An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta
National Economic & Social Council
NESC

Building a New Relationship between Voluntary Organisations and the State in the Health and Social Care Sectors

Paper from the Dialogue Forum with Voluntary Organisations

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Chapter 1. Introduction

The Dialogue Forum with Voluntary Organisations was established by the Minister for Health to provide a platform for regular and structured dialogue between the State and voluntary providers of health and social care services.[1] The impetus for this initiative was the Independent Review Group's contention, as outlined in their final report, that substantially improving the quality of the relationship between the State and voluntary organisations was critically important to improving the quality of service delivery, and to delivering better outcomes for service users.[2] The overarching mandate of the Forum is to build a new and more collaborative relationship between these actors. This will be key to delivering the transformative reform envisaged by Sláintecare, and achieving better quality people-centred health and personal social services.

Despite the prevailing problematic relationship, initial work for the Forum, undertaken by the NESC secretariat, concluded that a combination of factors—including a joint recognition of the need to change and a strong commitment to making the Forum work—suggested that there was fertile ground for cultivating a new paradigm of collaborative and productive engagement. This work also proposed a dynamic and iterative conceptual framework for fostering a new relationship, based on a commitment to intensive engagement, information-sharing, mutual trust and problem-solving deliberation.

The outbreak of the Covid-19 pandemic in early 2020 has had a dramatic impact, not only on the healthcare sector but on the wider economy and society. Significantly, the manner in which the national healthcare system has responded to this unprecedented public health crisis is an example of the aforementioned dynamic and collaborative framework in action, in real time. The crisis has transformed the environment in which the state and voluntary actors operate. It has also supported the transition to a new and more productive relationship, underpinned by a commitment to collective problem-solving, innovation and practical action. Equally, it has reaffirmed that mutual interdependence is a defining characteristic of Ireland's hybrid healthcare system

This paper draws on a series of qualitative interviews with senior decision-makers from public and voluntary organisations, which were carried out over the period June to September 2020. The paper seeks to document and analyse the health system's response to Covid-19 with the aim of:

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1 In the remainder of the report the term Dialogue Forum is used.

2 Independent Review Group (2019). Report of the Independent Review Group, established to examine the role of voluntary organisations in publicly-funded health and personal social services, available at https://www.gov.ie/en/publication/9b5f87-independent-review-group-examining-role-of-voluntary-organisations/

- highlighting the capacity of the health care system to respond to challenges in a flexible, innovative and dynamic manner;
- exploring the factors which underpinned the emergence of more collaborative and productive relationships between the voluntary sector, HSE, and other public actors during this period; and
- identifying lessons that can help foster a new relationship, with the capacity to drive transformative reform, deliver quality integrated services, and improve outcomes for service users and their families.

The paper is structured as follows. Chapter 2 provides a brief overview of Ireland's hybrid healthcare system—a key characteristic of which is the degree of mutual interdependence between the state and the voluntary sector. Chapter 3 discusses the impact of Covid-19 on the health and social care sectors. Chapter 4 considers cross cutting themes and lessons highlighted by the innovative and collaborative way in which the voluntary sector, HSE and others responded to the crisis. Chapter 5 considers how the Forum can harness the key lessons of this shared experience in building a new relationship, focused on developing integrated quality services, enhancing performance, and delivering improved outcomes for individuals. It is important to highlight that this study draws on numerous examples of innovative and flexible initiatives undertaken by voluntary organisations and the HSE since March 2020, and summaries of a number of these are provided in Appendix C.

Chapter 2: Ireland's Health and Personal Social Service Sector

2.1 A Hybrid System

There is a long and distinguished history, dating back to the 1700s, of voluntary organisations—often originating in religious and charitable bodies—providing hospital and social care to the poor and vulnerable in society, at a time when the state was either unable or unwilling to do so.[3] Since the foundation of the Irish State in 1921, the scale of state provision and funding of health and social care has gradually expanded, particularly since the 1960s. The 2004 Health Act sets out the legal framework for public funding of health and social care in Ireland. Under this legislation, the HSE is responsible for funding public hospitals, and certain other social services, directly under its authority. It also functions as the channel for the provision and management of state funding to voluntary organisations, and other organisations that provide health and personal social care services within the public healthcare system. The Department of Health is responsible for overall policy development and the provision of strategic oversight, in a manner designed to achieve its vision of '*A healthier Ireland with improved health and wellbeing for all, and with the right care delivered in the right place and at the right time*.'[4] A third key statutory actor is HIQA, an independent authority focused on improving health and social care services for people, through a combination of standard setting, the provision of assurances, the monitoring of compliance and ensuring enforcement.

As a result of this history, Ireland today has a hybrid or three-strand health and social care system. It consists of voluntary (independently owned and governed, not-for-profit), public (fully state-owned and governed, not-for-profit), and private (for-profit) hospital organisations, which provide a diverse range of services to the population. This hybrid system has evolved over many years, often in an ad hoc and unstructured manner. More recently, successive Governments have attempted to reform and overhaul the health and social care system in response to multiple challenges such as rising costs, technological advances, demographic pressures and changing public attitudes and expectations.

Although the Irish State's role in the funding, delivery and regulation of health and social care services has expanded considerably over the last four decades, the voluntary sector's role has also continued to grow in scale and scope. The voluntary sector currently provides approximately one-quarter of acute hospital services, and approximately two thirds of

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[3] Independent Review Group (2019)

[4] Department of Health (2021) Department of Health Statement of Strategy, 2012-2023, available at https://www.gov.ie/en/organisation-information/0fd9c-department-of-health-statement-of-strategy-2021-2023/

services to people with disabilities.[5] Voluntary organisations are also actively engaged across the spectrum of health and social care services, including mental health, older persons services, palliative care, advocacy and working with marginalised groups.[6]

The delivery of many of Ireland's core and essential health and personal social care services depends on the work of voluntary organisations. The voluntary sector is an integral and essential part of the overall public health system in Ireland. In the same period, the voluntary sector has become increasingly dependent on state funding for service delivery. In 2017, the State paid the voluntary sector approximately €3.3bn—nearly a quarter of the HSE's budget for that year—for services delivered. Consequently, the state and voluntary sectors have become increasingly intertwined, and the IRG report (2019) highlights that one of the defining features of our 'hybrid' system is the mutual interdependence between the two sectors.

Importantly, this mutual interdependence is more than just a 'funding relationship', as all three parties—the public sector, the voluntary sector and the private sector—operate within the same national policy framework. The Government is ultimately responsible for setting public policy across the health and social care system, and Sláintecare is the ten-year programme that has been developed to transform Ireland's health and social care services. There are also a series of sector-specific national strategies, e.g. New Directions (Disability Services) and Sharing the Vision (Mental Health), in this overarching framework. The interdependent nature of the Irish system ensures that all actors have a role to play in delivering national policies. Indeed the new national strategy for the mental health sector was co-designed by the state, service providers and service users. Furthermore, the HSE's National Service Plan 2021 clearly identifies the voluntary sector as an essential partner in the delivery of health and social care services, in an increasingly unified and integrated healthcare system.[7]

2.2 The Voluntary Sector

The voluntary sector now comprises a wide range of organisations that vary significantly in size, geographical coverage, and types of services provided. It includes:

- large acute teaching hospitals;
- specialist hospitals;
- national level disability providers;
- hospices;
- national and local mental health services;

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5 Independent Review Group (2019)

6 *Ibid.*

7 HSE (2021a) National Service Plan 2012, available at https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2021.pdf

- regional non-acute services;
- small community based support and social care services, and
- advocacy and representative groups.

The state provides funding to an estimated thirty-nine organisations under Section 38 of the 2004 Health Act, and over two thousand organisations under section 39 of the same legislation. The vast majority of these organisations are voluntary. Voluntary organisations can generate their own funding—for example, through donations, bequests, earned income and fundraising—as well as through statutorily-imposed patient charges and private health-insurance payments. While the level of public funding received by such organisations varies considerably, the IRG (2019) highlighted that it represents the majority of their income in most cases . For example, the Registered Irish Charities Social and Economic Impact Report 2018 indicated that public funding accounted for 65.4 per cent of the total income of 'Hospitals and Other Health organisations', and 94.5 per cent of the total income of Disability and Other Charities that were primarily funded by the HSE or other source of exchequer funding.[8]

2.3 The Role and Value of the Voluntary Sector

The IRG report (2019), which drew on interviews with stakeholders and on a public consultation exercise, noted a strong consensus that the voluntary sector brought innovation, flexibility, independence, and a strong commitment to the delivery of quality health and social care. A particular strength of voluntary organisations, compared to their public sector counterparts, s the scope to exercise greater autonomy and authority at local management level. This can facilitate a more prompt, innovative and flexible approach to problem-solving and service delivery. However, there is a strong view within the sector that this particular strength has been gradually undermined by the increased emphasis on standardised operational procedures and process compliance (see 2.4).

Secondly, the boards of voluntary organisations bring a local and community dimension, as well as their own personal and professional expertise, to bear on their work . There is, however, a perception that the burden and complexity of regulatory and governance issues, combined with persistent funding problems, are making it increasingly difficult for voluntary organisations to attract talented individuals to their boards. Their roots within the local community enables these organisations not only to be more responsive to local needs, but to act as advocates for service users. This strong local and/or community identity is also a key factor in fostering high levels of citizen engagement and voluntary activity. Theseare unique assets that the sector can draw on in seeking to provide quality services, both to individual service users and to the wider community. Public trust was shaken by high-profile financial scandals in a very small number of voluntary organisations.

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[8] Indecon (2018) Registered Irish Charities Social and Economic Impact Report 2018, available at https://www.charitiesregulator.ie/media/1489/social-and-economic-impact-report-2018.pdf

The IRG report (2019) also identified the relative weaknesses of voluntary sector organisations. These included a lack of resources, weak governance structures, service duplication, a multiplicity of organisations, and difficulties in meeting their statutory reporting and compliance obligations. In relation to governance, the report highlighted that, although boards did bring benefits to voluntary organisations, there were issues concerning a lack of relevant regulatory expertise, weak financial governance, and limited succession planning. Some of these problems relate to the financial constraints associated with the post-crisis era. Others, however, are indicative of deeper systemic issues within the sector.

2.4 A Problematic Relationship

Although it has been stressed that the statutory and voluntary sectors are mutually dependent on each other, this intertwined and complex relationship has been characterised by mixed success in terms of cooperation and collaboration. At the local level, there is evidence of strong and effective relationships that have facilitated quality service provision, collaboration and shared learning on improvement measures. However, at the national level, a combination of factors—reductions in state funding during the retrenchment period, poor communications, the introduction of more comprehensive regulatory and compliance procedures, and a succession of different structural reform processes—have contributed to the emergence of a more formalised, contractually based, command and control relationship between the state and voluntary sectors (IRG, 2019).

There is a perception within the voluntary sector that, despite their mutual dependence, the state undervalues and misunderstands the voluntary sector's role in, and contribution to, the provision of healthcare services (IRG, 2019). It is argued that the adoption of service-level agreements as the mechanism for procuring services, combined with a narrow interpretation of accountability—based on financial governance and process compliance—has facilitated a drift towards increased operational prescriptiveness, an insistence on standardised approaches, and a reduction in autonomy for voluntary organisations (Broderick, 2018; Jabbal, 2017; O'Shea et al., 2020).[9]

The apparent emphasis on financial governance, process compliance, documentation and multiple reporting has substantially increased the regulatory burden on all voluntary organisations (IRG, 2019). This burden has had a disproportionate impact on smaller organisations, who lack the administrative resources to meet these centrally imposed regulatory requirements. The cost of this regulatory burden is internalised by the voluntary sector, and it is argued that this has unintentionally undermined its capacity to meet the diverse needs of service users (O'Shea et al., 2020).

It is important, however, to recognise the statutory functions of the HSE and the constraints within which it operates. The HSE has a dual role. Firstly, it needs to support and work with

[9] Jabbal (2017) contends that the development of metrics and targets focused on compliance in the NHS is limiting innovation, and failing to drive operational improvements.

those organisations that it funds, including numerous voluntary organisations. However, while working with voluntary providers, it also needs to give assurances that public funding is appropriately accounted for, and that all publicly funded organisations are compliant with sound financial practice and good corporate governance, and that they meet the needs and expectations of the public.

The HSE has sought to put in place an effective accountability system for the public funding of voluntary organisations, through the development of Service-Level Agreements. Equally, some of the measures introduced by the HSE have been in response to weaknesses in financial governance, highlighted in various Comptroller and Auditor General reports. Service-level agreements also function as a mechanism for mitigating risk exposure on behalf of the state. There is a view that the existing contractual agreements try to take risk out of the system by shifting the burden to service providers. Equally, there is merit in the argument that ultimately it is the state who bears the risk if a service is either not delivered, or fails to meet appropriate standards.

The HSE is also operating in a budgetary framework that set by the government. Policy reforms, introduced since 2011, have increased the Department of Public Expenditure and Reform's authority over the control of budgets and staff numbers across the public service. The programme of unprecedented fiscal retrenchment, introduced between 2009-2013, also ensured that the HSE as a funding body was operating in an extremely difficult and contentious environment for a number of years. Although health expenditure has subsequently increased, so too has the demand for quality services. While there is an understanding of the burden that compliance and reporting places on voluntary organisations, there are similar pressures on the HSE. The scale of the public health budget, allied to the societal importance of healthcare provision, ensures that health expenditure is subject to intensive political and public scrutiny.

The performance management model that has developed across all areas of Government policy, including healthcare—particularly in the period since the economic and fiscal crisis—has tended to focus on monitoring inputs and outputs. The HSE is also subject to the same type of performance management and associated demands from the Department of Health, that it makes of the organisations it funds. Importantly, as discussed below, there is a growing consensus that the focus within the healthcare system needs to shift from inputs and outputs, towards a greater emphasis on performance, in terms of improving outcomes for people and their communities.

At the core of this problematic relationship is the perceived tension between accountability and autonomy. The challenge, as articulated in the IRG Report, is to find an appropriate balance between the necessary state control over policy and funding, while giving sufficient autonomy to the voluntary sector. This autonomy would enables it to continue to deliver agreed services to nationally determined standards of care, but in ways that play to its strengths. Trying to achieve the right balance between accountability and autonomy, both of which are equally important, is a complex challenge that is not unique to the Irish

healthcare system. Sabel (2018) contends that reconciling this problem can only be resolved by recasting it as accountable-autonomy.

There is a view that, while the policy system recognises the need for effective systems of accountability and autonomy, the nature of the reforms to date have tended to strengthen the accountability provisions, while failing to create the conditions for appropriate levels of autonomy. The reforms envisaged under Sláintecare do, however, provide an opportunity to get the balance right. As discussed in Chapters 4 and 5, there is evidence of a new relationship of 'accountable-autonomy' emerging from the Covid-19 experience.

