An Roinn Sláinte
Department of Health

Towards a Model of Integrated Person-centred Care

Findings from the Public Consultation on Geographic Alignment of Hospital Groups and Community Healthcare Organisations

Research Services and Policy Unit

Executive Summary

A public consultation on the process of Geographic Alignment of Community Healthcare Organisations (CHOs) and Hospital Groups was conducted by the Department of Health in April-May 2018 and this report provides a synthesis and summary of all submissions received. Through a structured online consultation questionnaire, the Department sought feedback and ideas from stakeholders and members of the public to assist the Department in assessing:

- The principles that should guide any alignment of Hospital Groups and CHOs;
- The importance, advantages and disadvantages of geographic alignment between health service delivery structures; and,
- The factors considered important in planning or implementing any changes.

Since the launch of the public consultation on the geographical alignment of Hospital Groups and CHOs, the Sláintecare Implementation Strategy was published.[1] It sets out a programme of reform commencing with the implementation of an initial set of key actions over the next three years. As such, the findings from this public consultation, and the information provided in the detailed submissions, will serve as a timely and important input to all involved in progressing the Sláintecare Implementation Strategy.

Submissions received

A total of 230 submissions were received; 66 responses were made on behalf on an organisation or representative body and 164 were submitted by individuals. A majority of submissions (213) were made using the online questionnaire and 17 responses were received through email and postal submissions.

Key Findings

- ✓ The majority of individuals are in 'strongly in favour' of the geographical alignment of CHOs and Hospital Groups.
- ✓ The majority of organisations are 'strongly in favour' of the geographical alignment of CHOs and Hospital Groups.

[1] Government of Ireland (2018). Sláintecare Implentation Strategy. Dublin: Government of Ireland. Available at: *https://health.gov.ie/wp-content/uploads/2018/08/Sl%C3%A1intecare-Implementation-Strategy-FINAL.pdf*

Guiding Principles

The main principles that should guide the process of geographical alignment were identified as:

- ✓ Delivery of safe, quality healthcare for patients;
- ✓ Achieving effective integration of healthcare;
- ✓ Ensuring services are organised around population needs; and,
- ✓ Ensuring more efficient use of resources.

Further principles that were specified in the submissions included: patient pathways; maintaining university links; avoiding duplication; having a critical mass of patients; and, equity of access to funding.

Benefits

The majority of respondents (individual and organisational) agree that geographic alignment has potential to:

- ✓ Enable and support integrated care;
- ✓ Enable and support coordination of services in health and social care;
- ✓ Enable and support population-based healthcare delivery;
- ✓ Facilitate effective cooperation with other state agencies/service providers;
- ✓ Enable and support population-based data analytics; and,
- ✓ Enable and support better planning.

Further benefits identified by respondents include:

- ✓ Improve patient experience and outcomes;
- ✓ Improve patient pathways;
- ✓ Facilitate greater ownership and community engagement;
- ✓ Enable stronger leadership;
- ✓ Facilitate a unified approach to healthcare;
- ✓ Improve resource allocation decisions;
- ✓ Improve decision making; and,
- ✓ Enable improvements for the health sector workforce.

While a large number of organisations agreed that geographic alignment could "enable and support performance assessment and management", a majority of individual respondents either disagreed or were unsure that this was a potential benefit.

Advantages

For both individual and organisational respondents, the most frequently selected advantage of geographic alignment was that it 'allows for integration of services'. Other advantages which ranked highest included:

- ✓ More efficient use of resources;
- ✓ Ensures coordination between different care sectors; and,
- ✓ Allows for population-based health planning.

Disadvantages

The disadvantages of geographic alignment most frequently selected by individual and organisational respondents were:

- × Disruption to services provided;
- × Associated cost of changes;
- × Disruption to current structures;
- × Potential breakage of links between hospitals currently linked;
- × Potential breakage of links between services within CHOs; and,
- × Administrative burden.

Other disadvantages identified included:

- × Local gaps in resources and services;
- × Change fatigue; and,
- × Greater uncertainty for patients and staff.

Weighing up the advantages and disadvantages

Most organisations and individuals agree that the advantages of geographic alignment outweigh the disadvantages. Of the small number of organisations that strongly disagreed with the statement (12% of those who answered this question), these predominantly derived from respondents from a hospital or Hospital Group.

Informing the move to geographic alignment

When asked about the factors that should inform any plans to move to geographical alignment, the majority of individuals and organisations reported that a high level of importance should be placed on:

- ✓ The organisation of existing CHOs;
- ✓ The organisation of existing Hospital Groups; and,

- ✓ Existing links between hospitals and universities.

There was mixed views from both sets of respondents regarding the importance of aligning with county boundaries. A majority of individual and organisational respondents agreed that high importance should be placed on the following factors when progressing geographic alignment:

- ✓ Existing patient flow patterns;
- ✓ Patient travel times and transport links;
- ✓ The population size/density of an area; and,
- ✓ The range of health services in an area.

In addition to those listed above, respondents suggested the following factors as being important to consider when progressing geographic alignment:

- ✓ An evidence informed approach;
- ✓ Patient experience and choice;
- ✓ Clinical leadership and governance;
- ✓ Impact on workforce and staff travel times;
- ✓ Clarity regarding responsibility and accountability;
- ✓ Equity; and,
- ✓ Resource availability and allocation.

One-to-one mapping of CHOs to Hospital Groups

There were mixed and contrasting views within both individual and organisational respondents when asked if geographic alignment means that every CHO has to map on-on-one with a specific Hospital Group:

- 37% of individual respondents responded that one-on-one mapping is necessary;
- 39% of individuals respondents did not agree and 24% were unsure;
- 43% of organisational respondents responded that one-on-one mapping is necessary; and,
- 32% of organisational respondents did not agree and 25% were unsure.

Of those that stated that one-on-one mapping is not necessary, reasons for their answer included:

- ✓ Structures should be based on patient access and pathways;
- ✓ There needs to be flexibility built into structures;
- ✓ It is not practical to deliver (e.g., due to cost, complexity or varying population densities), and,

- ✓ Factors other than geography are more important (population density, population health, patient flow).

Of those that stated that one-on-one mapping is necessary, reasons for their answer included:

- ✓ Is necessary for integration and collaboration between stakeholders;
- ✓ Would enable patient pathways and access;
- ✓ Would deliver greater economies of scale and greater efficiencies; and,
- ✓ Would facilitate better budgeting and funding decisions.

When to implement geographic alignment

The majority of respondents, (70% of individuals and 58% of organisations) expressed a view that a move to geographic alignment should start in the short term, defined for the purpose of this analysis as within the next 18 months. Some responses also stated that change should be dependent on:

- ✓ Appropriate planning and assessment (evidence base, clarity around structures, assessment of benefits and risks, implementation plan);
- ✓ Adequate financing to progress the changes;
- ✓ Investment in IT infrastructure; and,
- ✓ Stakeholder engagement.

The best approach to geographic alignment and integration

Less than 10% of individual respondents and 13% of organisational respondents are against implementing geographic alignment. The main rationale most cited for this is reform fatigue. There is very little support for progressing geographic alignment only (8% of individual respondents and 9% of organisational respondents). The reason most cited here is reluctance to add an additional new 'layer' in the form of regional structures.

The majority of respondents (individual and organisational) selected that geographic alignment and integration into regional care organisations should be implemented either at the same time or on a phased basis. For individual respondents, results are very similar in support of a phased approach (41%) and a simultaneous approach (43%). For organisational respondents, a larger number support a phased approach (44%) compared with a simultaneous approach (24%). Where respondents advocated for a phased approach, the reasons given included:

- Time for monitoring and appraisal;
- Minimises disruption;

- Complexity demands an incremental approach; and,
- Incremental approach is best for patients and staff.

Where respondents advocated for a simultaneous approach, the reasons given included:

- Greater efficiencies (time and resources); and,
- Change will not be effective if structures and governance not addressed together.

The services a regional integrated care organisation should be responsible and accountable for

The majority of individual and organisational respondents agree that the following services should be included in the 'basket of services' of regional integrated care organisations:

- ✓ Hospital care;
- ✓ Primary care;
- ✓ Home care;
- ✓ Community care;
- ✓ Residential long-term care;
- ✓ Public health;
- ✓ Mental health; and,
- ✓ Disability services.

Only approximately one third of respondents agreed that drugs and medicine purchasing should be included in the basket of services for regional integrated care organisations. Some respondents noted that this service should continue to be provided at national level.

Further opportunities

When asked to consider healthcare in the context of other sectors, information systems, services, and wider social and economic issues, respondents identified several opportunities associated with aligning geographic health and social care boundaries:

- ✓ Greater collaboration and engagement, including with sectors and stakeholders working in areas related to health; and,
- ✓ Improvements in IT infrastructure and data.

Recurring themes

A number of recurrent issues came though many sections of the consultation responses. Regarding where concerns were expressed about progressing with geographic, these predominantly related to two issues:

- Reform fatigue; and,
- Risk of impeding existing progress in integrated care.

Several conditions/factors/dependencies were raised by respondents throughout, which they said should be considered when moving to geographic alignment. These included:

- Investment in resources and ICT infrastructure;
- Focus on patient and patient choice;
- Focus on population health;
- Need for evidence base (national and international); and,
- Stakeholder engagement and stakeholder buy-in.

Further issues in the current health system were identified throughout the submissions, which may affect a move towards geographic alignment. These include:

- Organisational and service culture;
- Concerns regarding governance;
- Improving trust and confidence in the health system;
- Voluntary health and social care organisations;
- Private healthcare providers;
- Additional health system structures needed; and,
- Brexit and cross-border issues.

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Chapter 1 Introduction

The report of the all-party Oireachtas Committee on the Future of Healthcare, entitled Sláintecare, was published in May 2017.[2] In the Sláintecare Report, the goal of universal healthcare is framed in terms of co-ordinated person-centred care and considerable emphasis is placed on providing integrated healthcare for citizens. The report proposes that Ireland needs a new 'model of care,' i.e. a set of services which ensure that for each cohort of the population, the right care is delivered by the right person in the right place at the right time. It aspires to a new model of care which sees the citizen, rather than institutions, at the centre of service delivery.

Sláintecare envisaged an evolution of the current health structures, to create a strong, lean national centre with responsibility for national planning, strategy and standard setting, complemented in time by new regional integrated care organisations that can operate with appropriate autonomy within defined geographic areas and with clear reporting structures.

Sláintecare recognised that the relationship between Community Healthcare Organisations (CHOs) and Hospital Groups is critical in the pursuit of connected care and patient-centred service delivery and therefore recommended the alignment of CHOs and Hospital Groups as one of the fundamental principles underpinning the broader healthcare reforms. The Committee advised that *"further analysis and consultation should be undertaken to identify how alignment can best be achieved with minimal disruption to key structures including at Community Healthcare Networks (CHN) level".*[3]

Minister Harris, in his input to the Oireachtas Committee hearings, stated that he was: *"convinced that Hospital Groups and CHOs should be geographically aligned ... having Hospital Groups and CHOs operating on this basis will facilitate collective performance and accountability arrangements based upon pre-agreed and shared goals, budgets and incentives"*.[4]

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[2] Oireachtas Committee on the Future of Healthcare (2017). Sláintecare Report. Dublin: House of the Oireachtas. Available at: *https://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Oireachtas-Committee-on-the-Future-of-Healthcare-Slaintecare-Report-300517.pdf*

[3] Sláintecare Report, p.26 & p.89.

[4] Opening Statement by Minister for Health Simon Harris T.D. to the Committee on the Future of Healthcare (22/03/17); http://health.gov.ie/blog/speeches/opening-statement-by-minister-for-health-

Following the publication of the Sláintecare Report, the Minister committed to launching a consultation process on the issue of the alignment of CHOs and Hospital Groups, and to explore how integrated care might be achieved with minimal disruption. The public consultation was conducted by the Department of Health between April-May 2018 and this report provides a synthesis and summary of submissions received

1.1. Overview of the Public Consultation

The purpose of the public consultation was to gather views and perspectives on a range of issues surrounding geographic alignment. This will facilitate the Department in considering what actions to take and in a manner that reflects the broadest possible range of views from stakeholders and members of the public. Through a structured online consultation questionnaire, the Department sought feedback and ideas from stakeholders and members of the public to assist the Department in assessing:

- The principles that should guide any alignment of Hospital Groups and CHOs;
- The importance, advantages and disadvantages of geographic alignment between health service delivery structures; and,
- The factors considered important in planning or implementing any changes.

It is important to note that it was beyond the scope of the public consultation questionnaire and is beyond the scope of this report to address every aspect of geographic alignment. The full consultation questionnaire is available in Appendix 1.

1.2. Advertising the Public Consultation

Considering the issue under examination, it was envisaged that respondents would mainly be healthcare organisations and service providers. However, everyone with an interest in this issue was invited to participate in the public consultation. The Department of Health held a meeting with the Chief Executive Officers of Hospital Group and the Chief Officers of CHOs in advance of launching the public-facing consultation. The public consultation was advertised on the Department of Health website and via social media channels, and in national newspapers. In addition, the Department of Health contacted over 160 stakeholders from healthcare, academia, representative bodies and patient groups to inform them of the public consultation.

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simon-harris-t-d-to-the-committee-on-the-future-of-healthcare/

1.3. Overview of the Submissions Received

Everyone who made a submission on behalf of an organisation was asked to provide additional high level information about the organisation they were representing, and individuals were asked to provide additional information about their area of work, if they worked in the health and social care sector. This background information has been used to support the analysis of submissions in terms of identifying issues and views that may or may not differ across professions, settings or sectors.

A total of 230 submissions were received; 66 responses were made on behalf of an organisation or representative body and 164 were submitted by individuals. Out of these responses, the majority (213) were submitted using the online questionnaire provided and 17 responses were received through email and postal submissions. Responses received in forms other than the consultation questionnaire included letters, papers, and email.

1.4. Methodology

The questionnaire was created and distributed using online survey software. A detailed information note on geographical alignment was incorporated into the survey with brief background text preceding each section containing questions. The survey instrument comprised four main sections:

I. Background information on the respondent;
II. Importance of geographic alignment of Hospital Groups and CHOs;
III. How to achieve geographic alignment of Hospital Groups and CHOs; and,
IV. Opportunities for the future of integrated health and social care.

A combination of both quantitative questions and open-ended (qualitative) questions were used in each section. Submissions were made via the online survey platform and these were exported as a single database for further analysis using software for qualitative and quantitative data. Written submissions were also received, and the content of these submissions was integrated into the qualitative database for all submissions to be analysed collectively.

All quantitative questions were analysed using frequencies: the number of respondents who selected an item from a list of options. These results are presented as numbers or '*n values'*, rather than percentages as not every respondent answered every question and sometimes the number responding can be low to certain questions. It is important for the reader to be aware of the number of respondents for each question. These values are reported for both individuals and organisations, separately.

Qualitative questions were analysed using framework analysis which is a method that was developed by Richie and Spencer (1994) and is appropriate for data collected using structured formats such as consultation questionnaires that contain pre-existing themes. Building on pre-existing themes, framework analysis provides a systematic way of classifying, analysing, interpreting and reporting this qualitative data, and involves the following steps: familiarisation with data; developing a coding framework; coding the data; charting the coded data; and, mapping and interpretation. Framework analysis also enables themes and issue that are additional to those presented in the questionnaire to emerge, and be classified, analysed, and reported in the same way.

1.5. Sláintecare Implementation Strategy

Since the launch of the public consultation on the geographical alignment of Hospital Groups and CHOs, the Sláintecare Implementation Strategy was published.[5] It sets out a programme of reform commencing with the implementation of an initial set of key actions over the next three years. Among the actions identified relating to evolution of our health structures for advancement are the geographic alignment of Hospital Groups and CHOs, followed by the transitioning of the HSE structure to one with a strong, lean national centre with responsibility for national planning, strategy and standard setting, and the establishment of regional integrated care organisations. The findings from this public consultation, and the information provided in the detailed submissions, will serve as a timely and important input to all involved in progressing the Sláintecare Implementation Strategy.

[5] Government of Ireland (2018). Sláintecare Implentation Strategy. Dublin: Government of Ireland. Available at: *https://health.gov.ie/wp-content/uploads/2018/08/Sl%C3%A1intecare-Implementation-Strategy-FINAL.pdf*

Chapter 2 Analysis of Key Issues

There are five sections in this chapter that correspond with the structure and content of the questionnaire.

Section 2.1 presents a summary of respondent information.

Section 2.2 presents an analysis and summary of submissions on the topic of the guiding principles, advantages and disadvantages of geographic alignment of Hospital Groups and CHOs.

Section 2.3 presents an analysis and summary of submissions on the topic of **'**How to Achieve Geographic Alignment of Hospital Groups and CHOs'.

Section 2.4 presents an analysis and summary of submissions on the topic of 'Towards Integrated Health and Social Care' and cross-cutting themes.

Section 2.5 presents a discussion of other themes that were commonly referenced by respondents throughout the questionnaire.

Note on the presentation of the analysis

Most submissions used the questionnaire provided. Questions were optional and therefore not every respondent answered every question. A total of 17 submissions did not use the questionnaire, and these submissions were made in the form of letters, papers, and emails. All these submissions were analysed qualitatively.

It is for these reasons that the numbers presented from the analysis of quantitative questions from the questionnaire do not necessarily equal the overall total number of submissions received. The number of submissions that form the basis for the quantitative analysis for each question is reported with all figures and tables.

Note on papers received

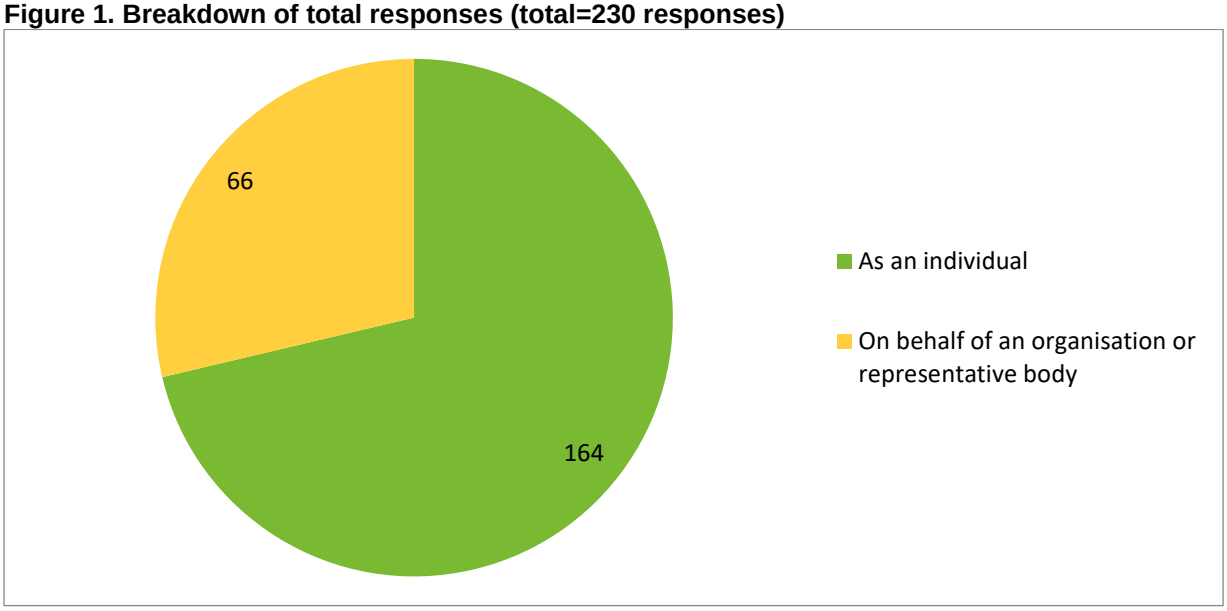
A number of position papers were received as part of the consultation along with and/or instead of a completed questionnaire. Although these papers have been reviewed and form part of this report, much of the detail within them could not be explored fully in this report. These papers are being considered in full and have been made available to relevant officials within the Department of Health.

2.1 Respondent Information

Respondent Information

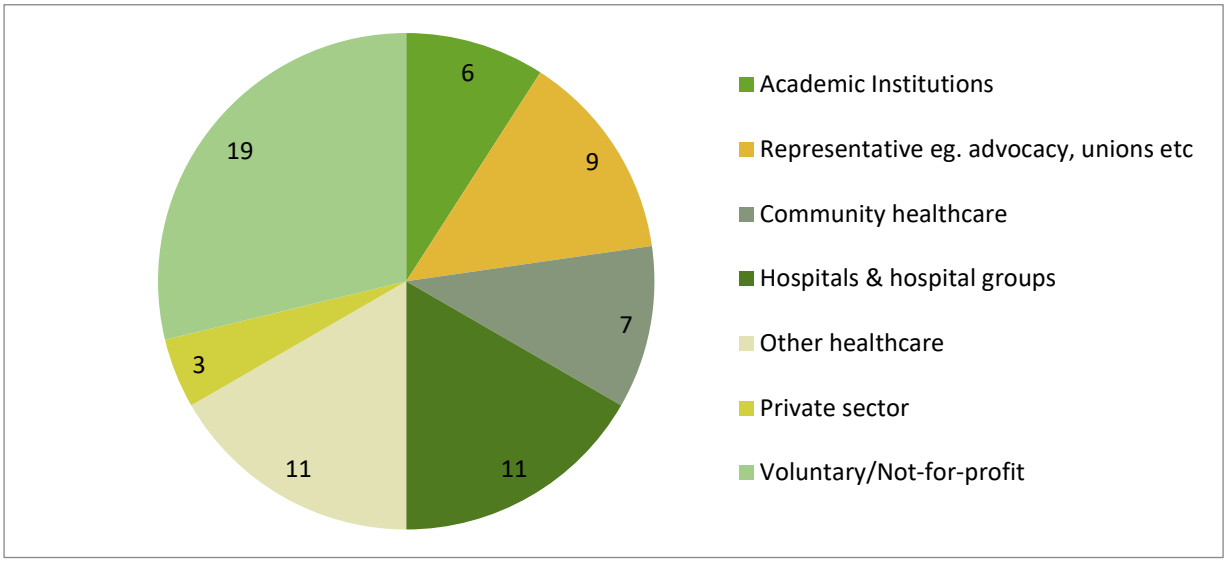
A total of 230 submissions were received; 66 (29%) responses were made on behalf on an organisation or representative body and 164 (71%) were submitted by individuals. Out of these responses, 213 (93%) were submitted using the online questionnaire and 17 (7%) responses were received through email and postal submissions. The majority of respondents (97%) submitted responses using the format of the questionnaire provided and eight respondents (3%) made submissions in other forms, including letters, papers and bullet points for consideration.

