This document covers the major perspectives emerging from the HSE commissioning work to “assist in the design of integrated services management”. The work was conducted between March and May 2008. It involved review of international experiences and extensive participation of stakeholders within Ireland. The report is structured as follows:-

- Executive summary
- Introduction and background
- Why integrated care?
- Historical context and case for change
- Potential refinements to the HSE organisation and operating model
- Potential implementation approach.

EXECUTIVE SUMMARY

Health services across the world are exploring how best to deliver care for patients/service users in a joined-up way. Many systems, including Denmark, Canada, Germany and Singapore, are moving to Integrated Care models with closer organisational integration of primary, community and acute care. Their goal is to provide more accessible, higher quality patient care, often out of hospital and closer to home. As Ireland’s population ages, the Irish Health Service will face increasing pressures to treat patients seamlessly across treatment settings (e.g.,) for chronic diseases. To meet its vision of providing easy access to high quality care and services, the HSE is undertaking a multi-year transformation programme to develop Integrated Care.
This report identifies potential high impact changes to the organisational model of the HSE to:

- Enable and accelerate the delivery of Integrated Care across all settings
- Accelerate the seamless localised integration of primary, community and acute care
- Fully harness clinician input into service design and clinical governance at all levels of the organisation
- Empower local clinicians, managers and other care providers to make decisions that address local patient needs.

While the creation of the HSE was an important step in taking a national perspective to ensure greater focus to patients, the service must continue to evolve to meet the needs of the Irish population. To fully capture the benefits of Integrated Care, there is a need for greater clinical involvement in designing care pathways and disease networks, developing standards and operating the service. Secondly, there is currently too much distance between local providers and the leadership of the HSE. The organisation has a number of layers with potentially overlapping functions and remits. Not only is this not duplication, it also slows the ability of the service to implement new models of care. Not surprisingly, stakeholders across the service feel that some structural change could bolster the ability of the HSE to deliver Integrated Care.

Drawing on the context and opportunities described above, as well as lessons learned from other services internationally, this report considers potential refinements across four key dimensions. These include the HSE top team configuration, clinical engagement, operational management structures, and supporting processes and capabilities.

At the top team level, the HSE should strengthen clinical leadership by appointing a National Director of Clinical Care; merge the PCCC and hospital pillars under a single National Director of Operations; and develop more robust planning and communications functions. In line with best practice, the number of direct reports to the CEO should be reduced.

Creating a role for a National Director of Clinical Care will strengthen clinical leadership and elevate the role of clinicians in the design and operation of the health service. At the same time, greater integration between the hospital and PCCC pillars will help facilitate collaboration across care settings and promote more effective resource allocation. This will create clearer local accountability for delivering to care groups and developing care pathways designed around the patient rather than the service.

At regional and local level, administrative structures should be simplified and made as lean as possible. International clinical evidence suggests that 6-10
regions with a catchment population ranging between 500 and 700 thousand people could deliver high quality integrated care services in Ireland.

Successful delivery of integrated care will also require several non-structural changes. These include:

- Providing a framework for consistent management of performance, quality and outcomes
- Empowering front-line clinicians and other professionals to make effective local decisions
- Attracting, training and retaining top clinical and managerial talent
- Establishing a robust planning process with strong local accountability for execution
- Ensuring timely availability of information to support high quality clinical and business decisions.

It is beyond the scope of this report to propose how current plans and proposals should be further developed. However, the next step is to ensure that the top team refinements and regional organisational principles highlighted in this work are translated into a compelling and practical implementation plan. Organisations that are successful in achieving significant improvements in performance as a result of organisational change usually devote 12 to 18 months of sustained focus to a detailed organisational change programme.

**INTRODUCTION AND BACKGROUND**

The Health Service Executive (HSE) was constituted in 2004 as part of the Health Act with the remit of providing Health and Social Services for everyone living in the Republic of Ireland. It is the single body responsible for ensuring that everyone can access cost effective and high quality public health and so social services. Currently, the HSE has a budget of almost €14bn and is the largest employer in the State, directly managing 65,000 employees, deployed across a wide range of services nationwide ranging from highly specialised hospital-based units through community nursing to emergency planning and public health. The challenges of managing such a complex range of services on a national level are manifold. To date, the HSE has adopted a functional ‘two pillar’ split in the management of (i) primary and community and (ii) acute services. This structure was designed to set standards and build excellence within the different patient care settings.

