REPORTS OF THE DUBLIN HOSPITAL INITIATIVE GROUP

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Dublin Hospital Initiative Group

SECOND REPORT

PROPOSED ORGANISATIONAL STRUCTURES FOR THE DUBLIN REGION

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Preface

INTRODUCTION AND PROCEDURE

1. Action Programme for the Health Services

On the 6th February 1990 the Minister for Health, Dr. Rory O'Hanlon T.D., announced an Action Programme for the Health Services for 1990 and beyond.

The Action Plan included a Dublin Hospitals Initiative - to improve the integration and efficiency of the acute Dublin Hospitals Services.

2. Dublin Hospital Initiative Group - Membership

The Minister asked David Kennedy to lead this Action Group. The other members of the group were appointed for their experience in the provision of health services in Dublin.

The members of the Action Group are:

1.	Professor David Kennedy (Chairman)	Deputy Governor, Bank of Ireland
2.	Dr. Conor Burke	Consultant in Respiratory Medicine, James Connolly Memorial Hospital
3.	Professor Davis Coakley	Consultant in Geriatric Medicine, St. James's Hospital
4.	Mr. Liam Dunbar	Chief Executive, St. James's Hospital
5.	Dr. Joseph Ennis	Consultant Radiologist, Mater Misericordiae Hospital
6.	Dr. Brid Fallon	General Practitioner
7.	Professor Muiris FitzGerald	Consultant Physician, St. Vincent's Hospital
8.	Mr. Austin Groome	Chairman, Meath Hospital, former Chairman, Eastern Health Board

9.	Mr. David Hanly	Chairman, Comhairle na nOspideal
10.	Mr. Kieran Hickey	Chief Executive Officer, Eastern Health Board
11.	Dr. Gerard Hurley	Consultant Radiologist, Meath Hospital
12.	Professor Michael MacCormac	Chairman, St. Vincent's Hospital
13.	Mr. Michael McLoone	Chief Executive, Beaumont Hospital
14.	Mr. Gearoid MacGabhann	Chief Executive, Mater Misericordiae Hospital
15.	Mr. Declan Magee	Consultant Surgeon, St. Colmcille's Hospital, Loughlinstown
16.	Ms. Eileen Mansfield	Matron, Adelaide Hospital
17.	Dr. John Mason	General Practitioner
18.	Dr. Brian O'Herlihy	Director of Community Care, Eastern Health Board
19.	Mr. Desmond Rogan	Secretary/Manager Adelaide Hospital
20.	Mr. Niall Weldon	Chairman, Beaumont Hospital
21.	Dr. Leo Vella	Consultant in Accident and Emergency, Beaumont Hospital

The Secretariat to the Group consists of:

Mr. Dermot McCarthy (Secretary)

Mr. Paul Griffin

Mr. Shay McGovern

Ms. Patsy Carr

Ms. Caroline Field

3. Interim Report

The interim report of the Group was presented to the Minister in June. The recommendations fall under three main headings:

- proposals for more effective management of hospital workload (which do not require additional resources);
- proposals which have resource implications. The main recommendation is that there should be an improvement in geriatric services both within and without the acute hospital.
- critique of existing organisational structure in Dublin;

Following the presentation of the interim report the Group continued in existence to complete a number of tasks including consideration of the options for structural change and management development which are dealt with in this report.

SUMMARY

Arising from the criticisms of the existing organisational structure for delivery of health services in the Dublin region contained in the Group's Interim Report, this Report contains recommendations for new structural arrangements for the management and delivery of health care in the Dublin region.

The principal objective of these proposals is to replace the present fragmented arrangements 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.

The recommendations are based upon the creation of five area units within the region, each of which would contain a comprehensive range of primary and secondary care services which would be brought together in a coherent and integrated service responding to identified patient needs in a structured way. Detailed consideration will require to be given to the precise form of management arrangements within the area but the emphasis would be on bringing together the various services required by the population of the area. Each area would receive an annual budget within a rolling framework and would be responsible for ensuring that service objectives were met as efficiently as possible.

Within each area, local district units would be identified with approximately 25,000 population. These would be the organisation units for delivery of primary and continuing care services. With a local support team the objective would be to bring locally-based staff together, with particular emphasis on the contribution of G.P.s to identifying local needs and shaping the health care response to them.

At a regional level, the recommendation is for the creation of a mechanism for dealing with strategic planning requirements for the region as a whole and with the organisation and funding of services which serve regional/national, rather than area needs. The region would also provide appropriate support services to area management but would not be involved in operational affairs appropriate to the area. The region is also the level at which public accountability requirements would be met through an appropriately structured public body.

In the case of services provided by voluntary agencies, the basis for funding and for service development will be expressed in contracts which will specify both the service role to be fulfilled and the resources to be made available to achieve those service objectives. The autonomy of voluntary agencies within the overall framework will continue and opportunities will be created for their active participation in the shaping of health care policies at both area and regional level.

The new structures will operate effectively only if the arrangements proposed for the more effective discharge of key functions at national level are implemented. Similarly, the objectives of these proposals will be met only if the requirements

outlined in Chapter 3 - including clarity of roles, multi-annual funding arrangements and flexibility in the use of human resources - are met. In particular, the streamlining of management and administration at area, regional and national levels outlined in the Report will be required in order to secure an organisational structure where more resources can be devoted to patient needs.

Above all, the recommendations call for the new organisation, and those who lead and staff it, to demonstrate a commitment to excellence in all aspects of patient care. This will require much greater emphasis on systematic efforts to ensure quality care and the development of personnel than has been the case to date.

Chapter One

CURRENT HEALTH CARE ARRANGEMENTS IN DUBLIN - A CRITIQUE

1.1 Introduction

1.1.1 In setting out to analyse the requirements for an effective management structure for the delivery of health services in the Dublin region, the Group identified those aspects of the arrangements for the delivery of health care which currently gave rise to concern. The success of any proposed change in organisational structures must be judged in terms of improvements in these areas and above all in terms of a more effective and efficient service to patients.

1.1.2 Despite the many strengths of the health care system in Dublin, not least the tradition of excellence in medical care and of an internationally recognised concern for quality in the nursing and caring professions, there are very significant defects in the present arrangements for delivery of care which result in a less than effective use of available resources. In summarising this position, the Group in its Interim Report stated that:

> "The present structures are notable for the fragmentation of the health service, the confusion as to roles and responsibilities of the various agencies and the lack of an effective overview of the interaction of services at levels of planning or delivery. The difficulties arise from the scale of the area and population to be served, the operational autonomy of most of the acute general hospitals and many of the non-acute agencies in the city, the fact that the geographical areas which apply in the organisation of community care services do not generally co-incide with the configuration of the populations served by acute hospitals and because of relative isolation of the more than 800 general practitioners in the region from the rest of the health care system. The present structures facilitate a lack of co-ordination and provide no proper basis for resource allocation or for performance review".

1.2 Causes of Fragmentation

1.2.1 Apart from the difficulties created by the size of the area and the population to be served, fragmentation in the delivery of services in the Dublin region arises in part from factors which are a feature of the health care services nationally. One of the sources of this fragmentation is the division of services into programme categories which were introduced on the establishment of the health boards in the

beginning of the 1970s. The management of services in community care, general hospital and special hospital programmes, while linking groups of services with a common profile in terms of suppliers, has led to fragmentation in the way in which services are planned and delivered both to the population of particular areas and to specific categories of patients. The difficulties created by the programme structure have been recognised in, for example, proposals to introduce, initially on a pilot basis, geographical management structures under the health boards. Under this arrangement, all of the services being provided for the population of a particular district would be subject to the overall control of a specific management team whose responsibilities would extend to all of the services required by the population in question.

1.2.2 The most specific evidence of the fragmentation caused by the programme structure is the difficulty which can arise as individual patients or groups of patients require services which fall under different programme headings. For example, the services required by patients following discharge from hospital after an acute illness form part of a separate service programme from the services of the acute hospital. Yet it is during the period of in-patient treatment that discharge arrangements are most appropriately made. The medical, nursing, social and psychological support of many categories of patient, and their families and carers, can be met in a comprehensive fashion only if the individual professionals involved in their care overcome the barriers created by present organisational divisions. One consequence of these barriers is the difficulty in establishing priorities as between different types of service and in assessing on a systematic basis the needs of areas in the planning of the health and social services.

1.2.3 Compounding the difficulties created by organisational structures is the absence of well-defined geographical units within which services may be delivered. So, for example, at present the catchment areas of acute general hospitals are not integrated with the catchment areas used by the psychiatric services, both in-patient and out-patient, and neither are they necessarily linked to the current boundaries of the community care areas which constitute the management units for delivery of primary health care in Dublin, Kildare and Wicklow. While much work has been done to develop information on the needs of the population of areas defined for other purposes - such as electoral districts in respect of which census data are collected - the absence of generally accepted boundaries has inhibited the development of well-focussed local plans.

1.2.4 A further complication in the effective delivery of health care in the Dublin region is the lack of co-ordinating arrangements to address the consequences of the operational autonomy of many of the agencies providing services to the population. This includes many of the acute general and specialist hospitals, as well as agencies providing mental health, mental handicap and social care services. In some cases, the activities of these agencies are reflected in more or less explicit agreements with the Eastern Health Board for the provision of specific services to particular areas or client groups. In many cases, and especially in the case of acute hospitals, there is no direct contact between the Eastern Health Board and the agencies concerned at the level of operational planning. Neither is there structured communication on service matters between the various independent agencies themselves. This reflects historical factors and the present role of the Department of Health as the direct funding agency for these hospitals. As a result of these arrangements the lines of communication between secondary and tertiary care providers in the Dublin area are with the Department, rather than within the region. The accountability

relationships are characterised by an individualistic approach with little structured exchange of information or experience. There are exceptions to this, however. For example, the planning and organisation of ambulance and accident and emergency services by the Eastern Health Board involves all of the hospitals concerned. A central planning committee for mental handicap services has been established involving the major voluntary agencies as well as the Eastern Health Board. Overall, however, integration, and even communication, occurs very often as a result of individual enthusiasm rather than as a feature of the organisational arrangements for the delivery of services.