Figure 1. Breakdown of total responses (total=230 responses)



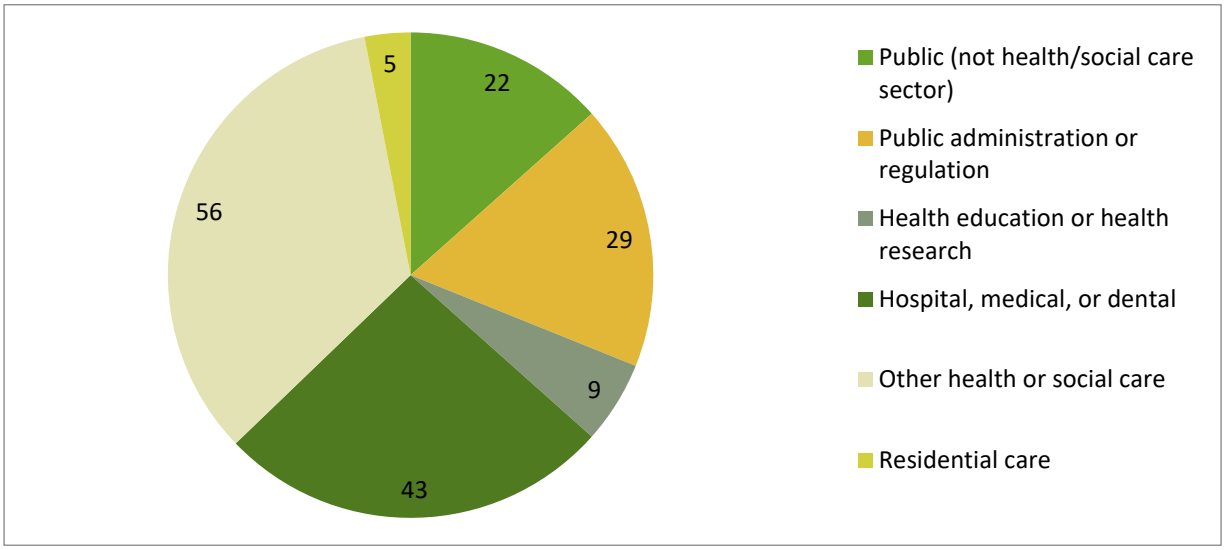
Responses were received from a broad array of organisations including hospitals and Hospital Groups, organisations involved in delivery of community care, representative organisations (e.g. unions, advocacy groups), academic institutions, professional training bodies, private sector organisations, charities and voluntary or not-for-profit organisations. The voluntary/not-for profit organisations were the largest single contributor within the organisational responses, comprising almost 30% (n=19) of submissions.

Figure 2. Breakdown of responses on behalf of organisations (n=66)



The individual responses received were categorised in such a way as to recognise that many of the submissions were from those who are currently employed in the health and social care sector. From the individual responses received, submissions were made from the following types of individuals: members of the general public (who are not employed in the health or social care sector), public administrators or regulators, professionals working in health-related education or research, professionals from the hospital, medical or dental sector, other health or social care professionals and individuals working in the residential care sector. The largest number of responses was submitted by hospital, medical and dental care professionals (26%; n=43) and professionals from other health or social care sectors (34%; n=56). It is also important to note that only 13% (n=22) of respondents were members of the public who are not employed in any way in the health and social care system.

Figure 3. Breakdown of responses made by individuals (n=164)



Responses by Region

In an attempt to capture the regional spread of the responses received while at the same time acknowledging and respecting the anonymity of respondents, individual respondents were asked to identify, from a pre-populated list of hospitals, where they would most likely be treated if they required emergency care. Table 1 shows the responses to this question.

All hospital options received at least one response, suggestive of a wide spread of respondents, but the largest number of responses stem from the east of the country, particularly those attending emergency departments in the Dublin catchment area. Respondents were most likely to receive emergency care from St. Vincent's University Hospital, followed by University Hospital Waterford and Cork University Hospital.

Table 1. Hospitals where individual respondents are likely to receive emergency care

Hospital Name	Number	Hospital Name	Number
St. Vincent's University Hospital	25	Midland Regional Hospital, Mullingar	4
University Hospital Waterford	18	Tallaght Hospital	4
Cork University Hospital	13	Letterkenny General Hospital	3
Mater Misercordiae University Hospital	11	Mayo General Hospital	3
Cavan General Hospital	10	Our Lady of Lourdes Hospital, Drogheda	3
Beaumont Hospital	8	Portiuncula Hospital, Ballinasloe	3
St. Luke's General Hospital, Kilkenny	8	Sligo Regional Hospital	3
Midland Regional Hospital, Tullamore	7	Naas General Hospital	2
St. James' Hospital	7	Kerry General Hospital	1
University Hospital Limerick	7	Midland Regional Hospital, Portlaoise	1
Connolly Hospital, Blanchardstown	6	South Tipperary General Hospital	1
University Hospital Galway	5		

2.2 Principles and Benefits of Geographic Alignment

In your opinion, what are the main principles that should guide the process of geographically aligning Hospital Groups and CHOs?

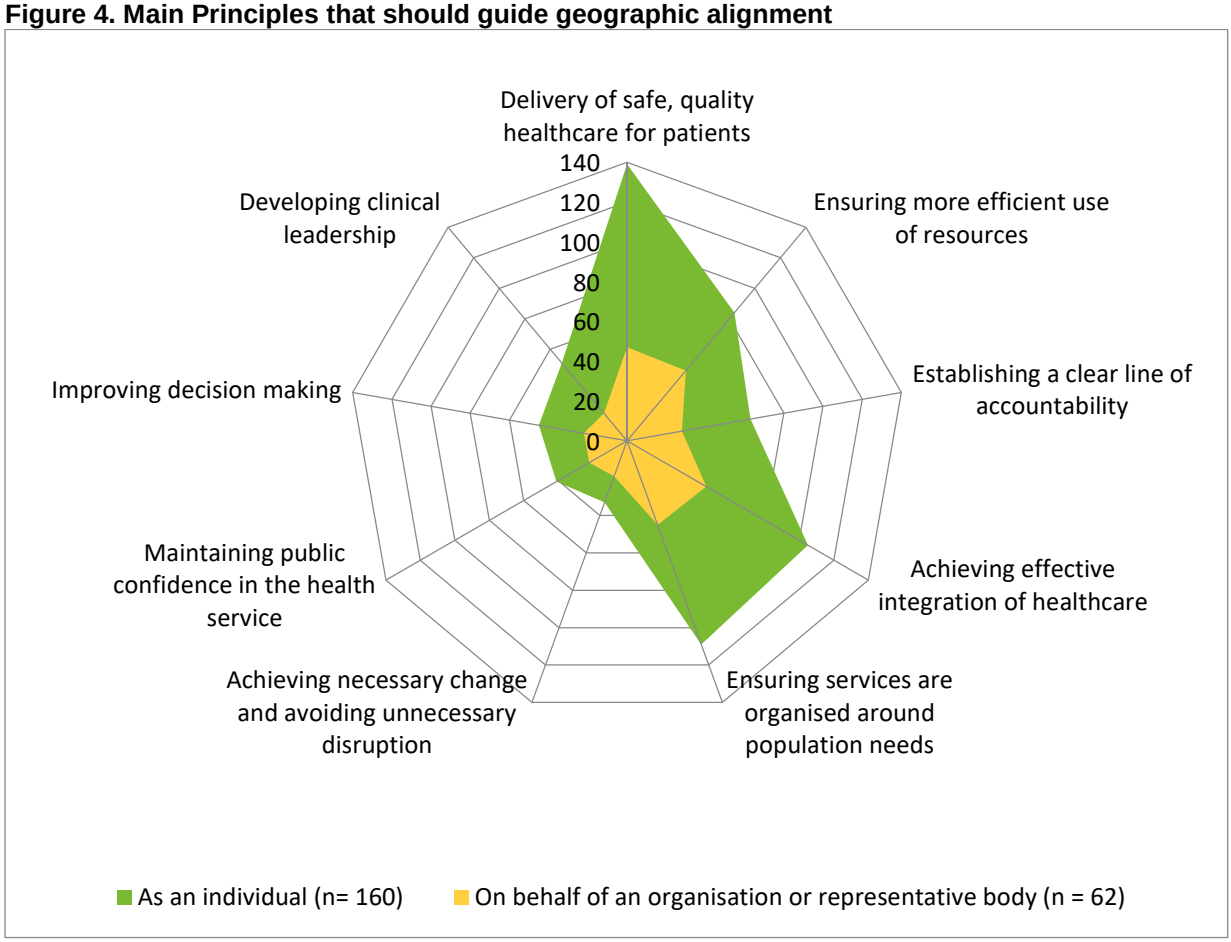
In this question respondents were asked to select as many, from a pre-populated list of principles, as they wished and they also had the opportunity to select 'other' and provide additional principles that they thought should guide the process of geographically aligning Hospital Groups and CHOs.

Key Statistics

Of the 160 individual responses received, 139 (87%) noted that the 'delivery of safe, quality healthcare for patients' should be a principle to guide the process of geographically aligning Hospital Groups and CHOs. The second largest principle selected by respondents (n=109; 68%) was 'ensuring services are organised around population needs' and this was followed by 'achieving effective integration of healthcare' (n=105; 66%).

Of the 62 organisational responses received to this question, the majority (n=47; 76%) also agreed that the 'delivery of safe, quality healthcare for patients' should guide the process, and this was followed closely by 'ensuring more efficient use of resources' (n=46; 74%)), 'achieving effective integration of healthcare' (n=46; 74%) and 'ensuring services are organised around population needs' (n=45; 73%).

Figure 4. Main Principles that should guide geographic alignment



Further views

Respondents had the opportunity to select 'other' and provide additional principles that they thought should guide the process of geographically aligning Hospital Groups and CHOs. A total of 14 organisational submissions and 18 individuals provided additional principles and through the analysis of feedback to this question, eight 'other' principles were identified to varying degrees and are described below.

Patient pathways

Overall, 11 submissions raised the importance of patient pathways as a guiding principle; six individuals and five organisations. Where additional details were provided, these included specific references to cardiac patient pathways (Organisation), "*primary care and public health integration*" (Organisation, Healthcare Organisation), and "*radiology*" (Individual, Health and Social Care Provider). The elimination of "*boundaries in pathways of care for patients*" (Individual, Health and Social Care Provider) was also raised.

Maintaining university links

Overall, three organisations and one individual raised the importance of maintaining university links as a guiding principle. In each of these submissions this was presented in terms of evidence-based care and decision making, innovation, and the central role of universities in existing structures. One organisation explained:

> "*Strong university medical links are extremely important and are fully integrated in all sites in addition to the link with [CHO name]*" (Organisation, Hospital or Hospital Group).

Further, an individual explained that maintaining links and collaborations with universities and academic institutions is needed to "*drive evidence based care and research relevant to service delivery*" (Individual, Health or Social Care Provider).

Clarity in governance and leadership

Although some of the detail in the responses received to this question are closely related to the pre-populated principles of "*Greater Clinical Leadership*" and "*Establishing a clear line of accountability*", it is worth highlighting some of the responses (3 individuals and 4 organisations) which stressed the need for "clarity" in relation to governance and leadership One respondent suggested the need for:

> "*a clear organisation which is a legal entity and is responsible for acute and community services with appropriate governance i.e. a board and chair of the legal organisation*" (Individual, Health or Social Care Provider).

Avoiding duplication

Avoiding duplication was identified by two individual and one organisation as an important guiding principle. The feedback highlighted the need to create a "*single budget across primary and secondary care*" (Individual, Health or Social Care Provider) and stressed the importance of "*removing duplication across structures and functions*" (Organisation, Academic Institution). Human resources management, services and financial management were mentioned as specific areas where duplication should be avoided.

Critical mass of patients

Two organisations raised the importance of a "*critical mass*" of patients, also referred to as patient volume, for the delivery of high quality healthcare. One respondent noted that:

> "*There should be a predetermined Minimum & Maximum Population determined prior to any alignment*" (Organisation, Community Healthcare).

Another respondent included details regarding a proposed population size:

> "*at least one million … in order to ensure a broad range of services in the hospitals within the entity and to build a resilient infrastructure to serve them*" (Organisation, Hospital or Hospital Group).

Equity

The principle of equity was raised by two organisations and one individual. This included both "*equity of access to services*" and "*equity of funding based on the population*". With reference to mental health services, one submission highlighted issues with the current arrangement and concerns that any changes should not exacerbate the current "*postcode lottery for those vulnerable in society who need access to mental health services*" (Organisation, Representative Organisation).

A note on further issues raised in this section

Investment in IT infrastructure was raised in this section on guiding principles, as well as in other sections of the submissions. This investment was framed as a pre-requisite condition for progressing both geographic alignment and integrated health and social care. Therefore, this issue is discussed later in, Section 2.5., where common issues that arose throughout many sections of the submissions, are collated and discussed.

Summary

The principles identified by the largest number of respondents that should guide the process of aligning CHOs and HGs were

- ✓ Delivery of safe, quality healthcare for patients;
- ✓ Achieving effective integration of healthcare;
- ✓ Ensuring services are organised around population needs; and,
- ✓ Ensuring more efficient use of resources.

Additional principles identified by respondents included:

- ✓ The importance of patient pathways;
- ✓ Maintaining university links;
- ✓ Avoiding unnecessary duplication;
- ✓ Critical mass of patients; and,
- ✓ Equity (of access and funding)

Please indicate how much you agree or disagree with each of the following statements: 'Geographic alignment will ...

This question asked respondents if they agreed, disagreed or neither agreed or disagreed with statements regarding what benefits geographic alignment might achieve. These statements can be found in Figures 5 and 6, along with the responses from individuals and organisations respectively. In addition to responding to pre-populated benefits, respondents were also given the opportunity to suggest other benefits of the geographic alignment of Hospital Groups and CHOs.

Key Statistics

160 individuals and 62 organisations responded to this question. A large majority of individual (n=122; 76%), and organisational (n=50; 81%) responses answered that geographic alignment will "enable and support integrated care". There was also a strong consensus view that geographic alignment will, "enable and support coordination of services in health and social care" (individuals: n=125, 78%; organisations: n=51, 82%), "enable and support population based healthcare delivery" (individuals: n=121, 75%; organisations: n=50, 81%), "enable and support population-based data analytics" (individuals: n=114, 71%; organisations: n=44, 71%), "facilitate effective cooperation with other state agencies/service providers" (individuals: n=107, 67%; organisations: n=41, 66%) and "enable and support better planning (individuals: n=120, 75%; organisations: n= 48, 77%).

It is interesting to note that while most organisations and individuals agreed with the benefit "enable and support performance assessment and management" this benefit also received the largest number of respondents selecting either "disagree" or "neither".

Figure 5. 'Geographic alignment will…' Individuals (n=126)

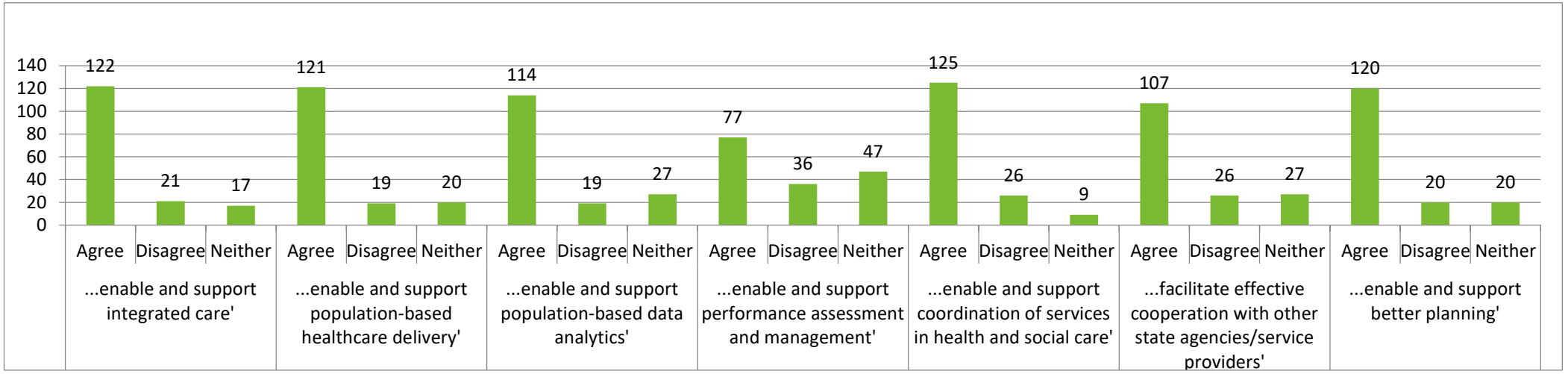
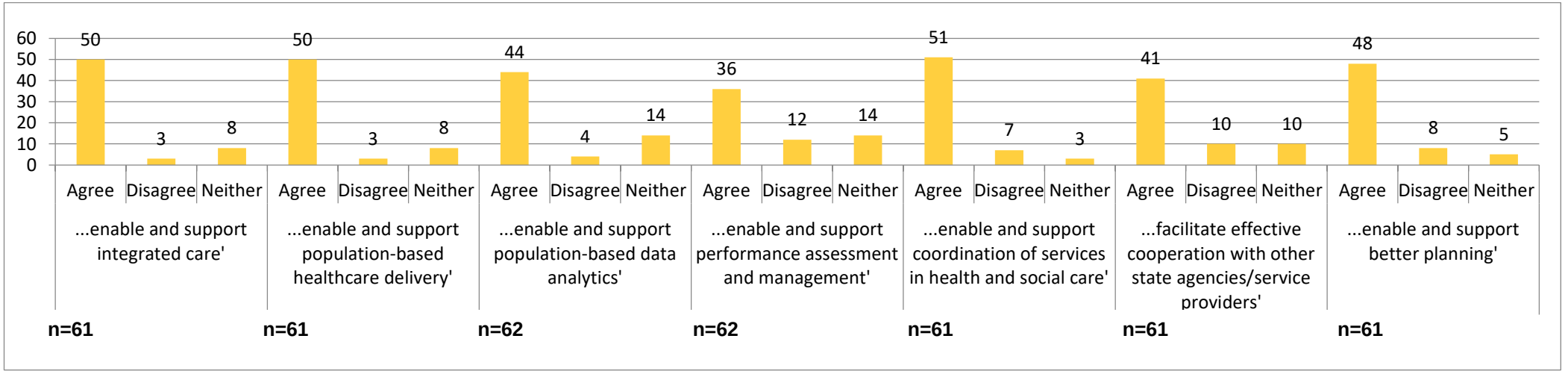


Figure 6. 'Geographic alignment will…' Organisations



Further Views

In addition to responding to pre-populated benefits, respondents were also given the opportunity to suggest other benefits of geographic alignment of Hospital Groups and CHOs. 68 individual respondents and 29 organisations availed of this opportunity and the additional benefits are set out below.

Many of the respondents re-iterated the benefit of '*Further integration of services'*. Reiterating the emphasis on the coordination of services, one respondent noted that "*direct alignment will facilitate the development of strategic relationships between professionals which will enhance patient care*" (Individual, Member of the General Public).

Improved patient experience and outcomes

A total of 11 individual and two organisations noted that geographic alignment would improve both patient experiences and related to this, would lead to "*better health outcomes*" for patients. Many of these submissions provided short statements identifying types of outcomes, including "*patient satisfaction*", "*safety*", "*quality*". Other statements included "*put patients first*", "*better healthcare experience*", "*less risk for patients and staff*" and "*value*".

Improving a person's experience navigating the health and social care system was noted by several individuals and organisations. This included improving awareness of what services are available, and where patients can access and receive services. One respondent noted that with the geographic alignment of Hospital Groups and CHOs "*patients will better understand the services available to them in their locality/region*" (Individual, Member of General Public). Another respondent emphasised that:

> *"There would be a visible connection / link between where a service user resides and where they can receive services with focused attention on integrated service provision"* (Individual, Public Administration or Regulation).

Some respondents provided greater detail in relation to improving patient experiences, with one respondent noting that geographic alignment of HGs and CHOs would lead to:

> *"... a potentially more appropriate patient response e.g. delayed discharges in the acute setting that might seem too costly to care for in a more community setting, however much more appropriate for the person"* (Individual, Public Administration or Regulation).

A further respondent replied that alignment would improve the delivery of chronic disease management by "*providing opportunities for people to avail of services in the Community for Chronic Disease Management rather than in [an] acute setting*" (Individual, Health or Social Care Provider).

Patient outcomes in relation to emergency care were also mentioned by one respondent:

> *"The Geo alignment for future health service delivery would assist in establishing Emergency Care Networks (ECN) … to optimise patient outcomes, safety, quality, access and value in emergency care, also benefits in aligning community support services to unscheduled and emergency care"* (Organisation, Healthcare Organisation).

Improved patient pathways

Building on the previous theme of patient experience and outcomes, several individuals and organisations provided their views on the benefit of geographic alignment for improving care pathways in general, and pathways related to specific diseases and patient groups. Many responses were short, and included single statements such as "*Streamlined patient pathways across a continuum of care"* (Organisation, Hospital or Hospital Group); "*Patient pathways can be clearly defined*" (Organisation, Voluntary/Not for Profit); "*Easier patient care pathway development and implementation*" (Organisation, Healthcare Organisation); and, "*Once aligned Group/CHO can develop seamless patient pathway as a first step towards regional integration*" (Individual, Public Administration or Regulation).

In terms of the relationship between acute and primary care settings, one individual reported that geographic alignment would lead to the provision of:

> "…*clearer information for patients particularly when they are moving from acute to primary care setting. It will also share responsibility across the service for organising the most appropriate setting for a patient to receive their care"* (Individual, Health or Social Care Provider).

In terms of specific pathways, one organisation explained the benefits of geographic alignment for referral pathways to radiology, which would lead to a:

> *"More effective pooling of Radiology resources - with regard to optimising referral pathways to Radiology investigations for GPs, promoting direct access to such services for GP patients … The current alignment is inefficient from a radiology service provision perspective"* (Organisation, Healthcare Organisation).