In the three years since its formation, the HSE has made good progress towards these goals. National frameworks have been developed and are in the process of being implemented in a number of areas. The National Hospitals Office has been instrumental in planning and driving hospital re-configuration while PCCC has invested heavily in the development and roll-out of the primary care strategy, aiming to integrate a range of primary care services across a network of PCTs (primary care teams).
However, the challenge of increasingly complex and expensive service demands spanning multiple settings of care, coupled with the overarching need to drive overall performance improvement in the service, has prompted the HSE to look more closely at its service delivery model. Of particular importance is the need to allocate resources efficiently and effectively across setting of care in way that best meets patient needs. Health delivery should be organised around the patient rather than the service.

To face this challenge and meet its vision of providing easy access to high quality care and services, the HSE is undertaking a multi-year transformation programme designed to deliver Integrated Care. The programme is both broad-based and ambitious, and 2008 is a critical year for delivery. Following on from the Acute Bed Capacity Review, the HSE decided to explore whether organisational changes would support the evolution to Integrated Care. The HSE commissioned a report to “assist in the design of integrated services management” which could be implemented as a natural evolution of the current HSE operating model. This work was neither a broad assessment of the current organisational performance of the HSE, nor a detailed, local level, organisational design exercise. Rather, the focus was on identifying potential high impact changes to the organisational model of the HSE at a high level to enable and accelerate the delivery of integrated care across all settings.

Specifically, this work seeks to:

- Accelerate the seamless localised integration of primary, community and acute care
- Fully harness clinician input into service design and clinical governance at all levels of the organisation
- Empower local clinicians, managers and other care providers to make decisions that address local patient needs.

This report reflects the input of a broad set of stakeholders. Over 100 front-line staff, managers, senior HSE leaders, Ministry officials, professional bodies and external parties were consulted between March and May 2008. We fully recognise that further consultation will be required as the recommendations are refined and acted upon.
WHY INTEGRATED CARE?

Health services across the world are facing fundamental challenges. Patient expectations continue to rise even as funding becomes more constrained. Frequently, health services are also the largest, most complex employers in a country. Not surprisingly, health service leaders continue to seek ways to improve quality, access and patient experience while ensuring long-term sustainability.

Across countries as varied as Denmark, Sweden, Canada, Germany, New Zealand, the US and Singapore, advances in medical and information technology as well as management science are enabling far more patient-centred and high quality models of care, often closer to the patient’s home. The success of these new models – many of which rely on far greater integration across traditional settings of care – is causing clinicians and managers alike to reconsider how to deliver high quality patient care.

In the latter half of the 20th century, most developed countries organised delivery of care into distinct settings. In particular, a clear separation emerged between primary care, often provided by single-handed general practitioners, and hospital care. Treatment of mental health was often also separate, giving rise to separate mental health hospitals. Given the technology available throughout most of the 20th century, this separation of primary and hospital care made a good deal of sense. For example, the sophisticated equipment available in hospitals was bulky and expensive, and most procedures were conducted in this setting. As a result, patients tended to move frequently between different settings of care. It became normal to go to one place for a consultation with a GP, to another for an X-ray or blood test, and to yet another to see the specialist.
Furthermore, we have also accepted historically that each location has its own method of record keeping, its own protocols and its own way of doing things. This inevitably leads to repeat tests, incomplete transfer of information from one professional to another, and higher odds of poor outcomes or less satisfactory patient experience. In retrospect, most health services have been organised around their settings of care rather than each individual patient.

Over the past 20 years, however, remarkable advances in technology and medical practice enabled a significant shift of care (and procedures) out of hospital and into the community setting. It is now possible for specialists such as cardiologists and neurologists to do much of their work in the community. Similarly, general practitioners can develop an expertise in cardiology or neurology. The boundary between primary and specialist care is beginning to blur. From a patient perspective, this makes complete sense. Diabetes does not manifest itself differently whether the patient is sitting in a GP’s office or in the hospital. It is the same disease, with the same complications. At the same time, information technology is making it possible for patients to have a single, secure, portable electronic medical record. Across countries, what most patients want is quick access to high quality, patient-centred care close to home and family. This is what integrated care seeks to deliver.

Successful integrated care providers, such as Kaiser Permanente in Colorado or Polikum in Germany, share several characteristics. They:

- Put the patient at the centre of care delivery
- Establish common quality and process standards
- Have strong clinical leadership
- Have a culture of collaboration and open communication
- Use information systems which enable seamless sharing of information at all points of care
- Offer incentives for good performance
- Create tightly connected, regional provider and clinician networks.

The results are reductions in side effects and complications, less waste, shorter waits and better outcomes.
Each service has its own history and context which shapes its response. As a result, several integrated care organisational models are emerging:

- **Sweden**, Ontario and Quebec have a regionally devolved structure with care integration a local level. Notably, Canada Health Infoway is laying the ground for integration of information across providers in Canada.

