* (page ix)

The Kennedy group (as it became known) made recommendations for new structural arrangements which included a new regional policy board and a strengthened management executive based on an area management structure.

Examining the role within the structure of the voluntary providers, the group stated their conviction that the independence and operational autonomy of the voluntary agencies should continue. They recommended

that *"the best way to achieve an integrated service to patients while maintaining the contribution of the voluntary ethos would be for the funding and service role of each agency to be expressed in detail in a contract between the area unit and the agency or hospital concerned."* (page 24)

2.2.5 *"Shaping a healthier future" (1994)*

The Health Strategy *"Shaping a healthier future"* was the culmination of the policy development process which had commenced in 1986 with *"Health - the wider dimensions"*. The Strategy described the particular problems of the Eastern region, where, *"to a greater extent than elsewhere, significant services are provided by voluntary agencies, but there is no single authority with an overall responsibility to co-ordinate all services and to ensure appropriate linkages between them"*. (page 30) It put forward proposals for legislation to provide for a new Authority in the Eastern region and to remedy deficiencies which were identified in relation to health board structures generally. [In the event, the latter were dealt with in the context of the Health (Amendment) (No.3) Act, 1996 (see Chapter 5)]

2.3 Current Arrangements

At present, the Eastern Health Board is statutorily responsible for services in Counties Dublin, Kildare and Wicklow. However, in practice, the bulk of the general hospital services and much of the mental handicap provision in the region are funded directly by the Department of Health and do not have any statutory links with the Board.

The Eastern Health Board employs approximately 9,000 staff and has a direct budget allocation of approximately £400 million (see table overleaf). Services provided by the Board include: environmental health services; dental services; AIDs/HIV/drug abuse services; child care and family support services; services for the elderly; services for people with physical and sensory disabilities; services for the homeless; community health services; counselling services; mental health services; public health services; medical services; some general hospital services and some mental handicap services. A full list of Eastern Health Board services is at Appendix V.

In addition to providing its own services, the Eastern Health Board also funds some voluntary providers directly including approximately 300 small

voluntary groups and associations (e.g. Committees for the Elderly, Community Playgroups, Youth Development Groups etc). This funding accounts for almost £70m of the Board's budget allocation of £400m.

£78 million is paid on behalf of the Eastern Health Board by the GMS (Payments) Board in respect of General Medical Services (medical cards) in its area. A further £74 million is provided to the Board by the Department of Social Welfare in respect of Supplementary Welfare Allowance payments. These payments are made by the health boards on behalf of that Department and include basic allowances, exceptional needs payments, rent and mortgage supplements, fuel allowances and back-to-school clothing and footwear payments.

1997 Non-Capital Determnation of Expenditure: Eastern Region

	Million £
Current Eastern Health Board Services	399
Funding by Department of Health direct to Voluntary Hospitals and Agencies in Eastern Region	465.2
Funding by Department of Health direct to Mental Handicap Agencies in the Eastern Region	77.7
Eastern Health Board GMS Services paid by GMS (Payments) Board	78
Supplementary Welfare Allowance Scheme (funded by Department of Social Welfare)	74
Total Funding for Eastern Region	**1093.9**

The Eastern Health Board's property extends over three counties. It consists of 320 units in different locations and includes hospitals, group homes, health centres, ambulance bases, community welfare offices, day care centres and outreach team centres.

The Department of Health provides direct funding of £465.2 million approximately to 29 voluntary hospitals and agencies in the Eastern region. Together these employ over 15,000 people. The Department also provides direct funding of over £77 million to the six largest voluntary mental handicap organisations, whose headquarters are located in the Eastern Region. These organisations employ over 3,000 staff. (A list of voluntary hospitals, agencies and mental handicap organisations directly funded by the Department of Health is at Appendix IV).

The private sector also plays an important role in meeting the overall health needs of the population in the Eastern region. In addition to providing private care to those who wish to avail of it, private hospitals provide significant services for clients of the Eastern Health Board, particularly in the areas of psychiatry and high-technology acute care.

To summarise, the total funding for health and personal social services in the Eastern region (excluding the private sector) amounts to over £1 billion and total employment is in the region of 27,000 staff.

2.4 Potential for improvements

Since the establishment of the Eastern Health Board in 1971, the population in its area has increased by almost one-third. The period since its establishment has also seen a marked increase in the range and extent of social problems (such as drug abuse, child abuse, and homelessness) which come under the aegis of the health board. In spite of these significant changes in its external environment, the organisational and management structure of the Eastern Health Board has remained virtually unchanged.

It is now generally accepted that the management structure of the Eastern Health Board is no longer suitable for the size of the region it serves and the scale and complexity of the issues it deals with. Elsewhere in the country and in the UK, the population size for the management of health services ranges between 200,000 and 500,000, while the population of Eastern Health Board is over three times that level, at 1.3 million.

A new Authority, managed through three areas, would enable the delivery of health and personal social services in the Eastern region to be brought closer to the people. Decisions regarding the provision of local services would be made closer to the point of delivery and would involve the local community, through its representatives on the Area Health Council.

An area management structure would also lead to improvements in co-operation and co-ordination between different professional groups within the health board, on the one hand, and between staff of the health board and the staff of the voluntary agencies, on the other. There is no formal interface for such co-operation at present. Each of the agencies providing services, whether statutory or voluntary, operates independently of all the others. The priorities of these individual organisations do not always coincide with the broader health needs of the population. The new Authority would replace this fragmented structure with one which has as its main focus the health needs and priorities of the population and the capacity to deliver services to meet those needs in a co-ordinated and efficient manner.

2.5 Effect on service delivery

The new arrangements we propose would have the potential to effect substantial improvements in the co-ordination and integration of services around the individual patient or client. Greater integration would improve all services including, for example, services for children; services for those with disability; Accident and Emergency services in the acute hospitals; services for the elderly and services for persons with a mental handicap.

2.6 Summary

This chapter reviews earlier studies of the organisational issues in the Eastern region and describes the current arrangements for the delivery of health and personal social services. It demonstrates the potential for greater co-ordination and integration of services and for decision-making to be brought closer to the local community.

Chapter 3 What we set out to achieve

3.1 Objective

The primary objective in any reorganisation of health service structures should be to achieve real improvements in the health and personal social services delivered to patients, clients and service users. The establishment of the new Eastern Regional Health Authority and the reorganisation of services which will accompany it will lead to a more integrated, efficient and patient-friendly service for the people of Dublin, Kildare and Wicklow.

3.2 Key characteristics

The foregoing chapter has shown that the potential exists for a major improvement in co-ordination and integration of services in the Eastern Region. Our main focus as a Task Force, therefore, has been to devise structures which will allow for the development of an integrated and patient-centred service. Together, we have developed a vision of the new Authority, the key characteristics of which we outline below.

- Its primary objective must be the delivery of a high quality, integrated, patient-centred, effective and efficient health and personal social service for the people of the region, in line with the targets and objectives set out in the Health Strategy *"Shaping a healthier future";*

- It must utilise to the best advantage of the patient or client all the resources at its disposal;

- In its relationship with the Minister and the Department of Health, it must act as an advocate for all care groups, services and service units in the region;

- In its structure and in its staffing, it must reflect the principle that all service units, whether statutory or voluntary, play an important part in the overall delivery of the region's services;

- It must develop with the voluntary hospitals and organisations currently funded by the Department of Health a relationship based on trust, partnership and mutual respect;

- It must equally understand and be sensitive to the views and requirements of both voluntary and statutory providers;

- It must treat all service providers, statutory and voluntary, in exactly the same manner. There must never be a perception that one sector or another is receiving more favourable treatment. The structural arrangements must be such as to ensure that all providers operate on a "level playing pitch";

- It must provide value for money and enhance the efficiency of the services.

Its relationships with both voluntary and statutory providers should be based on:

- Confidence that each sector is being treated fairly and equitably;
- Inclusiveness in the planning and development of services;
- Transparency in the funding mechanisms so that the same arrangements for service agreements and service plans apply to both sectors;
- Openness in the monitoring and evaluation of services and other outcomes.

3.3 Organisational culture

The focus of the new Authority would be significantly different from that of the current Eastern Health Board and from that of the Department of Health. The Authority would need to develop an organisational culture to reflect this difference.

The challenge for the Authority and for its management would be to develop an ethos of partnership between statutory and voluntary providers, with the shared objective of delivering a fully integrated service to patients and clients, and to develop the requisite level of co-operation between professionals and between agencies to achieve this. Appropriate skills, attitudes and aptitudes would be required in the senior staff of the Authority to facilitate this process. If the new Authority were to function effectively, the senior management positions at regional and area level would need to be filled by persons of the highest calibre.

3.4 Reorientation of services

It is vital for the success of the new arrangements that early progress be made in achieving real improvements in the services. We recommend that the new Authority should see as its primary task a re-orientation of services in the Eastern region so that:

- All services are primarily oriented towards the patient / client / household;
- Services are integrated around the patient / client and are seamless in the perception of the user;
- Close inter-professional liaison occurs at the point of service delivery;
- Close inter-service liaison occurs at all levels, particularly at local level;
- Quality and performance measures and targets are agreed and set for each service: these targets should include arrangements for inter-service liaison, referral, discharge, patient / client support and inter professional collaboration;
- A standard of excellence by national and international norms is the goal for all service units.