Greater ownership and community engagement

Overall, five individuals and two organisations noted the benefits of geographic alignment for those currently working in the community sector, insofar as this would "*improve team work*", lead to "*increased communication*", and promote "*good intra-area relationships leading to better co-ordinated care*". These benefits were closely linked to patient experience and shared decision making, as one respondent explained:

> *"it provides for an ownership and engagement with people which can bring them closer to being partners in their own healthcare rather than 'them' and 'us'. Geographical alignment may lead to better collaboration"* (Individual, Public Administration or Regulation).

This view was reiterated by an organisation which proposed that alignment would "*Create a sense of local ownership for patients and staff*" (Organisation, Hospital or Hospital Group). Another respondent explained that geographic alignment would lead to better communication and higher quality care, by introducing "*Efficiency of dealing with single contacts within your area, rather than multiple"* and noting that *"As relationships and trust build, it is easier to deliver high quality care*" (Organisation, Healthcare Organisation).

Stronger leadership

Overall, three individuals and one organisation suggested that clinical leadership across different disciplines and specialties would be stronger on a regional basis if services were geographically aligned. One respondent explained that geographical alignment would:

> "*Assist the development of more effective regional clinical leadership, particularly between General Practitioners and Specialists, and between different Nursing Sub Specialists*" (Individual, Health or Social Care Provider).

Another respondent suggested that leadership would be more transparent, with "*clearly identified service managers and referral agencies*" (Organisation, Healthcare Organisation). This theme shares similarities with the principle of clarity in leadership and governance that was raised in the previous section.

Facilitate a unified approach to healthcare

Although somewhat related to the pre-populated benefit 'enable and support coordination of services in health and social care', three individuals and one organisation raised the possibility of geographic alignment supporting a unified

approach, at both national and regional levels, as a benefit. This unified approach would include both "*Government and Health Professionals*" (Individual, Public Administration or Regulation) who would all be "*striving towards the same strategic plan*" (Organisation, Hospital or Hospital Group). From the perspective of service provision, one respondent indicated that this would lead to "*less confusion when trying to deliver community services to support acute services*", and for services users, this would lead to a:

> *"reduced risk of patient falling between two stools with more standardised approach where you have one CHO and HG working together"* (Individual, Health or Social Care Provider).

A unified approach in the area of standards was also raised by another respondent, particularly in relation to "*QA*[6] *[sic] across acute / community aligned areas*" (Individual, Health or Social Care Provider).

Improved resource allocation decisions

While related to, and perhaps implicit in the pre-populated benefit "enable and support better planning", it is worth noting the explicit reference by several respondents to the potential benefit of improved resource allocation. Feedback included statements such as "*Better alignment of funding resources to key 'need' areas*" (Organisation, Voluntary/Not for Profit) and, "*more balanced resourcing to primary care*" (Individual, Health or Social Care Provider). One respondent suggested that geographic alignment would "*Give a true identity to the local health services incorporating both acute and other health services and hopefully reduce the competition for resources*" (Individual, Public Administration or Regulation). Another respondent stated that:

> *"Appropriate geographic alignment can ensure such services are planned and delivered in line with identified local needs. These can include, but are not confined to, appropriate resourcing"* (Organisation, Representative Body).

One respondent also highlighted the benefits for budget management stating that "*it is almost impossible to ensure value for money and budgetary controls when the two sectors operate independently*" (Individual, Health or Social Care Provider), referring to acute and primary sectors.

[6] QA: Quality Assurance.

Improved decision making

A total of 6 individuals and two organisations reported that geographic alignment would lead to improved decision making. Views about what constituted improvement in decision making varied across individual submissions; One respondent explained that geographic alignment would "*shorten decision making time*" (Individual, Health or Social care Provider) while another felt that "*It will, hopefully, reduce the influence of large teaching hospitals and medical schools on planning decisions*" (Individual, Health Research or Education). Another respondent reiterated the benefits of local coordination, noting that geographic alignment would lead to "*collective ownership in the community and transparent decision making*" (Organisation, Community Healthcare).

Improvements for health sector workforce

Two organisations and one individual respondent discussed the potential benefits of geographic alignment for the health and social care workforce, insofar as this would lead to "*Flexibility in recruitment*" (Organisation, Hospital or Hospital Group), "*Better rotations for doctors and nurses so better training, more likely to stay in Irish Health Service*" (Individual, Health or Social care Provider) and an "*opportunity for staff to work across services*" (Organisation, Voluntary/Not for Profit).

In terms of training and future staffing, two organisations stressed the importance of maintaining existing ties with universities, and the geographic alignment of universities. One stated:

> *"While geographic alignment is important, the clinical leadership, research and development and the links with [University Name] are important for the future staffing and development of safe clinical services. Geographic alignment cannot provide the University (medical specialty in particular) links required for the training of specialist clinical staff, to enable delivery of quality safe services to patients in an acute frontline hospital unless the universities are aligned geographically"* (Organisation, Hospital or Hospital Group).

A note on further issues raised in this section

Throughout this section on the potential benefits of geographic alignment of Hospital Groups and CHOs, individual and organisational respondents suggested a number caveats and pre-requisites associated with progressing geographic alignment. Therefore, these issues will be discussed later in Section 2.5, where common issues that arose throughout many sections of the submissions, are collated and discussed.

Summary

The majority of respondents (individual and organisational) agree that geographic alignment has potential to:

- ✓ Enable and support integrated care;
- ✓ Enable and support coordination of services in health and social care;
- ✓ Enable and support population-based healthcare delivery;
- ✓ Enable and support population-based data analytics;
- ✓ Facilitate effective cooperation with other state agencies/service providers; and,
- ✓ Enable and support better planning.

Further benefits identified by respondents include:

- ✓ Improve patient experience and outcomes;
- ✓ Improve patient pathways;
- ✓ Facilitate greater ownership and community engagement;
- ✓ Enable stronger leadership;
- ✓ Facilitate a unified approach to healthcare;
- ✓ Improve resource allocation decisions;
- ✓ Improve decision making; and,
- ✓ Enable improvements for the health sector workforce.

While a large number of organisations agreed that geographic alignment could "enable and support performance assessment and management", a majority of individual respondents either disagreed or were unsure that this was a potential benefit.

What, in your opinion, are the main advantages of geographic alignment of Hospital Groups and CHOs?

This section builds on the potential benefits of geographic alignment presented in the preceding section. Here, respondents were asked to select as many advantages as they wished from a pre-populated list. Respondents were also given the opportunity to suggest additional advantages that were not listed.

Key Statistics

149 individual responses and 58 organisational responses were received to this question. The results are presented in Table 2.

For both individual and organisational respondents, the most frequently selected advantage of geographic alignment was that it 'allows for integration of services' (116 individuals (78%) and 46 organisations (79%). Two advantages which were selected second most often by individuals: 76% (n=90) selected 'more efficient use of resources' and 76% (n=90) selected "allows for population-based health planning".

The second advantage most frequently selected by organisational respondents was 'ensures coordination between different care sectors' (n=37; 64%), followed by 'more efficient use of resources' (n=36; 62%).

For both organisational and individual respondents, there was consistency in that the related issues of "greater accountability" and "greater visibility for performance" were selected least often. Only 24% of both individual and organisational respondents selected "greater accountability" as an advantage and 20% individual respondents and 16% organisational respondents viewed "greater visibility for performance" as an advantage of geographic alignment.

In addition to these results, 11 individuals and two organisations responded that there were no advantages associated with geographic alignment.

Table 2. What are the main advantages of geographic alignment?

	No. individual responses (n=149)	No. organisation responses(n=58)
Allows for integration of services	116	46
More efficient use of resources	90	36
Allows for population-based health planning	90	30
Allows for population-based resource allocation	89	31
Ensures coordination between different care sectors	86	37
Improved healthcare outcomes	67	33
Supports integration of data	56	19
Allows for greater focus on health outcomes	47	27
Greater clinical leadership	37	9
Allows for better financial decisions	37	19
Greater accountability	36	14
Greater visibility for performance	30	9
Allows for greater comparability	20	9

Further views

In addition to selecting from a pre-populated list of advantages, respondents were also given the opportunity to suggest additional advantages. A total of eight individuals and four organisations provided further feedback. However, for the most part, these respondents reiterated many of the advantages already listed: integration of services; integration of data; greater comparability. For example, in relation to data integration, one individual suggested "*aggregations of a range of health data and the ability to do meaningful comparisons across different areas/regions*" (Individual, Member of the General Public).

Further, and in relation to integrated service development, one respondent stated that geographical alignment was "*likely to improve stakeholder buy-in to service development*" (Individual, Health or Social Care Provider). Service development was also suggested as an advantage by some respondents. One respondent noted that services would be more "*streamlined*" (Organisation, Healthcare Organisation), while another referred to "*more streamlined services and integration*" (Organisation, Academic Institution).

Summary

The main advantages which ranked highest amongst individual and organisational respondents mirrored the key findings from the previous section on the potential benefits of geographic alignment:

For both individual and organisational respondents, the most frequently selected advantage of geographic alignment was that it ‘allows for integration of services’. Other advantages which ranked highest included:

- ✓ More efficient use of resources;
- ✓ Ensures coordination between different care sectors; and,
- ✓ Allows for population-based health planning.

What, in your opinion, are the main disadvantages of geographic alignment of Hospital Groups and CHOs?

Similar to the previous question, respondents were asked to select as many disadvantages as they wished from a pre-populated list. Respondents were also given the opportunity to suggest additional advantages that were not listed.

Key Statistics

149 individuals and 58 organisations responded to this question. The results are presented in Table 3. The most frequently selected disadvantages which were both selected by 38% of respondents was 'disruption to current structures' (n=56) and the 'associated cost of changes' (n=56). Other disadvantages frequently selected by individuals were "potential breakage of links between hospitals currently linked" (n=52; 35%), "disruption to services provided" (n=48; 32%) and "administrative burden" (n=44; 30%).

'Disruption to services provided' was the disadvantage most frequently selected by organisational respondents (n=25; 43%). Others disadvantages frequently selected by organisational respondents were 'associated cost of change' (n=24; 41%), "potential breakage of links between hospitals currently linked" (n=24; 41%), "disruption to current structures" (n=23; 40%) and "potential breakage of links between services within CHOs" (n=20; 34%).

For organisations, the least frequently selected disadvantages were collectively 'administrative burden', 'alignment should be on basis other than geography (e.g. with universities)', 'disruption to relationships between healthcare areas and academic institutions', and 'organisational healthcare structures are not very relevant to care delivery' (n=13, 22%). In addition to these results, 16 individuals and four organisations selected that there were no disadvantages associated with geographic alignment.

Table 3. What are the main disadvantages of geographic alignment?

	No. of individual responses (n=149)	No. of organisation responses (n=58)
Disruption to current structures	56	23
Associated cost of changes	56	24
Potential breakage of links between hospitals currently linked	52	24
Disruption to services provided	48	25
Administrative burden	44	13
Potential breakage of links between services within CHOs	39	20
Alignment should be on basis other than geography (e.g. with universities)	26	13
Disruption to relationships between healthcare areas and academic institutions	25	13
Organisational healthcare structures are not very relevant to care delivery	23	13

Further views

In addition to selecting from a pre-populated list of disadvantages, respondents were also given the opportunity to suggest additional disadvantages. A total of 23 individuals and 14 organisations provided further feedback. Much of the detail provided re-emphasised several of the disadvantages already listed above. A further 6 disadvantages emerged in response to this question, and these are briefly described below.

Local gaps in resources and services

One respondent noted that there was a "*danger of some areas being poorly resourced*", noting that at present "DLR HSE are poorly funded compared with other HSE areas in South Dublin" (Individual, Health or Social Care Provider). Another individual felt that geographic alignment could lead to "*resources being taken from one area to support another*". Similarly, in relation to area-specific needs, one respondent was concerned that geographic alignment "*Will not take into consideration the differences in the local contexts and the unique needs of each community*" (Organisation, Voluntary/Not for Profit). Another respondent noted concern that geographic alignment would "*result in greater gaps in care delivery as is*

the case now" (Individual, Public Administration or Regulation). Specifically, one respondent noted that "*psychiatric services [are] not included in hospital realignment*" (Individual, Health or Social Care Provider).

Change fatigue

A number of respondents (seven individuals and six organisations) highlighted their concerns over change (or reform) fatigue, stating that the "*changes will be meaningless*", or: "*alignment will be in name only and practice will not change*" (Individual, Health or Social care Provider). Another respondent re-iterated this sense of change fatigue, highlighting that this was "*another major re-structuring exercise within three years"* (Individual, Health or Social Care Provider). Finally, another respondent suggested that geographic alignment could lead to the loss of the service change skills and service change culture that have developed over time, noting that:

> *"Some groups and organisations have created very effective change groups, it would be a significant loss to lose the culture and skills of service change from within"* (Organisation, Academic Institution).

A note on change fatigue

The issue of change or reform fatigue was raised in several other parts of the consultation questionnaire, and in free-form submissions. Therefore, this issue is discussed further in Section 2.5, in terms that are broader than the current question.

Lack of patient choice in care setting

Two respondents discussed the potential risk of care not being delivered in an appropriate and local location or setting. One explained that "*patients may be stuck being treated in a hospital that they don't want to be treated in as it is in their group"* (Individual, Health or Social Care Provider). Another felt that:

> *"People in Ireland think of public services being delivered in the context of a County where at all possible. Counties form our sense of identity, loyalty, and pride. Therefore it is important that decisions are seen to be taken as locally as possible"* (Individual).

Greater uncertainty for patients and staff

Some respondents suggested that geographic alignment would lead to greater uncertainty for staff and for patients and clients. One explained that "*frequent organisational change leads to unrest among staff*" (Individual, Member of the General Public). In relation to geographic alignment and health information, one respondent felt that the changes would lead to uncertainty and fear among the public that "*their personal health information will be lost in the changes*" (Individual). Another respondent was concerned over whether patients will have "*any choice or say*" in the future as to where their health and social care will be delivered (Individual, Health or Social Care Provider). One organisational respondent indicated that this could lead to uncertainty about the privacy of accessing care in the future, particularly for clients "*attending specific personal clinics discreetly*" (Organisation, Voluntary/Not for Profit).

Increased administration and management layers

One respondent noted that the process would "*probably end up creating additional layers of unnecessary management grades*" (Individual, Health or Social Care Provider), while another stated that geographic alignment alone would:

> "*add an additional unnecessary layer of administrative bureaucracy (e.g. regional integrated care organisations on top of current structures) that would only add to the present sclerotic*[7] *administration*" (Organisation, Representative Body).

The same organisation advocated for geographic alignment with the following caveat: "*It is vitally important that funding is not diverted from delivering frontline services into additional layers of bureaucracy*" (Organisation, Representative Body). This theme shared similarities with the principle of 'Avoiding Duplication' which was raised in the section on Guiding Principles and with the pre-populated disadvantage of "administrative burden".

[7] Definition of sclerotic: becoming rigid and unresponsive; losing the ability to adapt (Oxford English Dictionary).

A note on additional themes in this section

In responses within this section, a small number of respondents provided their views about how organisational cultural differences within the healthcare system present a challenge for both geographic alignment and integrated care. The issue of organisational cultures will be discussed in the wider context of integrated care in Section 2.5.

Summary

The disadvantages of geographic alignment most frequently selected by individual and organisational respondents were:

- Disruption to services provided;
- Associated cost of changes;
- Disruption to current structures;
- Potential breakage of links between hospitals currently linked;
- Potential breakage of links between services within CHOs; and,
- Administrative burden.

Other disadvantages identified included:

- Local gaps in resources and services;
- Change fatigue; and,
- Greater uncertainty for patients and staff.

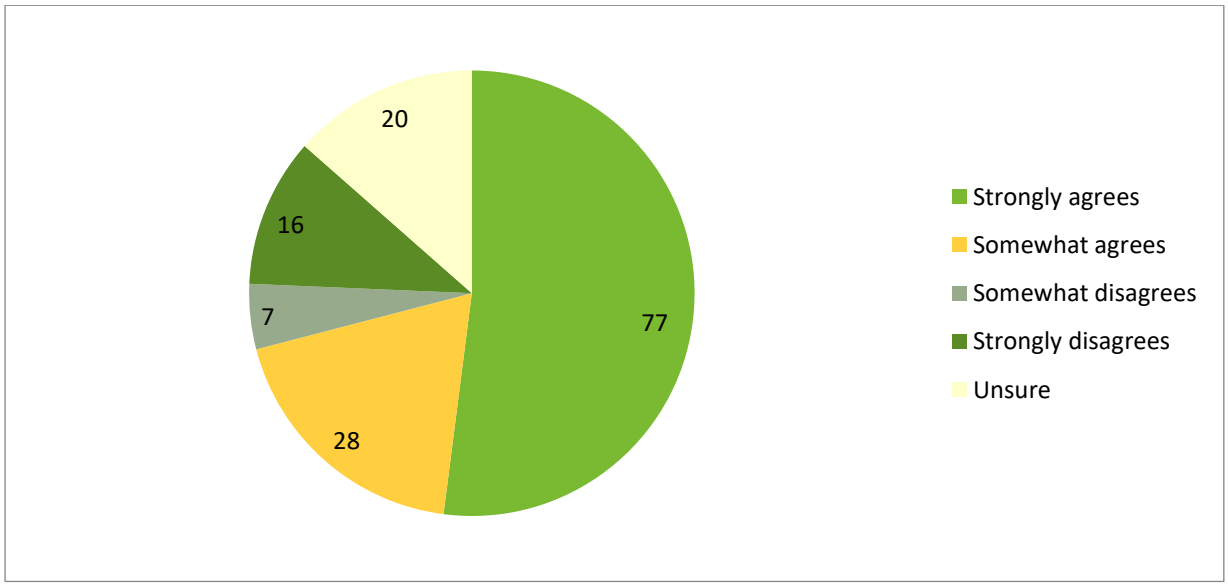
Considering all the advantages and disadvantages, how strongly do you agree with the following statement: *The advantages of geographic alignment of CHOs and Hospital Groups outweigh the disadvantages.*

This question asked respondents to select whether they strongly agreed, somewhat agreed, somewhat disagreed, strongly disagreed or were unsure with regards to the above statement.

Key Statistics

Of the148 individuals who submitted a response to this question, 105 (71%) agreed with the statement that the advantages outweigh the disadvantages (77 strongly agreed, 52%; 28 somewhat agreed, 19%). A further 16% disagreed with this statement (16 strongly disagreed, 11%; seven somewhat disagreed, 5%) and 20 (14%) were unsure.

Figure 7. 'Do you agree that the advantages outweigh disadvantages?' (Individuals)

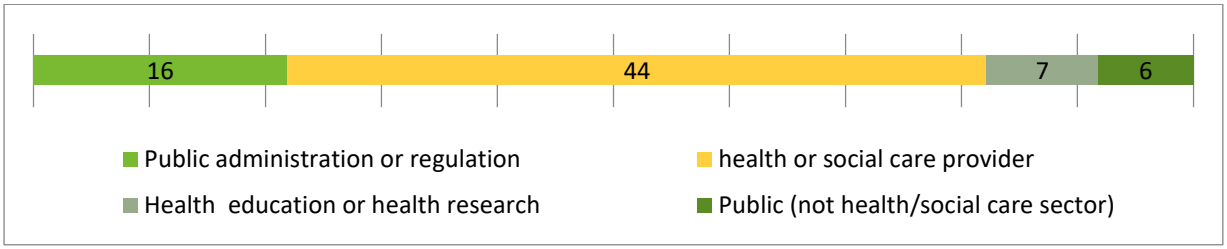


Note: n=148

The high-level breakdown of individual respondents who 'strongly agree' and 'strongly disagree' is shown in Figures 8 and 9, respectively. The largest group that 'strongly agree' are Health or Social Care Providers (n=44; 60%), followed by those who work in Public Administration or Regulation (n=16; 22%). However Health or Social care Providers also make up the largest group that strongly disagreed (n=9;

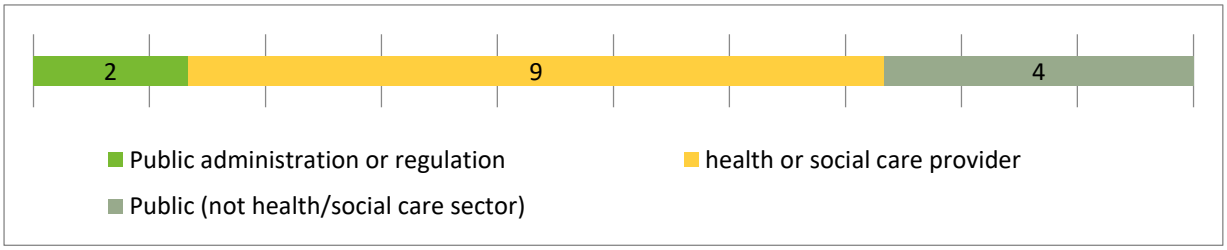
60%). It is therefore difficult to draw any meaningful conclusions from this high-level breakdown of respondents and/or the small numbers.

Figure 8. Breakdown of individuals that 'Strongly agree'



Note: n=73

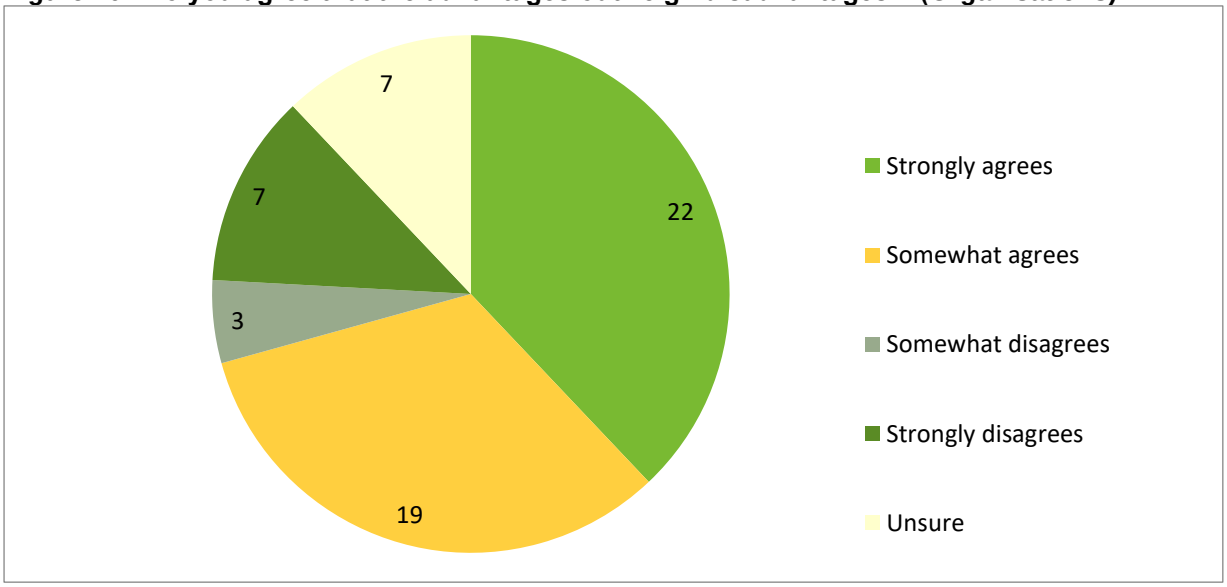
Figure 9. Breakdown of individuals that 'Strongly disagree'



Note: n=15

Out of the 58 organisations who submitted a response to this question, a majority (n=41; 71%) agreed with the statement that the advantages of geographic alignment outweigh the disadvantages (21 strongly agreed: 36%; 19 somewhat agreed: 33%). Similar to individual responses, a minority of organisations (n=11; 19%) disagreed with the statement (7 strongly disagreed: 12%; 4 somewhat disagreed: 7%) and 7 (12%) were unsure.