Significantly, a central conclusion of the IRG report was that the emergence of a problematic relationship between the statutory and voluntary sectors was undermining the collective capacity of the system to deliver necessary improvements to service users. Given the importance of the sectors' mutual dependence, for the delivery of the transformative reforms envisaged under the Sláintecare programme, this report called for a new relationship based on trust, partnership, collaborative engagement and mutual respect.

2.5 Building More Productive and Collaborative Relationships

The Minister for Health established a new Health Dialogue Forum in 2019, in response to the IRG Report. The Forum's role is to provide a regular platform for dialogue between the state and voluntary providers of health and social care services. Critically, it has an overarching mandate to build a stronger relationship between these actors. As already indicated, this is central to the delivery of policy reform and improved outcomes for patients and service users.

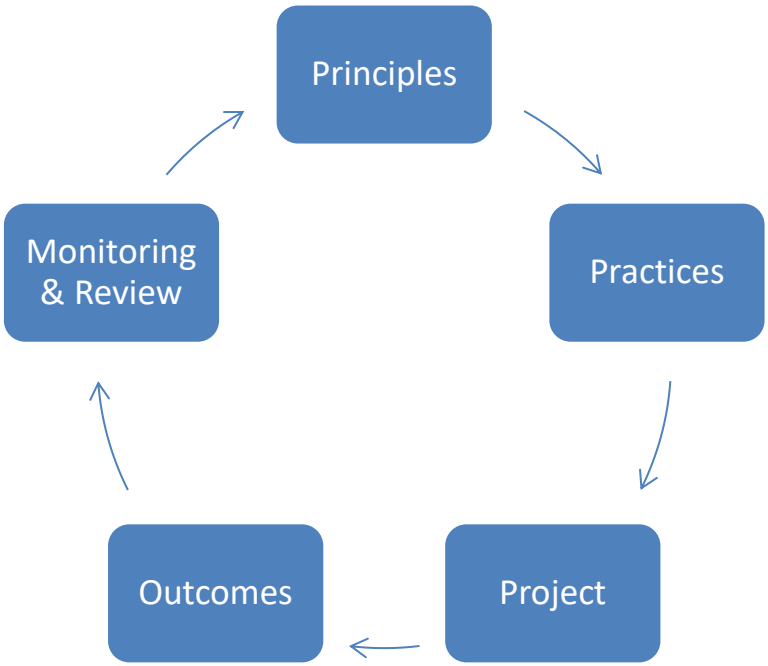
Changing relationships, organisational culture and attitudes is not easy. Furthermore, as in other advanced societies, the Irish healthcare regime will have to grapple with an increasingly complex and integrated set of challenges. These include: delivering the transformative reform associated with the Sláintecare Programme; demographic pressures; financial challenges; recruiting, training and retaining qualified staff; and rapid technological change. ,These have been compounded by the unprecedented public health emergency of Covid-19. Importantly, there is a growing recognition that addressing these challenges necessitates a dramatic step up in the level, and quality, of integrated working across the system.

There is also consensus that the pre-Covid-19 relationship between the state and voluntary sector was not 'fit for purpose', and did not provide the basis for addressing the challenges facing the sector, or delivering the vision articulated by Sláintecare. Despite the prevailing problematic relationship, earlier work by the NESC Secretariat concluded that there was fertile ground for cultivating a new paradigm of collaborative and productive engagement between the statutory and voluntary sectors. This view was based on factors such as mutual dependence and shared challenges; a joint recognition of the need for change and its

potential benefits ; shared values and a strong public ethos; local collaboration; and a strong commitment to making the Dialogue Forum work. -

The NESC Secretariat's work emphasised that building a more constructive and sustainable relationship was a dynamic and cyclical process, underpinned by intensive interaction, problem-solving deliberation, and interaction (see Figure 2.1). This conceptual framework highlights how the different elements—principles, practices, projects, outcomes and monitoring and review—can be combined to help foster a new paradigm of collaborative and productive engagement. As discussed in the remainder of this study, the way in which the state and voluntary sectors have responded to the complex challenges posed by Covid-19 is, to an extent, an example of this dynamic framework in action, in real time.

Figure 2.1: Building a Stronger Working Relationship: A Dynamic and Virtuous Cycle



Chapter 3. Covid-19—A National Heath Emergency

3.1 Introduction

The outbreak of Covid-19, and the introduction of the public health measures to control and prevent the spread of this global pandemic, has had an unprecedented impact. Those affected include public and voluntary organisations and their staff; and service users and their families and carers—right across the health and social care sectors. This chapter seeks to provide an overview of of this impact. As noted in Chapter 2, Ireland has a hybrid healthcare system consisting of public, voluntary and private service providers. This chapter draws heavily on examples from the voluntary sector, to demonstrate the impact of the crisis on healthcare providers, and how such organisations responded to it. Importantly, as shown in Chapter 4, voluntary bodies did not respond to the crisis in 'splendid isolation', but in a cooperative and collaborative partnership with the state as an integral part of a unified national strategy and healthcare system. This 'partnership' combined collective problem-solving deliberation with the fostering of a supportive environment, that enabled local-level innovation and tailored action.

3.2 Responding to Covid-19: A National Collaborative Effort

The HSE, with the Department of Health, NPHET, HIQA and various other public bodies, has been at the vanguard of the national response to the Covid-19 pandemic. The HSE has been the lead body in overseeing the health and social care system response to the pandemic. A number of key components and characteristics of this strategy are worth documenting.

There has been a strong emphasis on the use of clinical evidence and data—from national and international sources—to shape and drive decision-making. Covid-19 was an unprecedented global health crisis, and consequently the national strategy had be revised and changed in tandem with our evolving knowledge and understanding of this disease.

The reliance on evidence and data underpinned a comprehensive communications strategy, based on the almost daily provision of quality advice and guidance on a full range of issues; in particular, infection prevention and control measures.

There was also a concerted focus on adopting public health measures designed to protect the most vulnerable in society—in particular the elderly, individuals with complex and serious underlying health problems, people with disabilities, individuals experiencing homelessness, children in care, and those accessing social inclusion services.

The design of the national response accepted the highly complex and uncertain environment in which they were operating. Early in the crisis, Paul Reid, CEO of the HSE,

informed the political system that the HSE would get about seventy per cent of its response to Covid-19 right, but that there would also be mistakes and ongoing changes.[10] Although there was a high level of anxiety due to the uncertainty of the crisis, this perspective provided a safety net that served to unlock innovation in the healthcare system and ensure that 'fear did not turn into stagnation.'[11]

The HSE adopted what Paul Reid has described as a 'tight and loose' approach, which combined an emphasis on strong central guidance and direction—including strict oversight where required—with increased autonomy at the regional and local levels in terms of the design and implementation of specific actions (see section 4.5).[12]

From the outset of the crisis, the acute hospitals were identified as being in the front line of the battle against the pandemic. Hospitals developed preparedness plans for acute and critical care capacity, aimed at mitigating the risk associated with surge activity. As a result, Irish hospitals never became overwhelmed during the first surge. However, this necessitated the suspension of non-emergency elective surgery and outpatient clinics. At the same time, the HSE tried to sustain as many time-critical services as possible, including urgent elective, cancer and cardiology services. As the severity of the crisis intensified, more restrictive public health emergency measures were introduced in late March 2020 to curb the spread of the infection. This resulted in voluntary, public and private healthcare organisations either suspending and/or severely reducing a whole range of face to face/in-person services and supports. Community therapy provision fell significantly, due to capacity constraints arising from Covid-19 and the necessary redeployment of staff to support the Covid-19 response. This led to reductions in physiotherapy sessions, speech and language consultations, and the provision of psychology and occupational therapy services. As noted below there was also widespread disruption to respite and day care services.

A comprehensive approach to redeployment, to ensure that health workers could be reassigned quickly to areas of greatest need, was central to the HSE's response. Furthermore, in order to maximise flexibility, normal notice requirements for scheduling shift changes, different work hours, and changes to work location were temporarily suspended. These substantial changes, which were all the subject of discussion and agreement with the relevant trade unions, greatly enhanced the capacity of the health system to respond in an agile and flexible manner to evolving demands . They have also facilitated innovative initiatives, such as the voluntary scheme to enable public service nurses to work in private nursing homes due to staff shortages in the latter.

[10] Source: Research Interview
[11] Source: Research Interview
[12] Source: Research Interview

This period also witnessed the widespread adoption of new working practices, and an acceleration of tele-medicine and similar technology-enabled practices.[13] At the height of the pandemic, approximately 50 per cent of specialist consultations in the public sector were delivered remotely, while the use of smart technology enabled services for vulnerable patients—such as dialysis—to be moved to the home or community settings, where clinically appropriate. Similarly, the establishment of community assessment hubs, in Community Services, provided an appropriate and effective alternative to attending Emergency Departments.[14]

Over the course of the crisis the HSE oversaw an accelerated programme of investment in PPE, technology, drugs, infrastructure and other medical equipment. This included successfully competing in global markets for stocks of PPE and drugs that were in short supply. During this period, the HSE also established a nationwide test and tracing system from scratch.

The Department of Health was also a key player, working closely with NPHET, HSE, HIQA, government departments, the voluntary sector and a range of other public agencies. Through the provision of strategic oversight and support, the Department played a pivotal role in fostering an 'all of government' approach to this national health emergency.

Reflecting the focus on protecting the most vulnerable in society, a subgroup on Vulnerable People was set up early in March 2020, under the auspices of NPHET. It was chaired by a senior official from the D/Health, who was a member of NPHET.[15] The group's purpose was to provide oversight and assurance with regard to the specific preparedness of measures and actions required to protect vulnerable groups and individuals. The membership of this group included senior officials drawn from seven government departments, the HSE, the Local Government and Management Authority (LGMA), and the voluntary sector, along with public health specialists and a patients' representative. In addition, expert advisors and other stakeholders were periodically invited to update the group on emerging issues.

Among the key issues discussed at this peak-level subgroup were:

- communications with vulnerable groups;
- the development of a Community Support Framework;
- long-term care residential settings;
- inputting into guidance for vulnerable groups;
- the needs of specific groups of vulnerable people, and
- mental health and wellbeing.

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[13] HSE (2021b) Submission to the Health Dialogue Forum Group, internal unpublished report

[14] *Ibid.*,

[15] NPHET Vulnerable Subgroup, Draft Discussion Paper—progress to date, September 2020, unpublished.

The subgroup provided a weekly report to NPHET, ensuring that the latter's deliberations and decision-making was informed by their views and insights.

There is a general consensus that this subgroup was an effective forum that met its objectives, by ensuring that preparedness plans for different vulnerable groups were in place . A critical factor in this success was its approach, which was integrated, responsive, collaborative, cross-departmental and person-centred..

Although operational responsibility for the implementation of the preparedness plans remained with relevant departments and agencies, the subgroup played an important coordinating role, as well as providing strategic input to individual plans. The group also ensured that, as the nature of the crisis evolved, the focus on protecting the vulnerable remained a central element of the national response.

The subgroup's work on the development of a Community Support Framework provided the impetus for the establishment of Community Call. This proved to be effective and innovative in mobilising a wide range of actors and stakeholders to protect the elderly and most vulnerable in society.[16] Recognising the importance of communications tailored for vulnerable people, the subgroup supported the D/Health and HSE communications teams in developing initiatives aimed at these groups, across various media streams.. This included the design of bespoke and accessible material— for example, for people who were visually impaired or for those who may not have English as their first language.

Importantly, while the overall national strategy and response to COVID-19 was State led, , it has been a collaborative national effort that involved all the constituent elements of Ireland's hybrid national healthcare system.

> The voluntary health sector has worked extraordinarily well with us and this underscores for me the importance of building a new relationship with section 38 and section 39 organisations, grounded on mutual trust and respect. Our colleagues in community-based practice (GPs, pharmacists, dentists, and others) have also worked very closely with us, and already they are emerging as a driving force behind the shifting of care to the community. The commercial healthcare providers and private hospitals have also played their part in diversifying the pathways of care available to us in meeting patient need in a COVID-19 environment. (Paul Reid, 2021:2)[17]

As highlighted throughout this paper, the emergence of a more collaborative and productive relationship between the state and the voluntary sectors was both a significant feature of the national response to the crisis, and a key outcome of this shared experience**.**

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[16] NESC Secretariat (2021) Community Call: Learning for the Future, NESC Secretariat Papers, no.22 available at https://www.nesc.ie/publications/community-call-learning-for-the-future/

[17] HSE (2021a) National Service Plan 2021

3.3 The Suspension and Restriction of In-Person Services

Even prior to the implementation of restrictive public health guidelines in March 2020, front-line service providers in the disability, mental health, hospice and homecare sectors were already reporting a decline in people using centre-based and home-based services, due to concerns about potential infection. However, once the new restrictive measures were introduced in March, organisations across the healthcare system had to suspend and/or restrict a broad range of in-person health and social care supports, in order to comply with public health emergency guidelines.

As shown in Table 3.1, the initial impact on the provision of services and supports in the disability sector was quite dramatic. The loss of these services led to vulnerable adults and children facing the prospect of isolation, losing essential services, the curtailment of learning and development opportunities, and an increased reliance on their families—many of whom are elderly and themselves vulnerable to the virus.

Table 3.1: The Initial Impact of Government Public Health Emergency Measures on Service Provision in the Disability Sector: Selected Organisations

CRC • Closed Schools • Adult training and development centres stopped providing in-person services • In-person Clinical Services reduced • Scaling back of Assistive Technology and Specialist Seating Services • A significant restriction of the Gait service	**Enable Ireland** • Majority of service users stopped availing of day and clinical services and homes support for fear of infection • Closure of adult day services, schools and pre-schools. • Dramatic reduction in residential respite provision. • Reduction in provision of clinical/therapy services including restrictions in specialist services (motor management, seating and Assistive Technology). • Reduction in provision of personal assistance support and home supports (clients/families withdrawing from service).
Irish Wheel Chair Association • Ceased transport/bus services • Closed/reduced capacity in day centres • Reduced demand for Assisted Living Services (ALS) and capacity to deliver ALS also constrained • Rehabilitative rraining and school leaver services curtailed • Holiday respite service ceased	**Prosper** • Closed day centres • Temporarily closed respite services

In the mental health sector, the majority of organisations— including national bodies like Pieta, Grow Ireland, Jigsaw and Aware—were forced to close their offices to clients, and to suspend face-to-face therapeutic services, support/peer group meetings and class-based educational programmes. A Mental Health Reform Survey (2020) indicates that 76 per cent of respondents withdrew services they normally provided, due to the pandemic, an estimated average of 41 per cent of their normal service provision.[18]

In the hospital sector, the strategic decision to prioritise Covid-related infections resulted in the cancellation of all non-emergency elective surgeries and the suspension of outpatient clinics. Finally, homecare services were scaled back, in accordance with the public health restrictions and the HSE's decision to focus on high-priority individuals only.