The re-orientation and re-organisation of services should facilitate members of the public as far as possible to avail of health and personal social services at the location which is most convenient for them, regardless of where area boundaries might fall. The current freedom to avail of the hospital of one's choice should not be changed by the new arrangements.

3.5 Financial implications

The Task Force is aware of the need to ensure that the new arrangements do not impose any significant additional costs on the Exchequer. We believe that many of the developments we propose, such as formal service agreements, greater use of new technology and improved district management arrangements, are matters which would have to be addressed within the Eastern region in any event and will have to be funded accordingly.

The Regional Health Authority will take on aspects of functions currently carried out by the Department of Health in respect of the voluntary providers and by the Eastern Health Board in respect of the statutory

services. We do not, therefore, envisage that there would be an increase in the numbers engaged in management or administration in the region as a whole, but rather a pulling together of existing staff in the interest of greater efficiency and effectiveness.

We believe that our proposals for a slim, highly-specialised management team at the centre and for more effective integration at area and district level would result in a more efficient service for the Eastern region. Resources at Departmental, Authority and Area level would be better utilised and, in some respects, released for redeployment to the areas of the services which need them most.

Some initial non-recurring expenditure would arise from the acquisition of new Area offices. We believe that any additional staff costs in this respect would be marginal and would be offset in due course by increased efficiencies in the service.

3.6 Summary

The Task Force's main objective is to devise structures which will allow for the development of a high quality, integrated, efficient, effective and patient-centred service in the region. The Task Force is agreed that the new Authority, when established, must *"equally understand and be sensitive to the views and requirements of both voluntary and statutory providers"*.

The Authority will need to develop an organisational culture to reflect its unique focus. It should see as its primary task a re-orientation of the services in the Eastern region.

The Task Force is aware of the need to ensure that the new arrangements do not impose any significant additional costs on the Exchequer.

Chapter 4 Membership of the Authority and of the Area Health Councils

4.1 Parameters

In his statement of 27 November 1996, the Minister for Health laid down the following parameters for the membership of the Authority and the three Area Health Councils.

- Public representatives will hold a majority on the new Authority;
- Public representatives will be nominated to the Authority by Dublin Corporation and the County Councils of Fingal, South Dublin, Dun Laoghaire / Rathdown, Kildare and Wicklow;
- The Authority will also include persons drawn from the voluntary hospitals, mental handicap agencies and other voluntary bodies;
- Members of the three Area Health Councils will be drawn from the membership of the Authority.

In addition to the Minister's proposals, we recommend that:

- public representatives would hold the majority on each of the three Area Health Councils;
  and
- in so far as possible, public representatives would sit on the Area Health Council which corresponded to their own electoral district.

We have also taken into account the current membership of health boards. In addition to public representatives (who hold a majority on all health boards), the relevant legislation provides for the following to be members of a health board:

- registered medical practitioners, registered nurses, registered psychiatric nurses, registered dentists and registered pharmaceutical chemists, each elected from within their own membership;
  and
- persons appointed by the Minister

Finally, we have borne in mind the need to keep the overall membership of the Authority as low as possible, if it is not to prove too large and unwieldy to function effectively.

Finding a balance of membership which met all the above criteria and which dealt with the relevant interests fairly and equitably was not an easy task and was one which occupied a great deal of our time. We appreciate that the final decisions regarding the composition of the new Authority will be a matter for the Minister, in the context of the preparation of legislation to establish the Authority. However, we put forward our recommendations in this chapter in the belief that they represent a workable solution which appears to meet the legitimate concerns of all parties involved.

4.2 Representation of the professions

The Minister's statement outlining his proposals for the new Eastern Regional Health Authority was silent on the subject of representation on the Authority for the professions. At present, the membership of the Eastern Health Board includes thirteen representatives of registered professions elected by members of those professions employed across the region in both the statutory and voluntary sectors, as follows:

Registered medical practitioners	9
Registered dentist	1
Registered nurse	1
Registered psychiatric nurse	1
Registered pharmaceutical chemist	1

We were aware of demands for representation from other health professions and from other members of health board staff not currently represented on the Eastern Health Board. Having considered the matter carefully, we have come to the view that the issue of a broader representation for the professions is one which should be dealt with at a national level, as it would have implications for the membership of all health boards. Consequently, in the context of professional representation, we do not recommend any change for the new Authority from the current arrangements which apply to the Eastern Health Board.

We recommend the 13 members of registered professions on the Authority be divided between the three Area Health Councils as follows:

Northern Area	5
South Western Area	5
South Eastern Area	3

This division allows for the fact that the population of the South Eastern Area is smaller than that of the other two areas.

We recognise that, other than in the case of the registered medical practitioners, it would not be possible to provide representation for each profession on every Area Council. However, as all members of Area Councils would also be members of the Regional Authority, we are confident that this would not prove an obstacle to the registered professions in making an input to the overall process.

4.3 Ministerial nominees

We consider that the Minister for Health's existing powers to appoint three members to each health board is a potentially useful device to allow for representation on boards of the wider community interest. Accordingly, we recommend that legislation establishing the new Eastern Regional Authority provide for the Minister to appoint three members to the Authority. We also recommend that, in making her/his nominations, the Minister would take into account the existence of the three Area Health Councils and the desirability that each Council would include a Ministerial nominee among its members.

4.4 Representation of the voluntary sector

The Minister for Health has stated that membership of the Authority will include persons drawn from:

- the voluntary hospitals;
- the voluntary agencies providing services to persons with a mental handicap;
  and
- other voluntary bodies.

It is the view of the Task Force that these sectors should also be included in the membership of each Area Health Council. In order to allow for this, it would be necessary to provide for at least three members to be drawn from each of the three categories above, i.e. nine representatives from the voluntary sector in all.

Taken together with our recommendations in respect of registered professions and ministerial appointees, this would allow for the membership of the Authority, excluding public representatives, to be made up as follows:

Registered professions (as at present)	13
Ministerial appointees (as at present)	3
Voluntary hospitals	3
Voluntary mental handicap	3
Other voluntary bodies	3
Total	25

As to the selection of the representatives of the voluntary sector, we recommend that the necessary legislation provide for their appointment by the Minister from panels which would be put forward by the voluntary organisations in question.

4.5 Public representatives

As outlined in the foregoing section, we recommend a total non-public representative membership on the new Authority of twenty-five. The number of public representatives on the Eastern Health Board at present is twenty-two. This number would need to be increased in the case of the new Authority in order to retain a majority for public representatives. **We recommend that the total number of public representatives on the new Authority be thirty, as explained below.**

The twenty-two public representatives on the current Eastern Health Board, are nominated to the Board by their local authorities as follows:

Dublin Corporation	7
Fingal County Council	3
South Dublin County Council	3
Dun Laoghaire/Rathdown County Council	3
Kildare County Council	3
Wicklow County Council	3
Total	22

Dublin Corporation

With its population of 500,000, Dublin Corporation is by far the largest of the six local authorities in the region and this is reflected to some extent in its current representation on the Eastern Health Board. Nonetheless, it appears to be underrepresented when compared with the other local authorities in the region. Accordingly, **we recommend that the number of representatives for Dublin Corporation on the new Authority be increased to ten.** Furthermore, on the basis that approximately 300,000 of the City's population would form part of the Northern area, 150,000 would form part of the South Western area and 50,000 would form part of the South Eastern area, we recommend that the representatives from Dublin Corporation be assigned to the three Area Health Councils as follows:

Northern Area Council	6
South Western Area Council	3
South Eastern Area Council	1
Total	10

In line with the area boundaries as recommended in Chapter 9, we recommend that the six members who would sit on the Northern Area Council be drawn from among members of the Corporation elected in the North City; the three on the South-Western Area Council come from members elected in the South City and the member for the South Eastern Area Council be drawn from the elected representatives for the Pembroke electoral area in the South-East City.

Other local authorities

We recommend that the other five local authorities in the region (i.e. Fingal, South Dublin, Dun Laoghaire / Rathdown, Kildare and Wicklow) have four representatives each on the new Authority. All public representatives from Fingal would sit on the Northern Area Health Council, all those from South Dublin and from Kildare would sit on the South-Western Area Council and all those from Dun Laoghaire/Rathdown would sit on the South-Eastern Area Council.

In the case of Wicklow, we recommend that one of its four members be required to be nominated from the Baltinglass electoral area, and would sit on the South Western Area Council, and the other three would be nominated from the east of the county, to become members of the South

Eastern Area Council. This would be in keeping with the area boundaries as recommended in Chapter 9.