1.2.5 Two additional background factors in the pattern of services currently provided in the Dublin area are worthy of comment, particularly in the light of the need for a new integrated approach to health care delivery. Firstly, primary health care at general practitioner level is provided on a private practice basis for almost two-thirds of the Dublin population, while only a little over one-third receive primary health care from the State-provided General Medical Services (G.M.S.). This dichotomy presents considerable difficulties for co-ordinated care at present and will pose a challenge for any proposed new structures. Secondly, Dublin has an unusually large number of isolated small specialist hospitals and, in addition, has inherited a tradition of stand-alone maternity and paediatric hospitals. Thus, even at institutional level this is an unusually large degree of fragmentation of specialised services, on separate geographic sites. To compound matters further, there is a striking concentration of the majority of these specialised hospitals in the centre and south-city area. This pattern of specialist institutional care being provided on many disparate sites separate from general hospitals, together with the unusual degree of geographic clustering adverted to, presents a formidable problem now and in the future for an even distribution of co-ordinated services.

1.3 Uncertainty as to roles

1.3.1 The net result of these organisational factors is a sense of confusion as to the specific roles and responsibilities of many of the agencies responsible for delivering services in the region. With some exceptions regarding tertiary services, there is, for example, little explicit agreement about the type and volume of services to be provided by acute hospitals in the Dublin region. While their specialty profile is generally settled and the consultant establishment reviewed periodically as posts fall to be approved for filling by Comhairle na nOspideal, the overall service role of these hospitals is not stated explicitly or systematically reviewed. In parallel with this underlying uncertainty, there is a lack of clear targets for delivery of services to particular populations or client groups. This absence of targets is not confined to independent, voluntary agencies but is also a feature of the operational characteristics of public health agencies. This absence of a statement of role and specific targets, other than those generated internally by the agency or institution itself, and the absence of a framework within which links between each agency and the complementary health and social services can be developed and reviewed makes for a less than effective overall health care system.

1.3.2 One consequence of the absence of detailed targets for service delivery is the difficulty of reviewing performance to determine whether the quality and quantity of service is appropriate. While the Department sets budgets for individual hospitals in a way which takes into account their needs and performance, there is no explicit formula for identifying priority needs within the region as a whole. The absence of

appropriate performance indicators means that funding is largely a matter of judgement and perception, with funding for acute hospital services largely divorced from the allocation of resources to other health services in the region.

1.4 Underdevelopment of Management and Planning Skills at all levels of the Service

1.4.1 Again, this is not unique to the Dublin region. However, the present confusion of planning, evaluation, management and funding which has arisen as between the Department of Health, the Eastern Health Board and individual autonomous agencies has tended to weaken the incentive for these organisations to develop specialist expertise in the appropriate disciplines. In particular, the skills required to evaluate the overall needs of the population and the impact, at the margin, of allocating resources are not well-developed. The provision of leadership in the health system of the region, in terms of animating all of the various elements with a common vision and a sense of shared mission, has also been inhibited by the structural arrangements.

1.4.2. While the problems outlined above relate to the arrangements at an agency or institutional level, they have implications for the internal effectiveness of agencies. If the overall role of a service is ill-defined in terms of its links to the rest of the health care system, it is more difficult to structure the employment of professional and other staff in such a way as to maximise their effectiveness. If the role of a hospital or other agency is clearly stated in, for example, a contract with its funding authority, it is easier to draw up employment contracts for individuals or groups of staff in such a way as to emphasise their responsibilities - and contribution - in terms of the health care system as a whole.

Chapter Two

DESIRABLE CHARACTERISTICS OF NEW STRUCTURE

2.1 Introduction

2.1.1. In its Interim Report to the Minister, the Group stated that its approach to the question of future organisational arrangements for the management and delivery of services in the Dublin region would be informed by the following principles:-

- the planning of services should be based on an assessment of the overall health needs of identified communities;
- the allocation of resources to the different types and levels of care should take explicit account of their interaction and substitutability;
- the respective roles of the various institutions and services in regard to categories of need and groups of patients should be clearly understood;
- good communication links based on these mutually agreed roles must operate on a systematic basis;
- a role for clinicians to contribute to the planning and management process should be defined;
- adequate information on patterns of demand, utilisation and cost must be available to guide decision-taking;
- structured arrangements to review overall performance and the contribution of each element must apply;
- appropriate account must be taken of the demand made on services in Dublin by patients from outside the Dublin area.

2.2 Basis for alternative structures

2.2.1. In devising new structural arrangements for the Dublin region, the Group are of the view that the objective should be to secure an arrangement for the delivery of services which is:-

(a) **integrated,** with the organisation of services reflecting the needs of

individual patients and the population of the areas in question, rather than any arbitrary functional boundaries;

(b) **comprehensive,** with all of the services capable of being supported by a given population being provided locally to that population; and

(c) **efficient,** with patients' needs being dealt with at the most accessible and appropriate level of the health care system, that is, at the lowest practicable level of complexity and cost.

2.2.2. The Committee was clearly mindful that any proposals for restructuring, based on these principles, would necessarily be of a radical and fundamental nature, would require careful design and would involve surmounting considerable obstacles inherent in the currently fragmented and unevenly distributed services. Some members were of the opinion that such formidable difficulties should prompt a more gradualist reform based on a series of modifications of the existing structures. However, the Committee, as a whole, was of the view that the objectives set out above could not be attained in a comprehensive manner unless there was a major formal restructuring of the entire range of health services in Dublin.

2.2.3. This approach points to the need to move away from the existing organisational divisions between primary, secondary and continuing care services. It also points to the need for an integrated planning and management system to replace the fragmented arrangements in the Dublin area. The appropriate basis for providing an integrated, comprehensive and efficient service is the development of areas whose population are sufficiently large to sustain a comprehensive range of services, yet which are sufficiently compact to enable services to operate flexibly and efficiently on a sound basis of knowledge of local needs and priorities.

2.2.4. This approach would accord with the recommendations of the World Health Organisation regarding the rational development of health policy on the basis of primary health care. The WHO has advocated the development of a district health system, with characteristics similar to the criteria outlined above:-

> "A district health system based on Primary Health Care is a more or less self-contained segment of the national health system. It comprises first and foremost a well defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well co-ordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities".
>
> [Source: "The Challenge of Implementation. District Health Systems for Primary Health Care. WHO]

2.2.5 From a review of practice with regard to the organisation of the delivery of service in other countries and from a review of the planning norms which have applied to the development of services in the Irish context, the Group considers that an area containing a population of approximately 250,000 would represent the necessary basis for the development of a health care system based on the principles set out above. In 1986, the Census of Population recorded a population of 1.23 million within the area of the Eastern Health Board (including 116,000 in Kildare and 95,000 in Wicklow). On this basis there would be 5 areas in the present EHB region meeting the criteria set out above. Each area would contain a comprehensive range of services appropriate to the level of population. Some planning norms already exist as to the level of service to be provided in these areas (as in **Planning for the Future** in respect of psychiatric services, and **The Years Ahead** in respect of services for the elderly).

2.2.6 While the area level is the appropriate one for planning and integration of services, especially for the management of secondary and tertiary services, many services can most effectively be managed at a more local level. In particular, primary care services and continuing care services, including the psychiatric service, can most effectively be managed at the level of local districts containing 20-25,000 population. Such units or districts afford the opportunity to develop effective working relationships between complementary services, to create teams of staff whose experience and knowledge can be shared, to focus on specific targets for service delivery based on detailed knowledge of local needs and priorities and to involve local communities in the identification of priorities and in the promotion of their own health. The co-ordination of services at this level has been recommended in relation to psychiatric services and services for the elderly in particular. Within each such district, local neighbourhoods would be recognised in arrangements for the delivery of services with the overall objective of ensuring that services are as accessible as possible and linked to the arrangements for delivery of other relevant services to recognisable communities.

2.3 Management at Area Level

2.3.1 The operation of the new structural arrangements should maximise the degree of flexibility and autonomy afforded to those responsible for the delivery of services. In effect the "subsidiarity principle" would apply, with decision-taking being left to the lowest practicable level of management. This would be compatible with a general strategy of devolving responsibility for budget-holding to staff involved in the delivery of services. In particular, it would result in each institution or agency or unit having maximum flexibility to organise its affairs and its resources to achieve the objectives set for it within the context of the overall policy determined by the Department at national level. The service role of each agency or unit would be agreed, with, to the greatest extent possible, quantified measures of output to be achieved for the stated level of resource allocated to it. While the Group recognises that there may be a necessity to comply with central guidelines in relation to eligibility, charges, staff conditions and information requirements the management arrangements should reinforce initiative and flexibility. It follows that the role of management at the area level would be to ensure that individual districts and agencies deliver services in accordance with their agreed roles and that the health needs of the population of the area are systematically identified, prioritised and addressed. Area level management would not therefore be involved in the operational management of individual agencies and districts.

2.3.2 To achieve maximum efficiency, it is desirable that the area management be in a position to direct resources and priorities in accordance with the overall needs of the population. They should also be in a position to intervene to ensure that services which are not complying with their ascribed role or meeting their service commitments are required to do so at the earliest opportunity. This requires, ideally, an accountability relationship between the management of the individual districts and units and the area management in respect of predetermined levels and standards of service. It would also be desirable that the scope of responsibility of staff within the area should be capable of being redefined to respond to developments in the pattern of needs or priorities for the delivery of services. For example, in particular settings, it may be desirable to give a co-ordinating responsibility for services required by client groups and provided by a variety of agencies to appropriate personnel located in a particular agency, e.g. in respect of services for the elderly. For such co-ordinating arrangements to be effective, it is desirable that appropriate accountability arrangements apply, through their employing agency, to all staff delivering services to the population of the area.

2.3.3 The management structure and accountability arrangements need to combine elements of executive efficiency and appropriate public accountability. Detailed consideration needs to be given to devising structures and procedures to achieve these aims, and in particular to secure effective working relationships with the various professional groups delivering services to patients. Our proposals in this regard are set out in Chapter 4. It would be the primary responsibility of the area management structure to ensure that the services within the area complied with the targets set for them and that the needs of the area were fully reflected in the planning carried out for the region.