3.4 A Growing Funding Crisis for the Voluntary Sector

The cancellation of fund raising events and activities that generated earned income in compliance with the public health measures introduced to combat the spread of the virus also contributed to a major financial crisis for the voluntary healthcare sector. Surveys of charities and NGO's carried out by the Charities Institute of Ireland and The Wheel in March 2020 indicated that:

- Between 70% and 90% of charities had already cancelled fundraising events and campaigns;
- Approximately half of surveyed charities expected fundraised/earned-income losses of between €100,000 and €1m; and
- The loss of income for individual organisations ranged from 20% to 100%.[19]

The Mental Health Reform Survey (2020) indicates that 55 per cent of respondents had to cancel funding raising events and/or the provision of services that generate earned income, while one in three stated that the crisis was having a negative impact on revenue generating activities. On average survey respondents expected a decline in fundraising/earned income of approximately one-third for the year. Pieta, a national organisation working to prevent suicide and self-harm, generate eighty percent of their annual income through fundraising. As a result of the pandemic Pieta were forced to cancel their landmark fundraising event 'Darkness into Light' which annually raises €6m. Given that the organisation was already facing financial constraints, the cancellation of this event raised the possibility of significant redundancies and a scaling back of services and supports provided by their centres.

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[18] Mental Health Reform (2020) 'The Impact of Covid-19 on Mental Health Reform's Coalition Members', https://www.mentalhealthreform.ie/wp-content/uploads/2021/04/FINAL-The-Impact-of-COVID-19-on-Mental-Health-Reform-Coalition-Members.pdf. The sample for this survey was the seventy-five Mental Health Reform member organisations and a response rate of 56 per cent was achieved (42 organisations).

[19] Coalition of Community and Voluntary Organisations, (2020) A Stability Package for Charities, Social Enterprises & Community and Voluntary Organisations, Submission to Government

According to the Disability Action Coalition,[20] a new coalition of eight non for profit organisations, the biggest impact of the crisis on their sector has been the dramatic reduction in earned income due to the cessation of fundraising activities and social enterprises (see Box 3.1).[21]

Box 3.1: The Impact of Covid-19 on revenue generation: Disability Service Providers

- Chime raises approximately one third of its annual costs (€2m per annum) through social enterprises and fundraising. As of June 2020, they estimated that this funding had been reduced by 70 per cent.
- Enable Ireland's postponement of fundraising events and closure of 21 charity shops, means that the organisation is facing a potential loss of €1.5m in income in 2020, in a context where there is an existing €3.5 shortfall in funding.
- The Irish Wheelchair Association supplements the annual funding it receives from the HSE to provide disability services with approximately €2m of independently generated income. The organisation estimate that by mid-year they will have lost over €1m due to the cancellation of fundraising events and the closing of a number of charity shops.
- The Rehab Group are anticipating their fundraising will fall by approximately €400,000 over the course of 2020. By mid-year additional PPE costs alone for the organisation were €116,000.
- MS-Ireland estimate that income from fundraising will fall by between 25 and 40 per cent depending on the level of the restrictions over the course of the year.
- The National Council for the Blind Ireland (NCBI) spend approximately €9m per year to provide services to 8,000 people. This is composed of €6m from the HSE and €3m in earned income from fundraising and social enterprises. These latter activities almost completely stopped when Covid-19 restrictions were announced in late March.
- The CRC is facing a fundraising reduction of approximately €250,000 for the year.

Source: The Disability Action Coalition (2020)

These dramatic falls in income occurred in tandem with a substantial rise in costs due to the crisis. Firstly there are the substantial costs associated with adhering to public health guidelines including procurement of PPE, additional staff training, additional hygiene and cleaning activities and investment in facilities (for example new isolation units or redesigning offices/centres to comply with social distancing). Secondly, the remodelling of

[20] The Disability Action Coalition is a new coalition of eight not-for-profit disability service providers whose aim is to address the significant funding shortfalls that are threatening frontline disability services in every county in Ireland. The eight members are Irish Wheelchair Association, Enable Ireland, Rehab Group, Acquired Brain Injury Ireland, Cheshire Ireland, Chime, MS Ireland, and National Council for the Blind in Ireland.

[21] The Disability Action Coalition (2020) Submission by Gillian Murphy to the Oireachtas Special Committee on Covid 19 Response, SCC19R-R-0387 D, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-09-30_submission-gillian-murphy-communications-manager-the-disability-action-coalition-scc19r-r-0387_en.pdf

service provision to facilitate the delivery of services remotely and the design of new initiatives to meet emerging needs has also required considerable investment in equipment and training. This combination of falling income and rising costs posed a serious threat to many organisations capacity to maintain existing health and social care supports and services and in some instances the growing 'crisis' threatened their very existence.

3.5 A Growing Demand for Services

The escalation in the rate of Covid-19 infections ensured that the acute hospital sector in particular came under considerable pressure due to the rising demand for infection related medical services**.** The decision to suspend all non-emergency elective surgeries and other hospital-based activities is also serving to further increase pent up demand for treatment.

Although first and foremost a physical health emergency, the WHO have stipulated that:

> 'The isolation, fear, uncertainty and the economic turmoil (of the current pandemic) could cause psychological distress, and we could expect an upsurge in the severity of mental health illness, including among children, young people and healthcare workers.[22]

The pandemic combined with the social and economic impact of the measures introduced to contain the virus have the potential to both exacerbate existing mental health difficulties and create new problems. In the Mental Health Reform Survey (2020), approximately 50% of respondents reported an increase in demand for services and supports in the previous four weeks while 78% expected demand to increase in the coming months. Pieta, Jigsaw, Aware, Grow Mental Health Ireland, TurntoMe and Spunout have all recorded increased demand for their 'remote' services and higher levels of traffic on their websites

There is also emerging evidence that individuals with pre-existing mental health difficulties are actually less likely to seek help during the Covid-19 pandemic.[23] This allied to the fact that there is often an initial lag following major traumatic events before the associated mental health issues become transparent suggests considerable pent up demand for services and supports that will place increased strain on organisational capacity going forward.[24] Interestingly Samaritans Ireland reported that while the number of calls to their helpline did not increase during the height of restrictions there was a tangible increase in

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[22] A. Rourke (2020) 'Global Report: WHO says Covid-19 may never go away and warns of mental health crisis.' See https://www.theguardian.com/world/2020/may/14/global-report-who-says-covid-19-may-never-go-and-warns-of-mental-health-crisis

[23] Mental Health Reform (2020)

[24] Eighty per cent of the respondents to the Mental Health Reform Survey (2020) anticipate that demand for their services and supports will increase going forward, which correlates with the views expressed by various international health organisations.

the duration of calls and the levels of emotional stress displayed by callers.[25] A number of disability organisations indicated that the demand for services and supports actually increased as a result of the crisis. Similarly, in the eldercare sector the requirement for older people to 'cocoon' served to both increase their sense of isolation and the need for tailored interventions and supports to respond to their particular needs.

3.6 Staffing Issues

Across the healthcare system, public and voluntary organisations have had to deal with serious staffing issues such as increased staff absenteeism due to illness, self-isolation and caring responsibilities, losing staff to redeployment, reduction in staff hours, and in some cases redundancy. This was also a period of increased stress and anxiety for staff. A number of staff faced a situation where they had to try to balance continuing to deal with clients in emotional distress while also discharging their own care responsibilities.[26] For voluntary organisations, like their public sector counterparts, this created considerable capacity pressures in terms of providing services and supports, though in some instances internal redeployment from 'suspended services' served to alleviate this situation. A combination of caring responsibilities, self-isolation and cocooning also combined to reduce the level of volunteering on which so many voluntary organisations depend. For example volunteering fell by forty per cent in Samaritans Ireland with the result that that it was difficult for the organisation to operate a full roster on their 24/7 helpline.

3.7 Continuity and Contingency Planning

A key strength of the voluntary sector is its capacity to respond in an agile and flexible manner to evolving situations. Drawing on the strategic public health advice and guidance provided by the HSE and their own internal governance structures, senior management in many voluntary organisations responded to the new public health and clinical guidelines by quickly designing comprehensive business continuity or contingency plans.

> 'We had to very quickly come up with a business continuity plan that was robust, that could withstand Covid-19 and could set a path in place for recovery'. (S. Manahan, CEO, CRC)[27]

In seeking to respond to the aforementioned challenge, the CRC established seven multi-disciplinary core teams each of which was responsible for delivering primarily remote services to their respective client groups.[28] Similarly many other organisations such as

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[25] M. Mulvenna (2020) 'Examination of Calls and Calls Behaviour Pre-Covid-19 and Active Covid-19' University of Ulster, presentation to 'The Community Context: Learnings from Samaritans Ireland', Coalition Conversations Webinar Series see https://www.mentalhealthreform.ie/coalition-conversations/

[26] Mental Health Reform (2020)

[27] Source: Research interviews.

[28] The CRC (Central Remedial Clinic) provides a range of service and supports to adults and children with disabilities. See https://www.crc.ie/

Enable Ireland and the Rehab Group put in place internal management structures and associated business continuity plans to manage and coordinate their strategic response to the complex set of challenges unleashed by the pandemic (See Appendix C: Box E1).[29]

Although the types of services and supports provided by voluntary organisations differed according to their nature, size and sector, in practice their response to the Covid-19 crisis generally involved an intense focus on redesigning and remodelling the delivery of services and supports. This has involved a number of elements namely:

- Adopting remote working for staff within the organisation;
- Investing in extensive infection prevention and control measures;
- Keeping critical residential/accommodation services open;
- Transitioning to remote service provision; and
- Developing new ways to support and connect with clients

In seeking to protect their staff and adhere to the public health guidelines the vast majority of voluntary bodies quickly put in place measures to facilitate remote/home working for virtually all of their staff including management teams and those employed in administrative and professional support functions such as clerical, HR, IT, finance, procurement, risk management and compliance. Approximately eighty percent of the respondents to the MHR Survey indicated that the majority of their staff were engaged in home/remote working. Equally, all of the organisations interviewed for this study adopted wide scale remote working for their staff. There was a similar shift to remote working within the state sector. This flexibility was key to the voluntary sector maintaining its capacity to rethink and reconfigure their business model in terms of providing core supports and services to its clients, their supporters and families in a safe and effective manner. In addition to the necessary clinical and health care professionals, it is evident that having in place a strong organisational team in terms of administrative and professional services has been vital to the response of voluntary organisations. The administrative and professional support teams have functioned in effect as the engine rooms of organisational responses as they were key to overseeing the implementation of new health and safety measures, staff training and redeployment, the procurement of vital equipment and the redesign and remodelling of services and supports.

[29] Enable Ireland provides services and supports to 9,000 children and adults with physical, sensory and intellectual disabilities. See https://www.enableireland.ie/. The Rehab charity provides services and supports to children and adults with disabilities and/or experiencing disadvantage in their communities. See https://www.rehab.ie/

3.8 The Key Outcomes

Finally, this section of the chapter seeks to briefly consider the key outcomes of the voluntary sectors response to the unique challenges posed by this national health emergency.

In the context of the ongoing development and roll out of the national public health strategy for Covid-19 NPHET clearly identified Long-Term Residential Facilities as a high-risk area due to the congregation of vulnerable people. Critically, the HSPC report that a number of vulnerable groups in a various settings (disability, homecare, homelessness and other settings) recorded relatively low levels of infection, hospitalisation and mortality. These outcomes for vulnerable groups is a major achievement and it is certainly one that should be both recognised and valued. HIQA have also highlighted the collective success of the voluntary disability service providers in both limiting infections and managing outbreaks effectively.[30]

The National Community Care Network (NCCN) comprises 21 homecare provider who employ 3,000 carers and provide HSE funded services to approximately 7,000 clients (the majority of whom are older people). Importantly there has been a relatively low incidence of positive cases among both homecare clients and employees. As with the previous example, this is a very positive outcome given the nature of the crisis.

Secondly, in the midst of national health crisis, in which vulnerable groups were at most risk, it was more critical than ever that the voluntary sector continued to provide services and supports tailored to the needs of service users, their families and their carers. As is discussed in the next chapter this was primarily facilitated by the rapid and relatively smooth transition to remote service provision and in particular the use of a range of digital technologies to provide access to educational, training, therapeutic and social supports (see Section 4.8 and also Appendix C: Boxes, B1,B2, B3 and B4). As is outlined in Sections 4.9 and 4.11, voluntary organisations also strove to (re)connect with the their communities, service users and their families and carers through the design of new services and/or the remodeling of existing measures in response to new challenges and problems. The opportunity to more fully embrace digital provision and to offer flexible, remote and virtual services has improved processing time, removed certain barriers to accessing services, reduced the need for multiple engagements and overall streamlined service provision.[31]

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[30] Source: Research Interview; see also HIQA (2021) HIQA opening statement to the Oireachtas Special Committee on Covid 19 Response, SCC19R-R-0064 A, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-05-26_opening-statement-phelim-quinn-ceo-hiqa_en.pdf

[31] See Government of Ireland (2021) Covid-19 Resilience and Recovery 2021: The Path Ahead, available at https://www.gov.ie/en/publication/c4876-covid-19-resilience-and-recovery-2021-the-path-ahead/?referrer=http://www.gov.ie/ThePathAhead/

The positive feedback that has been received regarding clients experience of remote and digital services has resulted in a number of organisations committing to retaining these services as part of a future model of blended service provision. Interestingly despite the challenges posed by social distancing and concerns over increased isolation several organisations reported that service users and families felt supported by, and connected to the organisation during the crisis.[32]

There were also key aspects of the response to the public health crisis that were indicative of a 'fast-tracking' of existing national strategies in terms of the adoption of e-health services, the focus on community based service provision, integrated services and the emergence of more person-centred and tailored services and supports. This has been characterised as 'Sláintecare on Speed'. Indeed a number of interviewees referred to the fact that initiatives which had been the subject of discussion for a number of years, suddenly became a reality and were developed and implemented quickly in real time.[33]

> 'Mental health services have adapted and they have demonstrated extraordinary innovation in recent months. Practices and behaviours considered science fiction four months ago are now routine. That is remarkable. We must regain those learnings and advantages but we also need to make sure the capacity of the service is replaced (M. Rogan, MHI)**.'**[34]

The manner in which certain organisations have remodelled and redesigned their day services for adults with disabilities in the context of the crisis has effectively represented a fast tracking of the community-based, person-centred and tailored approach envisaged by the HSE's New Directions policy framework.

'Covid gave us the agility to be able to progress New Directions. It has accelerated and moved services closer to Individualised plans for clients. An initiative that would have taken years before Covid-19 we got there in twenty weeks.' (S. Manahan, CEO, CRC).[35]

Importantly service providers are reporting back that many service users enjoyed having more choice around their day and less structure and routine compared to the 'traditional centre-based day services.[36] Interestingly the National Incidence Management System's (NIMS) reports indicate a substantial fall in the reporting of challenging behaviours, which would suggest that certain individuals were benefitting from a less structured and more individualised plan of support.