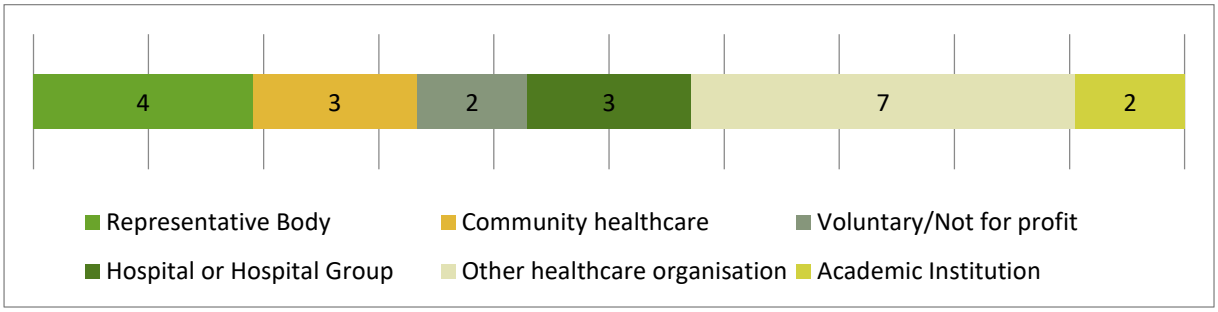
Figure 10. 'Do you agree that the advantages outweigh disadvantages?' (Organisations)



Note: n=58

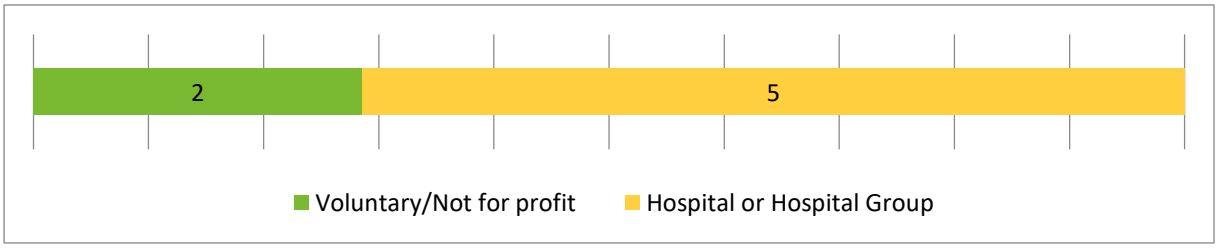
The organisations that strongly agreed and strongly disagreed with the statement were analysed by broad type and the results are shown in Figures 11 and 12 respectively. Of those that strongly agreed, there was a broad representation of most organisation types. On the other hand, of the small number of organisations that strongly disagreed with the statement (n=7, 12%), this predominantly comprised responses from hospital or hospital groups.

Figure 11. Breakdown of organisations that 'strongly agree'



Note: n=21

Figure 12. Breakdown of organisations that 'strongly disagree'



Note: n=7

Summary

- ✓ 90% of those who made an individual submission answered this question. Of these, 71% state that the advantages of geographical alignment outweigh the disadvantages, and 16% disagree with this statement.
- ✓ 88% of those who made an organisational submission answered this question. Of these, 71% of respondents agree that the advantages of geographic alignment outweigh the disadvantages, and 19% disagree with this statement. Of the small number of organisations that strongly disagreed with the statement (12%), these predominantly derived from respondents from a hospital/hospital group.

2.3 Achieving Geographic Alignment

In your opinion, what level of importance should be placed on the following organisational factors to inform any plans to move to geographic alignment of Hospital Groups and CHOs?

In this question respondents were asked to select the level of importance that should be placed on five pre-populated factors. Respondents were asked to select from a choice of “extremely high importance”, “high importance”, “little importance” “no importance” or “don’t know”.

Key Statistics

The results are summarised in Figures 12 to 17 below for each of the pre-populated “organisational factors”. For the purpose of analysis and representation of results, responses to “extremely high importance and high importance” are combined and referred to as “high importance”. Similarly, responses for “little importance” and “no importance” are combined and referred to as “little importance”

A large percentage of individual and organisational respondents stated that a high level of importance should be placed on ‘the organisation of existing CHOs’ (96 individuals, 66%; 43 organisations, 75%). There was also a strong and consistent view that a high level of importance should be placed on ‘the organisation of existing Hospital Groups’ (95 individuals, 65%; 36 organisations, 63%) and ‘existing links between hospitals and universities’ (86 individuals, 59%; 38 organisations, 67%).

The views of both groups were more mixed when considering the importance of ‘aligning with county boundaries’. A total of 77 individuals (53%) answered that little or no importance should be placed on ‘aligning with county boundaries’ and 33 organisations (58%) noted the same.

Figure 13. The organisation of existing Community Healthcare Organisations (CHOs)

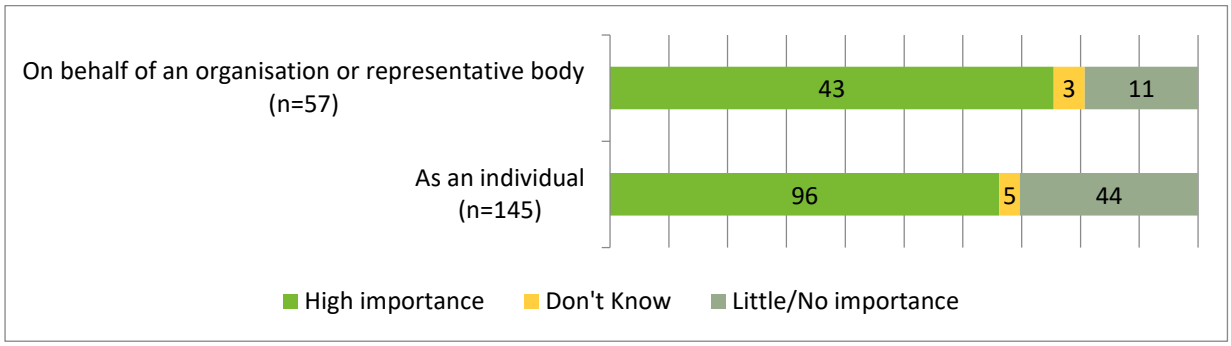


Figure 14. The organisation of existing Hospital Groups

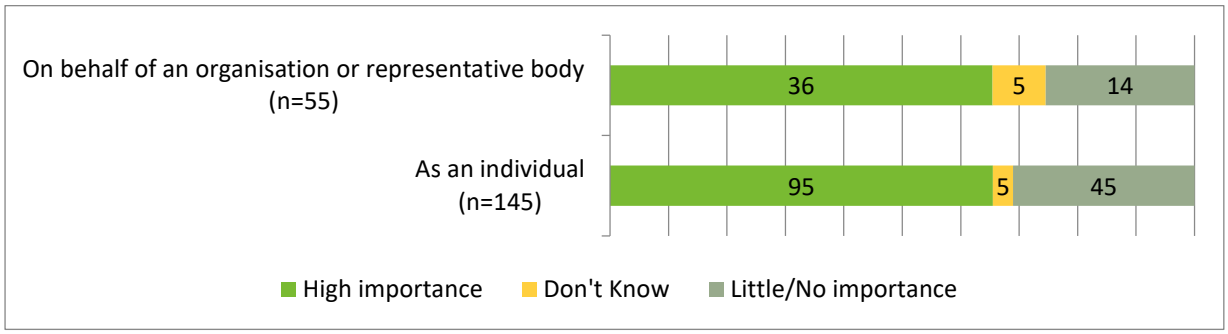


Figure 15. Aligning with county boundaries

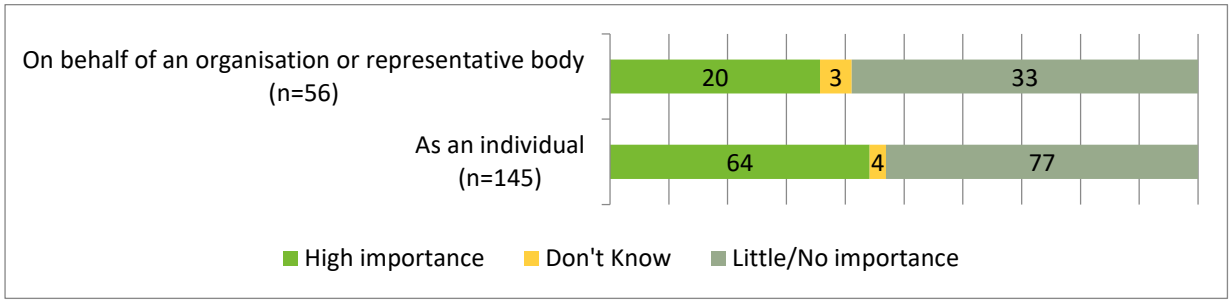


Figure 16. Existing links between hospitals and universities

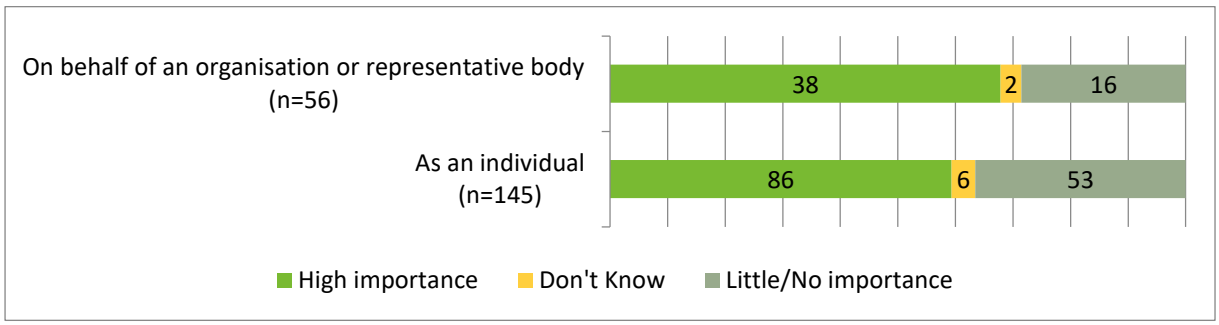
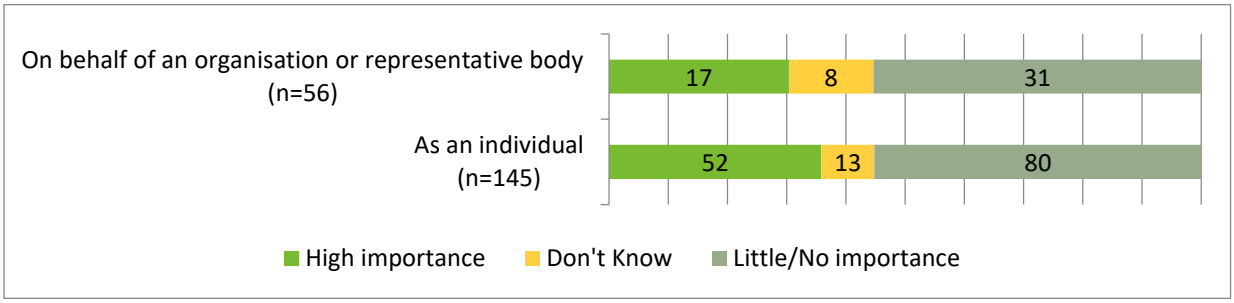


Figure 17. Organisational factors - Existing administrative history



Summary

The organisational factors which the majority of respondents placed high importance on when moving to progress geographic alignment included:

- ✓ The organisation of existing CHOs;
- ✓ The organisation of existing Hospital Groups; and,
- ✓ Existing links between hospitals and universities.

There was mixed views from both sets of respondents regarding the importance of aligning with county boundaries.

In your opinion, what level of importance should be placed on the following service provision factors to inform any plans to move to geographic alignment of Hospital Groups and CHOs?

As with the previous question, respondents were asked to select the level of importance that should be placed on four pre-populated service provision factors. Respondents were asked to select from a choice of "extremely high importance", "high importance", "little importance" "no importance" or 'don't know'.

After they completed this question, respondents were asked to provide any other factors (organisational or service provision or other) which should inform any plans to move towards geographic alignment of Hospital Groups and CHOs.

Key Statistics

A total of 145 individuals and 55 organisations completed this question on service provision factors. The results for the four pre-populated factors are summarised in Figures 18 to 21 below. For the purpose of analysis and representation of results, responses to "extremely high importance and high importance" are combined and referred to as "high importance". Similarly, responses for "little importance" and "no importance" are combined and referred to as "little importance"

A majority of both individual and organisational respondents stated that high importance should be placed on: 'the population size/density of an area' (131 individuals,90%; 52 organisations, 95%); 'patient travel times & transport links' (133 individuals, 92%; 49 organisations, 89%); 'existing patient flow patterns' (129 individuals, 89%; 48 organisations, 87%); and 'the range of health services in an area' (134 individuals, 92%; 52 organisations, 95%).

Figure 18. Existing patient flow patterns

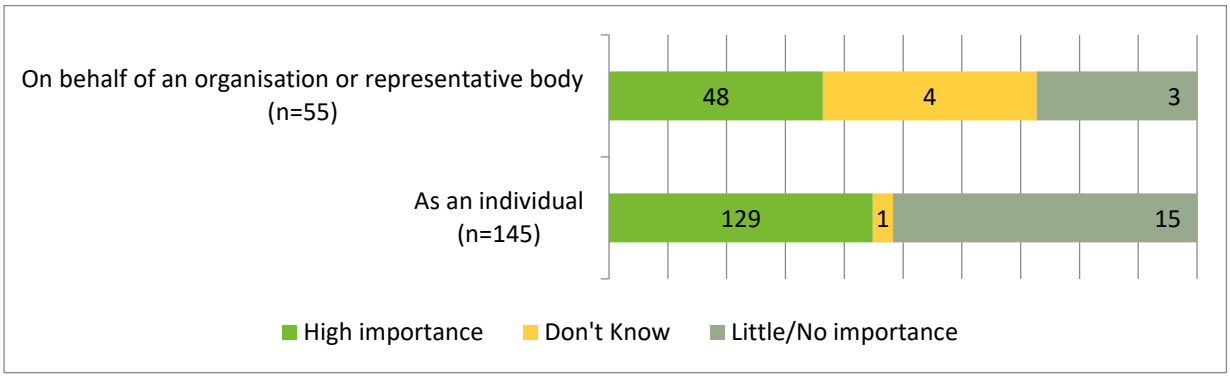


Figure 19. Patient travel times and transport links

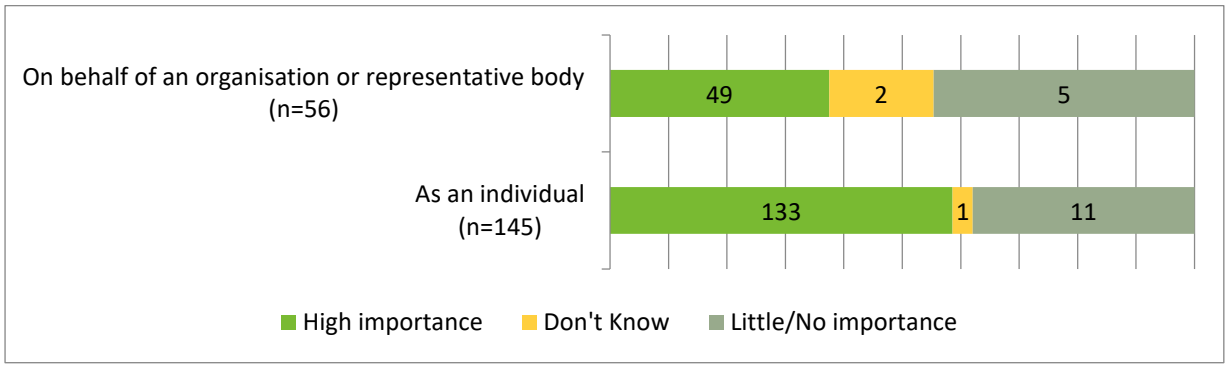


Figure 20. The population size/density of an area

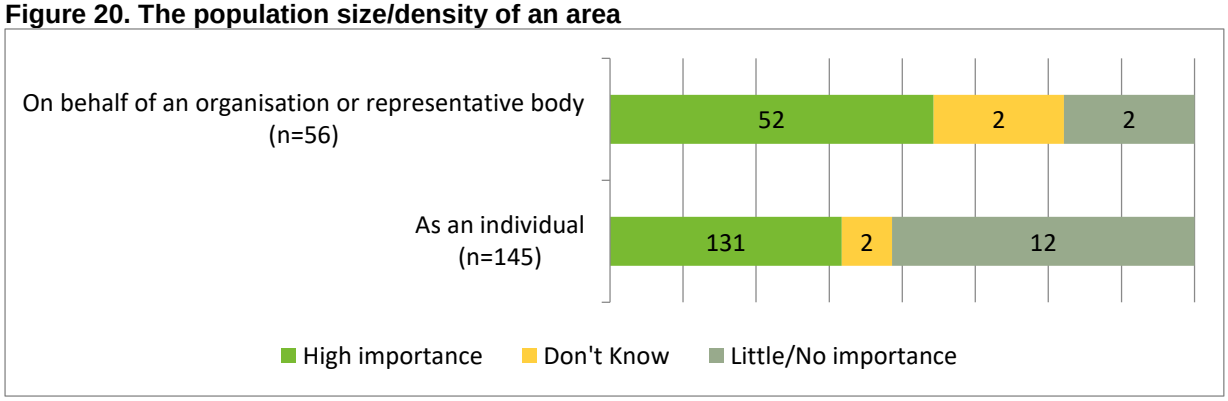
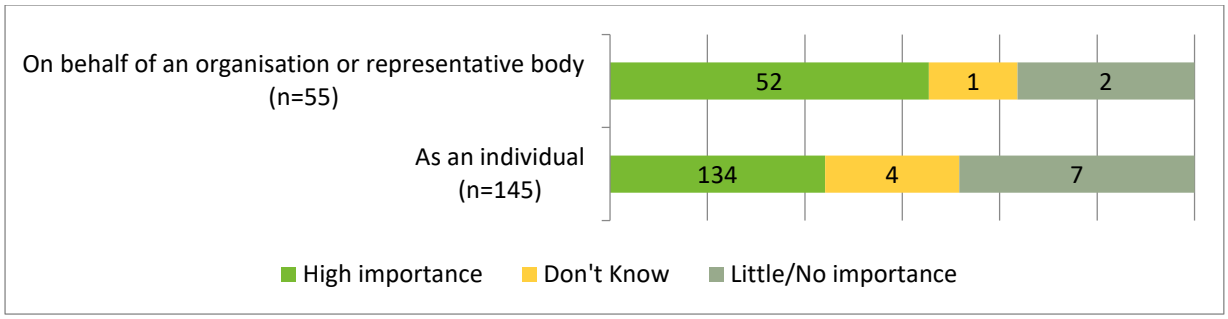


Figure 21. Service provision factors - The range of health services in an area



Summary

A majority of individual and organisational respondents agreed that high importance should be placed on the following factors when progressing geographic alignment:

- ✓ Existing patient flow patterns;
- ✓ Patient travel times and transport links;
- ✓ The population size/density of an area; and,
- ✓ The range of health services in an area.

Further Views

After they completed the questions scoring the importance level of pre-populated lists of organisational or service provision factors, respondents were asked to suggest any other factors (organisational or service provision or other) which should inform any plans to move towards geographic alignment of Hospital Groups and CHOs. In total, 48 individuals and 24 organisations provided further information.

A number of these responses took the opportunity to reiterate the importance of certain factors covered already, elaborating on why they believe these factors to be important. For example, four individuals and six organisations reiterated the importance of three related organisational factors: 'existing CHOs', 'existing HGs', and 'links between hospitals and universities'. The majority of these highlighted the disruption to existing services, service development, and current working relationships. To illustrate, one individual felt that more emphasis should be placed on "*strengthening links between hospitals***"** (Individual, Member of the General Public) and a second highlighted the importance of:

> *"personal links between management personal [sic] who have moved from hospital to CHO and vice versa, this will facilitate collaboration on integrated care pathways"* (Individual, Health or Social Care Provider).

A further individual felt that there are **"***good clinical links already in existence between model 3 and 4 hospitals and between GPs and local hospital*" (Individual, Health or Social Care Provider). In addition, one respondent noted that it was important that there would be:

> *"Recognition of work undertaken to-date by [hospital group] in all the hospitals in the group, the clinical pathways being developed for patient access to tertiary services, the involvement of [University] in the group and the development of the [academic centre]"* (Organisation, Hospital or Hospital Group).

Only a small number of respondents selected 'Existing administrative histories' as being of high importance however, one of those respondents who viewed this as being of high importance provided their rationale:

> "*It will be essential to retain the integrity of the 96 Community Healthcare Networks as a (geographical) building block for the new structures"* (Organisation, Healthcare Organisation).

Reiterating the importance of considering the range of health services in an area, two respondents raised the importance of national services and their availability at local

levels such as "*rehabilitation*", "*older persons services*" (Organisations, Voluntary/Not for Profit) and "*addiction treatment*" (Organisation, Voluntary/Not for Profit).

Overall, in addition to the elaboration on factors already listed, a further seven factors were raised in the submissions. These are described in the next section.