The public representation on the new Authority, therefore, would be as follows:

Dublin Corporation	10
Fingal	4
South Dublin	4
Dun Laoghaire / Rathdown	4
Kildare	4
Wicklow	4
Total Public Representatives	30

These 30 public representatives would serve on the three Area Health Councils as follows:

Public Representatives on Area Councils:

	Northern Area Council	**South Western Area Council**	**South Eastern Area Council**	**Total**
Dublin Corporation	6	3	1	10
South Dublin County Council	-	4	-	4
Fingal County Council	4	-	-	4
Dun Laoghaire / Rathdown Co Council	-	-	4	4
Kildare Co Council	-	4	-	4
Wicklow Co Council	-	1	3	4
Total	10	12	8	30

Taking into account all the previous criteria, the following is the proposed membership of the Area Councils:

Northern Area Council

Public Representatives		
Dublin Corporation (North City)	6	
Fingal County Council	4	10
Registered Professions		5
Voluntary Hospitals		1
Voluntary Mental Handicap Agencies		1
Voluntary Bodies		1
Ministerial Nominees		1
		19

South Western Area Council

Public Representatives		
Kildare County Council	4	
Wicklow County Council (Baltinglass electoral area)	1	
South Dublin County Council	4	
Dublin Corporation – South City (excluding Pembroke electoral area)	3	12
Registered Professions		5
Voluntary Hospitals		1
Mental Handicap Agencies		1
Voluntary Bodies		1
Ministerial Nominees		1
		21

South Eastern Area Health Council

Public Representatives		
Dun Laoghaire /Rathdown County Council	4	
Wicklow (excluding Baltinglass electoral area)	3	
Dublin Corporation South East City (Pembroke electoral area)	1	8
Registered Professions		3
Voluntary Hospitals		1
Voluntary Mental Handicap Agencies		1
Voluntary Bodies		1
Ministerial Nominees		1
		15

4.6 Constraints on increasing representation

As we indicated at the beginning of this chapter, the final decision regarding composition of the new Authority will be a matter for the Minister. We feel it is important to point out, however, that increases over and above our recommendations for any category of membership could have consequences for the overall membership of the Authority.

In order to allow for representation on each of the three Area Councils, any increase in the representation of the voluntary sector must be in modules of three and the public representatives must have a majority of three on the Authority at all times. If the number of non-public representatives on the Authority is increased, the public representatives must also be increased in order to maintain their majority and if all local authorities are to be dealt with equitably, public representatives must be increased in modules of six (i.e. one for each local authority concerned).

Thus, an increase of three in the representation for the voluntary sector would bring the total non-public representatives on the Authority to 28, and would immediately entail an increase of six public representatives, bringing the total membership of the Authority from 55 to 64. Further increases in representation for the non-public representative groups on the Authority would incur similar "leaps" in the total membership.

We have borne this important factor in mind when formulating our recommendations and we believe that the membership we propose is the most workable solution available, consistent with keeping the overall membership of the Authority to a manageable level.

4.7 Summary

We recommend that the membership of the Eastern Regional Health Authority be as follows:

Membership – Eastern Regional Health Authority

Public Representatives Dublin Corporation 10 Fingal County Council 4 South Dublin County Council 4 Dun Laoghaire / Rathdown 4 Kildare County Council 4 Wicklow County Council 4	30
Registered Professions	13
Voluntary Hospitals	3
Mentally Handicap Agencies	3
Voluntary Bodies	3
Ministerial Nominees	3
Total	55

Chapter 5 Regional Health Authority

5.1 Overview

Many of the problems which currently exist in the health services in the Eastern region are due, in whole or in part, to the absence of a single authority which would have overall responsibility for funding and co-ordinating all health and personal social services and for ensuring that those services are integrated around the individual patient. The proposed Eastern Regional Health Authority which we describe in this chapter will meet this deficiency.

In the next few chapters, we set out the key roles and responsibilities of the Regional Health Authority, the three Area Health Councils and the voluntary and statutory providers. The proposed structure is produced in graphic form in Appendix VIII.

5.2 The role of the Authority

The Minister's proposal of 27 November 1996 stated that the new Authority would:

- replace the Eastern Health Board;
- take on the function of funding of the voluntary providers in the region currently carried out by the Department of Health;
- assume responsibility for the co-ordination and integration of all health and personal social services in the region;
  and
- be managed through three Area Health Councils.

In replacing the Eastern Health Board, the new Authority would become the statutory body with overall responsibility for health services in the region.

We see the role of the new Authority at central level as one of:

- identifying the health and social needs of the population in its region;
- procuring funding from the Minister for Health for services in the region;

- planning the services in the region, including setting outcomes targets to meet identified needs;
- commissioning, by means of service agreements with various providers, measures or services to achieve agreed objectives;
- allocating resources to each of the providers, statutory and voluntary;
- working with other agencies within and outside the region to protect and promote health;
- monitoring and reviewing the services in the region against targets.

As part of its role, the Authority would determine overall policy in relation to health and personal social services in the region. In so doing, it should be required by legislation to take into account the policies and objectives of the Government, the needs and requirements of the region as a whole and requirements identified at area level, in the context of the area planning process.

The new Authority would inherit responsibility for the wide range of services currently provided directly by the Eastern Health Board. Eastern Health Board services include environmental health services; dental services; AIDs/HIV/drug abuse services; child care and family support services; services for the elderly; services for people with physical and sensory disabilities; services for the homeless; community health services; counselling services; mental health services; public health services; medical services; some general hospital services and some mental handicap services. (A full list of Eastern Health Board services is at Appendix V).

In the course of the consultation process, the point was made to us on numerous occasions that a conflict of interest might arise if the same body, whether the board of the central Authority or an Area Health Council, were responsible both for funding some services (i.e. in the voluntary sector) and directly providing others (i.e. those currently provided by the Eastern Health Board). We accept that this issue of a "level playing pitch" between statutory and voluntary service providers is a very real and valid concern for many of the parties which will be required to participate in the new arrangements.

Accordingly, **the Task Force recommends that the Authority at central level should have no management role in the direct delivery of the services currently provided by the Eastern Health Board.** Instead, this

task should be delegated under legislation to each of the three Area Health Councils, as outlined in Chapters 6 and 8.

5.3 Accountability

Legislation should provide that the new Authority will be accountable to the Minister for Health for all health and personal social services in its region. The Task Force recommends that voluntary service providers should be accountable under the terms of their service plans to the Authority and each voluntary provider should be required to nominate an accountable person for that purpose (see Chapter 7).

We recommend that the Authority should also be required to function within the context of the Health (Amendment) (No.3) Act 1996. This Act defines the remit of a health board, clarifies the respective roles of boards and their chief executive officers and strengthens accountability within the system through a range of measures, including the requirement that each health board produce an annual service plan and publish an annual report.

The Regional Health Authority would negotiate with the Minister and the Department of Health annually for the determination of expenditure for the region as a whole. It would then prepare a service plan for the region in line with its determination of expenditure, in accordance with the requirements of the Health (Amendment) (No.3) Act, 1996.

The Authority would have a Chief Executive Officer who would carry out the executive functions of the Authority and would be the Accountable Officer for the Authority. He or she may be required to appear before the Public Accounts Committee in relation to the overall expenditure of the Authority. Each of the three Area Chief Executives would report to the Regional Chief Executive Officer and be accountable for the provision of the statutory services within their area.

5.4 Service agreements and service plans

As stated earlier, the Authority at central level should be required by legislation to make agreements with service providers for the provision of services within its region.

In the case of larger providers, such as the major acute hospitals and the Area Health Councils (as the providers of the statutory services currently

provided by the Eastern Health Board), we recommend that the Authority negotiate service agreements to cover periods of three to five years. Service agreements would set general parameters as to the nature and quantum of services to be provided and, in the words of the Health Strategy, would give providers "*a greater degree of continuity than was possible in the past*" (Shaping a healthier future, page 34). Annual service plans containing precise levels of funding and detailed service requirements would be negotiated between the Authority and the major service providers within the context of these service agreements.

As signalled by the Health Strategy, these arrangements would be simplified in the case of smaller voluntary providers receiving funding from the Authority. However, we recommend that all providers, regardless of the size of their budget, should be required to produce annual service plans and to be accountable for the public funds they receive.

Further details on the form and content of service agreements and service plans are included in Chapters 7 and 8.

5.5 Monitoring

We recommend that the Authority should have statutory responsibility for monitoring the provision of all services in its region and for ensuring that service plans are adhered to. However, in order to allow for services to be planned and co-ordinated at a level as close as possible to the point of delivery, we recommend that the Regional Chief Executive Officer should have the power to delegate the task of monitoring the service plans of individual voluntary providers to the relevant Area Chief Executive. Further details on the monitoring of service plans are included in Chapter 7.

5.6 Region-wide Services

While we propose that, in so far as is possible, the delivery of existing Eastern Health Board services should be devolved to the three areas, nevertheless there are some services that should continue to be kept intact, in the interests of efficiency and effectiveness. These could include, *inter alia,* the functions of Estate Management and Procurement (in so far as they relate to the statutory services), Information Technology and the Ambulance Service.

We recommend that provision be made for some or all of these functions to be delegated by the Authority to an Area Health Council, which would then provide the relevant service on behalf of the Authority to the entire region.

5.7 National specialties

Policy on the development of national specialties is co-ordinated at present by the Department of Health, with the involvement of professional expertise and statutory and voluntary providers as required. This is an appropriate function of the Department, in line with its strategic role as outlined in its recent *Statement of Strategy,* and we believe it is one which it should continue to carry out.

Because of the absence to date of a single authority with responsibility for all acute facilities in the Eastern region, the Department is heavily involved at present in the implementation of its policy on national specialties in the major acute hospitals in the Eastern region. This function we would envisage being devolved from the Department to the new Regional Health Authority.