2.4 The Regional Dimension

2.4.1 Above the area level, there is a need for an overall framework within which the services delivered at area and district level can be managed. The primary functions to be discharged would relate to the allocation of funds to the areas and to services and institutions servicing a regional or national, rather than an area, need, (including the public health needs of the city and the region as a whole). Prioritisation of service demands from the areas would also be required within the context of national guidelines. Support services in respect of which economies of scale arise could also be located within a central services unit at regional level. This could cover the overall functions relating to finance, personnel, information technology and supplies. The arrangements made in relation to such services should not detract from the prime responsibility and autonomy of operational management but should ensure that all possible opportunities for greater efficiency are exploited. There is also a compelling case for developing a centre of expertise in relation to epidemiology and health care planning in respect of the needs of the region as a whole.

2.4.2 The Group recognises that many of the policy issues which will require to be determined in respect of the region will be of significance nationally. This reflects in particular, the important services provided by the Dublin acute hospitals to other regions and to the country as a whole. In addition to determining the supra-regional role of services in the Dublin area, it will be necessary for decisions to be taken nationally on issues such as the allocation of the health capital programme, the location of national centres for developing specialties and the manpower and

training policies which influence very significantly the way in which services must be organised and managed within the regions. Many of these issues are currently dealt with on a fragmented basis at national level by the Department of Health, Comhairle na nOspideal, the Postgraduate Medical and Dental Board and other bodies. If an integrated service is to be managed and delivered efficiently at the area level, appropriate arrangements must be made for these issues to be dealt with at national level in a structured way which reflects the needs and priorities of the Dublin region, as well as the position of other services around the country.

2.4.3 Analysis of these issues lead the Group to examine aspects of the organisation and management of the health service nationally. While these issues go beyond the scope of our remit, the Group did consider the case for assigning the co-ordinating and support functions required above the level of the area to an appropriate mechanism at national level, whether within the Department or in a new executive office. This would be consistent with the relationship required between national policy-makers and the health services outside the Dublin region. The seven health boards besides the Eastern have populations close to or less than that of the five areas which can be identified within the Dublin region. If such an approach were taken there might not be a regional element to the organisational structure, other than such co-operative arrangements as the five free-standing area units might establish.

2.4.4 On balance, the Group is of the view that a specific need exists to provide a regional focus for the Dublin area so as to ensure that:

- region-wide issues are addressed in a coherent fashion, e.g. public health and health education programmes;
- co-ordination with other services and agencies with an impact on health and health care can be effective;
- all possible economies of scale, in support functions and otherwise, are realised without the bureaucratisation which their provision at national level could entail;
- public accountability and strategic policy needs are most appropriately met.

Without such a regional focus, there is considerable risk that management and planning would become even more centralised than at present, the very antithesis of the objectives of the Group in proposing the development of strong, integrated area units for delivery of care.

2.4.5 Some members of the Group are satisfied that the effectiveness of the arrangements proposed for the organisation of services in the Dublin area will be secured only if there is a new approach to decision making at national level. They would see the regional element of our recommendations as an interim measure pending a more comprehensive overhaul of the structure nationally. This is an issue which may be more satisfactorily determined when experience is gained of the operation of the structures proposed in this Report.

2.5. Accountability of Management

2.5.1 If the potential created by new structures is to be realised, the authority of management to take necessary decisions should be clear-cut under any new arrangements. Management should, of course, then be accountable for those decisions. This accountability would lie in two directions: first, to the Minister and

the Department of Health, or any new national executive structure, in respect of compliance with national policies and guidelines in relation to finance and service needs, either as expressed in legislation or in respect of specific plans agreed on a rolling basis with the region. Secondly, it is necessary that there be an appropriate regional public body discharging functions in respect of representation of the public interest and of the wishes and priorities of consumers. Such a body would reasonably comprise public representatives from the local authorities within the region and representatives of community or consumer groups. It is not clear that the contribution of professional interests to policy and decision-taking is most effectively made within such a forum and the Group considers that a more effective means must be found for that purpose.

2.5.2 It would be desirable that, just as the functions of CEO's of health boards are currently specified in legislation, the roles and responsibilities of management as distinct from this public body would also be made clear on a statutory basis. The public body's functions would extend to overseeing and evaluating the delivery of services, making recommendations on priority needs to be addressed and to ensuring that the consumer view of services at individual and community level was properly reflected in decision-taking by management.

2.6 Summary

2.6.1 The characteristics of our conclusions regarding structural arrangements include:

(a) integration in the delivery of services to the population of an appropriate catchment area;
(b) a continuation of the voluntary agencies within the framework of integrated planning and management;
(c) the location of management and other functions at an appropriate level to maximise efficiency and minimise the risk of bureaucratic overload;
(d) the location of strategic management functions within the region, with the Department of Health ceasing to have direct operational involvement in the management of services in Dublin.

Chapter Three

REQUIREMENTS FOR EFFECTIVE OPERATION OF NEW STRUCTURES

3.1 Viable Unit Size

3.1.1 If guiding principles outlined in the previous Chapter are to be effective in producing a comprehensive, integrated and efficient health care system for the region, a number of essential conditions will have to be met. The **first** is that the size and population of each element of the proposed structures is appropriate. In particular, it is necessary that the area units, in order to be viable in delivering a comprehensive range of primary and secondary care services, should serve populations of approximately 250,000.

3.2 Clarity of Roles

3.2.1 The **second** requirement is that the role of each element of the new structure, including each level of management is clear. The objective should be to structure the decision-taking process so that the ratio of administrative and support personnel to those engaged in the delivery of services to patients is not increased. At present, approximately 11% of the staff of the health services are employed in management, administrative and clerical grades, the vast majority of whom are engaged in direct delivery of service to patients. About 2% of the staff of health boards are employed on central management duties. The streamlining of administration in an integrated structure should ensure that the necessary management and administration can be made more effective within existing staffing levels. It would also be necessary to ensure that as few levels of management as possible are involved in decision-making.

3.2.2 It is of critical importance that there should be no overlap or duplication in the functions of the management arrangements of area and regional levels. We envisage that these elements will operate on the basis of distinct but complementary functions. We would not envisage regional management being involved in the operational aspects of primary and secondary care. For tertiary and other regional services we would envisage the regional and appropriate area managements acting in unison to ensure prompt attention to areas of difficulty which may arise.

3.3 National Policy-Making

3.3.1 We consider that the Department should disengage from direct, operational involvement in the management of services in the Dublin area. It has been drawn

into such activity as a result of the arrangements for direct funding of the acute hospitals in the area by the Department. Because of the extent of that involvement, it has been commented, for example by the Commission on Health Funding, that the Department's role in the areas of national planning, specification of service targets and evaluation of needs and performance has not developed to an appropriate degree. By concentrating on its role at the national level in support of the Minister, including national strategies in relation to particular target groups, analysis of emerging patterns of illness and international liaison, the Department will be in a position to provide an overall strategic direction to the services in the Dublin region as well as nationally. We envisage that staff of the Department currently engaged directly in detailed aspects of services would be freed by this change in the Department's role to participate in the new structure and that the Department, reduced in size as a result, would develop its role in the key national policy areas outlined above. We have in the previous Chapter identified a range of specific tasks which will continue to require to be performed at national level and which will be of profound significance for the shape of the services in the Dublin region as well as throughout the country. Whether these tasks are performed within the Department or within a new national management structure, we are strongly of the view that these functions should be organised in a coherent way, removing fragmentation at the centre just as our proposals are designed to streamline decision-making within the region. We envisage that the Department or any new national structure which may be created (which must reflect the functions currently discharged by Comhairle na nOspideal) would also engage in a structured discussion with the region, in the context of a rolling three to five year plan, the targets and resources for which would be agreed with the Department.

3.4 Rolling Budgets

3.4.1 A **fourth** requirement for effective functioning of the proposed arrangements would be for the financial parameters within which new structures will operate to be clear and realistic. In particular, it is clear that the inefficiencies created by the present system of discrete annual budgets are reducing the scope for planned change and efficiency in the system. Accordingly, we consider that it is important that rolling budgets be established which, subject to annual adjustments in the light of short-term pressures, provide a reasonably stable basis upon which funding agencies and supplying agencies can plan. This is even more important in the case of capital funding, where the presence of planned programmes for replacement of equipment and maintenance of premises are of vital importance for the efficient delivery of service. We recognise that the annual budgetary cycle is a feature of all Government business but we believe that, in respect of the core funding requirements of agencies, a rolling budget linked to a parallel planning framework would greatly enhance the effectiveness of our proposed management arrangements. This budgetary framework should be linked to arrangements discussed below to provide incentives for agencies and individual professionals to achieve better value for money in the delivery of service through retention of at least a sizeable proportion of efficiency gains.

3.5 The Voluntary Sector

3.5.1 The **fifth** requirement for success is that the very important tradition of a major contribution to health care by the voluntary sector be maintained and

developed. In addition to the rich heritage which has been created by the varying organisations and the philosophies reflected in these bodies, the continuation of diversity in pursuit of excellence in health care would be a valuable contribution to the quality of care over the decades ahead. The voluntary hospitals, and the many voluntary bodies providing a wide range of health and social services, should be enabled to contribute to the shaping of health care in their areas and in the region as a whole. They must also, through effective management and funding arrangements, be helped to make the most effective possible contribution to patients' needs as an integral part of a coherent range of services, while retaining their distinctive character and internal autonomy.

3.6 Incentives for Efficiency

3.6.1 The **sixth** requirement for effective operation of the new structural arrangements for the Dublin region is the provision of positive incentives to harness the initiative and creativity of individuals and institutions in securing better use of the resources placed at their disposal. In particular, those individuals and units which demonstrate the capacity to achieve economies without sacrificing quality or effectiveness should be seen to benefit from their achievement through retaining a sufficiently large share of the resources thus made available for re-deployment. These incentive systems should apply within institutions and agencies as well as between them. The present practice of penalising, through clawing back of savings made, those who achieve economies is clearly counter-productive.

3.7 Participation in Decision-Making

3.7.1 The **seventh** requirement is that those with responsibility for the delivery of services to patients should have every opportunity to contribute to the shaping of policy and have effective control over, as well as accountability for, the resources placed at their disposal. The focus for this effort must be within existing agencies and services as much as in any new structures which may be created. We recognise that medical personnel play a unique role in determining the level and deployment of resources devoted to the various aspects of patient care. It is therefore of particular importance that arrangements be developed to reflect appropriately their contribution to the management of resources. The management process must be an inclusive one, drawing on the knowledge and expertise of all those involved in care of patients. We recognise that many alternative approaches may be appropriate in different settings if this objective is to be realised.