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[32] Source: Research Interview

[33] Source: Research Interview

[34] M. Rogan (MHI) cited in Dáil Eireann (2020) Official Report of Special Committee on Covid-19 Response, 14th July 2020, available at https://data.oireachtas.ie/ie/oireachtas/debateRecord/special_committee_on_covid_19_response/2020-07-14/debate/mul@/main.pdf

[35] Source: Research Interview

[36] Source: Research Interviews

This is not to suggest that the types of services and supports that emerged at speed in the heat of the crisis are the silver bullet with regards to smoothly transitioning to community based person-centred services. It is important to recognise that there is still a role for more structured centre-based service provision. In particular in moving towards more integrated community-based service provision it will be necessary to address not only the needs of service users but also their families and carers, as there are concerns that the burden of responsibility could be shifted onto 'families' if the appropriate resources and supports that are needed for quality integrated community-based services are not forthcoming. Indeed, it is worth noting that the Disability Federation of Ireland report that family carers who had to provide care in place of services for a sustained period have experienced negative mental health impacts during the crisis.[37]

As in discussed in more detail in section 4.3 the crisis has witnessed the emergence of more collaborative and productive relationships between the voluntary and statutory sectors. These more collaborative relationships moreover have demonstrated their capacity to resolve problems and deliver mutual benefits to both stakeholders.

As noted above the successful rollout of remote services has enabled many organisations to continue to provide essential services and supports to clients and their families and carers during the crisis. It is important, however, to be cognizant that the shift to primarily remote service provision during the height of restrictions has also revealed a tangible digital divide, which ensures that certain individuals were not able to benefit fully from these services and supports (see Table 3.2).

A number of factors underpin this emerging digital divide including—levels of digital literacy, access to IT equipment, broadband coverage, difficult home situations and availability of external support. It is also evident that that there are certain groupings in society—older people, people in direct provision, individuals with low levels of formal education—who may face more barriers in participating in digital services. This is not unique to the voluntary sector as the shift to greater levels of online working and service provision during the crisis has highlighted the stark digital divide that exists within society in general.

[37] Disability Federation of Ireland (2020a) Non-Covid-19 Healthcare, Submission to the Oireachtas Special Committee on Covid-19 Response, 1st of July 2020, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-09-30_submission-joe-dolan-chief-executive-officer-disability-federation-of-ireland-scc19r-r-0423_en.pdf

Table 3.2: Inclusion Ireland Surveys: A Digital Divide

Survey of Parents of Children with Intellectual Disabilities[38]	Survey of day centre service users and their families[39]
A small but not insignificant number (11%) had no access to equipment to enable them to access online teaching and supports 45% did not have access to High-speed broadband	7% of families indicted that they had no access to any form of technology (smartphone; iPad; computer) that would enable access to online supports 19% of family respondents stated that the person they support could not use the technology options due to the level of their disability 2% of family respondents indicated that the person they support could only use computer-based technology if substantial ongoing professional support was available

Service providers in the health and social care sectors have sought to address this situation by providing clients with equipment and/or disseminating written material and information packs as an alternative to online activities. Interestingly the Inclusion Ireland survey of parents of children with intellectual disability indicated that by far the biggest barrier to the provision of home education was the child's motivation (78% of respondents). Indeed a number of parents reported that their child's particular needs and behaviours meant that they required the ongoing one-to-one support of a skilled teacher

There is certainly emerging evidence in Ireland that the absence of the specialised, structured and intensive teaching provided by schools when combined with the loss of access to additional therapeutic supports is having a negative impact on children with complex needs and their families.[40] The Voluntary disability organisations recognised these challenges and many supported the provision of summer supports including summer camps and summer provision. It also indicates however that harnessing the potential benefits of distance learning for all children will require investment not just in technology but also in specialist assistive technology, adapted curricula and therapeutic supports.

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[38] Inclusion Ireland (2020a) Supporting Children to Learn, Written Submission to the Oireachtas Special Committee on a Covid 19 Response: 25th June 2020, Inclusion Ireland

[39] Inclusion Ireland (2020b) The impact of Covid-19 on people with intellectual disabilities and the disability sector, Submission to the Oireachtas Special Committee on a Covid 19 Response: available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-09-30_submission-enda-egan-ceo-inclusion-ireland-scc19r-r-0401_en.pdf

[40] Inclusion Ireland (2020a)

Inclusion Ireland also report that some parents of adults with disabilities have raised concerns about regression and decline in mobility, speech and language and physical skills in the absence of essential in-person therapeutic supports. This suggests that re-establishing, if not increasing the level of therapeutic supports will be vital going forward, including greater investment in the potential of e-health services.

A key theme of this study is the manner in which many voluntary organisations responded to the complex challenges presented by the pandemic in an agile, flexible and innovative manner. This has served to not only protect staff and service users but also ensure the continued provision of services and supports in extremely difficult circumstances. At the same time there is concern regarding variations in the level of service and supports provided to vulnerable people in this period.

Variability in service provision is one of the characteristics of Ireland's mental health system and it is not surprising that this came to the fore during the crisis.[41] It has been argued that the pandemic has served to expose existing fragilities within the current regime in terms of staffing levels, access to ancillary professional supports, adequate IT infrastructure and the response to the mental health needs of particular groups.[42] Reports from various grass roots forums for example have highlighted growing concerns about reductions in services, difficulties in accessing community and primary services and the lack of information about alternative options.

A survey of parents undertaken by Inclusion Ireland indicates considerable diversity of experience with regards the provision of learning supports for children with disabilities.

> 'The experience of parents across the country varies widely with some children having daily classes via zoom and access to educational facilities and smart applications from teachers but some other children having little or no contact or education provision. For many children education provision stopped on March 12. (Inclusion Ireland 2020a:14).'[43]

A second Inclusion Ireland survey of parents of adults who use disability days services, also suggests, albeit from a relatively small sample of respondents, variation in the provision of disability services and supports (see Table 3.3).

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[41] Source Research Interviews

[42] Mental Health Reform (2020b) Submission to the Special Committee on Covid-19 Response: The impact of COVID-19 on mental health in Ireland, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-09-30_submission-kate-mitchell-senior-policy-research-officer-mental-health-reform-scc19r-r-0502_en.pdf

[43] This survey was carried out between April 30 and 20th of May and 1064 people responded to it. See Inclusion Ireland (2020a)

Table 3.3: Inclusion Ireland Survey on Adult Disability Day Services

Family Member Respondents (Total: 296)

- 15% had no contact
- 5% were informed that contact was available in an emergency/crisis
- 34% received the occasional call
- 22% received regular contact and support from staff by phone
- 16% had regular online support for activities and learning
- 6% had occasional home visits from staff
- 2% had direct access to their day centre

Source: Inclusion Ireland (2020b).[44]

It is important to stress that that the results of these two surveys did not seek to distinguish between state or voluntary/non-governmental disability service providers of schools or day centre services.[45] At the same time, the results do raise questions regarding variability in service provision. Indeed one interviewee did remark that while their organisation was being innovative and continuing to provide various services and supports others in their opinion 'did not step up and were not delivering'.[46] There may be justifiable reasons why some organisations did not 'step up' including insufficient financial and technological resources, lack of IT skills or staff shortages. At the same time given that the 'standards of good performance' in terms of responding effectively were being set by organisations within the sector itself there would be merit in exploring what is required to enhance organisational capacity and resilience so as to ensure greater consistency in services and outcomes for individuals and their families.

While staff have displayed remarkable commitment, professionalism and flexibility during the crisis increased levels of stress, and anxiety in conjunction with exposure to high-risk situations has taken its toll on many individual's mental and physical well-being. As is discussed in the next chapter many organisations, including the HSE, have recognised the need to provide additional supports to 'protect staff' however, there is concern that many smaller organisations may not have the resources or skill-sets to provide adequate employee well-being/assistance programmes. More generally, it is also evident that working in a continual state of crisis, with resources and services stretched to the limit is not sustainable in the medium to long term.

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[44] This second survey, which was undertaken between May and June 2020, received 346 responses, 291 from family members and 55 from people with intellectual disabilities. See Inclusion Ireland (2020b)

[45] Indeed some schools for children with intellectual disabilities are partnerships between a voluntary body/charity and the Department of Education.

[46] Source: Research interview.

It is also important to recognise the increased levels of stress and anxiety faced by families and carers during the crisis. As noted earlier family carers have reported experiencing increased mental health issues. Additionally 62% of the respondents to Rare Diseases Ireland Survey stated that Covid-19 was having a negative impact on their mental health.[47]

A number of interviewees drew attention to the continued anomalies between the pay of staff in section 38 and 39 organisations. It is evident that the crisis has focused attention on the value of work undertaken by all front line health and social care staff and there is a growing societal consensus that all essential workers need to be valued, treated fairly and appropriately compensated.[48] Indeed in the midst of the crisis, due to redeployment there were instances where workers were undertaking the same job in the same location yet were subject to differing pay and conditions. Aside from its impact on morale in the sector, its continuance was seen by many interviewees as inequitable. In this context it is important to note the Government and the relevant trade unions negotiated a deal in 2019 on the restoration of pay that was cut following the economic crash for staff in fifty larger Section 39 organisation. A further agreement was reached in December 2020 that will facilitate pay restoration for employees in around 250 further Section 39 agencies.[49] Fórsa official Catherine Keogh described the agreement as a significant breakthrough for Section 39 workers.

> 'This has been an exceptionally challenging year for these workers…and these are the workers whose professionalism and experience was called upon like never before in response to that crisis. This is a welcome breakthrough, and some good news at the end of a long and very difficult year for them.' (C. Keogh; IRN, 2020: No.46).

Overall, the necessary public health measures adopted in response to the pandemic have had consequential impacts on well-being including psychological, emotional and social impacts. While this study has focused on the implications for the health and social sectors the pervasive nature of the virus ensured that there were adaptations, innovations and restrictions across every area of support (education, policing, child and family protection and support, direct provision) and every area of general public service (transport, social protection, immigration and road safety). The unprecedented nature and scale of the Covid-19 pandemic has ensured that its impacts have reverberated across the whole of society. Importantly, the concerted focus from the outset on seeking to protect the most vulnerable groupings in society served to mitigate the levels of mortality and morbity endured by these sectors of the population. At the same time, it is also evident that those who were most reliant on the state for key services and supports have suffered disproportionately due to the manner in which the crisis amplified existing structural inequalities in our system.

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[47] Disability Federation of Ireland (2020a

[48] C. Fitzgerald (2020) How We Value Work: The Impact of Covid-19. NESC Secretariat Covid-19 Working Paper Series, available at http://files.nesc.ie/nesc_background_papers/c19-2-how-we-value-work.pdf

[49] B. Sheehan (2020b) 'Welcome for 'pay breakthrough' in Section 39s, Minister's key role' IRN No. 46

‘The pandemic has also magnified the inequalities experienced by many vulnerable and disadvantaged communities such as the Irish Traveller community, the Roma community, migrants, those who are homeless, those living in Direct Provision and struggling with addiction. While less affected by the virus itself, the impact of the measures to protect society have had an enormous impact on children and young people, especially those that are vulnerable.’ (Government of Ireland, 2021:1)

Chapter 4: An innovative, flexible and collaborative response: Cross Cutting Themes

4.1 Introduction

The previous chapter provided an overview of the dramatic impact of the current public health emergency on statutory and voluntary organisations in the health and social care sectors. Importantly the national healthcare system has responded to this unprecedented crisis in an innovative, flexible and collaborative manner. The aim of this chapter is to document the key cross cutting themes that have both underpinned this response and contributed to emergence of more productive and collaborative relationship between the statutory and voluntary sectors.

4.2 A Unity of Purpose

Ireland and the world are experiencing a shock of enormous magnitude as a result of the Covid-19 pandemic. The scale and unprecedented nature of this national public health crisis has created a clear unity of purpose across all stakeholders in healthcare in terms of 'protecting' the population and in particular, the vulnerable from this deadly virus while continuing to provide where possible core services and supports. This 'unity of purpose' has provided an overarching framework for all the strategies, actions and initiatives that have been implemented since February 2020. It demonstrated moreover that Ireland's hybrid health system has the capacity to function as an integrated national health system with clear coherent voice and singular sense of purpose.

> 'Across the health and social care system (public, private and for-profit) there was evidence of a hugely dynamic response, undoubtedly driven by the shared understanding that it was vital everyone with a role to play in safeguarding the health and welfare of the public needed to be put on a war-like footing.' (HSE, 2021:2).[50]

In this context, several interviewees commented that the working relationship between the HSE and voluntary organisations during the crisis has been characterised by a stronger sense of collegiality and common purpose. Dealing with the crisis has also served to create a similar 'unity of purpose' between voluntary organisations working in the same sector.

[50] HSE (2021)

> 'It was a time of the greatest cohesion we've ever had. Everyone came together with a single purpose we all knew what the aim was namely to keep people safe' (A. Harnett, NFVSP).[51]

Interestingly the use of digital technology –in this case Zoom—not only created a new communication structure for this particular coalition of voluntary bodies but it also facilitated increased levels of engagement by members and enhanced information sharing which served to reinforce the shared sense of purpose within the group. A senior official in HIQA also commented that that the existing collective approach between voluntary organisations in the disability sector was further reinforced during the crisis and that this facilitated them engaging with the HSE in a very coordinated and focused manner particularly around the issue of protecting vulnerable individuals with disabilities in congregated settings.[52]

In the mental health sector the crisis has also fostered an increased level of inter-organisational interaction. This fostered a greater awareness of '*what each other is able to do'* and is encouraging a greater focus on the need to enhance service coordination and better harness collective resources.[53] Similarly as a result of their involvement in the Community Call initiative, a number of organisations who provide services and supports to elderly people in the Galway region, have indicated a willingness to continue to engage with each other and work more collaboratively in addressing shared problems for this particular vulnerable group.[54]

4.3 Intensive Engagement, Information Exchange and Collective Problem Solving

As was highlighted in Chapter 2, the Independent Review Group Report (2019) concluded that substantially improving the quality of the relationship between the State and voluntary organisations would be critically important to enhancing the quality of service delivery and ensuring better outcomes for service users. Significantly, the response to the Covid-19 health emergency has been underpinned by an unprecedented level of collaboration between the statutory and voluntary sectors and evidence of the emergence of more productive partnership-style relationships across the health and social care system.