Finally, we recommend that the Department ensure that structures are in place for co-operation between the new Authority and the other seven health boards, to allow access to national specialties by patients from outside the Eastern region.

5.8 Staffing

As the Regional Authority would have no role in the direct provision of services, it is envisaged that it would not have a large staff. We recommend a slim, high-level team, to include specialists in fields such as public health; health economics; strategic management; finance; human resource management and development; information systems; legal services etc. While the detailed structure would be a matter for the Regional Chief Executive Officer, we would envisage a grouping of the relevant specialist skills around the Authority's three main functions of service planning (including the identification of needs); contracting (including financial management) and monitoring of performance.

5.9 Summary

The Task Force recommends that the role of the Authority at central level should be to:

- identify the health and social needs of the population in its region;
- procure funding from the Minister for Health for services in the region;
- plan the services in the region, including setting outcomes targets to meet identified needs;
- commission by means of service agreement with various providers, measures or services to achieve the agreed targets;
- allocate resources to each of the providers, statutory and voluntary
- work with other agencies within and outside the region to protect and promote health;
- monitor and review the services in the region against targets.

The Task Force recommends that the Authority at central level should have no management role in the direct delivery of the services currently provided by the Eastern Health Board. Instead, this task should be delegated under legislation to each of the three Area Health Councils.

The Authority should negotiate long-term service agreements with the larger voluntary and statutory agencies. All providers should be required to produce annual service plans.

Monitoring of services should be the responsibility of the Authority but may be delegated to area level. Some services should continue to be kept intact in the interests of efficiency and effectiveness.

Policy on the development of national specialties should continue to be co-ordinated by the Department of Health. It is envisaged that the Authority would not have a large staff.

Chapter 6 Area Health Councils

6.1 The role of the Area Health Council

Within the overall framework of the Regional Health Authority, there will be three Area Health Councils within the Eastern Region: the Northern Area Council; the South Western Area Council and the South Eastern Area Council (see map, Appendix VI). We recommend that each Area Health Council should have significant powers under legislation to plan and co-ordinate all services within its area and should also be responsible for the provision within its area of the services currently provided by the Eastern Health Board.

Each Area Health Council should be required by legislation to:

- identify health needs and priorities within its own area;
- plan and co-ordinate the services within its area in co-operation with voluntary providers;
- monitor the overall provision of health and personal social services within its area;
- ensure that the terms of service plans relevant to its area are adhered to and that services are delivered within budget;
  and
- contribute to the regional planning process by communicating its assessment of needs and priorities to the Regional Authority on a regular basis.

Each Area Health Council should hold a service agreement with the Regional Authority for the provision within its area of services currently provided by the Eastern Health Board. In fulfilling this role, the Area Councils would function in the same manner as existing health boards in relation to the services they provide. Services provided by each Area Health Council would include environmental health services; dental services; AIDs/HIV/drug abuse services; child care and family support services; services for the elderly; services for people with physical and sensory disabilities; services for the homeless; community health services; counselling services; mental health services; public health services; medical services, some general hospital services and some mental handicap services.

Membership of the Area Health Councils would consist of members of the Authority, as described in Chapter 4. Details of the boundaries of each area are discussed in Chapter 9.

6.2 Area Chief Executive

The Area Chief Executive, while reporting to the Regional Chief Executive Officer of the Authority, should carry out his/her work in line with and in conjunction with the decisions of the Area Health Council.

The Area Chief Executive would have two important functions. First, he/she would have executive responsibility for the provision of the statutory services within the area and would lead a management team charged with this task. He/she would be responsible for the implementation of the annual service plan for the statutory services and would be financially accountable to the Regional Chief Executive Officer for all funds allocated for these services by the Regional Authority.

In order to ensure the maximum degree of devolution to area level, we recommend that the Area Chief Executive be assigned by legislation the appropriate powers of the Regional Chief Executive Officer with respect to the management of the statutory services in the area. These would include functions with respect to personnel and decisions regarding individual entitlement to services (e.g. medical cards).

The second important function of the Area Chief Executive would be the overall planning and co-ordination of all services, both statutory and voluntary, within the area. He/she would be responsible for ensuring co-operation between all providers in the area, while respecting the autonomy of voluntary providers in relation to operational matters.

In order to enhance his/her ability to plan and co-ordinate services across the area, we recommend that the Regional Chief Executive Officer be given power to delegate responsibility to the Area Chief Executive for monitoring service agreements held by voluntary providers within his/her area. In carrying out this function, the Area Chief Executive would be acting on behalf of the Regional Chief Executive Officer at all times and the formal relationship between the voluntary providers and the Authority would not be affected.

6.3 Providers' Forum

We recommend that a Providers' Forum be convened by each Area Chief Executive and comprise representatives of the providers of primary, acute and community based services in the area, both statutory and voluntary. The concept of a Providers' Forum at area level was suggested to us during the consultation process. This Forum would function as a mechanism for co-operation between all providers in the area, and allow providers to have an input into the service planning process. The Providers' Forum could operate on a general basis or could be convened, as the occasion demanded, as a sub-group made up of providers of specific services, i.e. an acute hospital providers' forum, a services for the elderly forum etc.

We would envisage the Providers' Forum operating in a spirit of mutual co-operation to achieve maximum efficiency, effectiveness and benefit to the individual patient or client. We envisage that the Forum would have an input into the preparation of integrated long-term plans for the area.
We recommend that all providers be required to participate in the Providers' Forum and to co-operate with the Area Chief Executive in this regard.

6.4 Summary

The Task Force recommends that each Area Council be required to:

- identify health needs and priorities within its own area;
- plan and co-ordinate the services within its area in co-operation with voluntary providers;
- monitor the overall provision of health and personal social services within its area;
- ensure that the terms of service plans relevant to its area are adhered to and that services are delivered within budget;
  and
- contribute to the regional planning process by communicating its assessment of needs and priorities to the Regional Authority on a regular basis.

Area Health Councils should hold service agreements and annual service plans with the Authority for the provision within their area of the services currently provided by the Eastern health Board.

The Area Chief Executive will have two important functions: responsibility for the provision of the statutory services within the area and responsibility for the overall planning and co-ordination of all services, both statutory and voluntary, with the area.

A Providers' Forum at area level, to include both statutory and voluntary providers, will be convened by the Area Chief Executive. It will function as a mechanism for co-operation between all providers in the area.

Chapter 7 Voluntary Providers currently funded by the Department of Health

7.1 Principles

Our proposals for the role within the organisational structure of the voluntary providers are based on the principles enunciated in the Health Strategy "*Shaping a healthier future*". As these principles are central to our analysis, we consider it useful at this point to quote them:

> *"In future the voluntary agencies will receive funding from the health authorities, to whom they will be accountable for the public funds which they have received.*
>
> *For the first time a specific statutory framework will be created between the health authorities and the voluntary agencies which recognise the role and responsibilities of both parties. The independent identity of the voluntary agencies will be fully respected under the new structure. They will retain their operational autonomy but will be fully accountable for the public funds which they receive. They will continue to have a direct input to the overall development of policy at national level."*
>
> (Shaping a healthier future, page 33)

Our interpretation of this passage is that **there would be no change under the new arrangements in the status or operation of any voluntary provider,** whether an acute hospital, a mental handicap agency or other service provider. Their ownership would not change, their governing bodies (whether boards of management or trustees) would remain and would retain all of their functions, and there would be no change in the existing personnel and recruitment arrangements. The close co-operation between the universities and their associated hospitals would be maintained.

What would change is that voluntary providers in the Eastern Region would receive their funding from the Eastern Regional Health Authority, instead of from the Department of Health, by means of an agreement between each voluntary provider and the Authority.

7.2 Service agreements and service plans

On the subject of service agreements the Health Strategy states:

> *"The larger voluntary agencies will have service agreements with the health authorities which will link funding by the authorities to agreed levels of service to be provided by the agencies.*
>
> *"It is envisaged that these agreements will, in general, be for terms of a number of years. This will give voluntary agencies a greater guarantee of continuity than was possible in the past. These agreements will set general parameters in relation to the level of funding and the associated service requirement. The amount of funding which can be provided in any year cannot be guaranteed in advance; this will depend on the resources and service requirements given to the health authorities by the Department of Health. The agreements will therefore provide that the precise level of funding, and the associated service requirement, will be determined annually between the authorities and the agencies concerned".* (Shaping a healthier future, page 33-34)

It is clear from this passage that service agreements should be long-term arrangements, covering perhaps a three-to five-year period. It is also clear that there would be a need for a more detailed level of agreement between the Authority and individual providers in relation to each year's allocation of funding. We recommend that this would take the form of an annual service plan, which would be agreed between each voluntary provider and the Authority and would become the basis for funding and services each year. The service plan would be drawn up within the context of the service agreement, but would provide greater detail and more precise expenditure figures for the relevant year.

Both the service plan and the longer term service agreements would be formal agreements between the provider and the Authority. The service plans would be built around key elements which would be common to all service plans held by the Authority, whether with voluntary or statutory providers.