- **Singapore** is centrally managed and organised along service lines, with parallel support services. An integrated network of local clinics and facilities feeds progressively into the national hospitals. There is a strong emphasis on prevention and the development of clinical protocols to ensure effective delivery of high quality care across all settings of care.

- **England** is organised across 10 regional Strategic Health Authorities of roughly 5 million population. Each is further subdivided into a total of 152 Primary Care Trusts (local purchasers) with 300,000 population. Nationally, there is a plan to shift a significant proportion of care out of hospitals and into community polyclinics.

- **Northern Ireland** is divided into 5 integrated social, community and acute healthcare trusts.
The implications for Ireland are that there is a significant opportunity to improve quality of care and patient experience by moving towards more integrated care. In this regard, two key questions emerge:

- What organisational model will best enable the delivery of integrated care in the Irish context?

- Beyond organisational structure, what should the HSE do to efficiently deliver high quality integrated care?
HISTORICAL CONTEXT AND CASE FOR CHANGE

Ireland is now grappling with many of the forces observed in health services across the world. However, it is important also to acknowledge significant differences in context. For instance, Ireland has a history of a very localized approach to care through the Health Boards and is undergoing significant demographic change and growth. In common with other developed economies, Ireland’s life expectancy has increased steadily over the past decade. The population’s health needs are becoming increasingly complex due to increased life expectancy and the prevalence of chronic diseases such as diabetes and obesity. In addition, a more sophisticated and informed public has increased expectations in terms of access and quality of care. Patients increasingly have access to medical information and have become more demanding of their clinicians. The Disability Act has led to a substantial increase in the quantity of services that must be provided.

Within this context, the HSE has made considerable progress in delivering service improvements, by developing an integrated hospital perspective based on national standards and in driving a community-driven agenda through PCCC. Indeed, the implementation of the national cancer strategy has been facilitated by the formation of the HSE as a national organisation. National primary and community care initiatives, such as the nursing home inspection process and the expansion of out of hours GP services nationwide, have improved greatly over the last three years. The national organisation of health care in Ireland is also driving efficient use of expenditure – e.g., through a more national focus on significant benefits in procurement providing economies of scale and standardisation.

At this point, it is useful to consider the recent evolution. The strength of Health Board approach (where operational and strategic responsibility was devolved to local level) was in ensuring some local identity and coherence to health provision. However, it had significant limitations in addressing the future needs of the population. In particular, there was an absence of consistency in standard setting, quality and resource allocation. There was also significant duplication of functions. With the advent of the HSE, most decision-making responsibility now lies at a national level. This has led to progress in a number of areas, including scale efficiencies, standardisation, best practice sharing and performance monitoring, which must be maintained. However, now that the national organisation has become established, the next step is to ensure that innovation, local and national clinical involvement, quality care delivery and decision-taking at the front line are promoted and encouraged. The service needs to strike the appropriate balance between local operational responsibility and centralised co-ordination and direction. This progression is illustrated in Exhibit 3.
The HSE is attempting to balance increasing demand in a cost-constrained environment.

While the structural change in 2005 helped the HSE gain a greater focus, the service must continue to evolve to meet the challenges outlined above. To fully capture the benefits of integrated care, there is a need for greater clinical involvement in designing care pathways and disease networks, developing standards and operating the service. Secondly, there is currently too much distance between local providers and the leadership of the HSE. The ongoing re-organisations – most fundamentally, the replacement of the Health Boards by the verified HSE – have brought many benefits, but also verifiable transitional challenges – organisational complexity, lack of clarity for accountability in certain areas, some overlap of functions/results. Not only is this not duplication, it also slows the ability of the service to implement new models of care. The most successful providers of integrated care, such as Kaiser Permanente or the Veterans Administration in the U.S., have lean regional and local management structures whose role is to support the efficient delivery of clinician-led services.

Not surprisingly, stakeholders across the service feel that some structural change could bolster the ability of the HSE to deliver integrated care. Specifically:

- Greater integration between the hospital and PCCC pillars would help facilitate collaboration across care settings and promote more effective resource allocation. This would create clearer local accountability for developing care pathways designed around the patient rather than the service
Creating a role for a National Director of Clinical Care would strengthen clinical leadership and elevate the role of clinicians in the design and operation of the health service.

Simplifying the top team and regional structures would create greater accountability for effective and efficient delivery. Administrative structures should be made as lean as possible.