In particular within the areas of disability, mental-health, palliative care and eldercare new national level 'virtual' forums or structures, comprised of senior decision makers from the statutory and voluntary sectors, were established early on in the crisis to oversee the

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[51] Source Author's Interview

[52] Source Research Interview

[53] Dáil Eireann (2020b) Official Report of Joint Committee on Health, Wednesday 7th October, available at https://data.oireachtas.ie/ie/oireachtas/debateRecord/joint_committee_on_health/2020-10-07/debate/mul@/main.pdf

[54] Source Research Interview

implementation of national public health advice and guidelines and to address Covid-19 related challenges in their respective sectors (see Appendix C: Boxes A1; A2: A3 and A4).

> 'The forum provided a much needed space for communication and a support structure for all providers. It created the sense of 'a united front and approach', we felt that we were being heard and the group was able to get things done quickly.' (P. Quinlan, Chair Voluntary Hospice Group).[55]

While the above comment relates to the palliative care, forum it is equally applicable to the peak-level structures that were set up in the disability, mental health and eldercare sectors.

Interviews with participants reveals that the work of these various forums was characterised by intensive engagement, extensive information exchange and data collection and a strong commitment to collective problem-solving deliberation. Covid-19 is an unprecedented national crisis and the healthcare systems collective knowledge of this virus and the types of problems it was creating for front line service providers was constantly changing, almost on a daily basis. The aforementioned fora enabled regular, structured and intensive engagement between voluntary organisations and senior decision makers within the HSE and the Department of Health on a weekly basis. At the height of the crisis, these formal weekly meetings were augmented by daily contact between senior officials from both statutory and voluntary organisations.

> 'There was positive, open and regular engagement between disability umbrella organisations and the HSE at national level. The umbrella organisations were able to raise issues that arose quickly and there was swift response.' (DFI 2020b:4).

This structured and intensive engagement afforded voluntary groups direct access to senior decision makers and expert policy centres within the HSE and this facilitated the latter in disseminating important guidance and communications in a timely fashion to umbrellas member organisations on the ground.[56] This was a valuable 'resource', which hitherto had not been available to service providers.

> 'Our direct access to senior expertise in policy areas such as infection control, occupational health and HR services allowed immediate measures to be put in place with the shared learning disseminated quickly to the organisations within the Voluntary Hospice Group.' (A.Houlihan, CEO Our Lady's Hospice)[57]

The above example is indicative of a second characteristic of these collaborative forums namely the extensive two-way flow of information and data. As highlighted in section 2 a central feature of the national response to Covid-19 has been the use of national and

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[55] Source Research Interview
[56] Disability Federation of Ireland (2020b)
[57] Source Research Interview

international clinical evidence to shape and drive decision making in an uncertain and rapidly changing environment.

Within the various peak-level forums, the provision of expert public health advice and guidance from the centre was complemented by the upward flow of information based on the knowledge and real time experience of front line service providers. In the disability sector, for example, the national umbrella groupings were asked to reach out to their member organisations with the aim of identifying and collating the key Covid-19 related issues they were grappling with (Appendix C: Box A1). Similarly the new national helpline funded by the HSE and operated by Alone was used to identify on a weekly basis the four or five major issues for older people during the crisis, and these would then be discussed within the Eldercare Forum (Appendix C: Box A2). A senior HSE representative considered the timeliness and quality of the information generated by these processes to be invaluable for public health policy and guidance during the crisis.[58] It also ensured that issues did not fester as they could be aired within the decision making centre very quickly. Conversely, in addition to receiving up to date guidance and advice, these structures afforded voluntary bodies a voice at the centre of the policy dialogue and a real sense that their concerns were being actively listened too.

The emerging problems and issues that were raised within the forums were viewed from the outset as shared problems that needed to be addressed collectively through problem solving deliberation. Commenting on collaboration in the mental health sector, one senior representative from the voluntary sector commented:

> 'The formal and structured engagement effectively facilitated a de facto 'disposing of boundaries' as the HSE and non-governmental organisations worked together to address shared problems.' (M. Rogan, MHI).[59]

Furthermore, in all of the forums if an issue could not be resolved in the context of the formal meetings the HSE committed to exploring it further with the relevant statutory bodies and bringing the answer back to a subsequent meeting. The way this worked in the disability area is described by one participant in the following way.

> 'It was like a figure eight with information flowing up and down between organisations at different levels…we would bring a spreadsheet which outlined the issues and tracked progress…, and we would work through the issues together and if it couldn't be solved here the HSE went back to individuals in the appropriate statutory bodies to see if a resolution could be found, and/or additional information provided. (A. Harnett, NFVSP).'[60]

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[58] Source: Research Interview

[59] M. Rogan (2020a) presentation to 'The Irish Context: Impact of Covid-19 on the mental health sector' Coalition Conversations Series, https://www.mentalhealthreform.ie/coalition-conversations/

[60] Source: Research Interview

Within this process, disability groups were afforded responsibility for relaying agreed solutions and any relevant supporting information back to their member organisations. Indeed based on this interaction they started in conjunction with the HSE, to produce regular FAQ documents that would assist member organisations by providing clear and targeted guidance on specific issues. A similar process also operated in the other forum in terms of the identification of specific actions that voluntary groups would commit to undertake.

Importantly there was strong and pragmatic action orientated focus to this collaborative dialogue as it was the capacity to identify problems, develop and or seek out potential solutions and act in a purposeful manner to address issues that served to foster deeper and more productive relationships between actors. Interviews with individuals from all four fora confirmed that numerous issues, some of which were real 'knotty' problems, were either resolved or progressed through collaborative solving deliberation, including:

- The distribution and use of PPE
- Training for staff
- The communication and customisation of public health guidance
- The redeployment of staff (including resolution of insurance issues)
- Funding challenges
- Testing and tracing practices and protocols
- Visiting protocols for residential settings
- Protecting vulnerable people in congregating settings and
- Initiatives to support the national health emergency response

As NESC's work on Community Call indicates this type of co-creation of solutions requires not only a commitment to problem solving deliberation but also an acceptance that the way of solving a problem may not be clear at the outset.[61] This capacity to resolve and/or progress issues in a manner that was mutually beneficial helped build higher levels of trust between the parties and reinforced their commitment to working in a more productive and collaborative manner. It also improved the level of coordination between groups including in the implementation of agreed actions. As one senior decision-maker stipulated;

> 'We knew we could do better and tackling Covid has displayed that we can and that we should'. (B. O'Regan, HSE).[62]

Interestingly in the disability area, the HSE are now seeking to build on the more productive and collaborative relationships that have emerged in the sector by reinvigorating and

[61] NESC Secretariat (2021)
[62] Source: Research Interview

rebranding the hitherto ineffective National Consultative Forum, as the National Consultative Committee (see Chapter 5 and Appendix C; Box A5). It is also worth noting that the national group who prepared the framework to support service providers in resuming day services involved representative of service users and families, service providers and the HSE. The approach within this framework of providing guidance while also affording individual organisations a degree of flexibility in their approach to the resumption of services was it is argued indicative of the growing influence of the sector in the policy dialogue.[63] One interviewee suggested that this contrasted sharply with their previous experience of policy issues where guidance would have been just handed down from the HSE without any input from the sector who delivers the service.[64] Similarly, it has been argued that notwithstanding the scale of the challenges facing the mental health sector the response to the current crisis has revealed how the sector can face major issues when they work together.[65]

4.4 Regional and Local Level Co-operation:

Peak level collaboration and engagement moreover provided a supportive framework for partnership working and cooperation at the local and regional levels in responding to the crisis. Although the IRG's report highlighted the problematic relationship between the state and voluntary sectors, it also drew attention to examples of innovative collaboration at the local level. A number of interviewees referred to the positive working relationships that had emerged within the Crisis Management Teams that were established within each CHO area and indeed one respondent described this as '*being where the real action was'.*[66]

Drawing on the success of the central forum in dealing with disability issues, the HSE asked each CHO area to engage with relevant voluntary organisations and establish a similar forum at this level. This initiative was dependent on the individual CHO and the commitment to better engagement with the voluntary sector remained quite variable. Indeed, there was a view expressed by a number of interviewees that where state-voluntary relationship were already positive, these were strengthened and enhanced during the crisis. This is important as it suggests the 'unprecedented' level of collaboration that emerged during the crisis to a degree built on existing co-operation between state and voluntary actors.

> 'We always had a good working relationship with the HSE and once we drew up the contingency plan and that was incorporated into their regional response it ensured at this stage we were now working on shared ground…what we were

[63] Source: Research Interview
[64] Source: Research Interview
[65] M. Rogan (2020a)
[66] Source: Research Interview

doing was part of their (HSE) response to the Covid 19 challenge.' (P. Reen, Prosper)[67]

Conversely, in some other situations pre-existing problematic relationships tended to persist. The NCCN have stipulated that the outbreak of Covid-19 has only served to exacerbate the historic lack of regular and constructive engagement between community providers and statutory bodies at both the national and CHO levels.[68] However, this should not detract from the fact that overall the majority of interviewees were of the view that there had been a discernible improvement in relationships at the local level during the crisis.

In developing and delivering a new Step Down Rehabilitative Facility for Covid-19 patients Clontarf Hospital reported a tangible improvement in their working relationship with the HSE as they collaborated in areas such as the design of clinical pathways; staff recruitment; procurement particularly of PPE and the implementation of public health guidelines and advice (See Appendix C: Box D6).[69] On the latter issue, for example the HSE not only produced an extensive range of very good policies and procedures but they also worked directly with the hospital, who then were able to adapt policies to their particular contextual needs.

Furthermore, within certain regions state and voluntary actors had already been working towards a more cooperative approach premised on the view that all of the key players needed to be involved in decision-making process while accepting that they all had different roles to play. The impact of the crisis would appear, however to have fast-tracked this 'trend'.

> 'Being in a crisis situation created the conditions for everyone to work more closely together and to get certain things done which would have been much harder in the past.' (P. Quinlan, Voluntary Hospice Group).[70]

4.5 Tight and Loose: Towards Accountable Autonomy

There has been within the voluntary sector a view that their relationship with the HSE over the last decade or more has been characterised by a drift towards operational prescriptiveness, an insistence on standardised approaches and a reduction in autonomy for voluntary organisations.[71] Significantly in the context of a national public health emergency there was evidence not only of unprecedented levels of cooperation between voluntary and state institutions but also of a new approach which has combined strong central guidance

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[67] Source: Research Interview

[68] National Community Care Network (2020) Input to the Dialogue Forum, 28th November 2020

[69] Source: Research Interview

[70] Source: Research Interview

[71] Broderick, B. (2018) 'Report on the Accountable Autonomy Symposium', Presentation to the National Federation of Voluntary Bodies, Mullingar, 30-31 May

and direction with increased autonomy at the regional and local levels. Paul Reid the Chief Executive of the HSE has described their strategy for tackling the pandemic as being a combination of a tight and loose approach.

> 'It was tight in the sense that there was a need at the centre for broad directional approach and loose in terms of encouraging people and organisations to get it done.'[72]

The provision of clear, strong, regular and informed advice, guidelines and direction from the centre was an essential element of the national response to this public health crisis. For example developing an effective approach to procuring and distributing PPE or establishing a national testing and tracing system from scratch both required comprehensive national strategies and robust oversight procedures. At the same time there was within the national response a discernible emphasis on freeing up service providers to be innovative, in terms of how they implemented guidance and resolved specific challenges. The system was given the resources and freedom to respond rapidly to service needs while working within the established control environment. This allowed for locally led decision making, strongly clinically influenced and sensitive to the local infrastructure and capacities. As was noted in section 3.2 staff redeployment was a central element of the HSE's national response to the crisis. In practice local crisis management teams, working with service managers led this process in line with local business continuity plans. This sense of 'extra autonomy' was particularly evident for voluntary organisations in the disability, mental health and hospice sectors, while in the case of voluntary hospitals it was more a case of fully exercising the degree of autonomy that they already had.

The aforementioned recognition by the leadership of the HSE that it was inevitable that mistakes would be made given the uncertain and complex nature of the virus, also served to provide a safety net that encouraged innovation and underpinned a 'go do approach' among local management and service providers.[73] One stakeholder described the new context as 'being allowed to get on with what you are good at'.[74]

Senior representatives from the hospice sector for example stipulated that during the crisis a tangible devolution of decision making from HSE headquarters to the local crisis management teams was accompanied by the affording of greater autonomy for taking action to individual voluntary organisations. Critically interviewees from all sectors agreed that affording greater autonomy to actors at the local level was pivotal in delivering the scale and pace of changes that have occurred since the outbreak of the pandemic in terms of the capacity and confidence to;

- fundamentally redesign the delivery of services,

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[72] Source: Research Interview
[73] Source: Research Interview
[74] Source Research Interview

- establish new services and supports, adopt new work practices and facilitate extensive staff redeployment,
- comply with rigorous public health guidelines and
- develop initiatives to support the national response to the pandemic.

The HSE have also taken steps that have the potential to substantially relieve some of the administrative burdens associated with existing accountability requirements. The experience of the HSE Integrated National Operations Hub (INOH) established to oversee the response to the COVID-19 crisis response and its role in streamlining information requests and oversight of key activities across the HSE has yielded important lessons about streamlining oversight arrangements, reducing duplication of effort within and across sectors, as well as the use of technology to simplify reporting. The rollout of the Integrated Financial Management System (IFMS) programme will also assist in building cross-sectoral financial management capability.

As was suggested in section 2.4 reconciling the need for both accountability and autonomy within the healthcare system requires this complex problem to be recast as 'accountable autonomy. It is arguable that the aforementioned tight and loose approach albeit fashioned to address a national health emergency is in fact an embryonic form of accountable-autonomy. Organisations in this regard had to 'demonstrate' that they had the capacity to deliver change and resolve issues in accordance with the overarching national approach. By taking effective action and delivering clear outcomes in accordance with national strategy individual organisations served to make the case for affording them greater levels of autonomy. At the same time as they have been willing to 'cede some control' to the local level, the HSE's management of the crisis has seen their standing and authority within the policy system arguably reach an all-time high. Similarly, public trust and confidence in the HSE and national health system has also grown in this period. Importantly in the midst of the crisis the need to work collaboratively to improve performance and deliver better outcomes has demonstrated how accountability and autonomy can be potentially be better reconciled.