The detailed format which a service plan might take remains to be worked out in consultation with all the parties involved, but we would envisage that the key elements of a service plan would include:

- quantum of service to be provided
- effectiveness

- efficiency
- equity
- quality
- access
- appropriateness of care
- responsiveness to the public

Service plans between the Authority and voluntary providers of services for people with a mental handicap would also take into account the agreement reached recently by those providers with the Department of Health and the Southern and Mid-Western Health Boards and outlined in *"Enhancing the Partnership"*.

Service plans should include a requirement to supply to the Authority such information as may be required to enable the plan to be monitored. The monitoring process would be agreed by all parties in advance so as not to infringe on the operational autonomy of the voluntary provider concerned.

We recommend that voluntary providers who conclude service plans with the Authority be required to designate an individual (usually the Chief Executive Officer or Secretary / Manager) who would be legally accountable in relation to it. This person would be required to account to the Regional Chief Executive Officer for the provision of service within budget and within other parameters (e.g. equity, quality, access) as set out in the service plan.

7.3 Funding levels

In order to create a climate of mutual respect, trust and partnership between the new Authority and voluntary providers from the outset, which would enable all parties to participate fully in the operation of the new arrangements, **the Task Force recommends that the first service agreements between the Authority and all providers, voluntary and statutory, should extend over the three-year period 1999-2001 and should be based on current agreed levels of service and agreed service developments, subject only to any national decisions which may affect overall levels of funding in the health services. These service agreements should be drawn up during 1998 with facilitation from the Department of Health. In addition, we recommend that the precise level of funding for each provider for the financial year 1999 should be determined in 1998 by the Department of Health.**

The Task Force notes that service agreements, as we propose here, will facilitate the introduction of multi-annual budgeting in the health services, if so decided.

7.4 National policy

The Task Force notes that the Health Strategy contains a commitment that voluntary providers will continue to have a direct input to the overall development of policy at a national level. We are encouraged by the fact that the Department of Health's recently published Statement of Strategy includes as a goal the putting in place of mechanisms which would bring this about. As this issue has emerged as one of major concern to the voluntary sector during our consultation process, we recommend that the Department proceed with these measures as a matter of priority, with a view to having the appropriate structures agreed with all parties by mid 1998.

7.5 Summary

Service agreements, covering a three to five year period, should be negotiated between the Authority and the major voluntary providers. Annual service plans should be agreed within the context of the service agreements and would form the basis for funding and services each year. There would be no change under the new arrangements in the status or operation of any voluntary provider.

The Task Force recommends the first service agreements between the Authority and voluntary providers should extend over the three-year period 1999-2001. They should be drawn up during 1998 with facilitation from the Department of Health and should be based on current agreed levels of service and agreed service developments, subject only to any national decisions which may affect overall levels of funding in the health services. In addition, the precise level of funding for each provider for the financial year 1999 should be determined in 1998 by the Department of Health.

The Task Force recommends that the Department of Health proceed with putting in place mechanisms to allow voluntary providers to have an input into the development of policy at a national level.

Chapter 8 Statutory Providers

8.1 Service agreements and service plans

It is crucial to the success of the proposed arrangements that the Regional Health Authority be seen to deal with all parties equitably. **The Task Force recommends, therefore, that the providers of statutory services within the Eastern region be subject to the same requirements concerning service agreements and annual service plans as would apply to voluntary providers.**

We have already referred to service agreements between the Authority and each Area Health Council in relation to the provision of services currently provided by the Eastern Health Board. We recommend that service agreements extend over three years, with the first agreement covering the period 1999-2001. The Task Force recommends that, as in the case of the voluntary providers, each Area Health Council be required to negotiate an annual service plan with the Authority, within the overall context of its service agreement, which would be the basis for its funding levels for the relevant year. The Task Force notes that service plans of this nature have been in operation on an administrative basis in relation to statutory services for some time.

As in the case of the voluntary providers, service agreements and annual service plans agreed between the Authority and each Area Health Council would be formal agreements. The annual service plans would be based on certain elements common to all plans negotiated by the Regional Authority, including:

- quantum of service to be provided
- effectiveness
- efficiency
- quality
- equity
- access
- appropriateness of care
- responsiveness to the public

The Area Chief Executive would have operational autonomy in the day-to-day management of the statutory services within his/her area but would be accountable to the Regional Chief Executive Officer under the terms of the service plans.

Responsibility for monitoring the area service plans would rest with the Authority, and with the Regional Chief Executive Officer in particular.

8.2 Acute hospitals

While the bulk of acute hospital care in the Eastern region is provided by the voluntary sector, the Eastern Health Board has direct management responsibility for three acute hospitals: James Connolly Memorial Hospital, Blanchardstown; St Colmcille's Hospital, Loughlinstown, and Naas Hospital. These hospitals function as part of the overall network of acute hospitals in the region.

Given that all other acute hospitals, being voluntary hospitals, would have a direct relationship with the new Authority at central level, we recommend that the method of funding of these three hospitals within the overall structure be reviewed by the new Authority on taking office.

8.3 District Management

The Area Chief Executive should lead a management team responsible for the provision of the statutory services in the area. We envisage there would be a unit of management for each district with a population of 150,000-200,000 approximately. These district arrangements would replace the existing community care areas of the Eastern Health Board.

Each District General Manager would be responsible for the direct management of statutory community services within the district. The District General Manager would also be responsible for ensuring that all services at local level are delivered in an integrated and co-ordinated manner, and for developing a seamless service with ease of referral and transfer between various providers, both statutory and voluntary, who are providing services within his/her district. The District General Manager would also be required to agree service plans with small voluntary groups and associations in his/her area which receive their funding from the Eastern Health Board at present.

We propose eight districts for the Eastern region and these are outlined in Chapter 9.

8.4 Summary

The Task Force recommends that the providers of statutory services within the Eastern region be subject to the same requirements concerning service agreements and annual service plans as would apply to voluntary providers. The method of funding of the three acute hospitals currently managed by the Eastern Health Board should be reviewed by the new Authority on taking office. A district management arrangement should be put in place to replace the existing community care areas of the Eastern Health Board.

Chapter 9 Area Boundaries

9.1 Criteria

The Minister for Health's statement of 27 November 1996 put forward a framework of three areas through which the Eastern Regional Health Authority would be managed.

The areas suggested in the Minister's statement were as follows:

Northern Area
Covering North of City, Fingal County and North Kildare.

South Western Area
Covering South West of City, South Dublin County, South Kildare and West Wicklow

South Eastern Area
Covering South East of City, Dun Laoghaire / Rathdown and East Wicklow.

The statement added that the final area boundaries would be *"subject to consultation and agreement with appropriate interests"*. We have consulted many of the interested parties over recent months, as indicated in Chapter 1, including the members of the Board and Management of the Eastern Health Board. The recommendations we put forward in this chapter take into account views put to us regarding area boundaries during that consultation process.
In arriving at our recommendations on the matter of area boundaries, we have borne in mind the following:

- We resolved to recommend changes in the Minister's proposals regarding the area framework only where we felt there was a compelling case;
- In the interest of community identity with, and ownership of the new arrangements, we resolved to respect the integrity of the existing local authority boundaries as far as possible;
- Where we had to depart from the local authority boundary, we agreed to follow electoral area boundaries in order to facilitate the Local Authorities in making nominations to the Regional Health Authority and to its Area Councils;

- Mindful of the importance of the large acute hospitals to the local communities which surround them, we took their location into account also.

9.2 Recommendations

9.2.1 Dublin Corporation

The Minister's proposal divides the Dublin Corporation area between the Northern, the South Western and the South Eastern Area Health Councils, but does not define the boundary between the South Western and the South Eastern Areas. Our recommendation on this matter has been shaped by a number of factors, as follows:

a) The south inner city would best be kept as a single unit of service to ensure co-ordinated programmes of services can be delivered for the population there;

b) Because of the links which have developed between St James's Hospital, Tallaght Hospital and Naas Hospital, they would be best located within the same area;

c) St Vincent's Hospital should be located within the South Eastern Area, as indicated in the Minister's statement;

d) The chosen boundary should follow local authority electoral areas to facilitate public representation on the Authority and on its Area Councils.

Taking all this into account, **we recommend that the boundary between South Western and the South Eastern Areas should coincide with the boundary between Dun Laoghaire / Rathdown and South Dublin County and, in the City, should follow the line of the Pembroke Electoral Area, to include Pembroke in the South Eastern Area and all the rest of the South City in the South Western Area.** (see map, Appendix VI).

We note that, as a consequence of maintaining the south inner city intact, the National Maternity Hospital would now be located in the South Western Area, although the majority of its patients would tend to come from the South Eastern Area. We recommend that the National Maternity Hospital be recognised as a major provider of services for the South Eastern Area and that it should participate accordingly in the service planning process for that area.

9.2.2 Kildare

The Minister's statement proposed that North Kildare should be included in the Northern Area and South Kildare in the South-Western Area.