Successful delivery of integrated care will also require several non-structural changes (Exhibit 4). These include:

- Providing a framework for consistent management of performance, quality and outcomes
- Empowering front-line clinicians and other professionals to make effective local decisions
- Attracting, training and retaining top clinical and managerial talent
- Establishing a robust planning process with strong local accountability
- Ensuring timely availability of information to support high quality clinical and business decisions.

During the work undertaken to prepare this report, both internal and external stakeholders expressed a strong desire to be involved in the change process.
There is a strong appetite for genuine service improvement at all levels of the HSE, with a broad understanding and acceptance that improvements will require trade-offs that are aligned with patient needs.

HSE staff delivering and managing front-line services expressed strong willingness and desire to take on further responsibility and accountability for front-line delivery. There was an eagerness to address problems at a local level without the need to escalate. A number of individual staff members expressed a desire for the introduction of a performance management system that accurately and equitably measured their performance, provided this system was coupled with the autonomy to perform their respective roles.

Individual pockets of good practice already exist within the service. Some areas are already providing integrated services, and conditions must be created to allow us to replicate these examples across the service. There are two key issues that must be addressed to allow this to happen. First, leadership capabilities must be built internally, and second, a blueprint must be developed for what form collaboration across primary and secondary care will take.

External stakeholders are similarly seeking proactive engagement on the current issues faced by the HSE, and this will help generate support and develop an aligned perspective.

**POTENTIAL REFINEMENTS TO THE HSE ORGANISATION AND OPERATING MODEL**

Drawing on the context and opportunities described above, as well as some of the lessons learned from other services internationally, we have examined potential refinements across four key dimensions (Exhibit 5). On each dimension, we considered a range of structural options, including optimising within the current two-pillar model. At this point, it is important to recognise that the core role of the HSE in terms of setting national standards and driving equality of access and standards of care across the service must be preserved.
At the top team level, the HSE should strengthen clinical leadership, create a single head of operations, and develop more robust planning and communications functions. Reducing the number of direct reports to the CEO would also help the HSE to more effectively deliver integrated care. Given the scale and complexity of a health service, reducing the number of direct reports to between 7 to 10 individuals would create greater accountability, strengthen the workings of the top team, and move the HSE in line with best practice.
Clinical leadership

A diverse and growing body of research underpins the impact of clinical leadership. A recent study by McKinsey and the London School of Economics, involving over 170 general managers and heads of clinical departments in the UK NHS, found that hospitals with the greatest clinician involvement in management scored some 50% higher on key measures of organisational performance than hospitals with low clinical leadership. In the 1990s, Kaiser Permanente, a large, integrated US payor and provider operating in several states, was struggling with declining clinical and financial performance, and was losing some top clinicians to private practice and rival organisations. A new CEO in Colorado – a paediatric surgeon – made clinical leadership an explicit driver of improved patient outcomes, defining the role of the clinician as “healer, teacher and leader” and revamping Kaiser’s leadership development programmes for doctors. Within five years of adopting this new approach, Colorado had become Kaiser’s highest performing affiliate on quality of care and a beacon of quality within US healthcare; patient satisfaction grew significantly; and staff turnover fell dramatically.

The exhibit below provides a high level perspective on the profile, responsibilities and success measures for this role (subject to further discussion and refinement).

EXHIBIT 6
KEY NEW ROLES – NATIONAL DIRECTOR, CLINICAL CARE AND QUALITY

Profile
- Clinical credibility
  - High level credibility and respect within the broader health sector
  - Strong personal relationships
- Management expertise
  - Strong operational/strategic focus – to support definition and delivery of risk/compliance systems, clinical pathways and standard setting across care settings
- Communication
  - Change management – to ensure successful implementation
- Collaboration
  - Capable of leading through influence
- Capacity
  - Track record of service innovation and a strong strategic thinker
- Supervision
  - To establish effective working relationships with all key clinical and non-clinical representatives
To work closely with the CEO and senior team to define and advance roll out of at least two key initiatives across localities through collating data from across the HSE
- To ensure strong alignment and engagement with national and regional bodies (e.g., INO, HSE)
- To ensure transfer of best practice service and clinical innovation across all representative bodies (e.g. IMO, NHO/PCCC)