4.6 Interdependency and Mutual Respect

As was reported in the IRG Report (2019) there was a perception within the voluntary sector that despite the interdependent nature of the Irish healthcare system the state continued to undervalue and misunderstand the voluntary sector's role in, and contribution to, the provision health and social care services. Interestingly the sheer scale of the health care challenges unleashed by global pandemic and the manner in which the state has sought to address them has served to reaffirm the interdependent character of the Irish healthcare system. As one senior HSE official stipulated;

> 'Neither the HSE, the service providers or the families of service users can do it all by themselves, however together they can…'[75]

During the crisis, there was evidence of a greater display of mutual respect for the work and role of the voluntary sector, indeed one representative from the voluntary sector alluded to the fact somewhat fractious, and irregular interactions with senior state officials transitioned during Covid-19 into regular, productive and more trust-based relationships.[76] Indeed to some respects this was an example of both parties *'earning the trust'* of the other. The considerable knowledge and expertise that voluntary organisations could bring to the table as front line service providers certainly appeared to be more valued during the crisis and as one individual described it, 'they began to see us problem solvers.'[77] One of the strengths of the community and voluntary sector in general is its capacity to intervene effectively in a way that state acting unilaterally could not deliver.[78] During the crisis the voluntary sector's organic rootedness in the community has enabled it to respond in quick and innovative manner and importantly there is a sense that this particular 'quality' is now more explicitly recognised and appreciated by the state. Equally, the voluntary sector recognise the leadership that the HSE has demonstrated in managing the response to this public health emergency and in particular have valued the extensive advice, guidance and collaborative support they have provided to both individual sectors and organisations in seeking to resolve the various challenges posed by pandemic.[79]

4.7 A More Balanced 'Performance' Dialogue:

Interestingly the increased level of engagement and cooperative working between statutory and voluntary actors would also appear to have shifted the power balance in the dialogue between funders and providers. It was strongly suggested by a number of senior practitioners that in the context of Covid-19 the dialogue shifted from an overt focus on containing costs and delivering set outputs to a greater emphasis on performance and delivering outcomes for service users and their families.[80] Indeed, to an extent the overarching outcome of keeping people safe drove most of the decisions taken. It is accepted that this shift will not be permanent and that it was also facilitated by the fact that in addition to the provision of additional emergency funding, the overall issues of additional costs and who would pay for it was essentially 'parked' during the height of the crisis. At the same time it was suggestive of the potential for the emergence of more balanced dialogue in which the issue of costs, organisational performance, service quality and outcomes for

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[75] Source: Research interview
[76] Source: Research interview
[77] Source: Research interview
[78] Government of Ireland (2019) Sustainable, Inclusive and Empowered Communities: A Five-Year Strategy to Support the Community and Voluntary Sector in Ireland 2019-2024, available at https://www.gov.ie/en/publication/d8fa3a-sustainable-inclusive-and-empowered-communities-a-five-year-strategy/
[79] Source: Research Interviews
[80] Source: Research Interviews

users are discussed in a more balanced and integrated manner. This would represent a discernible shift away from the 'command and control' type approach that had increasingly characterised the relationship between funders and providers over the last decade or more.[81] As noted earlier the HSE has a statutorily responsible to manage exchequer funds in a prudent manner and achieve best value for public money. The last twelve months have demonstrated that it is possible to establish strong oversight while also encouraging a 'can do' approach at the local level. Significantly, the CEO of the HSE has indicated that there now has to be a move away from how the HSE monitor organisations as the overall focus should not be on costs and outputs per se but rather on performance and outcomes.[82] A focus on agreed outcomes moreover can potentially be galvanising force that creates both a unity of purpose and space for local innovation.[83]

4.8 Remote Working and Service Provision—Towards a More Digital Future

Significantly, voluntary organisations have responded to these challenges in a flexible and innovative manner. Central to his has been the rapid development and adoption of the remote provision of services and supports for clients and their supporters/families to compensate for the suspension off in-centre and face-to-face services. This fundamental shift was indicative of a broader acceleration of tele-medicine, e-health and similar technology-enabled practices across the public healthcare system during the crisis.

Although Mental Health Reform had been actively promoting the potential of e-mental health services as part of an EU project for a number of years, the onset of the crisis effectively fast-tracked the roll out of digitally based remote service provision across the sector with national organisations such as Grow Ireland and Jigsaw establishing online individual and group based counselling and therapeutic services (see Appendix A: Box B4 and B5). As one practitioner noted:

> 'Discussions that were going on for several years suddenly became a reality as we have almost been transported five years forward in our practices and approaches'.[84]

Although some organisations such turn2me.ie and Spunout.ie were established to operate soley on line for the majority of organisations in the mental health area this 'transition' involved either establishing a new service for the first time and/or investing in a major expansion and upgrade of their existing online service provision. Undertaking such a transition in real time was challenging, as organisations had to address issues such as a sourcing equipment, upskilling staff and meeting the capital and current costs associated

[81] Independent Review Group (2019)
[82] Source: Research Interview
[83] HSE (2021)
[84] Source: Research Interview

with investment in IT. For an organisation like Pieta, the adoption of phone-based counselling involved a fundamental shift in their operating philosophy while issues such as privacy, quality control and operational logistics all had to be worked out at pace (See Appendix A: Box B3). The success of this the initiative however has encouraged Pieta, to actively explore other ways of delivering services remotely.

In practice, the sector has demonstrated considerable flexibility in overcoming these hurdles quite quickly and the Mental Health Reform Survey reveals that seventy-seven percent of respondents who previously had provided face-to-face services and supports were able to transition to delivering them remotely.[85] At the community level, to support specific population groups across the full life span, HSE NGO partners have worked hard to both increase their service provision at a national and community level, and to adapt their practices within Covid-19 restrictions.[86] As part of this the HSE have actively supported and funded the work of voluntary organisations e.g. Jigsaw, Alone, the Samaritans etc.

During the current crisis additional funding has also enabled the HSE to work with various partner organisations to extend the range of mental health and well-being services and supports available to both healthcare staff and the wider population (See Appendix A: Box 6). An increased emphasis on quickly designing accessible on-line quality information and educational resources tailored to the needs of individual's grappling with mental health issues has also been a discernible feature of response to the current crisis (see Appendix A: Box B8).

In the space of several month's a virtual digital revolution has also occurred in the disability sector with organisations such as Enable, the CRC, Rehab and Prosper providing a mix of teaching, clinical triage, training to clients and staff, social supports, individual and group counselling, psychological and behavioural therapies and information updates through online platforms.

In response to the closure and curtailment of existing services, Enable Ireland substantially enhanced their use of online and digital technology to provide ongoing clinical, training and social supports remotely to service users (Appendix A: Box B1).[87] This included the development, in partnership with Microsoft, of a pilot Virtual Service Centre offering a five-day programme of training, leisure and social activities for adults. Enable Ireland intend retaining this Virtual Service even when centre-based activities are resumed. The adoption of digital technology has allowed Enable to both continue to provide support and maintain

[85] Mental Health Reform (2020a)
[86] Government of Ireland (2021)
[87] J. O' Sullivan, (2020) Enable Ireland – The impact of Covid-19 on organisations providing services for people with disabilities, submission to the Special Committee on Covid-19 Response, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-09-30_submission-john-o-sullivan-ceo-enable-ireland-scc19r-r-0385_en.pdf

connections with their clients, families and carers at a time on heightened anxiety and uncertainty.

Similarly, the CRC have also exploited the 'opportunity' presented by the crisis to develop a suite of digitally based educational, training and development and clinical services for both adults and children (see Appendix A: Box B1). For example the CRC Adult Training and Development Centre have put in place a range of accredited and informal online programmes to enable adults with disabilities maintain their physical and mental health and continue to develop personal, social and employability skills.

Outside of the disability and mental health sectors, other voluntary organisations have also embraced the 'digital revolution' to provide innovative new service and supports. In response to the curtailment of support services for family carers such as respite care, day care family carer support groups, dementia cafes etc.,. Care Alliance Ireland (CAI) established an online family carer peer support group, facilitated by volunteers with social work and counselling qualifications and moderation experience, with additional support provided by former and current family carers (see Appendix A: Box B9). Since March 16, 1550 family carers have joined the online group, engagement levels have been extremely high and it has received positive feedback from participants. The Alzheimer Society of Ireland have also launched a new Online Support Group for Family Carers of People with Dementia that is designed to help alleviate the increasing pressure that family carers are experiencing as a result of the public health restrictions introduced to address the spread of Covid-19 (see Appendix Box: B10).

The need to adhere to public health guidelines including social distancing have created very difficult scenarios concerning both end of life situations and funeral services. Importantly the voluntary hospice sector through the use of phone-based and online services and supports has mobilised, redesigned and expanded its bereavement serves to meet these changing circumstances (See Appendix A: Box B7).

The development of more extensive remote service provision highlights voluntary organisations capacity to respond quickly and innovatively in meeting the needs of its service users. The provision of these key services was particularly important in ensuring a degree of 'service' continuity at time of growing anxiety and isolation.[88] This has required not only considerable investment in IT equipment and maintenance and the training of staff but also work in relation to the design of training material, governance arrangements, operational protocols and quality control.

As was highlighted in section 3.7 the shift to digital services in particular has served to highlight a tangible digital divide in society, which will have to be addressed if all individuals are to have equal access to publically funded health and social care services. This suggests

[88] Source: Research Interviews

that the ongoing development of digital/remote service will need to be accompanied by increased investment in assistive technology, training and personalised supports.

Notwithstanding this key issue, the positive feedback from service users has convinced numerous organisations, particularly in the disability and mental health sectors, to retain and indeed expand their capacity in this area, even with the resumption of normal centre-based activities as part of an enhanced and more flexible model of blended service provision. In part this is being driven by the fact that adherence to physical distancing requirements will continue to reduce capacity in centres and indeed the Rehab Group have indicated that as a result of this their day and training services will be delivered through a combination of approaches including in-centre, community-based, home-based and remote service delivery/supports.[89] Equally, the increasing emphasis on remote and digital services also reflects the potential benefits associated with this type of transformative change.

Firstly, it can enable organisations to expand their operational capacity and indeed CRC have cited this as reason for retaining their 'virtual clinics'. Secondly it can extend an organisations 'geographical reach' which is particularly important for those organisations which to date have been mostly urban based. Similarly the adoption of new technology can also assist organisations to engage with different cohorts of the population with Grow Ireland indicating that their new on-line peer networks is enabling them to reach a younger cohort of individuals, which had actually been attempting to do in recent years with only limited success. The provision of remote services and supports –some of which can be accessed 24/7—can also enable individuals to overcome certain time or physical constraints that previously would have limited them accessing such services. This is one of the particular advantages of on-line supports for carers who as a group are often time-poor given the nature of their caring responsibilities. Utilising remote services to undertake work can afford organisations flexibility in terms of the capacity to virtually redeploy staff to meet variations in geographical demand for therapeutic supports. Jigsaw have described how using remote services has enabled staff in Galway to provide support to some of their Dublin services while staff in Offaly are providing similar support to the Meath service.[90]

In seeking to further develop remote and/or digitally based services it will be important that the policy dialogue is not dominated by a focus on cost savings and operational efficiencies, though these can be a potential advantage of going digital. At the same time, there is also a need for upfront investment in infrastructure, training for staff and users and the cost of ongoing IT maintenance. Even if issue around digital poverty and low digital skills are

[89] Rehab Group (2020) Submission to the Special Committee on Covid-19 Response, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-09-30_submission-paul-cassidy-public-affairs-and-advocacy-manager-rehab-group-scc19r-r-0392_en.pdf

[90] Dáil Eireann (2020b)

addressed there will always be individuals for whom centre based, face to face services will be more appropriate.[91]

In making the case for the development of a blended network of services Dr. Martin Duffy (CEO, Jigsaw) suggested this has the potential to deliver a more responsive front line service, reduce waiting times, enhance community and primary care and alleviate pressure on specialist services.[92] Furthermore, he contends that as individuals have different and evolving needs the most effective approach is to facilitate multiple access points with low entry thresholds and to tailor the therapeutic offering to the unique preferences of young people and their family and supporters.[93]

' We are trying to have a suite of services that offers choice to young people, that is flexible and adaptable and which can therefore reach as many young people as possible…having a suite of offerings is the best way to offer quality mental health services to as many young people as possible'. (M. Duffy)[94]

Although this statement refers to one particular organisation in a particular sector, arguably it encapsulates how voluntary organisations can put the service user at the centre of the debate about how best to provide integrated and customised services and supports going forward. Digital service provision clearly has a pivotal role to play, not because it is digital per se or its capacity to reduce costs over the medium-term, but rather because of its potential in conjunction with other services to enhance the outcomes for services users.

4.9 (Re) Connecting with Communities:

A core strength of voluntary organisations is the extent to which they are embedded in the communities and during the crisis they have designed new initiatives and strategies focused on (re)connecting with their communities and providing new forms of support. Following the closure of their day centres, Prosper developed a comprehensive communications strategy which includes day service staff aiming to contact all of Prospers 700 clients (via phone or online technology) and on average approximately 2000 call have been made on a

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[91] Jigsaw have also indicated that the nature of an individual's family/home circumstances can be key in determining the relative suitability of online/phone services for young people compared to a face to face setting, see Mental Health Reform Coalition Conversations Seminar

[92] J. Duffy (2020) Jigsaw the National Centre for Youth Mental Health, Opening Statement to the Joint Oireachtas Committee on Health, 7 October 2020 available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_health/submissions/2020/2020-10-07_opening-statement-dr-joseph-duffy-ceo-jigsaw-the-national-centre-for-youth-mental-health_en.pdf

[93] Dáil Eireann (2020b) Official Report of Joint Committee on Health, Wednesday 7th October, available at https://data.oireachtas.ie/ie/oireachtas/debateRecord/joint_committee_on_health/2020-10-07/debate/mul@/main.pdf

[94] Dáil Eireann (2020c) Official Report of Special Committee on Covid-19 Response, 14th July 2020, available at https://data.oireachtas.ie/ie/oireachtas/debateRecord/special_committee_on_covid_19_response/2020-07-14/debate/mul@/main.pdf (p.11)

weekly basis since March (see Appendix A: Box C1). These regular one to one contacts have enabled Prosper to monitor how their clients are coping during an extremely stressful period. It also provides a 'voice' mechanism for service users and their carers as they can raise issues directly that are of concern to them. Feedback on this initiative indicates that service users enjoy the one-to-one engagement and both they and their carers/families feel connected and supported despite the suspension of centre based face-to-face services. Similarly the IWA, following the suspension and/or drastic reduction of their existing services, quickly developed a Community Supports Contingency Service' which has enabled them to provide a service, albeit different from their regular day service, to 4,000 clients while adhering to all appropriate HSE clinical guidelines (see Appendix A: Box C1).

Although there has clearly been a strong emphasis on harnessing the potential of remote services the IWA have continued to provide direct outreach supports for priority vulnerable clients in need of such support while Prosper developed a new community 'out-reach' initiative to provide direct 'person-to-person' support to fifty-five vulnerable individuals in their home or community. The implementation of this new initiative involved the redeployment of 'day-centre' staff to this 'out-reach' service and the complete re-design of daily practices to incorporate social distancing and Covid-19 related measures for the management of infection prevention and control in particular the extensive usage of PPE.