3.8 Flexible Deployment of Staff and Expertise

3.8.1 An **eighth** requirement for effective functioning of any new structure would be to make maximum use of the experience, skills and capacity of all of those engaged in the delivery of service, irrespective of their current status or employer. Within the present range of services in the Dublin region, there are many skilled and dedicated professionals, from all the health and management disciplines, who have the potential to energise the new organisational structure. Success will be achieved only if these individuals are identified, supported and enabled to perform to the maximum of their potential. At district, area and regional level, co-ordinating and management tasks will need to be performed which will straddle the boundaries

which currently fragment the delivery of services. The job description and the present contractual arrangements of those in a position to bridge these gaps must be capable of being amended appropriately and the needs of the patients to be served must be paramount in ascribing new roles and functions to these personnel. This will also be necessary if the management and co-ordinating functions are not to involve an increase in the numbers engaged in administration.

3.9 Funding of Tertiary Services

3.9.1 A **ninth** requirement for successful functioning of new arrangements will be to ensure that resources are allocated in such a way as to distinguish between the secondary and tertiary functions performed by hospitals in the region. The integrated management of services at area level should reflect the secondary care role of these institutions. However, a strategic view will need to be taken of tertiary services, both regional and national. Appropriate funding mechanisms must be found for these activities and the traditional method of encouraging innovation and the development of expertise must be developed also, through ensuring that individuals and agencies have incentives to keep abreast of development in their specialties internationally and to provide the highest quality service to patients in the region and nationally.

3.10 Commitment to Quality

3.10.1 A **tenth** requirement is for the new structure to be based on and animated by a comprehensive search for excellence in all facets of patient care. Unless those who lead, manage and staff it, demonstrate a real commitment to a quality service to patients this will not be achieved. This will require development of effective ways of tapping the enthusiasm of all staff and of recognising and rewarding excellence in their service to patients. The development of appropriate measures of performance and quality, of quality assurance programmes, of opportunities for feedback from both staff and patients and for identification of acceptable standards of service delivery must therefore be of the highest priority in the development of new structures and new management arrangements.

3.11 Training and Research

3.11.1 The arrangements made for delivery of service are also of crucial significance to the organisation of medical teaching and research. The role of the health services in these areas is not confined to the teaching hospitals but applies to all aspects of the service. An appropriate emphasis on these functions is not only an investment in the future of the health care system but is also an important stimulus to quality and effectiveness. It is therefore necessary to ensure that, in any new arrangements responsibility is clearly assigned to secure an appropriate balance between service, teaching and research functions and to ensure that they are discharged at an acceptable level of quality.

3.12 Development and Training

3.12.1 **Finally,** an organisation structure is as good or as bad as the quality of the

people who operate it. We have already referred to the need to ensure that key posts in the new structure are filled by the best people available and that all staff are encouraged to contribute to the greatest extent possible in the development of services for patients. The quality of the personnel available to fill health care management posts and the extent to which staff do, in fact, contribute to ensuring a quality service is only partly a function of innate ability or interest. Much more is it a reflection of an effective commitment to developing the human resource available to the health care system. Training and development policies for all categories of staff, but especially for those expected to discharge key management functions, must therefore be put in place immediately.

Chapter Four

CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

4.1.1 Having regard to the requirements for effective management and delivery of services in the Dublin region, the Group has reached a set of conclusions which we consider are most likely to achieve in operational terms the objectives outlined earlier. **We make these recommendations on the basis that all of the requirements for their effective operation outlined in Chapter 3 must be met.** These recommendations are also made on the basis that the existing staff involved in the delivery of services, whatever their current employing agency, will be afforded an opportunity to play as full a role as possible in the operation of the new structure, without increases in the staff assigned to administrative duties or in staff numbers overall.

4.1.2. The recommendations contained in this Chapter are based on the experience of members of the Group in the delivery of services. We did not have the time or expertise to pursue in detail many aspects of the new structures and working arrangements which will require detailed examination and specification before the proposals we have made could be implemented. We have seen it as our role to outline the general features of a desirable new arrangement and the principles which should guide it, rather than to produce a detailed blueprint. In particular, we have attempted to spell out the practical implications of our central conclusions: namely, that services should be delivered on an integrated basis within defined geographical areas and that the major contribution of voluntary agencies to health care in the region should be maintained and developed.

4.2 Implications of Size of Areas

4.2.1 The population basis required for viable area units is approximately 250,000 and this points to five areas within the region. Planning for services since the Fitzgerald Report has been based on the idea of six major general hospitals serving the Dublin region. In the case of one of these, the J.C.M.H., its catchment area extends to South Meath with approximately 13,000 people from that area being added to those resident within the E.H.B. region. The populations currently identified with the catchment area of each hospital are as follows:

Beaumont	206,300
J.C.M.H.	121,000
Mater	183,000
St James's	240,000
Tallaght	262,000
St Vincent's	247,000

4.2.2 **The Group are of the view that effective and efficient use of resources and a sufficiently uniform strength of management units within the region point to the desirability of having 5 areas** operate for the planning and delivery of comprehensive health care. One of these areas would incorporate the catchment areas of both the Mater and J.C.M.H. North Dublin would thus have two areas (the second incorporating Beaumont's catchment area) and the South Dublin/Kildare/Wicklow area 3 areas (incorporating the catchment areas of St Vincent's, St. Michael's and St. Colmcille's; Tallaght and Naas; and St. James's respectively). For illustrative purposes, Figure 1 (Appendix 1, page 62) shows a possible configuration for the boundaries of the proposed areas. The population and number of districts contained in each area would be as follows:

AREA	POPULATION	NO. OF DISTRICTS
NORTH EAST	242,501	8
NORTH WEST	254,767	9
SOUTH EAST	248,974	9
MID SOUTH	239,691	9
SOUTH WEST	246,755	9
REGION	1,232,238	44

4.3 Integration within Areas

4.3.1 **The primary objective of management of services at the area level is to achieve the maximum degree of integration between the primary, secondary and continuing care needs of the population.** While we do not suggest that there should be a prohibition on the use by patients of services outside their catchment area, we do consider that the emphasis in building up services should be on ensuring that there is no need for patients to travel outside the catchment area for the relevant range of services and that they, and their referring doctors, will not consider it necessary to do so. The principal tasks for management at the area level will therefore be to ensure that there is an overall assessment of needs for the population, that these are reflected in an area plan, which incorporates

provision for teaching and research activities, and that individual services within the area are resourced to fulfill their role in responding to needs. It is clearly desirable that, to the greatest extent possible, a consensus should exist between the various elements of the area health care system as to priority needs and the relative responsibilities of each element of the service. If consensus is not possible, decisions and plans must be formulated on the basis of a comprehensive consultation process to which all services can contribute.

4.4 Area Management Structure

4.4.1 We recognise that a variety of management arrangements could be identified with the objective of facilitating integration in the delivery of services at area level. The Group does not wish to rule out any particular arrangement but considers that the desired objectives are most likely to be achieved through the appointment of an area Chief Executive Officer who would be accountable for achievement of an effective and integrated service within overall service guidelines and available resources. The success of area C.E.O.'s in this regard will depend on their ability to develop effective working relationships with the key providers of service in the area, at both institutional and professional levels. While we do not wish to be prescriptive in this regard, we see merit in the concept of a management board for the area which would incorporate members drawn from the major hospitals in the area as well as from the other service categories, including general practice, mental health and mental handicap services. The Area Chief Executive Officer supported by his/her management board, would have responsibility for devising effective protocols to ensure co-ordinated planning and delivery of services, for ensuring that health agencies and services within the area implement these arrangements, for preparing needs assessments and development plans for the area and for deciding on the allocation of resources to the various services within the area within the overall framework established by the region. The Area C.E.O. would ensure that operational arrangements apply to give effect to the policy and plans and that the budget for services for the area was spent in accordance with agreed plans and priorities.

4.4.2 One of the key responsibilities of the area management board would be to ensure that the views of consumers of services in the area are fully reflected in the organisation and delivery of services. This would include views on the health and social needs of the area and its local districts and also feedback on the services from those who use them. This will require the development of systematic arrangements for ascertaining consumer opinion.

4.4.3 The area management arrangements should take full account of the existing management infrastructure within the area and the various agencies and institutions within it. The management board at area level must not seek to involve itself in tasks which can effectively be done within the local districts or independent agencies. However, we believe that there is considerable scope for realising efficiency gains by grouping functions which benefit from economies of scale. These support services, which include payroll, personnel, information technology and supplies, can be grouped at the area level or, if appropriate, at a more centralised level within the region.

4.4.4 **The effectiveness of management arrangements at the area level will be the key to the success of the structures which we propose.** The area level

will be the point of contact for all of the services and agencies located within its boundaries. The area management board will be able to draw on the support of the region and will reflect regional priorities and region-wide services in its funding decisions but funding and operational issues will be dealt with at the area level, which we envisage will be competent to deal with all operational issues which may arise.

4.5 Local Districts

4.5.1 **The basic unit for delivery of primary health care should be the local district.** Within each district, we envisage that a full range of primary care and continuing care services will be available. The re-orientation of staff towards the district should produce opportunities for greater integration of all of the community and continuing care services, including general practitioners, public health nurses, community psychiatric staff and those providing rehabilitation and day care services, including voluntary community organisations. We envisage that appropriate existing staff would, in line with recommendations already published by various review groups, be designated as co-ordinators of services for high priority target groups, such as the elderly and the mentally ill. The basic infrastructure for the provision of these services would be available from a local support team based in an appropriate setting, such as a health centre, community hospital or residential facility. We recognise that creating uniform geographical districts, though an important step in promoting effective primary care, will not of itself achieve the benefits of co-ordination and joint planning. Considerable attention will have to be given to devising and implementing the detailed organisational and working arrangements which will enable the potential benefits to be realised.