In our consultation with public representatives, it emerged clearly that there was a strong desire that County Kildare be maintained as a unit within the new arrangements. The inclusion of the whole of County Kildare in one area would not have any detrimental effect in the context of service delivery. Accordingly, **we recommend that County Kildare in its entirety be included in the South Western area.**

9.2.3 Wicklow

The Minister's proposal is to divide County Wicklow between the South Western and the South Eastern Areas along the natural boundary of the mountains. The operational arrangements for many health and social services already recognise an West/East division in the county and the pattern of hospital utilisation also follows this divide. **We recommend that the Baltinglass electoral area be included as part of the South Western Area and that the remainder of County Wicklow form part of the South Eastern Area.**

9.2.4 Fingal, South Dublin and Dun Laoghaire / Rathdown

We agree with the Minister's proposals which assign the three County Councils to the three areas as follows:
Fingal – Northern Area
South Dublin – South Western Area
Dun Laoghaire / Rathdown – South Eastern Area

9.3 Description of Areas

In line with our recommendations as outlined above, we recommend the following three areas for the new Eastern Regional Authority:

Northern Area	**Population (1996)**
Dublin City North	286,655
Fingal County	167,433
Total	**454,088**

South Western Area	**Population (1996)**
Dublin City South (excluding Pembroke Electoral Area)	149,562
South Dublin County	218,401
County Kildare	134,881
West Wicklow (Baltinglass Electoral area)	12,724
Total	**515,568**

South Eastern Area	**Population (1996)**
Dublin City South (Pembroke Electoral Area)	44,779
Dun Laoghaire / Rathdown	189,836
East Wicklow (excluding Baltinglass Electoral Area)	89,693
Total	**324,308**

The population of each Area will be as follows:

Area	**Population (1996)**	**% of total**
Northern	454,088	35%
South Western	515,568	40%
South Eastern	324,308	25%
Total	1,293,964	100

Each of these areas has a population which is significantly higher than that of the average health board. For purposes of comparison, the following table gives the population for the seven health boards outside the Eastern region.

Population for other Health Board Areas (1996)

- Midland Health Board 205,252
- North Western Health Board 210,112
- North Eastern Health Board 305,703
- Mid-Western Health Board 316,875
- Western Health Board 351,875
- South Eastern Health Board 390,946
- Southern Health Board 546,209

Population for proposed three Areas in Eastern region (1996)

Range	324,308 – 515,568
Average	431,321
Median	454,088

9.4 Districts

In Chapter 8, we recommended that within each area there should be units of management at district level, each district having a population of 150,000 – 200,000. We recommend that in line with normal practice in the other regions of the country, districts should follow local authority boundaries as far as possible, so as to underline local identity and instil a sense of community involvement and ownership. We believe that the recent establishment of three new local authorities in the Dublin region presents an opportunity for the new health structures to benefit from the growing sense of identity of these local communities.

We recommend that three districts be established in the Northern Area, three in the South-Western Area and two in the South Eastern Area. We recommend that these districts serve as units of management **only** and that they should **not** have a statutory basis. This would allow them to change over time, if necessary, as the needs of the population changed.

The districts we propose are as follows:

<u>Northern Area</u>

- Fingal County
- North City (Inner City and West)
- North East City

South Western Area

- South City
- South Dublin County
- Kildare and Baltinglass

South Eastern Area

- Dun Laoghaire-Rathdown and Pembroke
- East Wicklow

9.5 Summary

The Task force recommends that:

- County Kildare should be retained as a unit and become part of the South-Western Area;
- The Baltinglass electoral area of Co Wicklow should be included in the South Western area and the remainder of Co Wicklow should form part of the South Eastern area;
- The boundary between South Western and the South Eastern Areas should coincide with the boundary between Dun Laoghaire / Rathdown and South Dublin and, in the City, should follow the line of the Pembroke Electoral Area, to include Pembroke in the South Eastern Area and all the rest of the South City in the South Western Area. (see map, Appendix IV).

The Task Force recommends eight district units of management in the region : three in the Northern Area, three in the South Western Area and two in the South Eastern Area.

Chapter 10 Consultation process

10.1 Outline

As indicated in Chapter 1, we have engaged in consultation over recent months with many of the parties who have an interest in the proposals for a new Eastern Regional Health Authority and we intend to continue that consultation process on an ongoing basis throughout the period of transition to the new arrangements. In this chapter, we outline some of the main points which were made to us during the consultation process. (A list of organisations and individuals who made submissions to us is at Appendix III).

It would not have been possible for us to accommodate all the points made to us, as some were in direct conflict with others, and some more were in conflict with the terms of the Minister's statement. Nonetheless, we have been able to accommodate much of what was suggested to us and we believe that the various parties to the process will find their views reflected to some extent in the proposals outlined elsewhere in this report.

10.2 Main points

Among the main points put to us during the consultation process were:

1. Given the size and complexity of today's Eastern Health Board, services are too centralised both in terms of policy and delivery. It is necessary to devolve real authority to the three Areas so that much of the work normally done by a health board can be done at Area level.

2. There should not be any increase in bureaucracy. The work done at the level of the Region and that done at the level of the Area should be clearly defined to avoid unnecessary duplication.

3. In order to create the "level playing field" desired by both the statutory and voluntary providers, the Regional management should have no involvement in the day to day management of services. Its relationship with both voluntary and statutory services should be similar, with the same type of arrangements and involvement in the process of service planning, funding, evaluation and co-ordination. The statutory services should not have an "inside track".

4. On the other hand, the size of the voluntary sector, particularly the acute hospital sector, which absorbs a substantial proportion of the budget for the region as a whole, should not give rise to the community and social services being marginalised. The direct representation of the voluntary hospitals, mental handicap agencies and voluntary organisations on the Authority with no similar representation of the statutory sector should not give rise to a position of dominance by those services.

We believe the recommendations we put forward in this interim report will meet these requirements.

10.3 Alternative views

There were some views put to us during the consultation process which did not accord with the Minister's proposals as outlined in his statement of 27 November 1996. We quote them here to indicate the broad spectrum of points which were made.

1. There should be no change at all in organisational structures for the region: the Eastern Health Board should remain in place and the voluntary sector should continue to be funded directly by the Department of Health.

2. There should be no Regional Authority. Instead, there should be three separate health boards, one for each of the proposed areas. The size of the population in the region was quoted to justify this view, as each proposed board would be almost as big as the Southern Health Board, the biggest of the boards outside the Eastern region. Each of the three proposed boards should fund the voluntary sector in its own area. Co-ordination would be achieved either by the efforts of the Department of Health or by agreement between the three boards.

3. There should be a Regional Authority only, with no statutory powers at Area level. Instead, the proposed Area Council should be replaced by a Forum, involving the local members of the Regional Authority, the providers of services in the area and others with health expertise.

10.4 Summary

The Task Force consulted with many of the parties who have an interest in the proposals and intends to continue that consultation process on an ongoing basis throughout the period of transition to the new arrangements. Some of the main points made during the consultation process to date are outlined in this chapter.

Chapter 11 Timescale for implementation

11.1 Timescale

The reorganisation of arrangements for health services in the Eastern Region has been proposed on a number of occasions over the last decade. This has inevitably created an environment of some uncertainty in the region, particularly in the Eastern Health Board. It has also seriously inhibited any long term planning of services for the region as a whole.

We are very concerned that if the current uncertainty is allowed to continue it could have damaging consequences for staff and institutional morale and could ultimately lead to a deterioration in services. Because of this, it is our view that the change should be completed in the shortest possible time scale consistent with ensuring a smooth transition to the best possible arrangements. **We recommend that the target date for having the new Authority in place and carrying out its functions should be 1st January 1999.**

If this target date is accepted, we believe it would be desirable to have the Authority and the three Area Health Councils in place by mid 1998, to allow them to plan and prepare for their new roles. We note that local elections are scheduled for June 1998. We recommend that, following these elections, the newly-elected local authorities be required to nominate representatives to the new Authority. This would require the legislation establishing the Authority and the Area Councils to be enacted as soon as possible in 1998. (The current Health Board would, of course, continue in existence alongside the new Authority until the latter assumed its functions).

Furthermore, we believe that if the Authority is to be in place on 1 January 1999, it would be essential to have the Regional Chief Executive Officer and the three Area Chief Executives appointed as soon as possible, so that they can work with the Task Force in implementing the transition to the new arrangements.

11.2 Key tasks remaining

An immediate task for the Minister and the Department of Health would be the drafting and enactment of legislation to provide for the establishment of the Eastern Regional Health Authority and the three Area Health Councils, along the lines set out in this report. For the reasons outlined above, this task would need to be completed by early 1998 if the target date of 1 January 1999 is to be met.

For the Task Force, a key task would be the development of service agreements and service plans. As outlined in Chapter 7, we recommend that service agreements for the period 1999-2001 be drawn up during 1998 by the Task Force and the major voluntary providers with facilitation from the Department of Health. Detailed service plans to govern the delivery of services for 1999 would also need to be drawn up with all providers during the same period.

Other key tasks for the Task Force over the next 12-18 months would be:

- A continuation of the consultation process with all interested parties;
- The formulation of a detailed management structure at regional and area level;
- The formulation of a detailed information strategy, for both service and financial information, to assist in the provision of a seamless, integrated service;
- In conjunction with the key senior management (when appointed), the putting in place of the new management arrangements at area and district level;
- In conjunction with the Department of Health, the making of arrangements for the transfer to the new Authority of functions in relation to the funding of voluntary providers;
- The identification and acquisition of suitable accommodation for the Regional Authority and for the headquarters of each of the three Area Health Councils.

11.3 Summary

The Task Force recommends that the target date for having the new Authority in place and carrying out its functions should be 1st January 1999.