As indicated in Table 3.1 the CRC have had to scale back their Assistive Technology and Specialist Seating Service though they continue to provide a phone based supports for clients who may be having problems with their AT equipment or wheelchairs. Informally however the staff in the service have also been prepared to visit clients and carry out necessary repairs and wheelchair fittings in their gardens, while wearing full PPE. As the CEO of CRC noted:

> 'They carried out this specialist service, because they are committed to their clients and they knew the impact of not repairing their equipment would be too much for the individual and their families.'[95]

At the height of the Covid-19 restrictions, both HSE audiology services and private providers were closed for routine repairs of hearing aids, though in some instances emergency services were available. Importantly Chime through its online and outreach services continued to provide minor hearing aid repairs and batteries to people around the country, particularly older people who were cocooning.[96] This 'outreach' support was vital in reducing individual's isolation and ensuring they could continue to communicate with family and friends.

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[95] Source: Research Interview

[96] Chime (2020) Chime Submission to Special Committee on Covid-19 Response, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-08-04_submission-mark-byrne-chief-executive-officer-chime-scc19r-r-0409_en.pdf

A greater emphasis on the provision of community-based services has been a key objective of national healthcare policy for a number of years and as suggested above voluntary organisations are ideally placed to be in the vanguard of this form of tailored service provision. Interestingly the strategic response to the crisis has served as a catalyst for acceleration towards community based service provision across the health system as highlighted for example by the establishment of Community Assessment hubs, the remodelling of services for the homeless and other vulnerable clients and the provision of various medical services for vulnerable patients in home or community settings.

4.10 Addressing the Funding Crisis:

As was highlighted in Chapter 2, the combination of the dramatic falls in income and rising costs served to exacerbate an already precarious financial situation, with the result that many voluntary organisations in the midst of a public health emergency, had to address a major and immediate funding challenge. The sheer scale of this funding challenge was such that it posed not only a threat to voluntary organisations capacity to maintain existing health and social care supports and services, but also in in some instances the future existence of said organisations.

In response, voluntary organisations introduced a series of actions designed to mitigate this unprecedented funding challenge, including:

- The use, where possible of reserve funds particularly for the procurement of PPE and other safety related measures;
- Cutting costs of non-essential service delivery and deferral where possible of non-pay fixed costs;
- The hosting of 'on-line' fund-raising events;
- Re-allocating savings from the temporary suspension of certain activities;
- The closing and/or reduction of services, and
- Reducing staff costs through salary cuts, reduced hours, unpaid leave and in some cases redundancies.

The Wheel, the national association of community and voluntary organisations, charities and social enterprises, played a key role in assisting the voluntary sector to 'temporarily' weather this 'financial' storm. Having raised this issue with government in the early stages of the crisis, the Wheel formed a coalition of community and voluntary organisations to campaign for direct and immediate assistance from the state. A key factor in the success of this coalition was the collection of hard data on the scale of financial losses within the sector and its potential impact on both service provision and organisational survival. Importantly this coalition in its submission to government also identified the dormant accounts fund as a potential source of funding and in early May 2020, the Government used this facility to

establish a €35m Emergency Stability Fund.[97] In addition to the work of the Wheel and the associated coalition, support from the Department of Rural and Community Development was also a factor in 'persuading' other relevant departments of the need to take action to resolve the immediate cash flow liquidity crisis facing the sector.

In addition to the aforementioned €35m Emergency Stability Fund the Government have also introduced a number of other measures which have assisted voluntary organisations in dealing with their serious funding challenges namely;

- The Temporary Wage Subsidy Scheme;
- The provision of clear assurances around continued statutory funding;
- The decision by the new government not to introduce the planned 1 per cent (circa €20m) reduction in funding for disability services
- The €5m Innovate Together Fund and
- The €2.5m Community Call Fund

Importantly as part of the ongoing national strategy for dealing with the global pandemic, the HSE has also made substantial additional funding available for the procurement of PPE and investment in other necessary public health measures to prevent and control the spread of the virus. In relation to PPE, the main challenge has been not so much a lack of funding but rather the lack of equipment due to the surge in global demand for these products. Indeed according to one senior representative from a voluntary organisation where the expenditure was related to the safety of service users, cost was not a major consideration in the dialogue between funders and providers.[98]

The HSE also clearly signalled to organisations that the pre-existing service level agreements were effectively suspended as all stakeholders recognised that they are operating in exceptional circumstances. Indeed the prevailing view amongst interviewees from both the statutory and voluntary sectors was that in essence the issue of 'funding' the response to Covid-19—in terms of both investment to meet safety requirements and the costs of maintaining essential services—was to an extent 'parked'. The availability of additional 'emergency' funding in conjunction with the cost-saving measures introduced by voluntary bodies has helped to mitigate the prevailing funding challenge during the current crisis. At the same time as is discussed in the next chapter, the issue of how to put in place a sustainable funding model for voluntary organisations remains a critical and unresolved issue that will have to be addressed by all stakeholders.

[97] Coalition of Community and Voluntary Organisations (2020)
[98] Source: Research Interview

4.11 Protecting the Most Vulnerable

An emphasis on continuing to serve their communities, a strong sense of duty and a commitment to protecting the most vulnerable in society underpinned the actions and responses of the voluntary sector during the Covid crisis. Similarly, the HSE throughout the crisis have displayed their strong public sector ethos and the value that they place on delivering the highest standard of care to all who need it and of treating the service user with compassion and dignity. Indeed, they have highlighted that the primacy of the patient and client and a strengthened focus on the vulnerable patient/client groups has and continues to be a key driver for their action and decisions during the crisis.[99]

Section 4.2 highlighted the unity of purpose that was evident during the crisis and to extent this was an expression on the common values and ethos one finds across the public and voluntary health and social care organisations.

As was highlighted in section 3.7 the disability sector's success in protecting vulnerable individuals living in residential accommodation from a potentially high risk of death and infection was a remarkable achievement. The Disability Federation of Ireland have attributed this positive outcome to the hard work of, disability service providers, their staff and the HSE.[100]

HIQA is an integral part of the state apparatus for governance in the health and social care sector particularly in terms of standard setting. Notwithstanding restrictions imposed by public health guidelines, HIQA continued to undertake institutional inspections aimed at securing compliance and enforcement with national standards. Given the heightened levels of anxiety and stress posed by the crisis, this work performed an important assurance role to service users, their families and broader society. The vast majority of institutions inspected in this period met regulatory requirements and it was important that this was both monitored and recorded. At the same time, the inspections revealed a minority of cases where there were tangible risks for service users and in these instances, HIQA utilised their regulatory powers to ensure action was undertaken to improve the safety of residents.

Additionally over the course of the pandemic HIQA introduced a number of innovative measures that were designed to support service providers in protecting the most vulnerable individuals in residential settings including:

- Providing guidance and support to residential centres on managing the risk of COVID-19 infection through regulatory notices and making regular direct support phone calls with the managers of all centres during the outbreaks.

[99] HSE Submission (2021)
[100] Disability Federation of Ireland (2020b)

- Establishing an Infection Prevention and Control Hub to provide a helpline to providers and managers of residential services on the implementation of public health measures in their centres. And,

- Facilitating an expedited registration process to enable residential services to provide isolation and treatment facilities for people with disabilities who were suspected or confirmed to have COVID-19 infection. During 2020 HIQA processed 82 registration applications related Covid-19.

Disability service providers approached this challenging situation in a collective, engaged and focused manner. The Boards of management in the relevant organisations identified it as a risk early and quickly implemented proactive measures including the closure of day services, the implementation of robust infection control measures, staff training, the use of isolation areas and an emphasis on ensuring continuity of staff within locations. [101] Targeted action plans were also developed and there was an increase in the level and regularity of communication with clients, families and carers.

Disability providers benefited from the provision of exceptional support from the HSE social care as this enabled them to respond quickly and flexibly to what was a rapidly evolving crisis. This close collaboration ensured that the most up to date public health guidance and best practice was directly incorporated into changing operational and working practices within residential settings in particular the rigorous use of PPE and investment in associated staff training.[102]

The opening up new isolation units—which involves various tasks such as staff planning, governance procedures, fit out, training of staff and the repurposing of day facilities etc.,—was an integral part of the strategy for controlling the spread of the virus in residential settings for people with disabilities. HIQA's provision of expertise and guidance along with their introduction of an expedited registration process was pivotal to ensuring that service providers were able to quickly put in place quality and safe solutions to control infection.[103] This in part is reflective of HIQA's role in ensuring compliance with national quality standards. At the same time HIQA's relationship with service providers continued to evolve during the crisis as evidenced by an increased focus on the co-design of pathways that fostered innovation and resolved problems.[104] Importantly HIQA strongly endorsed the

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[101] National Federation of Voluntary Service Providers (2020) Impact of Covid-19 on people with disabilities and the disability sector: Submission to Oireachtas Special Committee on Covid-19 Response, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-09-30_submission-sean-abbott-chairman-national-federation-of-voluntary-service-providers-scc19r-r-0408_en.pdf

[102] *Ibid.*, This was reaffirmed in research interviews

[103] Source: Research Interviews

[104] Source: Research Interview

voluntary sector for its achievements in protecting vulnerable people in residential care settings during the pandemic.[105] Equally the voluntary sector have highlighted the key role played by HIQA in terms of both providing expert advice and guidance and also working collaboratively with service providers to resolve problems.[106]

The professionalism, skills, flexibility and commitment of staff was also central to the successful roll out of plans to control and prevent infection in residential settings.

- There was extensive redeployment, both within and between organisations, of staff from day programmes to support people in residential homes. In particular, with the close of associated day centres many residential settings moved to a 24/7 operating model.
- Staff agreed to more flexible working practices, cancellation of leave, longer hours and changes in rosters (including night and weekend working).
- Staff volunteered to work in isolation units, knowing that they would be working in a situation with confirmed Covid-19 cases.

Interviewees stressed that the response of staff during the crisis reflects the sectors focus on providing relationship-based supports premised on a long-term commitment to the person and their families.[107]

> 'Front line staff are highly committed to service users and they know them, their needs and their families very well'.[108]

Family carers also played a key role in containing the spread of infection amongst people with disabilities and voluntary organisations have continued to provide both guidance and outreach supports during this time while adhering to national health guidelines.

The National Community Care Network (NCCN) also managed to ensure a relatively low level of infections amongst their employee and their clients the majority of whom are older and therefore fell into the high-risk category. The NCCN contend that this positive outcome was a reflection of the hard work and discipline of carers and operational staff, the proactive approach of homecare providers and collaboration with family members who functioned as de facto 'informal' carers.[109] In contrast to the disability sector the NCCN contend that the level of support provided by the HSE and the various CHOs was for the majority of the crisis minimal and in essence, they contend that they were 'left to their own devices'.[110]

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[105] HIQA (2020)
[106] Source: Research Interviews
[107] Source: Research Interviews
[108] Source: Research Interviews
[109] National Community Care Network (2020)
[110] *Ibid.*,

4.12 The Quality of Staff: Committed, Flexible and Engaged

The quality of staff within the voluntary organisations has been pivotal to the sector's capacity to respond to the current crisis in an innovative, flexible and dynamic manner. Throughout this national health emergency staff across all sector have displayed high levels of commitment, engagement, flexibility and professionalism, which has been key to ensuring the safety of service users and the continued delivery of services. The willingness to embrace new working practices; learn new skills; accept redeployment and longer hours and participate in rapid and extensive organisational change while retaining an overriding focus on the health and well-being of vulnerable individuals and their families are all testaments to the skills and competencies of staff in the voluntary sector. This level of performance was matched in the statutory sector as public sector employees displayed similar levels of professionalism, flexibility and commitment in the face of the unprecedented adversity. From the outset of the crisis HSE management placed a strong emphasis on effective communication and ongoing consultation and engagement with staff and their representative bodies. Indeed a feature of management-staff meetings during this period was the extent to which information coming from staff, based on their day-to-day experience the crisis shaped the direction of these meetings.

As providers of health and social care services to vulnerable people staff in voluntary organisations were in the very front line of the national response to this dangerous and deadly pandemic. This combined with the fact that many staff also experienced major changes in their working practices and/or were redeployed ensured that this was also a time of considerable stress and anxiety. In section 3.5, it was indicated that voluntary organisations faced ongoing staff absenteeism and shortages over the course of the crisis and mitigating this has required a combination of staff engagement, creativity and proactive leadership. In some instances, professional staff—for example physiotherapists and occupational therapists—were redeployed as care assistants to address staff shortages. While this along with the redeployment of day staff helped to 'plug gaps' in residential settings for example the downside was that the critical support therapies that these professional staff normally provided were not available.

As is outlined below (see section 4.17) the willingness of staff to be redeployed to other voluntary, public and private organisations was pivotal in assisting the HSE address staff shortages and contain the spread of the virus in high-risk situations. In some instances this involved volunteering for redeployment to high-risk locations however as a senior manager from one organisation commented, 'staff saw past the dangers of Covid-19 and focused on the individuals who needed protection.'[111]

[111] Source: Research Interviews

4.13 Strong Collaborative and Engaged Leadership

Strong, collaborative and engaged leadership was also a key characteristic of voluntary organisations dynamic and flexible response to the challenges over the last six months. These leadership qualities facilitated the rapid design and effective implementation of comprehensive business continuity or contingency plans. In many organisations senior management teams convened, initially daily and then weekly, to review performance, discuss emerging issues and where necessary make any changes to their overall strategy. A number of senior managers stressed the role played by their Boards of Management in terms of providing not only expertise and advice but also strong backing especially when undertaking major organisational change.[112]

The scale of the changes associated with the fundamental remodelling and redesign of services and supports necessitated the full engagement and commitment of staff within organisations. Although many organisations already had a strong culture of employee engagement, some bodies established new virtual forums to facilitate employee input and afford employees the opportunity to raise issues and concerns. At the same time, the rapidly evolving nature of the crisis meant that it was not always possible to include employee voice in the decision making process. This reinforced the importance of ramping up the quality and regularity of communication, and in organisations such as the NOHC, Prosper, CRC and the Rehab Group an array of mechanisms were used—emails, newsletters, in-person briefings, progress reports, info sheets etc.,—to ensure that staff had a regular flow of information and an understanding of what to expect.'[113] A feature of this enhanced information flow was the lead role that the CEOs took in many organisations in term of communicating directly and regularly with staff to outline the changes that were occurring. There was also a similar emphasis in increasing the level of communication with service users, their families and their carers.

Senior management have also recognised the importance of acknowledging and celebrating staff for their work in extremely stressful circumstances.

> 'Employees need to feel connected and valued, and that they are making a difference and that their voice is heard within the organisation'. (Stephanie Manahan, CRC)[114]

This collaborative and engaged leadership style also extended beyond organisational boundaries as there was an increased level of cooperation between organisations operating in the same sector (see section 4.4). This included a greater emphasis on sharing information and knowledge, providing support to each other and working collectively to address common problems. Furthermore the more productive and cooperative

[112] Source: Research interviews
[113] Source: Research interviews
[114] Source: Research Interviews.

relationships that were forged with the HSE were also reliant on a collaborative and engaged leadership style (see 4.3.)