4.6 Contribution of G.P.s

4.6.1 The successful delivery of locally accessible and integrated care will require the full and active participation of general practitioners. We are aware that, at present, general practice is relatively isolated from the rest of the health care system. Acknowledging that the State is responsible for the general practice needs of less than 40% of the population, we nevertheless consider that investment in the infrastructure of general practice is of critical importance for the effective integration of health care delivery. We therefore recommend that, to the greatest extent possible, G.P.'s within each district should have ready access to all of the community support services which they require for the efficient and effective care of their patients. They should be actively encouraged to participate in identification of local needs and planning services in response to them. The G.P.'s in each district should, in turn, have a close involvement with and be supported by the general hospitals within their area through access to diagnostic facilities and through active efforts to build communication and liaison. In this way, G.P.'s will be encouraged to avail themselves of services within the area, rather than looking to services outside their own catchment area. Equally, the orientation of all services within the district will be improved through the unique knowledge of local needs possessed by G.P.'s. The creation of these new arrangements at district level will provide a framework within which the contribution of G.P.'s to the overall health needs of the population can develop and be reviewed on a systematic basis, thus helping to end the relative isolation of G.P.'s from the rest of the health care system. The most effective means of achieving these objectives can be explored in the pilot phase proposed below.

4.7 Identification of Districts

4.7.1 To devise a district unit for management of community and other non-acute services within the areas, we have already identified a population of 20,000/25,000 as desirable. To the greatest extent possible, the boundaries of District Electoral Divisions (D.E.D.s) should be used in establishing districts, since such boundaries respect local authority boundaries and statistical information is available for the population of these units as a basis for planning and evaluation. Using that principle and the desirability of respecting neighbourhoods and natural boundaries to the greatest extent possible, one can identify 44 sectors which meet the criteria set out above. This listing seems an appropriate basis for planning at this point. The districts in question are identified in the Appendix on Figure 2 in respect of Dublin and Figure 3 in respect of Kildare and Wicklow. The population of each is outlined on Table 1.

4.8 Regional Level Structures

4.8.1 Under our proposals the Eastern Health Board as presently constituted, would cease to exist and each area, with its local districts, would be self-contained regarding primary and secondary care services. However, the needs of the region will require strategic planning and the delivery of services catering for the population of the region as a whole. Furthermore, there are support functions which, because of economies of scale, may most effectively be organised at a regional level.

4.8.2 We recognise that creating a mechanism to deal with these region-wide issues could be perceived as adding an extra, and unnecessary tier to the management of the services. However, we believe that there are compelling reasons to provide a regional focus for the discharge of these functions. We have reached this conclusion on the basis that the roles of region and area managements would be distinct and that service providers would not be faced with a bureaucratic process of decision-taking within an unwieldy administrative hierarchy. We envisage that service issues involving primary, secondary and continuing care will be dealt with within the area. The regional input to service issues apart from setting strategic and budgetary guidelines, will be confined to specifically regional and national services, in which case the region would function as one unit with the relevant area management in the interest of flexible and accessible decision taking.

4.8.3 **We consider that specifically regional needs should be met by a unit which would function in respect of Dublin, Kildare and Wicklow** (although further consideration should be given to the question of incorporating South Meath into this structure). We believe that it is at this regional level that contracts should be negotiated and monitored in respect of services which serve a role in relation to the region rather than the area. This will require settling budgets with area management boards and their hospitals in respect of tertiary and other services which transcend the requirements of the individual areas. We envisage that the regional unit would have no involvement in the day-to-day management of service, which are most appropriately dealt with at area level. The objectives of management at the regional level would be to provide a strategic framework within which individual services are conducted and to allocate budgets to the areas and to the specialist services in accordance with agreed plans and priorities. The regional unit would also provide support services in areas where expertise and economies of scale

point to the benefits of a degree of centralisation. In many respects, the regional unit would operate on a basis analogous to a holding company in a commercial setting, where operating companies are supported in their various areas of activity without detailed supervision of their day-to-day activities.

4.9 Regional Management Arrangements

4.9.1 We envisage that the regional unit would take on aspects of functions currently carried out by the Department of Health in respect of the Dublin region, of the Eastern Health Board, which would cease to exist in its present form under these proposals, and, to some degree, of support functions currently carried out within individual agencies. We do not, therefore, envisage that there would be an increase in the numbers engaged in management or administration but rather a pulling together of existing staff in the interest of greater effectiveness. We do not wish to specify detailed management arrangements for the regional unit but their development should be geared to create a forum within which innovation can be stimulated and good practice identified, supported and extended while maintaining responsibility for service delivery within the areas. The Area C.E.O. would have a reporting relationship to a regional C.E.O., but we envisage that this accountability relationship would be expressed in terms of systematic review of performance and outcome rather than detailed supervision of operational tasks.

4.9.2 If the structures which we now recommend are to function effectively, the senior management positions at area and regional level will require to be filled by managers of the highest calibre. We recognise that there are difficulties in attracting and retaining appropriately qualified and effective staff to management positions in the health services. Suitable remuneration packages, which may require to be associated with fixed-term contracts, must be offered to ensure that these positions are filled appropriately.

4.9.3 The contribution of the regional structure to the achievement of the objectives of the new structure will be to support the area units while addressing:

- the need to provide specifically regional services, serving more than one area (e.g. regional specialties, public health policies and ambulance services);
- the need to allocate and manage resources on an equitable basis within the region;
- the need for flexibility in mobilising resources across area boundaries to deal with particular problems or to make best use of resources;
- the need to monitor and evaluate comparative performance of agencies with comparable service profiles and activity levels;
- the need to secure economies in the provision of support services e.g. legal services.

4.10 Accountability Provisions

4.10.1 The structures which we have outlined and, especially, the specific working relationships which will have to be developed if they are to operate in the manner we have proposed, will require considerable further consideration. Once final decisions have been taken on the precise structures to be put in place after an

appropriate period of further analysis and piloting, there may be a need to amend existing legislation governing the health care system to enable these structures to operate. Such amendments could relate to the status of the area and regional units and the roles and responsibilities of the C.E.O.'s at area and regional levels. It is beyond our remit to determine whether and if so, in what direction, such amendments might be necessary.

4.10.2 Role of Regional Board

Whatever the precise structural arrangements, there must be clear provision for the discharge of public accountability functions. We are convinced that it is necessary that the public accountability which properly attaches to bodies disbursing public money should be properly conceived. We do not consider that the detailed management of service delivery, including the overseeing of contracts for the delivery of services, should be the subject of examination by the policy board. Rather, we see the most valuable functions to be performed by such a board to be the determination of service objectives and priorities within national guidelines and the representation of community views to be reflected in the policy making process. We see these objectives being met most effectively at regional level through an appropriate public board. We consider that the board should comprise representatives of the elected members of local authorities in the region, of the agencies with a tradition of independent, voluntary service in the health care sector and of the professional groups involved. We consider that the overall composition should be redesigned for the Dublin region to reflect the unique characteristics of service provision there. Some of our members, however, would see merit in public accountability being met by the participation of elected public representatives in decision making at area level and on the boards of the various agencies providing services within the region.

4.11 Professional Input to Policy

4.11.1 We believe that these arrangements will be most effective if the professional expertise of those involved in delivering services is reflected fully in the policy-making process. This is most effectively done within the agencies and sectors where services are being delivered. We would hope that an increasing number of people with a background in service delivery will wish to fill management posts in the future. However, we recognise the need to ensure that decision-makers have a broad-ranging source of advice on issues which transcend the needs of any one agency. We therefore see the necessity for the establishment of structured arrangements to consult with and actively involve the professional delivering services, especially medical personnel from the acute clinical, primary care and public health streams, in shaping policy at both area and regional levels. We envisage the creation of these arrangements as being priority issues for the respective C.E.O's.

4.12 Clarifying Management Responsibilities

4.12.1 In order to ensure that the proposed mechanism works appropriately, we recommend that the functions of management, and in particular of the C.E.O.s at regional and area level, should be clarified. They should include functions which are currently the statutory responsibility of health board C.E.O.s, but should also extend

to executive functions which are, in practice, generally delegated by health boards to their C.E.O. at present. This would include authority to determine staffing levels within budgetary constraints and necessary national guidelines. Management performance should be reviewed by the board in terms of outcome, rather than for the board to involve itself in detailed operational matters.

4.13 Implications for Voluntary Agencies

4.13.1 Many of the services provided to eligible persons in the Dublin region, including acute general hospital services, are provided by voluntary bodies which are legally independent. In the case of voluntary hospitals, their funding and policy relationship has been with the Department of Health rather than with the Eastern Health Board. However, legally, the basis for their activity and funding is as agents on behalf of the health boards, including the E.H.B. **We have developed our recommendations in the conviction that the independence and operational autonomy of the voluntary agencies should continue as a valuable feature of health care in the region**

4.13.2 We believe 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. Such contracts should contain sufficient information flows and mutually agreed and satisfactory accountability arrangements for the paying authority to have effective oversight of the services being provided. Operational autonomy and independence within budgets and contract terms would thus be possible.

4.13.3 It would also be necessary to ensure that the management of the contracting agencies participated fully in mechanisms to ensure co-ordination of services within the catchment area. This would include participating in the work of the area management board and in the operation of protocols governing liaison between complementary services. It would also be necessary to make provision at regional level for ensuring that services were available outside the area unit where unsatisfactory performance arose in a particular agency or institution.

4.13.4 While a contracting arrangement with agencies could achieve the type of co-ordinated planning and delivery which is required, a difficulty may arise given the scale of the resources and the size of the management units within, in particular, the general hospitals relative to the rest of its area. While it is perfectly feasible to have operational management at the area level, it may be that the requirements for successful contracting, with appropriate monitoring and review of performance, would require a degree of effort and expertise, as well as access to comparative performance data, which might not readily be available within the area management team. This points to the need for the region to provide support to area management in making and reviewing such contracts. This would include the provision of information on activity, costings and other analysis in which the region would have particular expertise. The support from the region should be provided to areas in such a way as to strengthen the role of area management, rather than to take from or duplicate it.

4.13.5 **In summary**, the implications of the proposed arrangements for the voluntary hospitals include: the continuation of their legal independence and

operational autonomy; the right to continue to treat all patients referred to them and to innovate new services within the level of resources available, the opportunity to plan for development in a structured way with greater clarity as to the basis and level of funding available, the opportunity to participate actively in shaping health care policy in the area, including the provision of services complementary to the hospital's role and, finally, structured arrangements to clarify the service role of the institution in the changing circumstances of the health services over the years ahead. In return, those providing the funding for the delivery of services will have an opportunity to ensure that the contribution of the voluntary hospitals is made as effective as possible, both in terms of placing its role within an overall planning framework and ensuring that it forms part of a coherent response to the varying health needs of the population.