In order to achieve that date:

- the Authority and the Area Councils should be in place by mid - 1998;
- legislation to establish the Authority should be enacted early in 1998;
- the Regional Chief Executive Officer and the three Area Chief Executives should be appointed as soon as possible.
- The key tasks for the Department of Health and the Task Force over the coming 12-18 months are outlined.

Appendix I

Ministerial Statement 27/11/96

Appendix I

"Minister for Health announces restructuring of health services in Dublin, Kildare and Wicklow"

The Minister for Health, Mr Michael Noonan, T.D., today (27th November, 1996) announced that the Government has agreed to his proposals for the establishment of an Eastern Regional Health Authority which will have responsibility for the funding of all health and personal social services in Counties Dublin, Kildare and Wicklow.

"Under the new arrangements, all services, both voluntary and statutory, will be funded by the new Authority, facilitating more integrated planning, delivery and evaluation of health and personal social services in the area" the Minister said. "I believe this will enable the Authority to promote a more effective, efficient and patient/consumer friendly delivery system in the region"

These proposals are being brought forward in response to the Health Strategy "Shaping a Healthier Future", which identified the need for substantial changes in the administration of services in the Eastern Health Board region. At present, the Eastern Health Board is formally responsible for services in Counties Dublin, Kildare and Wicklow. However, in practice, the bulk of the general hospital services and much of the mental handicap provision in the region are funded directly by the Department of Health and do not have any formal links with the Board. As a result, there is insufficient integration and co-ordination in relation to service delivery and little integrated planning of services for the region.

Summary of main points
The main points of the Minister's proposals are:

- A new Eastern Regional Health Authority will replace the Eastern Health Board and will be responsible for the funding of all health and personal social services, both statutory and voluntary, in Counties Dublin, Kildare and Wicklow;
- Public representatives will hold the majority on the new Authority. Councillors will be nominated to the Authority by Dublin City Council and the county councils of Fingal, South Dublin, Dun Laoghaire-Rathdown, Kildare and Wicklow;

- The Authority will also include persons drawn from the voluntary hospitals, mental handicap agencies and other voluntary bodies;
- The Authority will be managed through three Area Health Councils, whose members will be drawn from the membership of the Authority;
- Area Managers, reporting to the Chief Executive Officer, will be appointed to correspond with the Area Health Councils.

Area Boundaries

The Government has agreed a framework of three areas for the new Authority. The final area boundaries will be subject to consultation and agreement with appropriate interests. The areas suggested are as follows:

Northern Area (Population 405,000)
Covering North side of City, Fingal County and North Kildare.
Includes the Mater, Beaumont, Blanchardstown and the Rotunda hospitals.

South Western Area (Population 490,000)
Covering South West of City, South Dublin County, South Kildare and West Wicklow.
Includes St James's, Tallaght and Naas hospitals and the Coombe Women's Hospital.

South Eastern Area (Population 352,000)
Covering South East of City, Dun Laoghaire/Rathdown and East Wicklow.
Includes St Vincent's, St Columcille's (Loughlinstown), St Michael's (Dun Laoghaire) and the National Maternity Hospital.

Establishment of Task Force

The Minister also announced that he intends to establish a high-level Task Force to oversee and manage the implementation of his proposals. The Task Force will be led by Mr Donal O Shea, currently Chief Executive Officer of the North Western and North Eastern Health Boards, who will be released to work on it on a half-time basis. It will have six other members, four of whom will be an Assistant Secretary from the Department of Health, the Acting Chief Executive Officer of the Eastern Health Board, a representative of the voluntary hospitals and a representative of the voluntary mental handicap agencies. The Minister intends to appoint two other members to reflect the views of business and community interests.

"The Task Force will work out the detailed organisational and administrative arrangements which will be required for the transition to the new structures" the Minister said.

The full transition to the new arrangements is expected to take two to three years. The Minister will request the Task Force to produce an interim report by 30th June, 1997.

Appendix II

Membership of Task Force

Appendix II

Membership of the Task Force on The Eastern Regional Health Authority

Donal O Shea, Chief Executive Officer, North Eastern Health Board, (Chairman)

J.A Enright, Assistant Secretary, Department of Health

P.J. Fitzpatrick, Chief Executive Officer, Eastern Health Board

Nicholas C. Jermyn, Chief Executive Officer, St Vincents Hospital, and Chief Executive Officer, St Luke's and St Anne's Hospital

Muireann Morris, Chief Executive Officer, Sonas Housing Association

Sr Catherine Mulligan, Provincial, Daughters of Charity of St. Vincent de Paul

Brian Sweeney, Siemens Group Chairman, Ireland

Directorate
Martin Devine
Derek Dockery
Bairbre Nic Aongusa (Department of Health)

Secretariat
Elaine Corrigan
Sadhbh Lyons

Appendix III

Submissions received by the Task Force

The following submissions had been received by the Task Force by 30th June 1997

Adelaide & Meath Hospital Dublin incorporating The National Children's Hospital
Cluain Mhuire Service (St John of God)
Coombe Women's Hospital
Daughters of Charity of St Vincent de Paul
Department of Psychology, St Brendans Hospital, Dublin 7
Dublin Academic Teaching Hospitals - Chief Executive Group
Dublin City University
Environmental Health Officers - Eastern Health Board
Environmental Health Officers Association
Faculty of Health Sciences, Trinity College
Faculty of Public Health Medicine, Royal College of Physicians
Incorporated Orthopaedic Hospital of Ireland
Irish Hospital Consultants Association
Mater Misericordiae Hospital
Mater Private Hospital
National Maternity Hospital
National Rehabilitation Hospital
St James's Hospital
St Michael's Hospital, Dun Laoghaire
St Vincent's Private Hospital, Herbert Avenue, Dublin 4
St Vincent's Hospital, Fairview
The Rotunda Hospital
University College Dublin

Appendix IV

Voluntary Hospitals and Voluntary Mental Handicap Agencies in the Eastern Region directly funded by the Department of Health

Voluntary Hospitals / Agencies
Directly funded by the Department of Health
- Eastern Region –

1. St James's
2. Beaumont
3. Mater
4. St. Vincent's, Elm Park
5. Meath
6. Adelaide
7. St Michael's Dun Laoghaire
8. Royal Victoria Eye & Ear
9. Coombe
10. National Maternity, Holles St
11. Rotunda
12. Our Ladys, Crumlin
13. Temple Street
14. National Children's Harcourt St
15. St Luke's/St Anne's
16. Hume Street
17. Cappagh Orthopaedic
18. Inc. Orthopaedic, Clontarf
19. National Rehabilitation Hospital
20. Our Lady's Hospice
21. Royal Hospital, Donnybrook
22. Dublin Dental Hospital
23. Leopardstown Park
24. FDVH
25. St Vincent's, Fairview
26. St Mary's, Baldoyle
27. Central Remedial Clinic
28. National Rehabilitation Board
29. Drug Treatment Centre

Voluntary Mental Handicap Agencies
Directly funded by the Department of Health
- Eastern Region –

1. Stewart's Hospital
2. St John of God Brothers
3. Childrens Sunshine Home
4. St Michael's House
5. Daughters of Charity of St. Vincent de Paul, Navan Rd
6. Sister of Charity of Jesus and Mary
   Mooreabbey, Monastervin, Co Kildare

Appendix V

Services provided by Eastern Health Board

Current Services provided by the Eastern Health Board

1. Ambulance and Transport
2. Child Care and Family Support
3. Dental and Orthodontic
4. Community Welfare
5. Environmental Health
6. Community Health Services including Public Health Nursing, Home Help, Women's Refuge and Services for Travellers
7. Physical / Sensory Disabilities
8. Psychiatric Services
9. Immunisation
10. Services for Elderly
11. General Practice Unit
12. Homeless
13. Mental Handicap
14. Community Alcoholism
15. AIDS / HIV / Drugs Service
16. Speech and Language Therapy
17. Addiction Counselling Service, Bereavement Counselling, Adult victims of sexual abuse counselling service
18. Public Analysts Laboratory
19. Public Health Laboratory
20. Occupational Therapy
22. Registration of Births, Marriages and Deaths
23. Physiotherapy
24. Medical Services – these include Ophthalmic , Medical & Surgical Appliances, Maternity and Child Health, General Practitioner, Medical Cards, Family Planning and Pregnancy Counselling, Women's Health, Children's Health and Community Drugs Scheme
25. Overseas Medical Services
26. External Agencies - palliative care, services for the physically disabled (residential facilities), Forensic Service, Vocational / Rehabilitation Services

Special Care Hospitals

Vergemount, Clonskeagh
St Loman's Hospital
St Brendan's, Grangegorman
St Ita's Hospital, Portrane

Acute General Hospitals

James Connolly Memorial Hospital
St Columcille's Hospital (Loughlinstown)
Naas General Hospital

Non-acute General Hospital
Cherry Orchard Hospital

Hospitals / Homes for the Elderly
St Marys
St Vincent's
St Colman's
Wicklow District
Baltinglass District
Bru Chaoimhin
St Clare's
Clonskeagh
St Brigid's
Cuan Ros
Baggot Street Community Hospital
Sir Patrick Dun's