Evidence Informed

Two individuals and four organisations highlighted that it was essential for research to be conducted to inform any process of alignment, and that there be a transparent evidence base underpinning any decisions made. One respondent noted that international evidence should be considered: *"It is important that the international evidence-base informs any plans to move to geographic alignment of Hospital groups"* (Organisation, Representative Body). A second respondent stressed the importance of a solid evidence base in raising their concern over the rationale for change:

> *"A clear rationale as to why geographical alignment is considered important. Disease knows no boundaries and the proposal seems designed to create the impression of change for change's sake"* (Organisation).

One respondent highlighted the importance of learning from previous reforms:

> *"Critical evaluation on Hospital Groups, Community Health Care Organisation, Slainte Care [sic] Report and the establishment of HSE using robust research analysis is required. We need to do a look back at key learning from all the changes using evidence based approach"* (Individual, Member of the General Public).

The matter of evidence-based planning was raised throughout the consultation and is also discussed in more detail in Section 2.5.

Patient experience and choice

A focus on patients was raised by six individual respondents. This included an emphasis on improving patient experience and outcomes and supporting choice: "*Patient choice is the reason why hospital groups do not have geographically defined boundaries*" (Individual, Health or Social care Provider). The circumstance of older rural patients was also raised by one respondent:

> *"Not all healthcare needs are emergency based. The requirement to see a physio/PHN[8]/OT[9] is essential to the elderly person who lives at home alone"* (Individual, Health or Social Care Provider).

In relation to patient choice, one respondent stated that "*Patients should not be forced into attending a service they do not necessarily want to attend just because it is in the jurisdiction of where they live*" (Individual, Health or Social Care Provider).

A further respondent noted that local access is more important to service users than the organisation of the health and social care system:

> *"…service users aren't interested in cho's [sic] or hospital groups or divisions or care groups. They just want to know where they can receive medical attention in a timely fashion as close to their home as is reasonably possible"* (Individual).

The impact on the care of patients was also highlighted by one respondent: "*The disruption to continuity of patient care with recent alignment of services within hospital groups and CHO's should be considered*" (Organisation, Hospital or Hospital Group).

Clinical leadership and governance

A number of respondents (two individual and six organisational) raised the related issues of clinical leadership and governance as important factors to consider in a move towards geographic alignment of Hospital Groups and CHOs. One stated that:

> "*The focus of governance in any newly merged structures should be rebalanced to facilitate increased clinical governance input at organisational board levels so as to prioritise the delivery of safe, high-quality, timely care to patients*" (Organisation, Representative Body).

Another noted that "*Currently, there is a dilution of clinical decision-making, autonomy and authority*" (Organisation, Representative Body).

Impact on workforce and staff travel times

The issue of staff travel was raised by several respondents with two constituent elements: workforce location and working conditions. One individual explained:

[8] PHN: Public Health Nurse
[9] OT: Occupational therapist

> *"Staffing resources and cost of living - to spread expertise you need to make geographical areas attract [sic] to recruit staff to provide these services"* (Individual, Health or Social Care Provider).

In terms of working conditions, time spent travelling within CHO areas was highlighted by a respondent:

> "*The current areas are totally unworkable for staff ... they waste time travelling instead of spending it on service user care*" (Individual, Health or Social Care Provider).

Clarity regarding responsibility and accountability

The term of 'accountability' was stated by several individuals, but no further detail was provided. Related to this, one organisational respondent noted that there are "*too many divisions and lack of clarity on who is responsible for what from an acute hospital perspective leading to delays in discharge planning*" and there is a "*need for integrated community and hospital services under single management structures e.g. physiotherapy, OT, SALT, Dietetics*" [10] (Organisation, Healthcare Organisation).

Equity

The issue of equity in resource allocation, access and patient outcomes was raised by three individuals and one organisation. One stated that:

> *"The level of disadvantage / health inequalities / poor health outcomes in certain areas - this should be factored into plans for alignment and for future resource allocation"* (Organisation, Representative Body).

Another respondent raised the issue of "*Quality differentials related to service provision and equity of access and use*" (Individual, Health Education or Research) and a further response highlighted the importance of fair resource allocation in order to reach those most in need:

> *"The allocation of resources fairly distributed cognisant of disadvantage and ensuring those most in need are encouraged to access services rather than making it more difficult for them"* (Individual, Health or Social Care Provider).

[10] OT: Occupational Therapy: SALT: Speech and Language Therapy.

Resource availability and allocation

Resource allocation was mentioned in relation to equity, but also separately in terms of current resources available in an area: *"the absence or weakness of certain services within the catchment" (*Individual, Public Administration or Regulation*),* and the need for *"Protected Budgets and money to follow the service user"* (Organisation, Voluntary/Not for Profit).

A note on other factors presented in this section

Several other factors were raised in this section, which were also raised throughout the submissions received (e.g., IT infrastructure; reform fatigue; and pre-existing integration work). These factors are discussed in greater detail in Section 2.5.

Summary

In the previous section, the following pre-populated factors were scored by respondents as being of high importance when progressing plans towards geographic alignment:

- ✓ The organisation of existing CHOs;
- ✓ The organisation of existing Hospital Groups;
- ✓ Existing links between hospitals and universities;
- ✓ Existing patient flow patterns;
- ✓ Patient travel times and transport links;
- ✓ The population size/density of an area; and,
- ✓ The range of health services in an area.

In addition to those listed above, respondents suggested the following factors as being important to consider when progressing geographic alignment:

- ✓ An evidence informed approach;
- ✓ Patient experience and choice;
- ✓ Clinical leadership and governance;
- ✓ Impact on workforce and staff travel times;
- ✓ Clarity regarding responsibility and accountability;
- ✓ Equity; and,
- ✓ Resource availability and allocation.

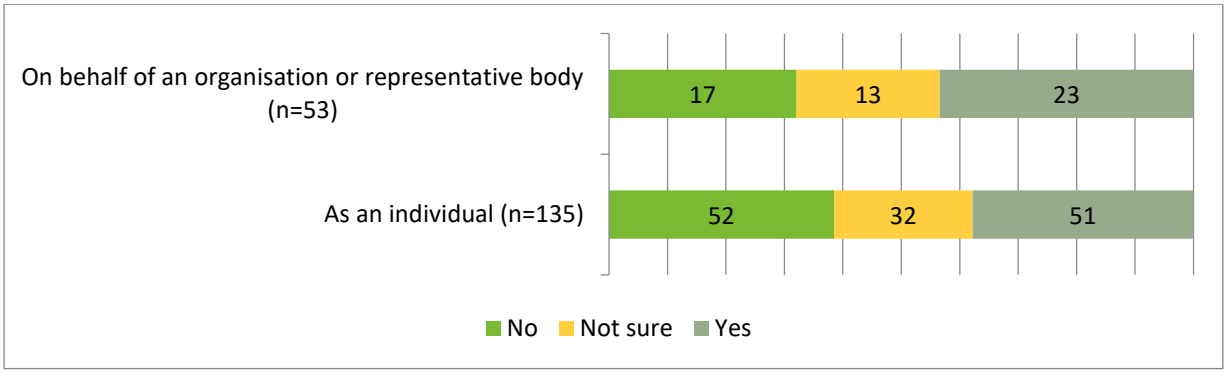
In your opinion does geographic alignment of Hospital Groups and CHOs mean that every CHO needs to map one-on-one with a specific Hospital Group?

In relation to this question, respondents were asked to answer either 'yes', 'no' or 'not sure' Respondents were then asked to expand on their response.

Key Statistics

The results, which show mixed and contrasting views within both individual and organisational respondents, are presented in Figure 22. Out of the 135 individuals and 53 organisations that responded to this question, 52 individuals (39%) and 17 organisations (32%) did not agree that geographic alignment means that every CHO needs to map one-on-one with a specific Hospital Group. Alternatively, 51 individuals (37%) and 23 organisations (43%) answered 'yes' to this question and 32 individuals (24%) and 13 organisations (25%) were 'unsure'.

Figure 22. One-on-one alignment of CHOs and Hospital Groups



Further Views

A total of 89 of the possible 135 individuals who responded to this question elaborated on the rationale for their answer. Similarly, 32 of the 53 organisations who responded to the main question expanded on their answer to the previous question. In this section, responses are clustered depending on the respondents answer to the previous question.

Respondents who selected 'No'

Out of the 52 individuals and 17 organisations that answered 'no' to the above question, 31 individuals and 11 organisations gave more information to explain their answer.

Structures should be based on patient access and pathways

The importance of defining structures based on patient access and patient pathways, rather than geography, was expressed by five individuals and two organisations. In addition to this, five individuals and one organisation stated that patient access to specialised services should be considered when organising structures. One respondent stated:

> *"The focus should be on the delivery of patient services at the various levels of care required (primary, acute, continuing care). Acute highly specialised care is best delivered within hospital groups aligned to universities. Integrated care GP & Primary care should be delivered in consultation with local GP's, Primary care and hospitals by developing specific patient care pathways and funding integrated models"* (Organisation, Hospital or Hospital Group).

On a related point, one respondent stated that structures should aim to harmonise the referral process between hospitals and CHOs meaning that "*alignment need not be defined by exact geographic boundaries*" (Individual, Health or Social Care Provider).

Need for flexibility in structures

The importance of flexibility in structures was highlighted by four individuals and one organisation. One respondent stated:

> *"Some patients fall on borders, they need to be able to access the best placed and the best provider for the care that is required for them. Rigidity doesn't work in patient centred care"* (Individual, Public Administration or Regulation).

Not practical

The practicability of aligning Hospital Groups and CHOs one-on-one was questioned by two individual and two organisational respondents, noting that "*it may not be possible to map one*-on-one" (Individual, Health or Social Care Provider) and "*This is not practical nor possible currently*" (Individual, Health or Social Care Provider).

Factors other than geography should be used

Several responses suggested that factors other than geography are more important when deciding upon structure and that these need to be considered. The factors stated included "*Geography and population analysis*", "*clarity*" and "*population health*". One respondent expressed the opinion that "*The geographic spread of hospitals with increased density in cities means this may not be useful"* (Individual, Member of the General Public).

Respondents who selected 'Not sure'

Of the 32 individuals and 13 organisations that were '*unsure'* about aligning CHOs and Hospital Groups one-on-one, 16 individuals and two organisations expanded on their selection. Similar themes to those brought up by respondents who answered '*no'* were mentioned. The practicability of aligning CHOs and Hospital Groups one-on-one was again questioned by six individuals and one organisation. One individual stated:

> *"It is difficult to know if this is possible. Some population base served by some of CHOs and one Hospital Group is very low compared to other CHO and HG whose population base is very high. Future mapping of Hospitals to CHOs may divide current hospitals aligned in a hospital group and defined patient pathways"* (Individual, Health or Social Care Provider).

Similar to the previous section, two individuals expressed the view that flexibility is needed in the structures of the health system and one individual stated that structures should "*match the natural flow of patients*" (Individual, Public Administration or Regulation). A further respondent stated that the move would be "*costly*" (Individual, Public Administration or Regulation) and one organisation expressed the view that structures should depend on the "*population*" (Organisation, Voluntary/Not for profit).

Respondents who selected 'Yes'

Out of the 51 individuals and 23 organisations who selected 'yes' to the question, 42 individuals and 17 organisations gave greater detail explaining their answer. The following section outlines the main factors identified by respondents. Other factors raised by those who agreed that CHOs should map one-on-one with Hospital Groups include achieving "*a consistent approach to records and patient history*" (Individual), the importance of academic linkages to foster the "*learning culture envisaged*" (Individual, Health or Social care Provider).

Allows greater collaboration between stakeholders

A large proportion of respondents expressed the view that one-on-one structures are important in achieving integration in the healthcare system and to promote collaboration between stakeholders. One respondent stated:

> *"In order to provide a truly integrated Healthcare system which is person-centred, there needs to be one area, with one budget and one governance structure. Anything else will continue to provide a dis-jointed, more expensive, less safe service"* (Individual, Health or Social Care Provider).

Promotes patient flow and access

Eight individuals and four organisations expressed the view that structuring the system so that CHOs are mapped one-on-one with Hospital Groups, will promote patient flow and patient access. One of these organisations stipulated that:

> *"CHOs and a Hospital Group do not need to be run administratively as one but do need to align in geography for better patient access and flows across the acute sector. Geographical alignment would allow for consistent service delivery, agreed pathways to and from the hospitals to one CHO that is already standardising processes across a region rather than county specific"* (Organisation, Community Healthcare).

Greater efficiency

"*Efficiency*" was noted by five individuals and one organisation as a factor influencing their view that CHOs and Hospital Groups should map one-on-one, with one respondent stating that there are "*economies of scale in management costs*" (Individual, Public Administration or Regulation) to be made and another l stating that "*Currently there is duplication of administrative and management structures resulting in loss of productivity and waste of valuable financial and human resources*" (Individual, Public Administration or Regulation).

Allows for better budgeting and funding decisions

The importance of having structures align one-on-one for funding and budgeting purposes was raised by two individuals. One respondent indicated that "*we need to move to a funding model based on population needs assessment*" and that this is "*not possible to do without one-on-one alignment*" (Individual, Member of the General Public).

Summary

There were mixed and contrasting views within both individual and organisational respondents when asked if geographic alignment means that every CHO has to map on-on-one with a specific Hospital Group:

- 37% of individual respondents responded that one-on-one mapping is necessary;
- 39% of individuals respondents did not agree and 24% were unsure;
- 43% of organisational respondents responded that one-on-one mapping is necessary; and,
- 32% of organisational respondents did not agree and 25% were unsure.

Of those that stated that one-on-one mapping is not necessary, reasons for their answer included:

- ✓ Structures should be based on patient access and pathways;
- ✓ There needs to be flexibility built into structures;
- ✓ It is not practical to deliver (e.g., due to cost, complexity or varying population densities), and,
- ✓ Factors other than geography are more important (population density, population health, patient flow).

Of those that stated that one-on-one mapping is necessary, reasons for their answer included:

- ✓ Is necessary for integration and collaboration between stakeholders;
- ✓ Would enable patient pathways and access;
- ✓ Would deliver greater economies of scale and greater efficiencies; and,
- ✓ Would facilitate better budgeting and funding decisions.

The Sláintecare Report proposed a phased approach to any changes of existing structures, with geographic alignment of Hospital Groups and CHOs first, followed in time by integration into regional integrated care organisations.

What, in your opinion, is the best approach?

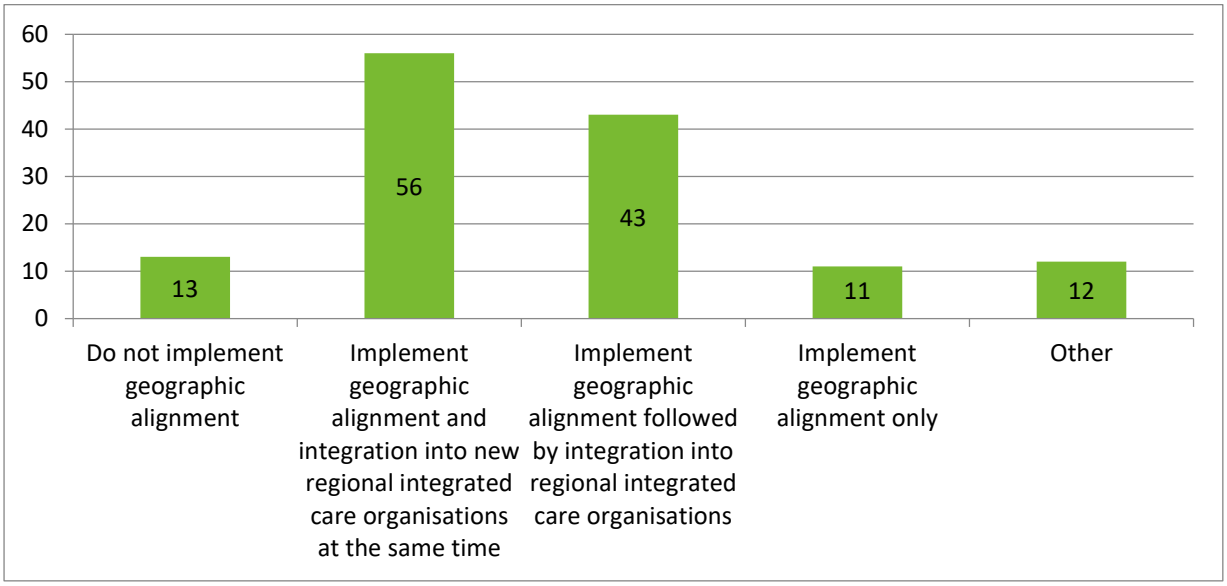
Respondents were asked to choose what they felt was the best option from the following pre-populated lists: 'Do not implement geographic alignment', 'Implement geographic alignment and integration into new regional integrated care organisations at the same time', 'Implement geographic alignment followed by integration into regional integrated care organisations', 'implement geographic alignment only' or 'other'.[11] If 'other' was chosen, respondents were asked for more information. Respondents were then given the opportunity to explain their answers.

Key Statistics

A total of 135 individual respondents answered this question. The results are shown in Figure 23 below. Less than 10% of respondents (n=13) suggest not implementing geographic alignment and fewer again (8%) suggest implementing geographic alignment only. The largest number (n=56; 41%) of individual respondents state that the best approach to implement geographic alignment is to implement geographic alignment and regional integrated care organisations at the same time. This is followed by 43 (34%) who state that the best approach is to implement geographic alignment followed by regional integrated care organisations.

[11] Further information on regional integrated care organisations was given in the supporting background information document, which was presented at the start of every consultation questionnaire. This document can be found at: https://health.gov.ie/consultations/

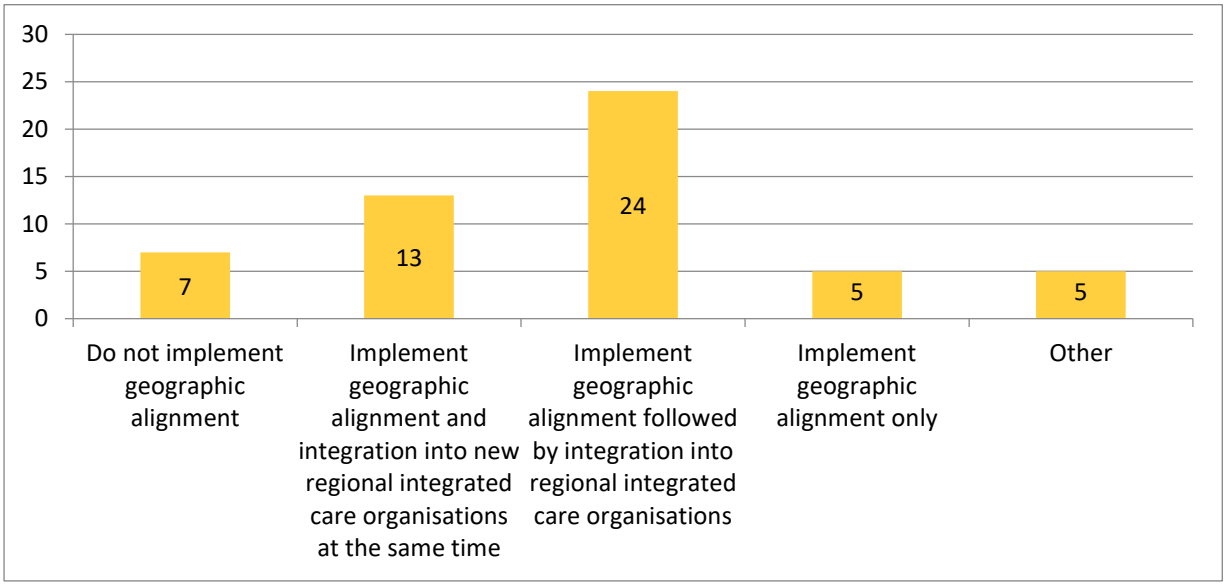
Figure 23. Best Approach to Geographic Alignment (Individuals)



Note: n=135

The results for organisational respondents shown in Figure 24 mirrors those of the individual respondents in that very few responses support either not implementing geographic alignment at all (n=7; 13%) or implementing geographic alignment alone (n=5; 9%). For organisational respondents, however, the largest number of respondents (n=24; 44%) state that the best approach is to implement geographic alignment followed by regional integrated care organisations compared with 13 respondents (24%) who state that the best approach is to implement geographic alignment at the same time as regional integrated care organisations.

Figure 24. Best Approach to Geographic Alignment (Organisations)



Note: n=54

Further Views

Respondents who selected 'Do not implement Geographic Alignment'

Of the 13 individuals and seven organisations who stated, 'do not implement geographic alignment', three individuals and one organisation expressed the view that geographic alignment is not necessarily best for the patient. The restrictiveness of geographic alignment was listed by one individual and one organisation as the reason to not implement. The instability in the system and "*reform fatigue*" was mentioned by two individuals who stated, 'do not implement geographic alignment'. One organisation explained that administrative burden was the reason to not implement geographic alignment, stating that "*as organisations get bigger, so do the administrative demands*" (Organisation, Community Healthcare).

Four individuals and two organisations expressed views that geographic alignment would impede the ongoing progress that has been made under the current structures. One respondent stated:

> *"Hospital groups have made significant progress in developing patient pathways, links, networks & relationships. To change at this time would have a significant impact on patients and staff"* (Organisation, Hospital or Hospital Group).

Respondents who selected 'Implement Geographic Alignment Only'

In total, 11 individuals and five organisations selected 'implement geographic alignment only'. The main rationale for this view was a concern over adding another layer to the current structure:

> *"The fear of implementing a regional structure will put another layer into the service"* (Organisation, Hospital or Hospital Group).

Respondents who selected 'Implement Geographic Alignment Followed by Integration into Regional Care Organisations'

Of the respondents that selected '*Implement Geographic Alignment Followed by Integration into Regional Care Organisations*', 43 individuals and 24 organisations gave further details on why they selected this approach. Some of the most common issues raised are included below.

Time for monitoring and appraisal

The most common reason given for this approach was to allow for measurement of performance of revised boundaries to take place. One respondent stated:

> *"Take a phased approach to allow for revised boundaries to be bedded down relationships established and joint performance to be measured and monitored. Once work processed and structures fine-tuned commence planning for integration at regional level"* (Organisation, Healthcare Organisation).

Minimising Disruption

Minimising disruption was stated by three individuals and two organisations as the rationale for their preferred response. One respondent noted:

> *"… geographic alignment followed by integration into regional integrated care organisation would be less disruptive than alignment and integration at the same time. The geographic alignment would be allowed to mature prior to the move towards integration"* (Organisation, Healthcare Organisation).