4.14 Implementation

4.14.1 We have already drawn attention to the fact that many detailed issues will require further examination before the arrangements which we have outlined in this Report could be implemented. For example, the Group recognise that for effective organisational development the whole system of health service organisation needs to be considered as part of the re-structuring of any part of it. These issues include:-

- the precise accountability relationships between the various elements of the structure;
- the way in which specifically national functions will be discharged and how these will relate to the region and the areas;
- the format of contracts with service providing agencies and the process by which they will be negotiated;
- the manner in which medical and other staff will be involved in shaping policy within the region and the areas;
- the information requirements to be met for optimal performance of the structure;
- the activities for which regional organisation or provision will be appropriate.

4.14.2 The Group had neither the time nor the expertise to specify the answers to the issues outlined above. Furthermore, the Group deliberately chose not to be prescriptive on these issues since we believe that the arrangements which we have outlined are most likely to prove effective if they are elaborated with the active involvement of the agencies and individuals who will be required to operate them. We envisage that, if it were decided to adopt our recommendations, a special development phase would be required during which these detailed arrangements would be explored and determined. One way of doing so would be to develop these arrangements on a pilot basis in one or more areas so that the various issues can be explored with appropriate consultancy support. This could be complemented by a process of consultation throughout the region to identify issues and tasks which would have to be addressed in the detailed implementation of these proposals.

4.15 Conclusion

4.15.1 The arrangements which we have recommended in this Chapter should make for greater consistency and effectiveness in the planning and delivery of services. They should ensure that the many services which currently address patients' needs in a fragmented way can be co-ordinated so as to ensure that:

- efficiencies are achieved;
- responsibility for decision-making is clearly assigned to those with the best opportunity for determining priorities;
- the optimal use is made of available human resources.

APPENDICES

1. POSSIBLE BOUNDARIES FOR AREA UNITS
2. SUGGESTED DISTRICT BOUNDARIES FOR DUBLIN
3. SUGGESTED DISTRICT BOUNDARIES FOR KILDARE AND WICKLOW
4. POPULATION OF PROPOSED DISTRICTS

FIGURE ONE

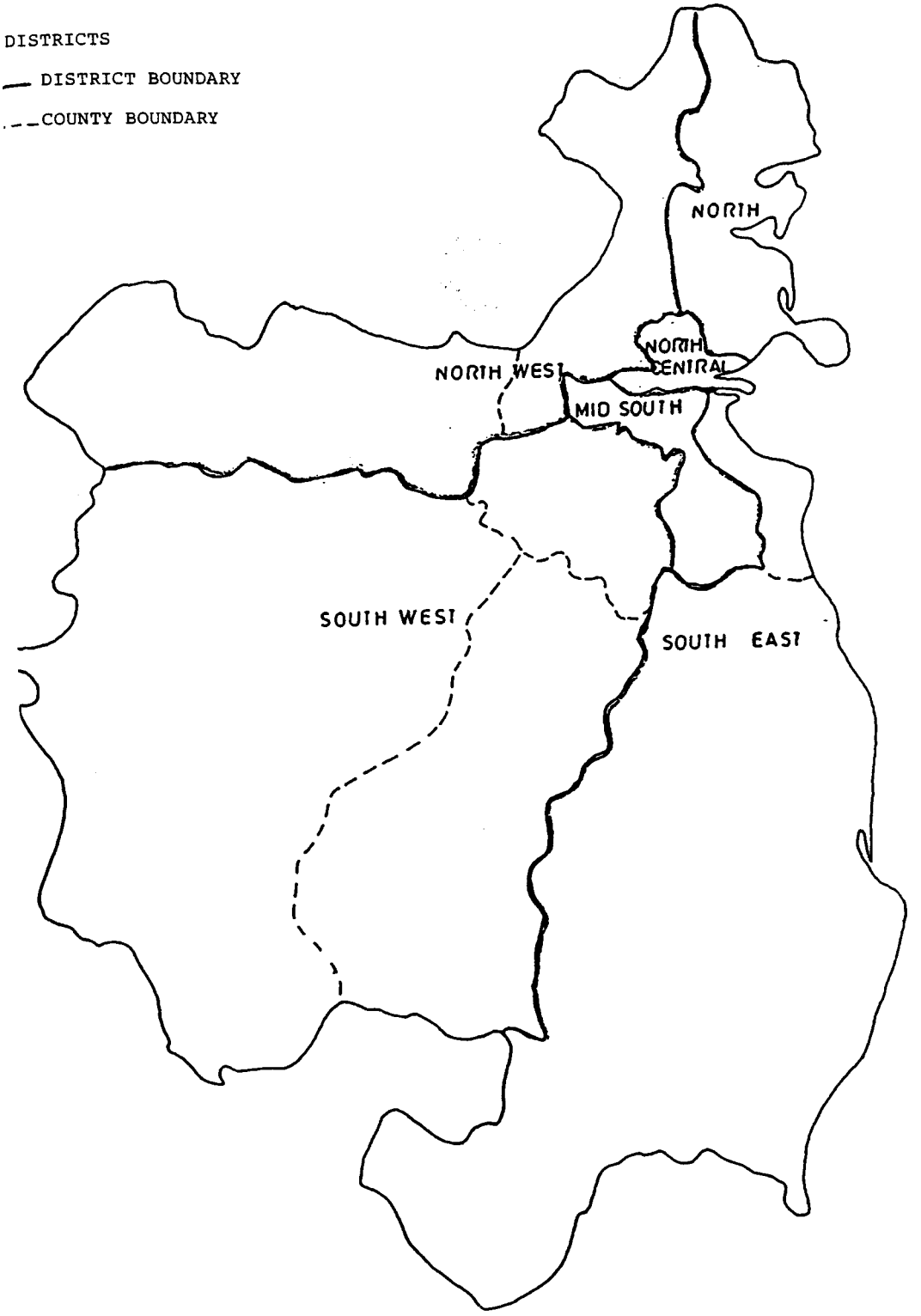
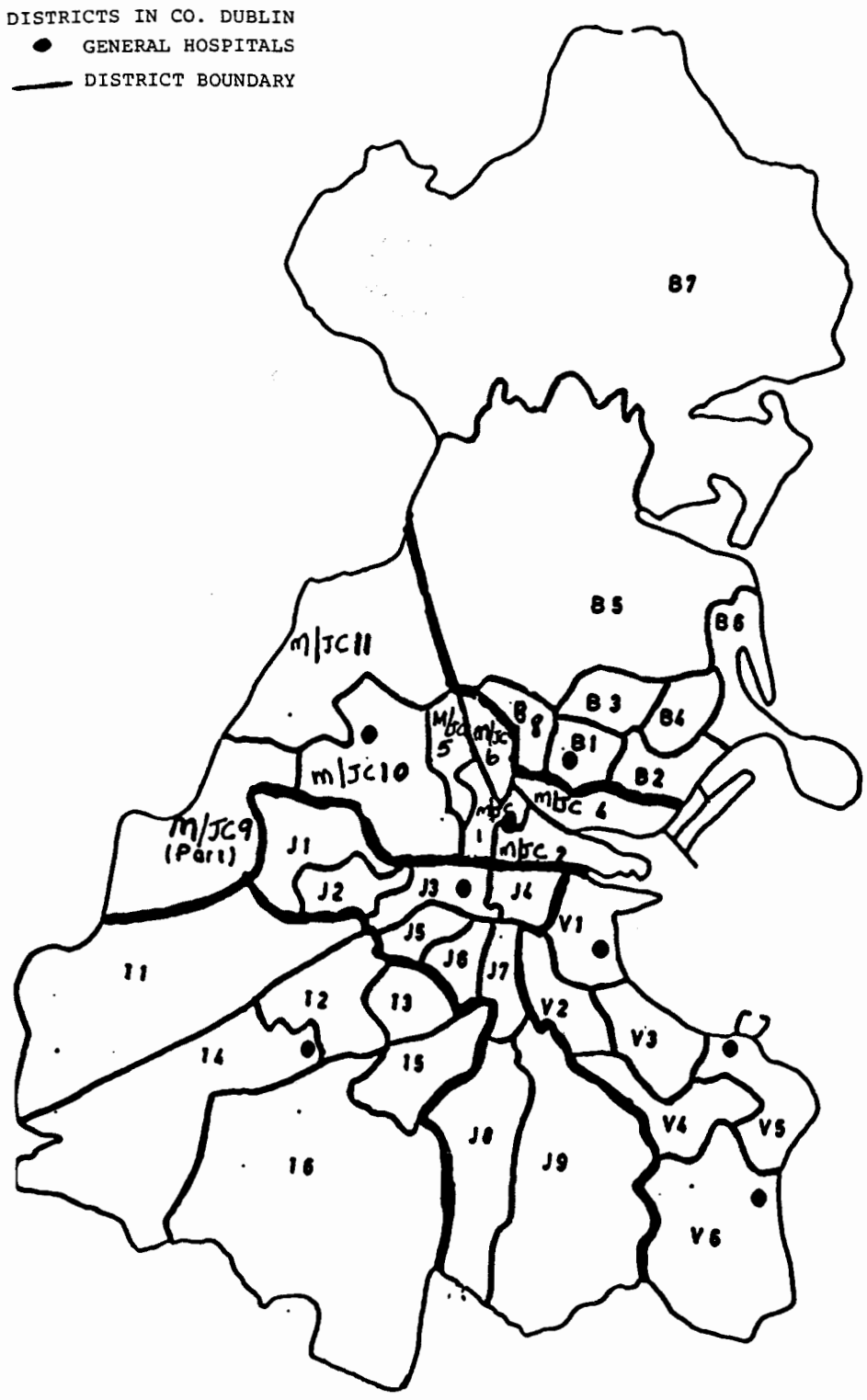

DISTRICTS
DISTRICT BOUNDARY
COUNTY BOUNDARY
NORTH
NORTH CENTRAL
NORTH WEST
MID SOUTH
SOUTH WEST
SOUTH EAST

FIGURE TWO


DISTRICTS IN CO. DUBLIN
GENERAL HOSPITALS
DISTRICT BOUNDARY
B7
B5
B6
B3
B4
B8
B1
B2
M/JC11
M/JC10
M/JC9 (Part)
J1
J2
J3
J4
J5
J6
J7
J8
J9
I1
I2
I3
I4
I5
I6
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V3
V4
V5
V6
mbc 1
mbc 2
mbc 4
mbc 5
mbc 6