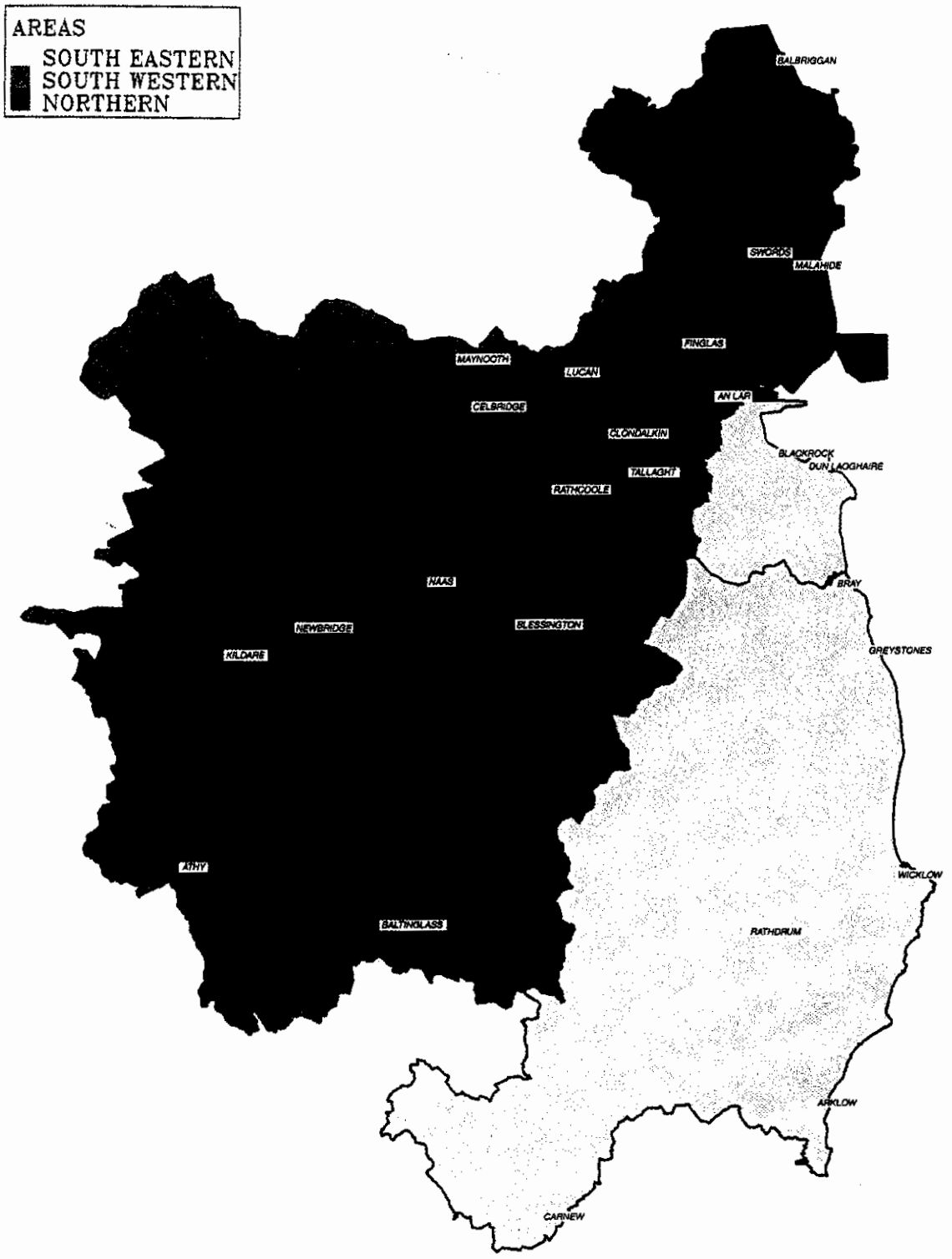
Functional Departments
Public Health Medicine
Estate Management
Technical Services
Personnel
Customer Services
Management Services
Communications
Finance

Appendix VI

Area and District Maps

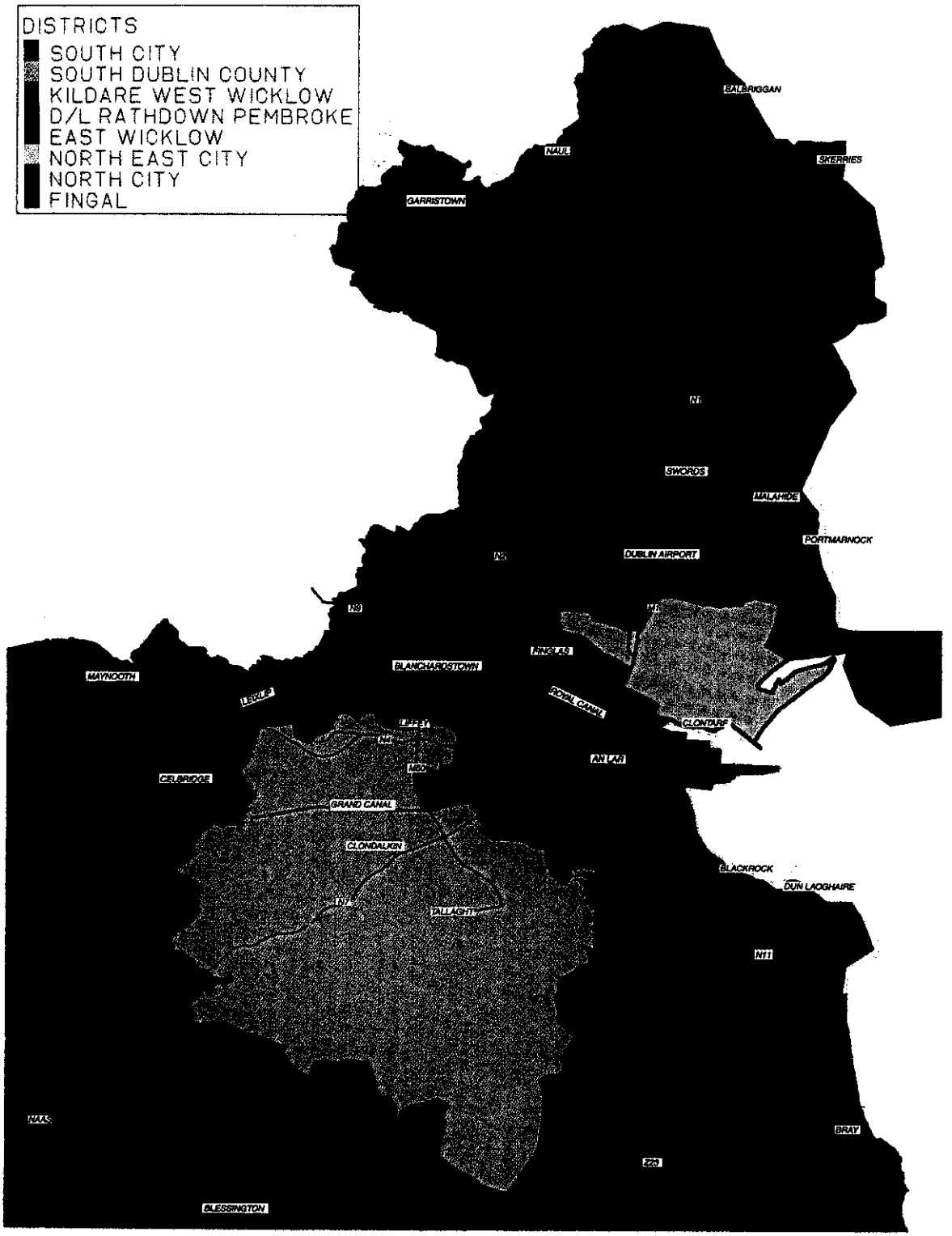
EASTERN REGIONAL HEALTH AUTHORITY

Proposed Area Boundaries



EASTERN REGIONAL HEALTH AUTHORITY

Proposed District Boundaries



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Appendix VII

Glossary

Glossary

Region	-	Counties Dublin, Kildare and Wicklow
Area	-	3 Areas in Region: Northern; South Western, and South Eastern
District	-	Management Unit at sub area level, follows mainly local authority boundaries **Northern:** Fingal, North City West, North City East **South Western:** Kildare and Baltinglass, South County Dublin, South City **South Eastern:** Dun Laoghaire – Rathdown and Pembroke and East Wicklow
Voluntary Hospitals		Includes all hospitals, both public voluntary and privately owned voluntary currently funded directly by Department of Health
Voluntary Mental Handicap Agencies:		All mental handicapped organisations currently funded directly by Department of Health
Voluntary Agencies:		All voluntary organisations currently funded by Department of Health
Voluntary Organisations:		All voluntary organisations currently funded by Eastern Health Board
Statutory Services:		All those services currently provided by the Eastern Health Board, including those directly funded by the Eastern Health Board
Service Agreement:		Long-term agreements between the Authority and the major providers, extending over three to five years, setting general parameters in relation to levels of funding and the associated service requirement.

Service Plan: Annual formal agreements between the Authority and each service provider containing detailed levels of funding and services for the relevant year

Appendix VIII

Proposed structure of Eastern Regional Health Authority

Proposed Structure for the Eastern Regional Health Authority