Key responsibilities
- Strategy
  - To define a clear, detailed vision and operating plan for the future
  - To define the key functions: risk/compliance; clinical pathway; care setting across care settings
- Management expertise
  - To drive the quality and risk agenda for the entire organisation
  - Full integration of new structure of chief clinical officer (e.g. DOHC, NHO/PCCC)
- Leadership
  - Leadership and drive clinical governance
  - To establish a framework of high and consistent clinical standards across care settings
  - Support the delivery of clinical decision making
  - To ensure clinician involvement in performance
  - To drive the quality and risk agenda for the entire organisation
- Management expertise
  - To ensure clinical leadership an essential part of the organisation’s strategic thinking
- Clinical development
  - To define the key functions: risk/compliance; clinical pathway; medical education; interface with department; standard setting and best practices; exchange medical roles
- Supervision
  - To ensure clinical governance
  - To set priorities
  - To ensure effective delivery of key programmes (e.g., cancer, diabetes)
- Supervision
  - To ensure effective delivery of key programmes (e.g., cancer, diabetes)

Success measures 2008 –
- Full integration of new structure of chief clinical officer (e.g., integration of winter initiatives, population health, EAHs...)
- To set priorities
- To build organisational strength and ensure strong clinician engagement at both local and national level
- To ensure strong alignment and engagement with DOHC, programmes (cancer, diabetes, care setting across care settings, etc.)
- Review high impact health initiatives (e.g., Diabetes, elder people, cancer etc., ensuring appropriate processes for implementation are in place and delivered roll out of at least two key initiatives
- Definition of national quality and risk performance metrics
- Ensure that the post is effective and visible, i.e., identify high-caliber board members within top teams to act as credible advocates of the role

** Care groups leads and associated roles may fall under either Chief Clinical Officer or Head of Planning
Integration of service delivery

While the dual pillars served to solidify primary care and hospitals, the current organisational model does not foster the collaboration we would see in the best integrated care services. There is a choice to be made as to whether greater integration of the pillars would lead to better delivery of integrated care. One of the HSE’s challenges will be to deliver improved quality in a resource-effective way.

As part of this work, we have explored how best to optimise within the current organisation structure - across the existing primary and secondary care pillars. This would have a lower risk of disruption, but would require complex incentives and performance metrics to manage this at a national level. Whether such incentives could ever be strong enough to foster the cooperation needed to deliver integrated care is an open question. While there are emerging examples of integrated care in some parts of Ireland, the evidence from the front line is that having separate local organisations for primary care and hospitals is making it more complex than it need be to share resources and expertise across settings. From a patient perspective, care should be designed to minimise jumping around from facility to facility and clinician to clinician. In short, care is usually best organised in effective pathways tailored to address the patient’s needs.

Alternatively, the HSE could integrate the two pillars, which would allow for more effective management of a single budget. This would require more change, and significant thought would need to be applied to the number of sub areas to create under this integrated directorate. The advantage would be that under integrated leadership, incentives would be aligned for resources and expertise to be shared seamlessly across care settings. Indeed, the operational focus of a single delivery organisation could more easily turn to the development of integrated care pathways.

International experience across healthcare services and other industries suggests that clear operational accountability is critical to achieve operational effectiveness and quality in large organisations. Given the goal to deliver the benefits of integrated care, international evidence and management best practice clearly point to uniting all services under a single head of delivery. This individual will stand a better chance of creating the conditions for collaboration across care settings than separate heads, each accountable for only a portion of the care pathway. Again, we highlight a ‘working draft’ of what the role of such a head of integrated operations might comprise.
## Role Description – National Director, Integrated Care

### Profile
- **Leadership**
  - Strong leadership, team management, performance management and coaching skills
  - Good broadband-based experience of healthcare and social care system (not necessarily acute) – across care, access and quality dimensions
  - Experience in leading and delivering 3-5 year strategic plans
  - Experience in leading a divisionalised organisation
  - Strong record of change management
  - Track record of successful stakeholder management at the highest level
  - An organisation builder capable of defining roles, capabilities and processes
- **Strategy**
  - To develop a 100 day integration plan for Integrated Services
  - To define and agree the priorities operational plan (consistent with strategic plan)
  - To set and agree targets (include with agreed metrics e.g., access, cost and quality)
  - To allocate and manage resources across areas and all settings of care
  - To ensure the organisation is fit, flexible and efficient in serving the needs of patients and front-line healthcare professionals
  - To ensure IT solutions for integrated care handling (electronic patient records) in collaboration with other corporate ICT or embedded ICT functions
  - To lead operational planning/contracting with the multiple external agencies
  - Leadership and cooperation across top team
  - To work collaboratively and effectively with HSE teams (e.g., planning and chief clinical offices) and external stakeholders
  - To manage operational KPI, finance and other embedded support teams and ensure adequate regional resource is available
  - To ensure proper communication links with corporate support functions
  - To work collaboratively and effectively with HSE teams (e.g., planning and chief clinical offices) and external stakeholders
  - To jointly manage budget allocation processes together with the Planning and Finance Directorate