FIGURE THREE

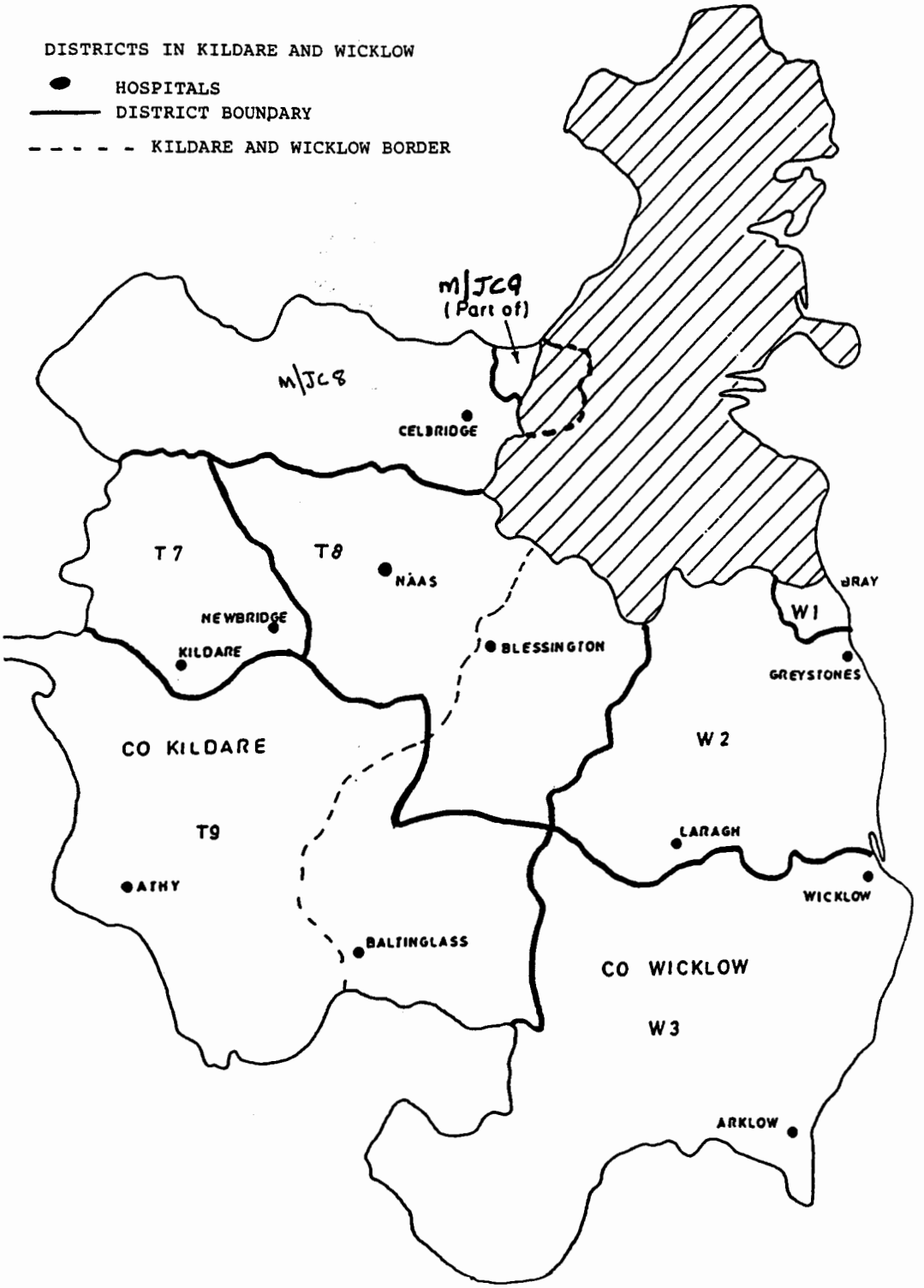

TABLE ONE

TABLE OF DISTRICT SIZES

Locality Code	Population
B1	29,666
B2	28,345
B3	29,054
B4	30,561
B5	32,317
B6	31,348
B7	30,885
B8	29,875
M/JC1	27,478
M/JC2	29,198
M/JC4	26,926
M/JC5	32,336
M/JC6	31,105
M/JC8	25,262
M/JC9	25,561
M/JC10	29,589
M/JC11	24,789
V1	23,230
V2	25,940
V3	28,243
V4	31,448
V5	29,571
V6	27,902
V7	24,686
V8	24,028
V9	33,926
J1	25,360
J2	24,184
J3	26,642
J4	26,712
J5	30,019
J6	26,544
J7	28,407
J8	27,365
J9	24,458
T1	24,553
T2	21,371
T3	31,470
T4	23,604
T5	28,745
T6	26,310
T7	29,741
T8	31,353
T9	29,608

FINAL REPORT

DUBLIN HOSPITAL INITIATIVE GROUP

February 1991

CONTENTS

PREFACE

The various reports prepared by the Group have identified measures which will increase significantly the effectiveness with which the Dublin hospitals meet the demands placed upon them. These recommendations have been derived from good practice models already operating in some areas. The continuing achievement of the highest possible standards of effectiveness will, in our view, require structural changes which will promote integration in the planning and delivery of services. For that reason, the proposals made by the Group on structural reform are regarded as essential to achieve permanent improvements.

The objective of policy should be to secure a hospital service which provides the highest possible quality of care at the lowest possible level of cost. In this final Report, we present general conclusions, reflecting our own analysis as to the steps necessary to meet this objective.

David Kennedy
Chairman

INTRODUCTION

1.1 Action Programme for the Health Services

On the 6th February 1990 the Minister for Health, Dr. Rory O'Hanlon T.D., announced an Action Programme for the Health Services for 1990 and beyond.

The Action Plan included a Dublin Hospitals Initiative - to improve the integration and efficiency of the acute Dublin Hospital Services.

1.2 Dublin Hospital Initiative Group - Membership

The Minister asked David Kennedy to lead this Action Group. The other members of the Group were appointed for their experience in the provision of health services in Dublin.

The following were appointed members of the Action Group:

1.	Professor David Kennedy (Chairman)	Deputy Governor, Bank of Ireland
2.	Dr. Conor Burke	Consultant in Respiratory Medicine, James Connolly Memorial Hospital
3.	Professor Davis Coakley	Consultant in Geriatric Medicine, St. James's Hospital
4.	Mr. Liam Dunbar	Chief Executive, St. James's Hospital
5.	Dr. Joseph Ennis	Consultant Radiologist, Mater Misericordiae Hospital
6.	Dr. Brid Fallon	General Practitioner
7.	Professor Muiris FitzGerald	Consultant Physician, St. Vincent's Hospital
8.	Mr. Austin Groome	Chairman, Meath Hospital, former Chairman, Eastern Health Board
9.	Mr. David Hanly	Chairman, Comhairle na nOspideal
10.	Mr. Kieran Hickey	Chief Executive Officer, Eastern Health Board

11.	Dr. Gerard Hurley	Consultant Radiologist, Meath Hospital
12.	Professor Michael MacCormac	Chairman, St. Vincent's Hospital
13.	Mr. Michael McLoone	Chief Executive, Beaumont Hospital
14.	Mr. Gearoid MacGabhann	Chief Executive, Mater Misericordiae Hospital
15.	Mr. Declan Magee	Consultant Surgeon, St. Colmcille's Hospital, Loughlinstown
16.	Ms. Eileen Mansfield	Matron, Adelaide Hospital
17.	Dr. John Mason	General Practitioner
18.	Dr. Brian O'Herlihy	Director of Community Care, Eastern Health Board
19.	Mr. Desmond Rogan	Secretary/Manager Adelaide Hospital
20.	Mr. Niall Weldon	Chairman, Beaumont Hospital
21.	Dr. Leo Vella	Consultant in Accident and Emergency, Beaumont Hospital

The Secretariat to the Group was provided by the Department of Health.

Mr. Dermot McCarthy (Secretary)

Mr. Paul Griffin

Mr. Shay McGovern

Ms. Patsy Carr

Ms. Caroline Field

1.3 Inaugural Meeting and Terms of Reference

On the 26th February 1990 the Minister, in addressing the first meeting of the group, asked that it initiate measures to improve the co-ordination of hospital services and to improve the integration of hospital and other services.

The Minister asked that the initial report from this initiative would be presented to Government before the Summer Dail recess.

The hospitals covered by the exercise are:

Mater Misericordiae Hospital
James Connolly Memorial Hospital
Beaumont Hospital
St. James's Hospital
Meath Hospital
Adelaide Hospital
St. Vincent's Hospital

1.4 Reports Issued

The Group has completed three reports to date.

1.4.1 Interim Report (June 1990)

The recommendations in this first report fall under three main headings:

- proposals for more effective management of hospital workload (which do not require additional resources) by implementation of identified best practice procedures in many areas;

- proposals which have resource implications. The main recommendation under this heading is that there should be an improvement in geriatric services, both within and without the acute hospitals;

- critique of existing organisational structure in Dublin.

1.4.2 Second Report (October 1990)

The Group completed its Second Report for the Minister in October 1990. This report followed through on the critique of organisational structures in Dublin by proposing major changes in the arrangements for the delivery of health services in the Dublin region. The principal objective of these proposals was to replace the present fragmented arrangements 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 Dublin region.

1.4.3 Third Report (February 1991)

The Group submitted a Third Report to the Minister in February 1991 making recommendations on out-patient services, the management of waiting lists, the development of geriatric services within the acute hospitals (the recommendations on this topic were submitted in December 1990), the referral of patients from outside the Dublin area and a review of the implementation of the good practice recommendations in the Interim Report. Recommendations were also made on an implementation strategy for the Third Report.

1.5 Work of the Group

1.5.1. The Group has met in plenary session on thirteen occasions, including one two-day meeting. The preparation of reports was facilitated by the establishment of six Sub-Groups which, between them, met on a total of fifty occasions. In addition, meetings were held on a number of occasions with representatives of the individual hospitals covered by our remit and with a variety of other health care personnel. Representatives of the Group also visited Birmingham and London in the course of preparing the recommendations on out-patient services and the management of waiting lists.

1.5.2 The Group wishes to record its appreciation of the full co-operation and support which it received from the hospitals and the Eastern Health Board, as well as from the many individual staff members and other health care personnel who gave so readily of their time and experience during the course of the Group's work.