Complexity demands a phased approach

The scale and complexity of the health and social care system and of geographic alignment was mentioned by three individuals and one organisation. One respondent noted that: "*A 2 step approach seems to be a sensible option given the complex nature of the system*" (Individual, Health or Social Care Provider).

Incremental approach is best for patients and staff

One individual and three organisations expressed the view that this approach would be best for patients and staff. One responded stated: "*There will be resistance to change among some groups. If this happens in an incremental fashion it may be easier to get stakeholders on board*" (Individual, Health or Social Care Provider).

Other rationales mentioned in support of a phased approach included "*to ensure success*" (Individual, Health or Social care Provider), because it is "*what the report recommends*" (Organisation, Healthcare Organisation), because it will "*enable stability*" (Individual, Health or Social Care Provider), because it is "*more acceptable*" (Individual, Health or Social Care Provider) and for "*easiness*" (Organisation, Representative Body).

Respondents who selected 'Implement Geographic Alignment and Integration into Regional Integrated Care Organisations at the Same Time'

Efficient use of time and resources

Of the 56 individuals and 13 organisations that selected 'Implement geographic alignment and integration into regional integrated care organisations at the same time', 12 individuals and six organisations stated the reason for this approach is to ensure an efficient use of time and resources. A number of responses identified that change should happen in a short time frame:

> "*In the shortest possible time*" (Organisation, Healthcare Organisation);
>
> "*Best to do it quickly*" (Individual, Member of the General Public), and,
>
> "*Make the necessary changes without further delay*" (Individual, Health Research and Education).

Minimising disruption was stated as the reasoning behind this approach by six individuals and three organisations. One respondent stated:

> *"Multiple definite organisational changes over a single time period may be less disruptive than an elongated period of rolling changes"* (Individual, Health Research and Education).

In addition to this, six individuals and one organisation expressed the view that this approach would be best for patients and staff. One stated:

> *"One overall vision of the changes planned that have a quick timeline [*will*] get better engagement from both patients and staff"* (Individual, Public Administration or Regulation).

Effectiveness - Structure and governance issues need to be addressed together

The effectiveness of the change was mentioned by four individuals for the rationale behind this approach. One individual stated:

> *"Geographical alignment without new integrated structures will fail. Both need to be created at the same time"* (Individual, Health Research and Education).

One respondent noted that "*interim administrative basis organisations without clear timeline to legal status have a damaging effect*" (Individual, Health or Social Care

Provider). Another stated that "*structure, function and governance must be in place together*" (Individual, Public Administrator or Regulator).

Views on how best to align Hospital Groups and CHOs

In addition to the opinions expressed above on either one-on-one alignment or the phasing of alignment, a number of respondents gave specific examples of how Hospital Groups and CHOs could be aligned. Not all suggestions can be expressed in this report, and a sample of these suggestions is presented here. A large representative body stated:

> *"The integrated model of care should not incorporate two separate structures as currently exist with the Hospital Groups and CHOs. The current CHOs should be dismantled and appropriately integrated with Hospital Groups"* (Organisation, Representative Body).

Another respondent expressed a similar view stating:

> "*Reduce the number of CHO's expand/amalgamate the CHOs from 9 to 6"* (Organisation, Academic Institution).

One organisation that recommended a phased approach to implementation stated that the first phase of implementation could have "*particular hospital groups interacting with two CHOs*" (Organisation, Healthcare Organisation).

Another respondent expressed that it is important that "*CHO's are not too geographically diverse*" as this may cause structures to become "*unmanageable*" (Individual, Health or Social Care Provider).

Summary

Consistent with earlier findings, less than 10% of individual respondents and 13% of organisational respondents are against implementing geographic alignment. The main rationale most cited for this is reform fatigue.

There is very little support for progressing geographic alignment only (8% of individual respondents and 9% of organisational respondents). The reason most cited here is reluctance to add an additional new 'layer' in the form of regional structures

The majority of respondents (individual and organisational) selected that geographic alignment and integration into regional care organisations should be implemented either at the same time or on a phased basis.

For individual respondents, results are very similar in support of a phased approach (41%) and a simultaneous approach (43%)

For organisational respondents, a larger number support a phased approach (44%) compared with a simultaneous approach (24%). Where respondents advocated for a phased approach, the reasons given included:

- Time for monitoring and appraisal;
- Minimises disruption;
- Complexity demands an incremental approach; and,
- Incremental approach is best for patients and staff.

Where respondents advocated for a simultaneous approach, the reasons given included:

- Greater efficiencies (time and resources); and,
- Change will not be effective if structures and governance not addressed together.

In view of other advances in the healthcare sector, when should a move towards geographic alignment begin?

Respondents were asked when they thought a move to geographic alignment should begin (without any suggested answers). A total of 109 individual and 43 organisation responses were received for this question.

Suggested timeframes

Short term change

In answering the question as to when geographic alignment should begin, the majority of respondents, 76 individual responses (70%) and 25 organisational responses (58%), expressed a view that a move to geographic alignment should start in the short term, defined for the purpose of this analysis as within the next 18 months. Expressions used were '*as soon as possible'*, '*2018'*, '*this year'* and "immediately"

The reasons given for the view that change should occur in the short term included that "*existing structures are not working*" (Individual), to '*support proper implementation of SláinteCare [sic]*' (Representative Body) and "better patient outcomes" (Individual, Public Administration or Regulation). One individual stated that:

> *"The current lack of alignment and integration between acute hospital and community sectors impedes effective and efficient patient care right now"* (Individual, Health or Social Care Provider).

Medium to longer term change

An additional three individuals and two organisations explicitly stated that the move should happen in the medium term, expressing views of between three and 10 years.

Some respondents (two individuals and four organisations) indicated that they were unsure about when a move should take place.

After appropriate planning and assessment

In answering the question as to when geographic alignment should begin, a number of respondents stressed the importance of appropriate planning and assessment prior to a move towards geographic alignment (six individuals and four

organisations). One respondent stated that: *Planning should begin in September 2018, but a proper evidence-based project / programme management approach should be taken* (Individual, Health or Social Care Provider).

Another highlighted the need for an assessment of geographic alignment, stating:

> *"Reviewing existing aligned services and prioritising and assessing benefits and risks should be undertaken perhaps with academic institutions within the relevant areas - key to success will be collaboration, transparency, state of readiness and funding*"(Organisation, Academic Institution).

Others expressed the view that before a change to structures occurs, clarity around the new structures and an implementation plan is needed.

Dependencies

In answering the question as to when geographic alignment should begin, a number of respondents expressed views on the critical dependencies and enablers that must be considered as part of any move towards geographic alignment.

The need for IT infrastructure as an enabler of geographic alignment was raised by some. Sufficient financing was identified as essential for the move to geographic alignment by others, with one respondent specifically highlighting the need for financing in "*primary care*" (Individual, Health or Social Care Provider).

The importance of stakeholder engagement was mentioned as being necessary prior to any move to begin geographical alignment.

Others expressed the view that a move towards geographic alignment should only commence "*after legislation setting up legal basis for organisations*" (Individual, Health or Social Care Provider). One respondent stated that the move should only commence once "*the new HSE Board is appointed*" and stipulated that this should not be "*during winter*" (Organisation, Community Healthcare).

Other dependencies raised included the following. One individual stated that "*it is of paramount importance that all issues pertaining to the new GP contract are realised, well in advance*" (Individual); The need for strong top-level management was noted by a small number of respondents; One respondent stressed the need to resolve the issue of "*consultants engaging in private practice in public hospitals*" and rethink "*how our hospital teaching model is delivered*" before an effective move can take place (Organisation, Representative body).

Summary

The majority of respondents, (70% of individuals and 58% of organisations) expressed a view that a move to geographic alignment should start in the short term, defined for the purpose of this analysis as within the next 18 months. Some responses also stated that change should be dependent on:

- ✓ Appropriate planning and assessment (evidence base, clarity around structures, assessment of benefits and risks, implementation plan);
- ✓ Adequate financing to progress the changes;
- ✓ Investment in IT infrastructure; and,
- ✓ Stakeholder engagement.

2.4 Towards Integrated Health and Social Care

This section presents a summary of issues and views received in relation to a move towards integrated health and social care. This includes views gathered through two specific questions in the consultation questionnaire about the basket of services a regional integrated care organisation should be responsible and accountable for, and opportunities for the future. Further views about the importance of geographic alignment for integrated care, and factors that should be considered in any move towards geographically aligning Hospital Groups and CHOs which were discussed by respondents are also presented thematically.

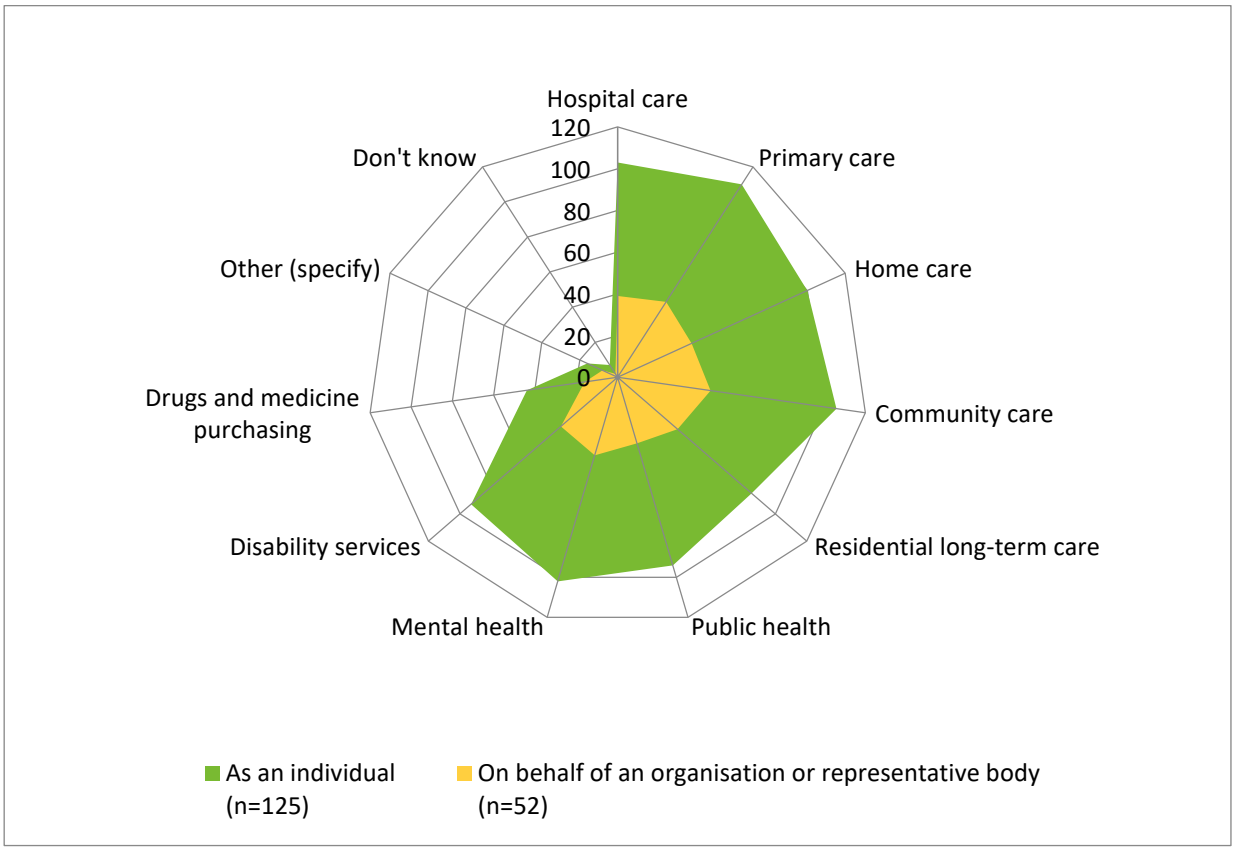
Considering the recommendations in the Sláintecare Report and the move towards integrated care, in your view, what services should regional integrated healthcare organisations be responsible and accountable for?

Respondents were presented with a pre-populated list of services and could select as many answers as they wished. Respondents were also given an opportunity to add additional services not listed.

Key Statistics

A total of 125 individuals and 52 organisations responded to this question. As illustrated in Figure 25 the majority of respondents, both individual and organisational, indicated that regional integrated care organisations should be responsible and accountable for hospital care, primary care, home care, community care, residential long-term care, public health, mental health and disability services. Only approximately one third of respondents (44 individuals, 35%; 16 organisations, 31%) agreed that drugs and medicine purchasing should be included in the basket of services for regional integrated care organisations.

Figure 25. Basket of services



Further views

A number of respondents (46 individuals and 22 organisations) provided more detailed commentary on the rationale behind their answers above. Some key points emerging are detailed below.

Services which should be provided at National level

The view that drugs and medicines purchasing should be conducted at a national level was highlighted by three individuals and one organisation. The importance of managing public health at a national level was also highlighted by two individuals and two organisations.

Disability services

While the majority of respondents selected that disability services should be included within the basket of services for regional integrated care organisations, as exemplified by the following statement: "*management of mental health and disability services should not be separated from other health or social care services*" (Organisation, Representative Body), a small number of respondents expressed the

view that disability services should not be included in the basket of services. One respondent argued that disability services "*outside the health sector*" (Individual, Health or Social Care Provider) should not be included.

Additional services to exclude

A further 10 services spanning were listed by respondents, however there was little explanation provided for these. They included "asylum seeker services [sic]; "civil registration"; "laundry"; "patient advocacy"; "transport"; "graveyards"; "adult survivors of abuse abroad services", "accommodation", "homelessness" and "elderly care".

Respondents were also asked to suggest any other services for which regional integrated care organisations should be responsible and accountable for, but which was not provided in the pre-populated list. Fourteen individuals and seven organisations elaborated on services to include. These responses are described below

Additional services to include

Further services which some respondents suggested should be included are listed below:

- "Health and wellbeing promotion", "health education", "preventative care"; "Health screening" "immunisation";
- "National emergency services", "ambulance services";
- "Rehabilitation services"; "re-ablement care ";
- "Transitional care"; "step down facilities; "short-term residential respite care";
- "Services for older people", "homecare";
- "Rheumatology"; "pathology";
- "Addiction services";
- "Voluntary services";
- "Patient advocacy";
- "Commissioning services"; and,
- "Maternity and children's services".

Summary

The majority of individual and organisational respondents agree that the following services should be included in the basket of services of regional integrated care organisations:

- ✓ Hospital care;
- ✓ Primary care;
- ✓ Home care;
- ✓ Community care;
- ✓ Residential long-term care;
- ✓ Public health;
- ✓ Mental health; and,
- ✓ Disability services.

Only approximately one third of respondents agreed that drugs and medicine purchasing should be included in the basket of services for regional integrated care organisations. Some respondents noted that this service should continue to be provided at national level.

Aligning geographic health and social care boundaries with other recognised boundaries (such as counties), might present valuable opportunities to consider healthcare in the context of other sectors, information systems, services, and wider social and economic issues.

Please provide your views on the potential opportunities.

A total of 61 individuals (37% of respondents to this question) and 32 organisations (48% of respondents to this question) shared their views on the potential opportunities arising from the geographic alignment of Hospital Groups and CHOs. Respondents identified that geographic alignment may provide opportunities for "*education*" (Organisation, Voluntary/Not for Profit), "*procurement*" (Individual, Health or Social Care Provider) and improved allocation of resources "*based on regional population needs*" (Individual, Health Research or Education). In addition to these specific statements, the following themes emerged from the views shared in response to this question.

Greater collaboration and engagement (including with those working in other areas related to health)

The opportunities for greater communication and collaboration between a wide range of stakeholders were expressed by 12 individuals and seven organisations. A number of these respondents also specified that this provides opportunities for wider community engagement with the healthcare system. Respondents identified that there are potential advantages from greater collaboration with "*county councils*", "*government*", "*Gardaí*", "*academic institutions*", "*youth services*" and "*social care*", as well as greater collaboration with stakeholders from areas such as housing, education, transport and cross-border stakeholders. One organisation stated:

> *"Significant opportunities to collaborate with education, youth services, Higher Education centres, innovation centres, access to regional development funding, Carers associations, community organisations"* (Organisation, Healthcare Organisation).

One respondent also stated the potential benefits in terms of environmental health and housing, stating:

"*…the health authority would be better placed to advocate for housing to meet the needs of the vulnerable and marginalised groups. It would also support planning and delivery of environments which support health, e.g. well-maintained footpaths and recreation areas"* (Organisation, Academic Institution).

Improvements in IT infrastructure and data

Opportunities for improvements in ICT infrastructure and data were identified by five individuals and four organisations, suggesting that geographic alignment may "*allow for integration of ICT systems*" (Organisation, Hospital or Hospital Group), "*use of digital technologies*" (Individual, Private Sector) and "*collection and analysis of data*" (Health or Social Care Provider). One individual specified that an integrated IT system would "*greatly improve on the quality and efficiency of the service*" (Individual, Public Administration or Regulation). Another individual reflected on the opportunity for IT systems in relation to patient records stating:

> *"There is a real opportunity with this move to look at electronic patient records and unique hospital identifier numbers for patients that transfer from primary care/ community into secondary and tertiary care ... So much time is wasted currently between administration and repetition of records across centres"* (Individual, Health or Social Care Provider).

Note on aligning with county boundaries:

A number of respondents discussed whether CHOs and Hospital Groups should align with county boundaries and gave a variety of views on whether they should or should not align. The issue of aligning with county boundaries will be discussed in section 2.5 of this document.

Summary

Opportunities identified include:

- ✓ Greater collaboration and engagement, including with sectors and stakeholders working in areas related to health; and,
- ✓ Improvements in IT infrastructure and data.

All things considered, how strongly in favour of geographic alignment of CHOs and Hospital Groups are you?

Respondents were asked to state whether they were strongly in favour of geographic alignment, somewhat in favour, unsure, somewhat against or strongly against. Respondents could choose only one answer.

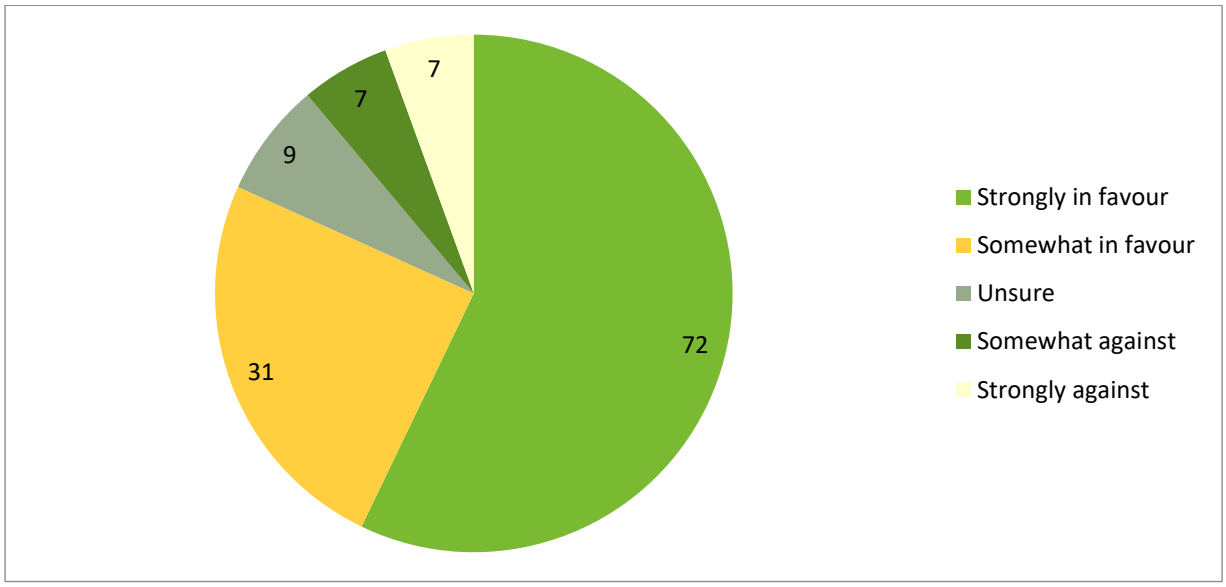
Key Statistics

Of the 126 individuals who answered this question, the majority expressed the view that they were in favour of the geographical alignment of CHOs and Hospital Groups, 72 (57%) expressing that they were “strongly in favour” and 31 (25%) expressing that they were “somewhat in favour” (82% in favour when combined). A total of 9 individuals (7%) stated that they were unsure whether they favoured it or not. The remaining 14 individuals (11% against when combined) expressed the view that they were against the geographic alignment of CHOs and Hospital Groups, where seven of these individuals were “strongly against” it and seven were “somewhat against it”.

To try to gauge, even at a high level, if there are particular types of respondents who are most in favour or most against geographic alignment, respondents were analysed by their respective types/categories. Due to small numbers in some groups, results for “strongly in favour” and “somewhat in favour” were combined and entitled “In favour”. Similarly, results for “strongly against” and “somewhat against” were combined and referred to as “Against”.

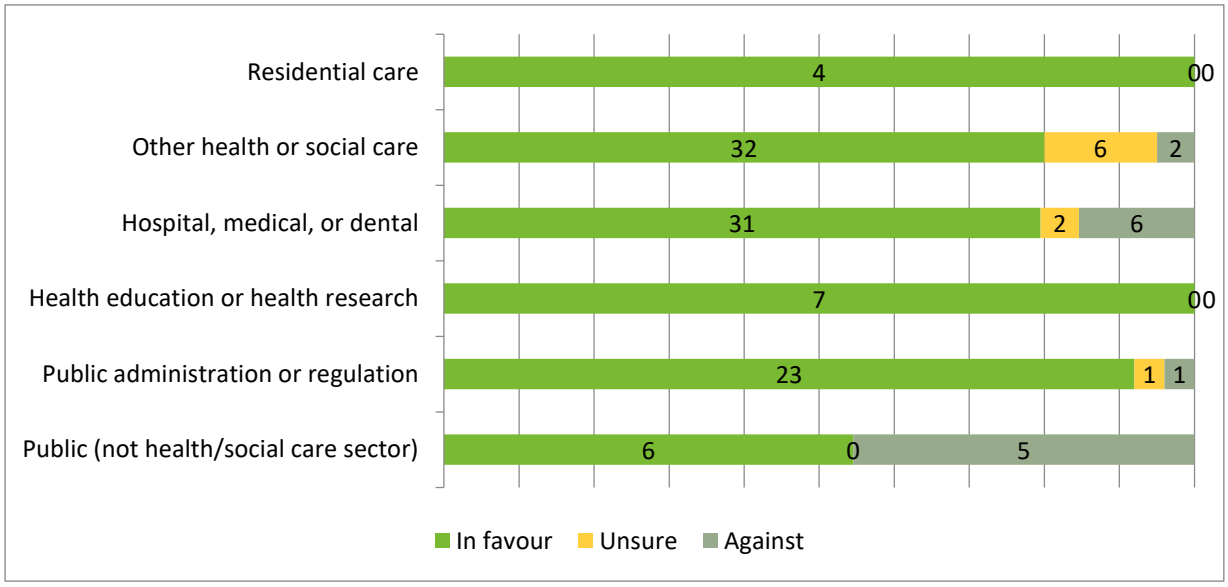
As illustrated in Figure 26, individual respondents across all categories are broadly in favour of geographic alignment.