### Responsibilities
- **Success measures 2008**
  - To successfully integrate LHO and PCCG and ensure integrated service delivery across all settings of care
  - To deliver a year on year operational plan with agreed line and corporate support functions
  - To build effective, constructive relationships with internal and external stakeholders
  - To ensure effective engagement of stakeholders and workforce
  - To deliver and maintain a business plan consistent with the corporate plan
  - To build organisational strengths by groups, capabilities and processes to deliver the key long term plan aspirations
  - To lead the implementation of a public health initiative in collaboration with the department of the chief clinical officer
- **Success measures 2009 +**
  - More efficient integration of service
  - Integration of key national health initiatives into business plans
  - Fully operational electronic patient handling
  - Tertiary services integrated into service model

### Planning
Planning is another area where the natural evolution to integrated care calls for greater coordination. In particular, we would emphasise the need for planning across 3 time horizons – 1 year, 3-5 years, 10 years+. Each brings its own challenges – and it is critical they are brought together in an effective role. Health services are increasingly moving to planning based on population health needs and cost-benefit considerations rather than historical budgets. There have already been some moves in this direction within the HSE and this should continue. Furthermore, the global trend towards payment of hospitals by DRGs (disease related groupings), developing incentives for quality, and providing patients with transparent information with which to make choices on their care, has raised the importance of policy and planning functions. Just as private companies have developed business intelligence functions to analyse trends, make cost-benefit tradeoffs and better understand consumer needs, so too must health services.

### Communications
The role of effective communications is becoming more critical across organisations and countries. The level of public and press scrutiny will only increase. Information sources continue to proliferate. Organisations need to adapt to fundamentally new levels of transparency and challenge. In fact, many private companies and health services are exploring new models of how best to manage in this new world. This requires rethinking both internal and external communications. In the HSE context, communications would be better served by being represented at the top team level, a role focused on both internal and
external communications – setting appropriate standards, skills and processes to ensure a high quality, proactive dialogue with key stakeholders.

We therefore feel that these four new roles could significantly strengthen the top team:

- The National Director of Clinical Care and Quality would provide clinicians with a formal voice and role in service reform, planning and decision making. S/he would manage the quality and risk agenda and drive the implementation of patient-centred care pathways aligned with integrated quality and patient experience goals. S/he would also play a central role in defining the national frameworks and standards to guide clinicians in delivering the highest quality care.

- The National Director of Integrated Care would ensure joint and effective operational decision-making across all settings of care and aligned with patient needs, while establishing robust operational reporting lines. The heads of the regional HSE bodies would report into the National Director of Integrated Care, as would a post with responsibilities to drive efficiency and effectiveness in hospitals.

- The National Director of Planning would drive the development of a robust 3-5 year plan based on a solid fact base and aligned with population health goals, clarifying and consolidating the planning functions throughout the organisation. S/he would provide a link between departmental policy, expert advisory groups and long-term planning, and provide a dedicated care group interface for the Department of Health and Children, ensuring transparency on care group development budgeting and expenditure.

- The National Director of Communication would be responsible for effective communication flows within the organisation and to external stakeholders, ensuring sufficient visibility of and preparation for potential external communications challenges. S/he would also be key in standardising, supporting and enabling local communications.

It will be critical for all National Directors to work closely together in order to fully realise the benefits of Integrated Care. For instance, while the responsibility for designing the annual planning framework should sit with the National Director of Planning, the accountability for developing and delivering the annual plans should lie with the National Director of Integrated Care, working closely with the National Directors of Clinical Care and Quality, Finance, Human Resources and Planning. Similarly, no single department should own the “challenge” function. Rather, all National Directors should be sufficiently engaged to provide feedback and challenge on the plans of other directorates. Typically, the performance management function would be that of the National Director of Integrated Care, with Finance providing regular performance updates. Planning would usually have a more long-term horizon and be less involved in monthly and quarterly reporting. Further work will be
required to specify in detail the relationship between key directorates and how this cascades to regional level.

Regional level

At regional level, the two pillar organisation is currently divided into 8 regions for hospitals and 32 LHMs in primary care. International evidence suggests that regions with a catchment population of between 300 to 700 thousand people can efficiently deliver high quality services for most care needs. Highly specialized services such as specialty paediatrics and transplantation require larger catchment areas (Exhibit 8).

Dublin has the highest population density, coupled with the highest rate of population growth. As the country’s largest urban centre, it has a distinctive demographic profile, with a large minority grouping and specific social inclusion challenges. In addition, national level tertiary and community care institutions are concentrated in the capital. Dublin-based institutions serve varying catchment areas, with the national tertiary centres often co-located with regional or local acute services. There is evidence of high numbers of patients accessing the Dublin hospitals from outside their respective catchments, even for non-specialist acute services. The large voluntary hospitals deliver services independently and with little HSE involvement.