Progress of the Group

2.1 The Group was established to improve the co-ordination of hospital services and to improve the integration of hospital and other services in the Dublin area. The achievements of the Group have to be measured in terms of actual improvements in these areas. It is too early to judge the impact which all of our recommendations will have, since many have yet to be implemented. However, the feedback from the hospitals on their experience in implementing the 'good practice' recommendations in our Interim Report is extremely positive to date.

2.2 Although the Group's recommendations on 'good practice 'are already having a positive impact in helping hospitals to cope with their workload, nevertheless we believe that the recommendations on organisational reform (Second Report) should have a much more profound and a more permanent impact on healthcare efficiency in the Dublin region. Unless there are fundamental structural changes on the lines proposed, we believe that the benefits accruing from implementation of the other recommendations will be limited in scope and unlikely to survive indefinitely. We understand that the proposals in our Second Report are under consideration by Government and we urge that the process of implementation, starting with a properly monitored pilot scheme as recommended by us, should commence as soon as possible.

2.3 Apart from the specific recommendations for action, the Group's achievements can also be reviewed in terms of the manner in which it went about its

task. The Group was unusual in its structure and terms of reference. We believe that the process by which its recommendations were prepared and agreed is in itself worthy of note.

Fundamentally, the work of the Group demonstrates that the hospitals concerned and the other services can co-operate together

- to identify common problems;
- to agree on aims and objectives for the service;
- to reach consensus on action.

2.4 The Group received full co-operation from the management and staff of all of the hospitals and the Eastern Health Board. This co-operation was received from staff in all disciplines and at all levels and involved

- open acknowledgement of problems and deficiencies;
- full sharing of views and experiences;
- full access to available information.

2.5 The Group in its Reports has demonstrated that there is a capacity within the hospital system to identify models of good practice in dealing with common problems. Such good practice models are of general application, since they are based on analysis of the factors which give rise to widely-shared problems.

2.6 The work of the Group has demonstrated that, within the hospitals, there is a clear willingness

- to learn from the experiences and ideas of other institutions;
- to change established practices and procedures;
- to seek external assistance;

when tangible benefits are demonstrated to arise from models of good practice.

2.7 However, the very success of the Group, in demonstrating both the capacity and the willingness of the hospital system to reform itself, shows up clearly the inadequacies of the present organisational structure where there is little opportunity or incentive for such reform to take place. Without the impetus provided by the existence of this ad hoc Group, there is little reason to believe that any change would have taken place. This is why we believe that radical structural reform is needed.

Strengths of the Group in carrying out its tasks

3.1 The composition of the Group was such that it became an effective forum in which to develop an overview of the role and problems of the acute hospitals in the context of their place in the health care system, locally and nationally. A wide spread

of experience and expertise was immediately available because of the variety of backgrounds of the members of the Group. This arose from the fact that the members represented

- a range of hospital specialty expertise;
- a wide spread of management experience;
- valuable expertise from the fields of nursing, general practice and public health.

3.2 The varying perspectives on issues available within the Group has convinced us that a multi-disciplinary approach is essential if a proper understanding of the role and problems of the acute hospitals is to be achieved. The future planning and delivery of health services, to be effective, must, we believe, be based on an inter-sectoral approach. In addition, the problems and responsibilities of the acute hospitals cannot be adequately addressed unless full account is taken of the complementary role which they play with other parts of the health care system, especially at primary and continuing care levels. The consensus achieved within the Group in formulating our recommendations demonstrates that such a broadly-based approach is feasible and capable of attracting a wide level of support.

3.3 Our recommendations on structural reform are aimed at achieving the same benefits as the inter-sectoral approach. The problems of the hospitals should not be addressed independently of the other components of the health care system.

3.4 The co-operation we received and the openness with which problems were acknowledged and discussed by representatives of the hospitals suggest that the Group was seen to have a degree of independence and lack of bias. The forum created by the Group was accepted as a legitimate and helpful opportunity for hospitals to reflect on long-standing problems.

3.5 The Group's work was aided by full support from the Department of Health, including access to the service information available to the Department. The Department's efforts to secure implementation of the good practice recommendations helped to underline the significance of our approach and has provided critical support to the implementation phase to date.

Difficulties experienced by the Group

4.1 In approaching its terms of reference, the Group experienced difficulty as a result of the general absence of a clearly defined role and objectives for the hospitals. Hospitals, especially in Dublin, face a variety of demands and pressures and are expected to deal with a wide variety of categories of patient. The relative priority to be afforded to the different types of service is often unclear. While each hospital can establish greater clarity about its own objectives, the overall role of each hospital has regional and even national implications.

4.2 Proper management and planning of the hospital service is hindered by the striking absence of reliable and comparable data on key aspects of performance and cost. Hospitals at present have only a general impression of the efficiency and effectiveness of their performance relative to other institutions.

4.3 In addition to lack of information, the absence of analytical skills in the evaluation and comparison of key areas of activity is contributing to the extent of many of the problems which beset the hospital system. Many of the issues addressed by the Group had not previously been the subject of systematic enquiry within the hospitals, despite their overall significance.

Conclusions

5.1 A fundamental characteristic of the hospitals we reviewed is that they are not organised to identify and respond directly to the demands placed upon them. Their services have tended to develop on the basis of individual clinical practice or as a result of institutional or academic pressures. Evaluation of how well institutions serve major categories of users - such as the elderly or Accident and Emergency cases - has not, to date, significantly influenced hospital policies or management. In short, the hospitals tend to be production-driven rather than market-driven.

5.2 If the planning and management of the acute hospital service are to be effective, then clear service objectives and targets related to the major demands made on the hospitals must be given a high priority.

5.3 We are satisfied that the present degree of isolation of the individual Dublin hospitals is both unhelpful and unnecessary. Greater collaboration in the analysis of common problems and in the identification of good practice must be facilitated. This can be achieved without compromising the independence which these institutions represent.

5.4 Acute hospital services cannot operate effectively or successfully in isolation from the rest of the health care system and, in particular, from the primary and continuing care sectors. We are, therefore, convinced that planning and evaluation of services must be based on an integrated approach, embracing community, acute and continuing care services. In particular, we wish to draw attention to the impact on acute hospital services of the present inadequate provision for rehabilitation services and the care of the young chronic sick.

5.5 We were not in a position to determine whether the resources available to the acute hospital system are adequate to fund the services which they are required to deliver. The need for additional resources in a number of aspects of the service was clear, for example, for additional services for the elderly. However, the question of whether the available resources are being used with maximum possible efficiency requires more and better information and evaluation. We have recommended measures to deal with this situation and our proposals for structural change are designed to ensure that these needs are met on a continuing basis.

5.6 In order for hospitals to make the best use of the resources at their disposal, there is an urgent need for a programme of management development for both management staff and clinicians. The quality of management in the hospitals must be developed to match the scale of the challenge posed by the demands of a busy acute hospital. The absence of explicit development programmes for key personnel and inadequate pay scales are major contributors to many of the problems which we have identified.

5.7 There is ample evidence of the quality and commitment of the staff of the hospitals we reviewed. As institutions, they are clearly committed to excellence in the care of patients. A re-orientation of their approach to the planning and evaluation of their work, allied to structural and policy developments on the lines we have recommended, should secure the highest standards of achievement in all aspects of patient care for the future.

5.8 A theme running through many of the problems we analysed is the need for greater senior input from clinicians to decision-making within the hospitals. If resources are to be used to maximum effect and if patients are to receive an optimal service, more experienced judgement must be brought to bear sooner and more consistently in the management of patient care. This is likely to require an increase in the ratio of senior to junior posts within the hospital system.

5.9 Many of the problems which we have identified result from a failure to appreciate fully the needs and problems of those using the hospital service. We therefore recommend that the consumer perspective on the performance of the service should receive much more attention for the future. Appropriate feedback mechanisms must be developed so that hospital activity can be organised in a way which responds most effectively to the needs of patients. Specifically, we are recommending the introduction of service quality programmes by the hospitals similar to those used in industry. The feedback would be used to monitor performance in critical service areas.

5.10 All of our work to date confirms us in the conviction that structural changes, on the lines set out in our Report of October 1990, are necessary to secure the effective delivery of acute hospital services in Dublin. The identification of acute hospitals with their natural catchment areas and the integrated management and planning of services within those areas would help to ensure that the best use is made of resources. It would also help to ensure that hospitals, and other services, are clear as to the role which they are expected to fulfil. Contracts with the voluntary hospitals would specify these service requirements and funding associated with them. We are satisfied that such radical change in structural arrangements is necessary to enable the full benefits of an integrated service to be achieved.

5.11 In addition to structural change at regional level, we are of the view that policy at national level needs to address a number of critical areas which impact on the performance of the hospital system. A number of these issues were dealt with in our Second Report. They require careful attention, not least in relation to the role of the Department of Health. In particular, the present method of allocating resources contributes significantly to the difficulties faced by the Dublin hospitals. Single year budgets and the generally incremental approach to funding give little encouragement to the most efficient use of existing resources. In our Reports, we have identified that the re-allocation of existing resources, in many cases, can deal effectively with hospital problems. Such re-allocation can be hindered by the existing financing arrangements. In addition, there is little incentive to invest in efficiency measures over a period of time when the annual funding system is unable to take account of such change. Ideally, resource allocation to hospitals and to other agencies should be used as an instrument to support the clarification of service objectives and to secure high standards of performance in terms of both efficiency and effectiveness. Present arrangements fail to meet these criteria.

5.12 The absence of capital budgets and of adequate arrangements for capital

planning constitute a major difficulty in securing the effective operation of the hospital system. Each of the acute hospitals represents a very substantial investment in premises and equipment. Without proper planning for refurbishment and replacement of equipment, those assets are likely to be operating inefficiently. In addition, planning for new investment and realistic prioritisation of service developments are impossible without an adequate framework for capital planning. A rolling 5-year capital programme is essential to meet these requirements.

5.13 In order to maintain the momentum generated by our work,and pending the creation of new structures in the Dublin region, we recommend that immediate steps be taken in a number of critical areas. First, an advisory group should be established to assist the Department in securing implementation of the good practice recommendations in our Third Report. Second, the Department of Health, with the active involvement of representatives of the services and professions, should commission work to address the policy problems at national level identified in the preceding paragraphs.