Figure 26. 'How strongly in favour of geographic alignment of CHOs and Hospital Groups are you?' (Individuals)



Note: n=126

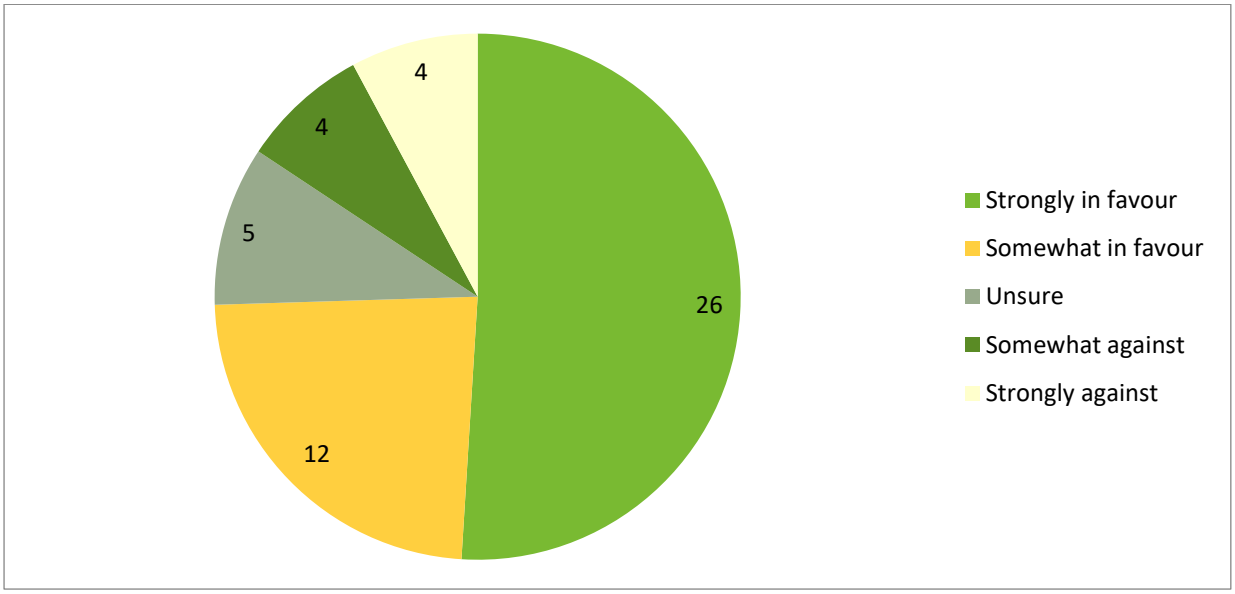
Figure 27. Breakdown of Individual Responses



Note: Strongly in favour and somewhat in favour, and strongly against and somewhat against were combined due to small sample sizes. n=126

Out of the 51 organisations that responded to this question, the majority were in favour of geographical alignment of Hospital Groups and CHOs with 26 (51%) stating that they were "strongly in favour" and 12 (24%) stating that they were "somewhat in favour" (75% In favour when combined). A total of four organisations (8%) were unsure whether they favoured it or not. The remaining eight organisations (16% against when combined) were against geographic alignment, with four "strongly against" and four "somewhat against".

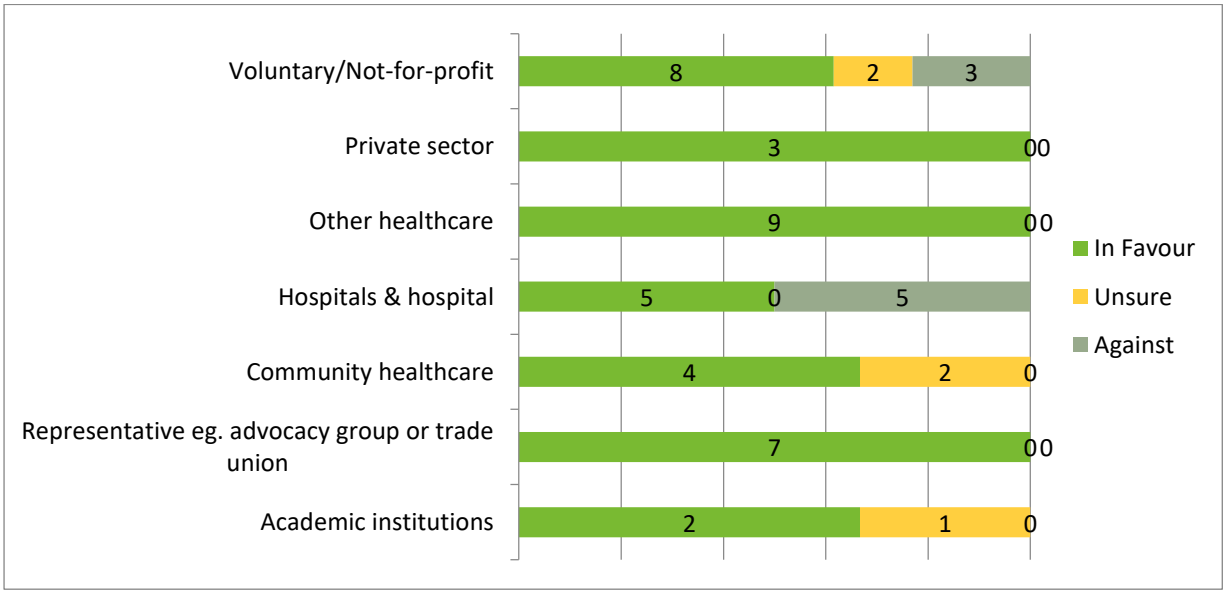
Figure 28. 'How strongly in favour of geographic alignment of CHOs and Hospital Groups are you?' (Organisations)



Note: n= 51

Respondents were analysed by their respective types/categories and the results are shown in Figure 29. Due to small numbers in some groups, results for "strongly in favour" and "somewhat in favour" were combined and entitled "In favour". Similarly, results for "strongly against" and "somewhat against" were combined and referred to as "Against". While it is hard to draw any substantive conclusions from these small numbers, it is clear that there are polarised responses amongst the hospital/hospital group category.

Figure 29. Breakdown of Organisation Responses



Note: Strongly in favour and somewhat in favour, and strongly against and somewhat against were combined due to small sample sizes. N=51

Summary

- ✓ 82% of individual respondents stated that they are in favour of geographical alignment of CHOs and Hospital Groups, 57% selecting “strongly in favour” and 25%) selecting “somewhat in favour”;
- ✓ 11% of respondents are against geographic alignment and 7% are unsure;
- ✓ 75% of organisational respondents stated that they are in favour of geographical alignment with 51% selecting “strongly in favour” and 24% selecting “somewhat in favour”; and,
- ✓ 16% of respondent are against geographic alignment and 8% were unsure.

The group with most polarised views on this issue are respondents from hospitals/hospital groups.

2.5 Recurring Themes

There were several issues or 'themes' that recurred throughout various sections of the submissions. Some of these themes have briefly been discussed within specific sections in the report, but a number of themes are expanded on here in this section and they have been grouped under the following headings:

- Concerns regarding geographic alignment of Hospital Groups and CHOs;
- Conditions for the geographic alignment of Hospital Groups and CHOs; and,
- Issues in current health system which will have implications for geographic alignment.

Concerns regarding geographic alignment of Hospital Groups and CHOs

Where concerns were expressed regarding geographic alignment, these focused predominantly on two issues, the risk of derailing existing progress in the direction of integrated care and the issue of reform fatigue.

Risk of impeding existing progress in integrated care

A number of organisational submissions provided information on work that has been completed, or in train, in developing integrated care in the absence of geographic alignment. Some respondents urged that consideration be given to reviewing ongoing progress before any changes are made. One organisation stated:

> *"Policy-makers must take account of the work that has already been undertaken since the establishment of the groups and the potential negative impacts reorganisation of structures will have on this" (*Organisation, Hospital or Hospital Group*).*

Another respondent noted that performance improvements have already been seen for patients in their region in terms of integrated health and social care:

> *"I have seen clear benefits from the [hospital name] being part of the [hospital group] and it is important to the population that it serves, that it be retained therein. We have seen the refined referral pathway and common assessment screening tool for Health and Social care professors; a 100% reduction in patients being discharged before assessment … 50% improvements in day of surgery admission rate; 50% improved theatre turnaround times"* (Individual, Health or Social Care Provider).

A number of organisations provided detail of what they viewed as the strength of existing structures in delivering integrated care. One respondent explained:

> "*[Hospital names] has been in existence for more than a century, and has become stronger since the establishment of [Hospital group]. We have links to secondary care and primary care and these links are being developed and nurtured across the group"* (Organisation, Hospital or Hospital Group).

Another respondent provided several examples of "*integration work*" and "*collaboration and cross-site working*" involving different disciplines and patient groups, noting that further re-structuring "*could reverse the progress that has already been achieved in the collaborative working within the [Hospital group] towards achieving integrated, high quality care*" (Organisation, Academic Institution).

Reform fatigue

The terms 'reform fatigue' and 'change fatigue' were used by respondents throughout the submissions. The issue of fatigue was discussed in terms of the disadvantages, the principles, and other factors to consider in a move towards geographically aligning Hospital Groups and CHOs. This issue was raised by both organisations and individuals, and was presented as a negative factor for providers and patients with one organisation stating that "*There is a huge element of "Change Fatigue" within the system already"* (Organisation, Community Healthcare*)*, another stating that: "*reform fatigue for providers is a real negative*" (Individual, Health or Social Care Provider), and another noting that this would constitute "*another major re-structuring exercise within three years*" (Individual, Health or Social Care Provider).

One organisation described "*a workforce which is dedicated and hardworking, but is already under significant pressure*" and stated that geographic alignment could be seen as a return to previous structures:

> *"There is no doubt that the health sector is suffering from reform fatigue. Successive administrations have introduced reforms aimed at improving the delivery of healthcare to the citizens of Ireland. However, it is clear that not all have succeeded. There is a significant danger that the geoalignment of hospital groups and CHOs will be viewed as a return to the structure of health boards and regional directors of operations of the past, which were abolished in 2004. This may have distinct knock on effects from healthcare professionals who may not buy into the new structures"* (Organisation, Hospital or Hospital Group).

Conditions for the geographic alignment of Hospital Groups and CHOs

Several responses highlighted conditions or factors or dependencies to be given due consideration prior to planning for geographic alignment. These are discussed briefly below.

Investment in resources and ICT infrastructure

Adequate resources were noted as a dependency for the implementation of geographic alignment by several respondents. Respondents noted how changes should be linked to both "*improvements in funding*" (Individual, Health or Social Care Provider) and "*appropriate services and manpower to support these changes*" (Individual, Health or Social Care Provider). In relation to staffing resources, one organisation stated:

> *"In order to ensure optimal person-centred services are provided, the current under staffing of services must also be rectified through a properly funded and agreed integrated workforce plan"* (Organisation, Representative Body).

The development of a suitable ICT system was seen by multiple organisations and individuals as an essential pre-requisite for geographical alignment of HGs and CHOs, and for the further development of integrated health and social care. To illustrate:

> *"Do not demerge organisations unless there is a new ICT system planned and ready to go to replace what you are breaking" (Individual, Health or Social Care Provider).*

Focus on patient and patient choice

Consistently, respondents expressed the view that any change to the health system or to structures should be patient-centred. When respondents were asked to submit any final comments, 12 individuals and five organisations reiterated the view that what is best for patients needs to be a key consideration. One individual stated:

> *"Structures are just structures. Most ordinary citizens don't know or care about CHO's or hospital groups. Indeed most HSE staff working on the ground know very little about CHO's or hospital groups. People just want to receive good quality, timely services as close to their home as possible without having to go back to the bottom of the pile … Make the structures work around the population as opposed to the population working around the structures"* (Individual, Public Administration or Regulation).

An emphasis was placed on greater inclusion of potentially vulnerable populations in relation to improving their access, experience and outcomes. One individual noted that geographic alignment might cause "*health inequalities*" and that consideration needs to be given to a "*larger population base with deprivation factors and socio economic factors*" (Individual, Health or Social Care Provider). Another individual discussed the issue of privacy for service users:

> *"In area of LGBT individuals often seek support outside their local area initially for fear of disclosure … so their records are not accessible to neighbours and friends who generally work in local areas. Many young people especially are worried about disclosure … they can't travel to get where support is in the bigger areas"* (Individual, Health or Social Care Provider).

A further Individual noted that "*Patient choice is the reason why hospital groups do not have geographically defined boundaries. This principle should be recognised for CHOs also*" (Individual, Health or Social Care Provider).

Focus on population health

The importance of population health was raised in several submissions and is closely related to the importance of patient-focused change. One organisation outlined international trends in the evolution of health and social care systems, from an initial primary focus on the provision of healthcare to a focus on improving population health which includes disease prevention, health promotion and better chronic disease management. They noted that "*population health methodology is used extensively in the evaluation of accountable care organisation*" (Organisation, Hospital or Hospital Group). This was reiterated by a second organisation in relation to services design:

> *"A new alignment could also promote services designed with population needs in at their core such as nurse led clinics, domiciliary care provision and community midwife services. With ever increasing challenges facing our population including our ageing population and increase in chronic diseases, management of these could be more appropriately dealt with by ensuring a health service which ensures a population health approach"* (Organisation, Representative Body).

A second organisation stating that:

> *"If we are to shift the emphasis of health towards promotion and prevention, it is imperative that population-based planning is situated in community healthcare governance structures with a strong emphasis on expanding community-based services and improved pathways to secondary and tertiary care"* (Organisation, Academic Institution)

Need for an evidence base

The need to create a sound evidence base for geographic alignment was consistently expressed throughout the consultation. It was advised that both national experiences and international experiences are used to inform any future decisions or any plans to move towards geographic alignment.

National evidence

A number of national programmes were highlighted as examples to inform the formation of an evidence base. One organisation suggested a number of programmes of ongoing work aimed at integrating services. These include: "*Collective Leadership and Safety Cultures (COLEAD*)" and "*Systematic Approach to improving care for Frail Older Patients (SAFE)"* (Organisation, Academic Institution).

One individual suggested that robust evaluation of the Irish model is needed, stating:

> *"Need to critically evaluate Irish community and hospital services using a methodology similar to the King's Fund Reimaging Community Services"* (Individual, Health or Social Care Provider).

Evidence-based planning was also discussed by one organisation in relation to the current and future workforce:

> *"The importance of workforce cannot be underestimated and the focus of aligning CHOs and Hospital Groups for the development of an integrated model must include the development of an integrated workforce plan. Nurse and midwife staffing must remain central to the integrated care model. The work of the Staffing Taskforce must be enhanced and broadened in order to develop a system wide, evidence based approach to staffing. Appropriate retention measures must also be developed including accommodation and infrastructure"* (Organisation, Representative Body).

International evidence

It was suggested by several respondents that international evidence be drawn on when constructing an evidence base for any move towards geographic alignment. Suggestions of international examples came from "*Scotland*", "*Denmark*", "*Australia*", "*Canada*", "*England*" and "*New Zealand*". In particular the "Canterbury Model" in New Zealand, the National Health Service in Britain and "Local Health Integration Networks" in Ontario have been suggested by a number of respondents.

Stakeholder engagement and stakeholder buy-in

The importance of stakeholder engagement and stakeholder buy-in was highlighted by a number of respondents throughout the consultation. Stakeholders were identified as being "*clinicians*", "*GPs*", "*staff*" more widely and "*patients*". Respondents expressed that it was necessary to "*get buy in from stakeholders first*" (Individual, Health or Social Care Provider) and that it is important that any change be "*communicated with all stakeholders*" (Organisation, Voluntary/Not for profit). One organisation noted the impact of lack of stakeholder engagement, stating that in the past "*there has been relatively poor buy in from staff to the organisational brand, which impacts on motivation, empowerment and coherence across the current organisational structure*" (Organisation, Representative Body).

Issues in current health system

Several respondents highlighted issues that exist currently in the health system, some stating that these issues should be resolved prior to any move to geographic alignment.

Organisational and service culture

Several respondents shared the view that there are differences in organisational and service culture within CHOs, and between CHOs and acute services that must be improved. One individual explained that

> "… [the] *spread of CHO are very difficult to navigate [CHO name] is so spread that it is now fragmented and wasteful to administer in terms of contact time and also it is culturally very different"* (Individual, Public Administration or Regulation).

A second individual shared their view about "*cultural differences between CHO and acute services*" and that "*relationships need to be built between CHO and acute*" (Individual, Health or Social Care Provider). One organisation shared their concern about a culture that is hospital dominant:

> *"Hospital dominant culture is a danger to the vision of developing excellent primary and community care which is more likely if administered as one entity"* (Organisation, Community Healthcare).

From the perspective of the hospital, one organisation shared their view that progress has been made:

> *"The CHO structure is currently in disarray and very difficult to navigate from a hospital perspective. Staff want to embed the current structures and links [Hospital Group] and [University] which are still in development, but good support has been provided from [Hospital Group] in terms of service improvement and university linkages for training of doctors, nurses and HSCPS"*[12] (Organisation, Hospital or Hospital Group).

Governance

The issue of governance was raised by several respondents, one stating that it has "*deteriorated in recent years owing to the remarkable lack of clarity on the government's part about high level governance*" (Organisation, Representative Body). Another organisation expanded on the issue of current governance, stating that "*Making changes based on geography without the associated Governance clarity will not benefit the public or staff. There is a requirement for: System clarity, Accountability, Certainty for staff*" (Organisation, Community Healthcare).

Improving trust and confidence in the health system

The issue of improving trust and confidence in the healthcare system was raised by several respondents. One individual noted that a guiding principle of geographic alignment should be "*Improving trust and confidence in the health services"* (Individual). A second individual felt that it is important to *"take the politics out of healthcare"* (Individual, Public Administration or Regulation). Another individual felt that *"High quality health services should be provided as much as possible at one site... and not be influenced by local politicians keeping their voters happy* (Individual, Health or Social Care Provider).

Voluntary health and social care organisations

In relation to voluntary healthcare practices, one individual stated that

> "*I do not believe that true integrated health services will ever be possible in Ireland until all 'Voluntary' (but highly paid) Hospitals are assimilated into the national Health Service"* (Individual, Health or Social Care Provider).

[12] HSCPS: Health and social care professionals.

A second individual felt that "*Voluntary hospitals are strongly represented at hospital group level and often conflict with wider HSE aims*" (Individual, Public Administration or Regulation). One large organisation expressed the view that any moves towards geographic alignment should mot commence until the "*parameters within which State and Voluntary Hospital relationships are governed and executed*" (Organisation, Hospital or Hospital Group) are developed.

Private healthcare providers

The role of private healthcare providers was raised by a number or respondents throughout the consultation. One organisation stated that change "*cannot be effective*" until the issue of "*consultants engaging in private practice in public hospitals*" (Organisation, Representative Body) is resolved. One individual stated that integrated health services will not *"be possible until Private Healthcare is completely separated from Public Healthcare"* (Individual, Health or Social Care Provider).

Regional, County and cross-border issues

Several respondents expressed views on the current structures in the south east of the country in particular, and these respondents have stated that recent structural changes have had a detrimental impact on the healthcare system in this region. One individual has stated that any further breakup of the south east region will "*move resources*" from the area and lead to "*worse outcomes*" (Individual, Member of General Public). Another individual stated that "*The 2040 vision is to develop south east as a region - this should be reflected in health planning"* (Individual, Health or Social Care Provider).

Separate to the section on factors to consider when moving towards geographic alignment, several respondents expressed views on whether healthcare structure boundaries should or should not align with county boundaries. One organisation stated:

> *"Unless there are compelling reasons to do otherwise, there is a strong case to have health service boundaries coterminous with other administrative boundaries. That is how the Census and other CSO data are reported, facilitating health service planning"* (Organisation, Representative Body).

Another respondent stated:

> *"There is no advantage in aligning health and social care boundaries to county boundaries that were established in the 16th century and do not reflect current population spread"* (Organisation, Representative Body).

Other views expressed regarding county boundaries were that "*natural patient flow*" (Individual, Public Administration or Regulation) needs to be considered when deciding on boundaries and that in some situations "*partial alignment*" (Organisation, Healthcare Organisation) to county boundaries may be preferred.

Over the course of the consultation, two responses highlighted the need for consideration to be given to cross border issues with one individual stating that opportunities could arise from geographic alignment in terms of "*all-island services for rare conditions and cross border working*" (Individual, Health or Social Care Provider). Speaking on the importance of cross border relationships, one organisation stated that:

> *"BREXIT cross border working relationship needs careful consideration when making the alignment decision"* (Organisation, Community Healthcare).

Suggestions on additional health system structures

A few respondents offered suggestions on other structures that could be formed alongside any changes towards geographic alignment, to achieve further service delivery goals.

One organisation stated that to "*maximise efficiency and flexibility*" there should be "*a single, well-resourced national Public Health Centre*" established as well as "*national units*" and a "*public health department in each integrated service delivery area*" (Organisation, Academic Institution).

Another organisation stated that a "*HSE strategic centre*" should be developed in parallel which would be responsible:

> *not only for strategy, planning, provides resourcing revenue and capital, national frameworks etc, but also for ensuring a common approach at a national level across e-health, procurement, HR, payroll, finance and other integrated systems together with standardised processes, operated consistently and sustainably in a standard way* (Organisation, Healthcare Organisation)

Summary

A number of recurrent issues came though many sections of the consultation responses. Regarding where concerns were expressed about progressing with geographic, these predominantly related to two issues:

- Reform fatigue; and,
- Risk of impeding existing progress in integrated care.