Dublin should be served by an integrated care system that is as robust as that elsewhere in Ireland. Further work will be needed to determine the best service organisation in the capital. One option, for example, would be for tertiary hospital services to be managed separately from primary care.
Whether the HSE opts to retain the two pillar structure or move to greater integration, we would recommend simplifying and aligning regional management structures. A potential regional organisational model could define regions representing between 300 to 700 thousand people, with Dublin either managed as a larger integrated region or split into smaller sub-units. Highly specialized services and networks (e.g., cancer) could be managed at a national level. This would imply moving to 6-10 regional management areas. Whichever regional structure is ultimately selected will need to be aligned with the roll out of Primary Care teams across the country, as well as mental health, disability and community care strategies.

Ultimate accountability for regional performance would sit with the regional heads, with strong representation from networks and care groups.

Exhibit 9 outlines the pros and cons of various regional structure models. Our work suggests that organisational integration across pillars is the preferred model. However, further work will need to be completed to determine the preferred detailed approach.

<table>
<thead>
<tr>
<th>EXHIBIT 9</th>
<th>POTENTIAL APPROACHES TO OPERATIONAL MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimise &quot;2 pillars”</td>
<td>Integrated across pillars (National Director, Operations)</td>
</tr>
<tr>
<td>Description</td>
<td>4 area model</td>
</tr>
<tr>
<td>- Maintain current structure address challenges through processes and incentives</td>
<td>- National Director, Operations with 4 areas (current boundaries)</td>
</tr>
<tr>
<td>Rationale</td>
<td>- &quot;2 pillars&quot; not broken-key to minimize risk to current service delivery</td>
</tr>
<tr>
<td>Concern</td>
<td>- Increased complexity without addressing fundamental barriers</td>
</tr>
<tr>
<td>Time for material impact (months)</td>
<td>18 - 24</td>
</tr>
<tr>
<td>Risk</td>
<td>- Low disruption risk</td>
</tr>
<tr>
<td>- High risk of under delivery</td>
<td>- Moderate high risk of under delivery</td>
</tr>
</tbody>
</table>

Source: Team analysis
POTENTIAL IMPLEMENTATION APPROACH - KEY STEPS TO DRIVING CHANGE

It is beyond the scope of this report to propose the decision-making and consultation process around these proposals. However, the discussion below offers some perspectives on the key actions required to fully realise the benefits of the proposed changes. The next step is to ensure that the top team refinements and regional organisational principles highlighted in this work are translated into a compelling and practical implementation plan.

It is essential that the HSE and its stakeholders recognise the scale of the challenge. Organisations that are successful in achieving significant improvements in performance as a result of organisational change usually devote 12 to 18 months of sustained focus to a detailed organisational change programme. Indeed, many of those interviewed for this report felt that the current organisation suffers from the fact that previous organisational changes have not been fully implemented at all levels. As a result, several legacy structures remain, often with vague or overlapping mandates. For the proposed changes to have meaningful impact, it is essential that regional structures be simplified and care pathways piloted and implemented across the country within 12-18 months.

From our experience, there are 4 key elements which need to be in place for any change to successfully take root (Exhibit 10). First, the leadership needs to role model important behaviours. For integrated care, this would for instance mean that the National Directors of Care, Planning and Operations would collaborate closely in the design of pathways, protocols and standards that benefit patients. If front-line clinicians and managers are asked to collaborate effectively, so too must their leaders on the top team. Second, a very clear narrative for how the system will run needs to be cascaded throughout the organisation. All the way to the front-line, HSE staff should be able to describe what is integrated care, why it is important and what it means in their day to day role. Third, staff at all levels will need to be trained to best deliver integrated care. Fourth, supporting mechanisms such as annual planning, clear quality standards and targets, and individual performance evaluations will need to be implemented.
THE INFLUENCE MODEL CONSISTS OF FOUR CHANGE LEVERS DESIGNED TO SHIFT MINDSETS AND BEHAVIOURS

"I will change my own behaviour if…"

Role-modeling
"I see superiors, peers and subordinates behaving in the new way"

Fostering understanding and conviction
"I know what is expected of me – I agree with it, and it is meaningful"

Developing talent and skills
"I have the skills and competencies to behave in the new way"

Reinforcing with formal mechanisms
"The structures, processes and systems reinforce the change in behaviour I am being asked to make"

Mindset & behaviour shifts

Top team leadership will be critical. (Exhibit 11).

EXHIBIT 11
THE SENIOR TEAM WILL NEED TO PLAY A CENTRAL ROLE DRIVING THE PROGRAMME FORWARD

<table>
<thead>
<tr>
<th>Chief Executive Officer Change Agenda</th>
<th>National Director, Integrated Care Change Agenda</th>
<th>National Director, Clinical Care and Quality Change Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Identify and appoint proposed national directors</td>
<td>1 Identify and appoint regional heads*</td>
<td>1 Drive clinical and professional stakeholder engagement</td>
</tr>
<tr>
<td>2 Drive broad stakeholder engagement</td>
<td>2 Define and agree roles and responsibilities of regional operation heads</td>
<td>2 Agree priority development and reform areas</td>
</tr>
<tr>
<td>3 Refine and agree overall operating framework for new structure</td>
<td>3 Agree devolved decision rights to front line</td>
<td>3 Establish fora to drive protocol and pathway development</td>
</tr>
<tr>
<td>4 Drive communication strategy aligned with programme goals</td>
<td>4 Ensure visibility of operational performance</td>
<td>4 Develop and agree regional clinical representation</td>
</tr>
<tr>
<td></td>
<td>5 Agree performance management regime</td>
<td>5 Develop agreed clinical quality and risk standards and goals</td>
</tr>
</tbody>
</table>

* Execution to be supported by CEO and HR Directorate
An implementation framework (Exhibit 12) should start to align the organisation around the change programme and ensure that the right senior talent is in place to drive change. Key to success will be:

- Gaining alignment on the vision and service goals
- Building the top team by identifying key leaders, gaps and providing the necessary leadership training
- Defining and setting up the regional and local structures, including simplifying the layers
- Creating a planning framework to be used by the areas to develop operating plans
- Developing a performance management regime
- Designing and piloting care models, starting by selecting a number of priority areas and developing pathways to roll out.

**EXHIBIT 12**

**IMPROVING SYSTEM PERFORMANCE WILL REQUIRE COORDINATED EFFORT ALONG KEY STRANDS**

<table>
<thead>
<tr>
<th>Key outputs/activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top team talent and staffing</td>
</tr>
<tr>
<td>• Create stable top team</td>
</tr>
<tr>
<td>• Fill new National Director roles</td>
</tr>
<tr>
<td>• Fill area lead roles</td>
</tr>
<tr>
<td>Alignment on vision and system goals</td>
</tr>
<tr>
<td>• Clear rationale for change jointly developed with DoHC and shared widely with key stakeholders</td>
</tr>
<tr>
<td>• Clarification of DoHC and HSE roles</td>
</tr>
<tr>
<td>• Agreement of key performance targets for system</td>
</tr>
<tr>
<td>Structure / Roles</td>
</tr>
<tr>
<td>• Define regional and local structures</td>
</tr>
<tr>
<td>• Agree responsibilities and decision rights for each level in structure</td>
</tr>
<tr>
<td>• Develop job description for key roles regionally/locally</td>
</tr>
<tr>
<td>Performance Management</td>
</tr>
<tr>
<td>• Define and execute transition plan; including simplifying layers</td>
</tr>
<tr>
<td>Planning</td>
</tr>
<tr>
<td>• 3-5 year strategic review plan developed and agreed with key stakeholders ensure a strong linked architecture of 1 year, 3-5-year and 10-15-year planning</td>
</tr>
<tr>
<td>Models of Care</td>
</tr>
<tr>
<td>• Select priority pathways/services and develop new delivery models</td>
</tr>
<tr>
<td>• Pilot models locally</td>
</tr>
<tr>
<td>Leadership and Clinical Engagement</td>
</tr>
<tr>
<td>• Identify key managerial and clinical leaders</td>
</tr>
<tr>
<td>• Train leaders to drive transformation</td>
</tr>
<tr>
<td>Culture / Mindsets</td>
</tr>
<tr>
<td>• Move from top down, reactive model to locally empowered, patient centered view</td>
</tr>
<tr>
<td>• Identify key interventions required to make this practical</td>
</tr>
</tbody>
</table>

Source: Team Analysis
Clearly, significant further work is required to define the appropriate pace and sequencing of the proposed changes (balancing the desired positive impact with the need to avoid disrupting service delivery in the interim). However, what is clear is that Integrated Care has the potential to significantly improve the quality of care and services available to patients across Ireland. Achieving the full benefits of this agenda will require not just structural modifications, but also sustained efforts to drive changes in processes, mindsets and behaviours across the system.
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