A number of conditions/factors/dependencies were raised by respondents throughout, which they said should be considered when moving to geographic alignment. These included:

- Investment in resources and ICT infrastructure;
- Focus on patient and patient choice;
- Focus on population health;
- Need for evidence base (national and international); and,
- Stakeholder engagement and stakeholder buy-in.

A number of issues in the current health system were identified throughout the submissions, which may affect a move towards geographic alignment. These include:

- Organisational and service culture;
- Concerns regarding governance;
- Improving trust and confidence in the health system;
- Voluntary health and social care organisations;
- Private healthcare providers;
- Additional health system structures needed; and,
- Brexit and cross-border issues.

Appendix 1 - Consultation Questionnaire

Section 1: Your Information

In this section, we ask you to tell us about yourself so we can look at the responses received from different points of view. This is the only reason for collecting this information.

Q1 Are you making a submission on behalf of an organisation or representative body, or as an individual?

- ○ On behalf of an organisation or representative body (1)
- ○ As an individual (3)

If you are you making a submission as an individual and not on behalf of an organisation or representative body, please skip to Q1.6 (page 16)

Organisations and Representative Bodies

Q1.1 What is your title and name (optional)?

Q1.2 Name of organisation

Q1.3 Address of organisation

- ○ Number (1) _____
- ○ Street address (2) _____
- ○ Village/Town/City (3) _____
- ○ County (4) _____
- ○ Postcode (if in Dublin) (5) _____

Q1.4 Type of organisation

- ○ Union/Staff Representative Body (1)
- ○ Regulatory Body (2)
- ○ Public Interest Group (3)
- ○ Advocacy Body (4)
- ○ Volunteer/ Not For Profit (5)
- ○ Representative Body (6)
- ○ Regulatory Body (7)
- ○ Patient Interest Group (8)
- ○ Academic Institution (9)
- ○ Hospital (10)
- ○ Hospital Group (11)
- ○ Community Healthcare Organisation (12)
- ○ Community Healthcare Network (13)
- ○ Other (14)

Q1.5 If 'Other' please specify

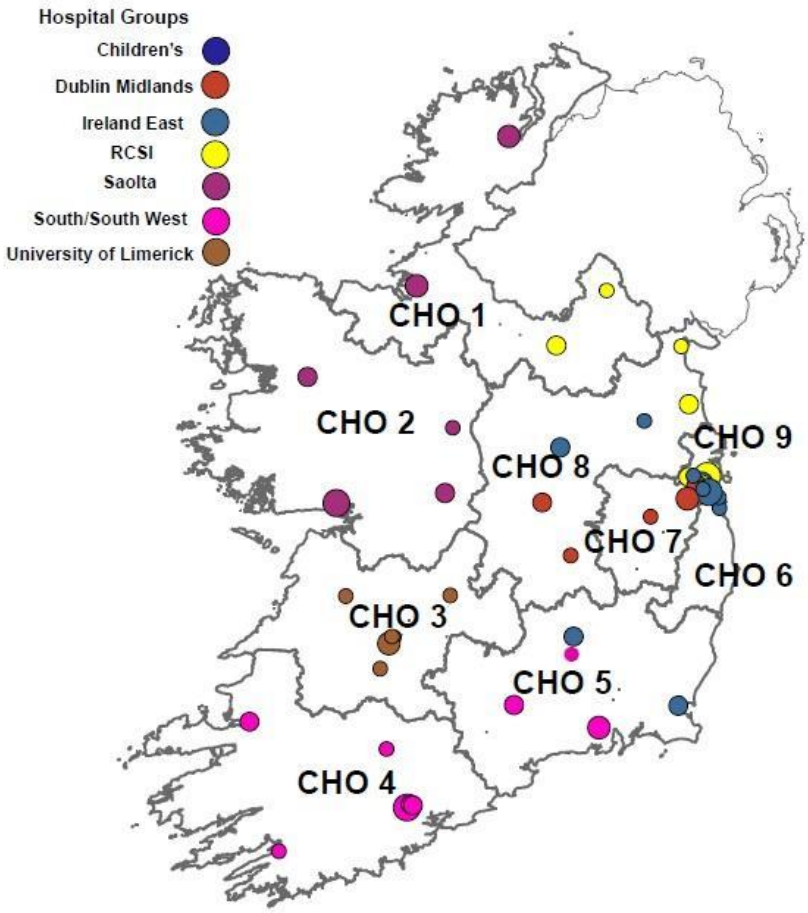
_____

Q1.6 Under the Health Act 2004, is your organisation a Section 38 or Section 39 provider?

- ○ Yes- Section 38 (1)
- ○ Yes- Section 39 (2)
- ○ No (3)
- ○ Don't know (4)

Q2 Please select the CHO you are located in.

- ○ CHO 1 (1)
- ○ CHO 2 (2)
- ○ CHO 3 (3)
- ○ CHO 4 (4)
- ○ CHO 5 (5)
- ○ CHO 6 (6)
- ○ CHO 7 (7)
- ○ CHO 8 (8)
- ○ CHO 9 (9)
- ○ Not Sure (12)
- ○ Not Applicable (11)



Please skip to Section 2 (page 22)

If you are you making a submission as an individual and not on behalf of an organisation or representative body, please complete this section.

Individuals

Q1.7 What is your name (optional)?

_____

Q1.8 Do you currently work in the health or social care sector (optional)?

- ○ Yes - as a health or social care provider (1)
- ○ Yes - as a health or social care administrator or regulator (2)
- ○ Yes – in research
- ○ Yes - other (Please specify) (3)

_____

- ○ No (4)

If you answered 'Yes- as a health or social care provider' please answer Q1.9 Otherwise please skip to Q1.10

Q1.9 Please select the area you work in (optional)

- ○ Hospital activities (1)
- ○ Medical and dental practice (2)
- ○ Other health activities (allied health and therapies) (3)
- ○ Residential nursing care activities (4)
- ○ Residential care activities for mental health or substance abuse (5)
- ○ Residential care activities for older or disabled persons (6)
- ○ Other residential care activities (hostels, community homes, sheltered accommodation) (7)
- ○ Social work activities (without accommodation) for older or disabled persons (8)
- ○ Social work activities (without accommodation) (family planning, advisory bodies, welfare services) (9)
- ○ Child day-care activities (10)
- ○ Other (Please specify) (11)

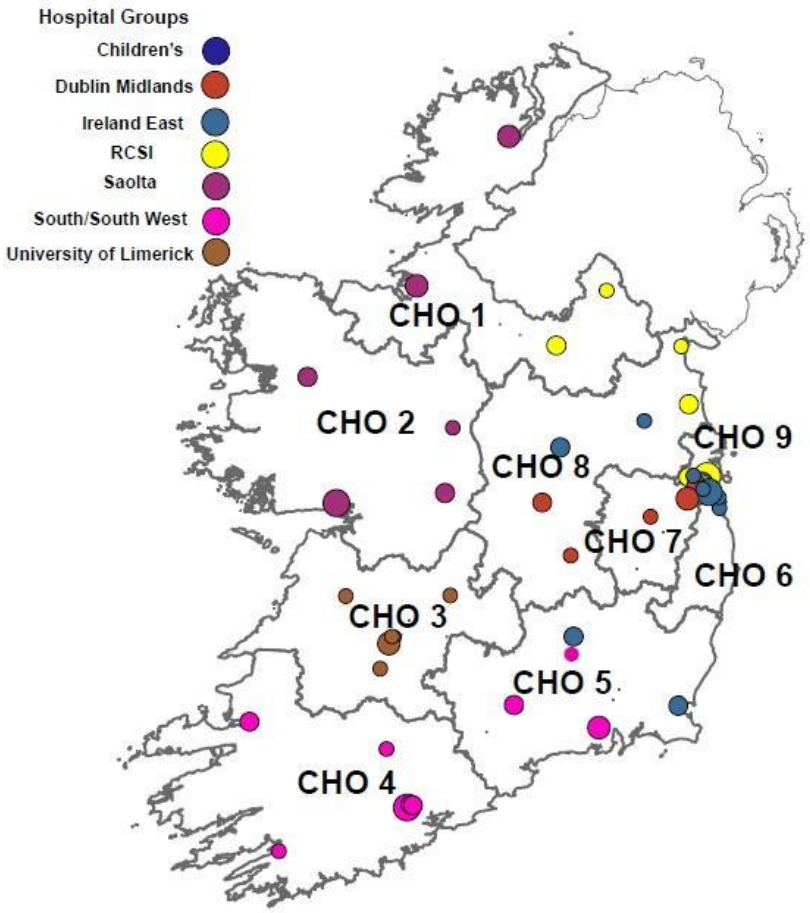
_____

Q1.10 What is your address (optional)?

- Street Name (1) _____
- Village/Town/City (2) _____
- County (3) _____
- Postcode (if in Dublin) (4) _____

Q2 Please select the CHO you are located in.

- ○ CHO 1 (1)
- ○ CHO 2 (2)
- ○ CHO 3 (3)
- ○ CHO 4 (4)
- ○ CHO 5 (5)
- ○ CHO 6 (6)
- ○ CHO 7 (7)
- ○ CHO 8 (8)
- ○ CHO 9 (9)
- ○ Not Sure (12)
- ○ Not Applicable (11)


Hospital Groups
Children's
Dublin Midlands
Ireland East
RCSI
Saolta
South/South West
University of Limerick
CHO 1
CHO 2
CHO 9
CHO 8
CHO 7
CHO 6
CHO 3
CHO 5
CHO 4

Q3 Which of the following hospitals are you most likely to go to if you require **emergency care**?

- [ ] Beaumont Hospital (1)
- [ ] Cavan General Hospital (2)
- [ ] Connolly Hospital Blanchardstown (3)
- [ ] Cork University Hospital (4)
- [ ] Kerry General Hospital (5)
- [ ] Letterkenny General Hospital (6)
- [ ] Mater Misercordiae University Hospital (7)
- [ ] Mayo General Hospital (8)
- [ ] Mercy University Hospital – Cork (9)
- [ ] Midland Regional Hospital Mullingar (10)
- [ ] Midland Regional Hospital Portlaoise (11)
- [ ] Midland Regional Hospital Tullamore (12)
- [ ] Naas General Hospital (13)
- [ ] Our Lady of Lourdes Hospital – Drogheda (14)
- [ ] Our Lady's Hospital – Navan (15)
- [ ] Portiuncula Hospital Ballinasloe (16)

- [ ] Sligo Regional Hospital (17)
- [ ] South Tipperary General Hospital (18)
- [ ] St. James's Hospital (19)
- [ ] St. Luke's General Hospital – Kilkenny (20)
- [ ] St. Vincent's University Hospital (21)
- [ ] Tallaght Hospital (22)
- [ ] University Hospital Galway (23)
- [ ] University Hospital Limerick (24)
- [ ] University Hospital Waterford (25)
- [ ] Wexford General Hospital (26)

Section 2: Importance of Geographic Alignment of CHOs and Hospital Groups

Q4 In your opinion, what are the **main principles** that should guide the process of geographically aligning Hospital Groups and CHOs?

(You can select more than one)

- [ ] Delivery of safe, quality healthcare for patients (1)
- [ ] Ensuring more efficient use of resources (2)
- [ ] Establishing a clear line of accountability (3)
- [ ] Achieving effective integration of healthcare (4)
- [ ] Ensuring services are organised around population needs (5)
- [ ] Achieving necessary change and avoiding unnecessary disruption (6)
- [ ] Maintaining public confidence in the health service (7)
- [ ] Improving decision making (8)
- [ ] Developing clinical leadership (9)
- [ ] Other (please provide details) (10)

_____

Q5 In this question we ask you to consider the benefits of geographic alignment for future health service delivery.

Please indicate how much you agree or disagree with each of the following statements:

Geographic alignment will ...

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
... enable and support integrated care (1)	○	○	○	○	○
... enable and support population-based healthcare delivery (2)	○	○	○	○	○
... enable and support population-based data analytics (3)	○	○	○	○	○
... enable and support performance assessment and management (4)	○	○	○	○	○

... enable and support coordination of services in health and social care (5)	○	○	○	○	○
... facilitate effective cooperation with other state agencies/service providers (6)	○	○	○	○	○
... enable and support better planning (7)	○	○	○	○	○

Q5.1 Are there other benefits of geographic alignment for future health service delivery that you would like to add?

- ○ Yes (1)
- ○ No (2)

Q5.2 If yes, please provide further information on the other benefits of geographic alignment that you would like to add.

Q6 What, in your opinion, are the **main advantages** of geographic alignment of Hospital Groups and CHOs?

(you can select more than one)

- ☐ Allows for integration of services (1)
- ☐ Greater accountability (2)
- ☐ Improved healthcare outcomes (3)
- ☐ Greater clinical leadership (4)
- ☐ More efficient use of resources (5)
- ☐ Greater visibility for performance (6)
- ☐ Allows for greater focus on health outcomes (7)
- ☐ Allows for population-based resource allocation (8)
- ☐ Allows for population-based health planning (9)
- ☐ Ensures coordination between different care sectors (10)
- ☐ Allows for better financial decisions (11)
- ☐ Supports integration of data (12)
- ☐ Allows for greater comparability (13)
- ☐ Other (Please specify) (14)

_____

☐ No advantages (15)

Q7 What, in your opinion, are the **main disadvantages** of geographic alignment of Hospital Groups and CHOs?

(you can select more than one)

- [ ] Disruption to current structures (1)
- [ ] Potential breakage of links between services within CHOs (2)
- [ ] Disruption to services provided (3)
- [ ] Disruption to relationships between healthcare areas and academic institutions (4)
- [ ] Administrative burden (5)
- [ ] Potential breakage of links between hospitals currently linked (6)
- [ ] Associated cost of changes (7)
- [ ] Alignment should be on basis other than geography (e.g. with universities) (8)
- [ ] Organisational healthcare structures are not very relevant to care delivery (9)
- [ ] Other (Please specify) (10)
_____
- [ ] No disadvantages (11)

Q7.1 Considering all the advantages and disadvantages, how strongly do you agree with the following statement:

*The advantages of geographic alignment of CHOs and Hospital Groups **outweigh** the disadvantages.*

- ○ Strongly Disagree (1)
- ○ Somewhat Disagree (2)
- ○ Unsure (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

Section 3: How to Achieve Geographic Alignment of Hospital Groups and CHO

Q8 In your opinion, what level of importance should be placed on the following **organisational factors** to inform any plans to move to geographic alignment of Hospital Groups and CHOs?

(Tick each of the items below)

	No importance (1)	Little importance (2)	High importance (3)	Extremely high importance (4)	**Don't know** (5)
The organisation of existing Community Healthcare Organisations (CHOs) (1)	○	○	○	○	○
The organisation of existing Hospital Groups (2)	○	○	○	○	○
Aligning with county boundaries (3)	○	○	○	○	○
Existing links between hospitals and	○	○	○	○	○

universities (4)					
Existing administrative history (5)	○	○	○	○	○

Q9 In your opinion, what level of importance should be placed on the following **service provision factors** to inform any plans to move to geographic alignment of Hospital Groups and CHOs?

	No importance (1)	Little importance (2)	High importance (3)	Extremely high importance (4)	**Don't know** (5)
Existing patient flow patterns (1)	○	○	○	○	○
Patient travel times and transport links (2)	○	○	○	○	○
The population size/density of an area (3)	○	○	○	○	○
The range of health services in an area (4)	○	○	○	○	○

Q10 Are there other important factors that should inform any plans to move to geographic alignment of Hospital Groups and CHOs?

- ○ Yes (1)
- ○ No (2)

Q10.1 If yes, please provide further information on the other important factors that should inform a move to geographic alignment of Hospital Groups and CHOs.

_____

_____

_____

_____

_____

Q11 In your opinion does geographic alignment of Hospital Groups and CHOs mean that every CHO needs to map **one-on-one** with a specific Hospital Group?

(For example, every Hospital Group could be aligned with one CHO, alternatively a Hospital Group could be aligned with more than one CHO or one CHO could be aligned with more than one Hospital Group.)

- ○ Yes (1)
- ○ No (2)
- ○ Not sure (3)

Q11.1 Please provide details to help us understand the reasons behind your answer on whether Hospital Groups should map one-on-one with a specific CHOs.

_____

Q12 The SláinteCare Report proposed a phased approach to any changes of existing structures, with geographic alignment of Hospital Groups and CHOs first, followed in time by integration into regional integrated care organisations.

What, in your opinion, is the best approach?

- ○ Do not implement geographic alignment (1)
- ○ Implement geographic alignment only (2)
- ○ Implement geographic alignment followed by integration into regional integrated care organisations (3)
- ○ Implement geographic alignment and integration into new regional integrated care organisations at the same time (4)
- ○ Other (please provide details) (5)

_____

Q12.1 Please provide brief details to help us understand the reasons behind your answer on the best approach to changing existing structures.

_____

_____

Q13 In view of other advances in the healthcare sector, **when** should a move towards geographic alignment begin? Please explain your answer.

Section 4 Towards Integrated Health and Social Care - Opportunities for the Future

Q14 In the SláinteCare Report, geographic alignment of Hospital Groups and CHOs is part of a process of achieving integrated health and social care delivery. Internationally, where health and social care is delivered by regional integrated care organisations, the ‘basket of services’ that an organisation is held responsible and accountable for can vary. In almost all instances these organisations have responsibility for integration of hospital care, primary care, home care, community care, and residential long-term care. In some, but not all instances, the 'basket of services' includes public health, mental health and disability services. Responsibility for drugs and medicines purchasing often sits outside the scope of these organisations.

Considering the recommendations in the SláinteCare Report and the move towards integrated care, in your view, what services should regional integrated healthcare organisations be responsible and accountable for?

(you can select more than one)

- [ ] Hospital care (1)
- [ ] Primary care (2)
- [ ] Home care (3)
- [ ] Community care (4)
- [ ] Residential long-term care (5)
- [ ] Public health (6)
- [ ] Mental health (7)
- [ ] Disability services (8)
- [ ] Drugs and medicines purchasing (9)
- [ ] Other (specify) (10)

_____

- [ ] Don't know (11)

Q15 Please provide any other views on the 'basket of services' that regional integrated care organisations should be responsible and accountable for.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Q16 Aligning geographic health and social care boundaries with other recognised boundaries (such as counties), might present valuable opportunities to consider healthcare in the context of other sectors, information systems, services, and wider social and economic issues.

Please provide your views on the potential opportunities.

_____

_____

_____

_____

_____

_____

_____

_____

Q17 All things considered, how strongly in favour of geographic alignment of CHOs and Hospital Groups are you?

- ○ Strongly against (1)
- ○ Somewhat against (2)
- ○ Unsure (3)
- ○ Somewhat in favour (4)
- ○ Strongly in favour (5)

Q17 Before you finish this Consultation Questionnaire, please include any additional views you may have on geographic alignment of CHOs and Hospital Groups.

An Roinn Sláinte
Department of Health

Thank you for completing this Consultation Questionnaire. If you have any queries, please contact **geoalignment@health.gov.ie**

Appendix 2 – List of Respondents

Note: A number of individuals and organisations did not disclose their name, title or organisation name and therefore are not included in the following tables.

Individual Respondents

Table 4. List of Disclosed Individual Respondents

Aaron O Doherty
Alice Gormley
Ann Hogan
Ann Marie
Anne Matthews
Aoife Byrne
Bernard Gloster
Caralyn Horne
Caroline Joyce
Celia Nichol
Councillor Ray McAdam
Damien English, TD, Minister for Housing and Urban Renewal
David Walsh
Donncha O'Gradaigh
Dr Gerard Crotty, Consultant
Dr Ronan Fawsitt
Dr Ronan Foley
Dr. Mary Gray
Eileen Malone
Elaine Howlin
Fionnuala Geraghty
Genevieve Collins
Helen McEntee, TD, Minister of State for European Affairs
Joseph G O'Beirne
Karen Sweeney
Mark Doyle
Mary Doyle
Mary Keogan
Mary O' Dwyer
Michelle Egan
Mr. Gerry McEntee, Ireland East Hospital Group

Noel Rock
Nora Mc Cabe
Owen Davin
Pat Deering
Patrick Condon, Consultant Eye Specialist
Paul Harkin
Paul Tucker
Professor John Browne
Professor John R Higgins
Roisin Shortall, TD
Ross Cullen
Shauna Bradley
Sinead Heaney
Suzanne Keenan
Tadhg Costello
THomas Kelly
Tina Vaughan
Tony Canavan
Willie Penrose T.D.

Organisation Respondents

Table 5. List of Disclosed Organisation Reepondents

Ability West
Association of Executives of Hospital Groups
Barnardos
Catholic Institute for Deaf People
CHO 8
Christine Buckley Centre for Education & Support
Chronic Pain Ireland Ltd
Clinical Strategy and Programmes Division, HSE
Clinical Strategy and Programmes, HSE
Clondalkin Drug & Alcohol Task Force
College of Health & Agricultural Sciences, University College Dublin
Drogheda and District Support 4 Older People
Faculty of Public Health Medicine of the Royal College of Physicians of Ireland
Fórsa Trade Union
Galway Hospice
Hand in Hand CLG

Health Promotion and Improvement, HSE
Health Reform Alliance
Health Service Executive
Health Systems Group, UCD School of Nursing, Midwifery and Health Systems, College of Health and Agriculture Sciences, UCD
HSE
HSE Midlands Louth Meath CHO (CHO 8)
HSE South East (Responsible for Lab IT in UHW, St. Lukes Hospital Kilkenny, STGH, WGH
Ireland East Hospital Group
Irish Heart Foundation
Irish Hospital Consultants Association (IHCA)
Irish Medical Organisation (IMO)
Irish Nurses and Midwives Organisation
Mater Hospital
MyMind
National Clinical Programme in Surgery
National Community Care Network - NCCN
Nursing Homes Ireland
Nutritics
Offaly Centre for Independent Living
Offaly Traveller Movement
Our Lady's Hospice and Care Services
Our Lady's Hospital, Navan. Co. Meath
Polio Survivors Ireland
Regional Health Forum West Region
Regional Hospital Mullingar
Rotunda Hospital
Saoirse Addiction Treatment Center
Saolta University Health Care Group
Shankill Old Folks Association
Shankill Old Folks Association
Social Care CHO DNCC
Southside Partnership DLR
St Andrew's Resource Centre
St Doolagh's Park Care and Rehabilitation Centre
St. Luke's General Hospital, Kilkenny
Tabor Group
The Alzheimer Society of Ireland
The Dales Centre,
Thurles Community Social Services
Traveller Youth Support Project
Univeristy of Limerick

Westmeath centre for independent living LTD
Wexford General Hospital
Wicklow Child & Family Project