This of course required a reciprocal approach from statutory bodies and the willingness of the HSE to establish the various collaborative forums demonstrated the emphasis they placed on building a strong, inclusive and collective response to the crisis.). As already indicated in 4.5 the HSE's emergence as a more authoritative leader within the policy system has in part been premised on a willingness to both devolve authority to other actors and to include other stakeholders in the decision making process.

Policy and advocacy bodies such as the Wheel also displayed strong and collaborative leadership style as highlighted in particular by the latter's work on the funding challenges facing many community organisations (see 4.10). This in particular highlighted the Wheels capacity to articulate a problem, convene a space for the sector to come together on an issue and mobilise and lead a coalition designed to achieve the necessary changes to resolve a problem.

4.14 Core Values and Strengths

The HSE, in its original submission to the IRG acknowledged the distinctive role of the voluntary organisations and the essential nature of their contribution to the health system. That submission points to a number of core strengths of voluntary bodies and highlighted a range of good practices which the HSE is keen to preserve in its delivery model including; their capacity to innovate, their advocacy role, and their track record in the delivery of quality services and well-developed corporate and clinical governance models

It is also evident that the core strengths and values of the voluntary sector—a community focus; flexibility and agility; a commitment to innovation and the capacity to provide tailored and customised responses—very much came to the fore and drove the manner in which they have responded to the current national emergency**.** The Sláintecare Programme Implementation Office concluded for example that the manner in which voluntary organisations responded to the amplified pressures of Covid-19 demonstrated their agility and responsiveness in meeting population needs.

Voluntary organisations are by their nature embedded in the communities and groups that they serve. This ensures that their actions are driven by a concerted focus on the needs of service users and their families/carers, which was critical in the context Covid-19 when the primary aim was to protect vulnerable individuals. A number of interviewees commented that the willingness of staff to 'to go the extra mile' for their clients was in part driven by the fact that 'they know them and understand their needs'.[115] This 'reach' into the community also enabled needs to be identified and responded too relatively quickly, as demonstrated by the following examples;

[115] Source: Research Interviews

- The 'communication' programmes that the CRC and Prosper put in place to ensure that service users and families remained connected to the organisation (see Appendix A: Box C1 and C2);
- The CRC and Chimes outreach initiatives to fix essential equipment for people with disabilities;
- The customising of public health messaging by the Rehab Group, Chime and Chesire Ireland to make it more appropriate for certain groupings see Appendix A Box D7); and,
- Establishing online peer networks for carers (see Appendix A: B9 and B10)

As was outlined in section 4.3, Alone through the operation of the national Covid-19 helpline garnered key information on issues facing older people that was channelled upwards to the national level eldercare group. Through the organisations existing helplines Alone volunteers were also alerted to the increased number of older people who were experiencing high levels of distress including expressing very negative emotions and suicidal ideation. In response to these findings Alone developed a joint memorandum of understanding with Samaritans Ireland and Dublin Samaritans whereby Alone clients experiencing such negative emotions could be transferred directly to the latter organisations to avail of their specialised crisis-based counselling support services (see Appendix A, Box C3).[116]

The decision making process within voluntary organisations has traditionally been less bureaucratic than their public sector counterparts thus enabling them to respond more quickly to emerging situations.[117] This flexibility and agility was evident in the rapid and early decisions many organisations took to redesign existing operational models to facilitate the remote delivery of a range of services and supports in line with social distancing requirements (see 4.8). At the same time, it is important to highlight that in the context of managing the response to the crisis the HSE and Department of Health have also delivered an unprecedented level of change and innovation in remarkably short period.[118]

Both Cappagh Hospital and Clontarf Hospital have a strong record of accomplishment in terms of change management, performance and service delivery. This ensured they had the organisational capabilities and capacities to develop, design and implement major projects of change—transitioning into an orthopaedic trauma centre and establishing a Covid-19 Rehabilitative Set Down Facility respectively –during the crisis (see Appendix A: Box D1 and

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[116] C. Moore and L. Hamra (2020) Covid-19: What are callers and volunteers telling us? presentation to 'The Community Context: Learnings from Samaritans Ireland', Coalition Conversations Webinar Series https://www.mentalhealthreform.ie/coalition-conversations/

[117] IRG Report (2019)

[118] Dáil Eireann (2020d) Official Report of Special Committee on Covid-19 Response, 19th May available at https://data.oireachtas.ie/ie/oireachtas/debateRecord/special_committee_on_covid_19_response/2020-05-19/debate/mul@/main.pdf

D6). . It was also important that the HSE had the confidence that both organisations would be capable of delivering these change projects.

Similarly Northside Home Care's ability to fundamentally redesign their meals on wheels service into an expanded core service –going from providing 1000 hot meals over 4 days to 2,700 chilled meals on a seven day basis—was premised on the fact they had 'the knowledge, structure and linkages in the community to make it happen'.[119]

4.15 Resilient and Robust Organisations

The capacity of many voluntary bodies to oversee extensive operational change at fast pace is indicative of the fact that they are resilient organisations, as evidenced by their ability to absorb stress, re-establish critical functions and work very effectively, and in some cases, thrive in altered circumstances. Indeed many of the characteristics that are attributed to resilient private sector enterprises—diversity, adaptability, redundancy, fostering innovation and building new collaborations—are equally applicable to many voluntary organisations in the health and social care sectors. It is important to stress that such organisations did not become good or 'resilient' organisations overnight, rather they already were such entities. As a one provider of community homecare services stated:

> ''Voluntary organisations were able to be flexible and innovative because they were already doing it pre Covid. We have to be quick to innovate and think on our feet in order to manage challenges.'[120]

A collaborative leadership style; an engaged and professional staff; a willingness to embrace change; an emphasis on innovation; a focus on learning and review; a culture of quality service and the adoption of a person-centred approach are all organisational capabilities and competencies that 'good' organisations in the voluntary sector have actively fostered and invested in. The crisis created a context in which organisations were able to mobilise and harness these existing organisational capabilities to develop and implement strategic and innovative responses. The converse of this is that some bodies who were a difficult position pre the crisis lacked the requisite organisational assets that would have enabled them to respond in more flexible manner and as such have continued to struggle.

As was outlined above the quality of staff has been key factor in the performance of voluntary organisations during the crisis. This reflects the emphasis that voluntary bodies have placed on investing in workforce development. This has included building strong teams not just of clinical and healthcare professionals but also where possible critical business and organisational support functions—administration, corporate governance, compliance and risk management, finance, procurement, HR, marketing and fundraising. As was referred to earlier the business and administrative supports teams have functioned as the 'engine

[119] Source: Research Interview
[120] Source: Research Interview

rooms' of organisational activity since early March (see section 3.6). A number of interviewees for example highlighted the critical role played by their heads of procurement in sourcing PPE under very difficult and stressful situations. As was outlined earlier (3.6) strong management teams were also pivotal in quickly developing and implementing effective and innovative business continuity plans.

> 'It was our previous investment in clinical governance and senior management staff that ensured that we were able to adapt in the right way when Covid-19 hit us.'[121]

A strong focus on workforce development continued throughout the crisis as organisations have invested extensively in areas such PPE training and the expansion of digital skills. Cappagh's transition to an orthopaedic trauma centre for example necessitated theatre staff acquiring new clinical skills and there were similar instances of clinical skill development in Clontarf Hospital and the National Rehabilitation Hospital Dun Laoghaire.

The importance of investing time and resources in fostering staff engagement and communicating effectively with all stakeholders –staff, clients and families/carers—has already been highlighted. It is worth reiterating however, that for many organisations this was a case of stepping up or redesigning such activities.

A key factor in the National Orthopaedic Hospital Cappagh's (NOHC) successful transition to a Trauma Centre were the interdisciplinary huddles which met each morning to discuss the daily schedule of surgeries and then reconvened in the evening to review performance with the aim of applying any lessons and learning to support continuous improvement and enhanced clinical outcomes (see Appendix A: Box D1). The NOHC view the crisis as a learning experience that can potentially augment their capacity to deal with future public health emergencies. Furthermore, they are actively exploring if a number of changes introduced during the crisis– new staff rosters; extended theatre hours and weekend working—can be retained as they have the potential to provide both additional operational capacity and increased flexibility for staff. Northside Home Care Services have also been documenting their performance during Covid-19 and are using this to develop a five point strategic plan for going forward. Weekly meetings to review experience, monitor performance and highlight issues that require additional advice and guidance were key factors in Pieta House's successful roll out of their new phone-based crisis counselling service (Appendix A: Box B4). These are all examples of a strong culture of organisational learning and monitoring within the voluntary sector, which has underpinned extensive organisational changes during the crisis.

Importantly a number of organisations introduced initiatives that were designed to support the well-being and health of their employees. Measures introduced by the Rehab Group included resilience workshops led by an in-house psychologist, toolkits and tips for minding

[121] Source: Research Interview

one's mental health and up to date information on how to access additional supports. Each hospital group mobilised their existing support services e.g. psychology departments, medical social work etc., to provide on the ground support to all staff. The CRC introduced a debriefing week off for all staff redeployed to other organisations before they resumed their normal work as a way of recognizing their effort and also providing them with a 'space' to decompress, as in some instances they had been working in high risk situations (see Appendix A Box D1). Concern has been raised however that smaller organisations may lack the resources and skillsets to implement necessary employee assistance programmes.

The manner in which organisations responded to the crisis clearly highlights the importance of developing good and resilient institutions. These same organisational qualities and capabilities will be even more important in driving the scale of reform that is required across both the health and social care sectors. In this context, it is important to stress that voluntary organisations earned income has in part traditionally functioned in a manner similar to the learning and development budget of private companies, in that it was used to foster organisational learning, innovation and workforce development—the very organisational attributes and capabilities that were drawn upon in responding effectively to Covid-19. Although it is important to be cost-effective, hyper-efficiency can erode the institutional redundancy that agile and resilient organisations rely upon in responding to unexpected and uncertain challenges. Although this section has focused on voluntary organisations it also evident that statutory organisations across the healthcare system also demonstrated their resilience and robustness during this national public health emergency.

4.16 Adopting Public Health Advice and Guidance

A core part of the HSE's role in managing the healthcare sector's strategic and operational response to the national public health emergency was the provision of high quality and regular public health guidance and advice for controlling and preventing the spread of Covid-19 infections. Drawing on the latest national and international research and knowledge the HSE constantly updated and disseminated their expert advice in relation to issues such the use of PPE, social distancing, hygiene measures, testing and tracing, dealing with virus outbreaks, deep cleaning etc.,.

The procurement and distribution of sufficient quantities of PPE was a major challenge for the HSE and one that was shared with health systems in other countries given the dramatic increase in demand for this product. This was a complex multi layered challenge and inevitably there were mistakes and delays especially in the early months of the crisis. In some instances, voluntary organisations sourced their own PPE and in the home care sector for example a mini-consortium comprising six service providers was established to address their procurement challenge. Overall given the evolving and complex nature of this challenge the prevailing view amongst interviewees was that the HSE's centrally coordinated procurement approach had worked very well.

In section 4.3 it was indicated how peak level collaborative structures enabled voluntary groups to have direct access to expert advice which could then be disseminated quickly to member organisations. There was also a strong collaborative characteristic to this engagement as service providers also worked with the HSE to customise and tailor guidelines to the needs of their particular sector. A joint working group was established for example to co-produce, based on NPHET's initial advice on the use of PPE, more tailored guidelines for situations were individuals with an intellectual disability were living in their own home (see Appendix A: Box D8). This partnership style approach was also evident in the HSE's engagement with individual organisations. This facilitated organisations drawing upon this expertise and advice in adapting guidelines to their particular needs as was the case for Clontarf hospital amongst others (see 4.4). Similarly, as was highlighted in section 4.11, the crisis has witnessed the emergence of more collaborative problem solving relationship between individual organisations and HIQA. Given the sheer amount of information and the evolving nature of the advice, some organisations in the disability sector—for example the Rehab Group, Chesire Ireland and Chime—recognised the importance of filtering, customising and disseminating information in formats suited to their service users (Appendix A: Box D8). In the case of the Rehab Group psychologists and behaviour therapists were available to assist service users to digest and better understand the public health information around hand washing, social distancing, cough etiquette and testing.[122]

4.17 Supporting the National Public Health Response

As an integral and essential part of the overall public health system the voluntary sector was always going to be front and centre in the 'battle' against Covid-19. Since February, the individual and collective actions of voluntary organisations across the entire spectrum of health and social care services have been designed to support the national collective effort to protect staff and vulnerable individuals while continuing to provide essential services and supports.

Critically voluntary organisations have also displayed a willingness and capacity to go beyond their organisational mandates and boundaries by undertaking actions and initiatives that have contributed to the wider national public health strategy for both preventing and controlling the spread of the virus and caring for those who became infected. While more detail on selected initiatives is provided Appendix A, the actions that have been undertaken by individual voluntary organisations to reinforce the national healthcare systems capacity to respond to this evolving public health emergency has included the following:

- The transitioning of the National Orthopaedic Hospital (Cappagh) into an Orthopaedic Trauma Centre as a means of relieving pressure on acute hospitals in the region (see Appendix A: Box D1)

[122] Rehab Group (2020)

- The CRC developed a comprehensive redeployment programme under which 109 staff have provided approximately 12,000 hours of care in twelve different locations including private and voluntary nursing homes, voluntary hospitals, hospices, a HSE Contact Tracing Centre, the Croke Part Testing Centre and the new City West Self-Isolation Facility (see Appendix A: Box D2)
- Prosper's redesigning and repurposing of buildings to provide additional designated residential spaces for HSE patients recovering from Covid-19 or other crisis situations (see Appendix A: Box D3).
- The Irish Wheelchair Association's provision of transport assets and buildings to the HSE to support and enhance testing and tracing operations (see Appendix A: Box D4).
- The establishment of a Step Down Rehab facility for Covid-19 patients in Clontarf Hospital (see Appendix A: Box D5).
- Enable Ireland signed over part of their Kildare Service building to the HSE for 6 months for use as a Community Assessment Hub.
- The provision by hospice providers of nurses to upskill and educate staff in HSE nursing homes in the provision of palliative care.

As was outlined in Chapter 3 staff redeployment has been a core element of the HSE's response to the pandemic. The enhanced capacity to quickly reassign staff has been particularly key to addressing increasing workloads, ensuring critical services were delivered and containing the spread of the virus in high-risk situations. While this section has referenced the particular comprehensive programme initiated by the CRC, during the crisis a significant number of voluntary organisations from a cross the health and social care sectors have played a key role in facilitating extensive redeployment not only within own organisations but also between organisations across the voluntary, public and private sectors.

4.18 Trade Unions: Supporting Flexibility and Change

The unprecedented and rapid pace of change across the health and social care sectors during the current crisis has been achieved without any significant industrial relations issues, which highlights the positive partnership-style role played by the trade unions in this period. Extensive staff redeployment along with ongoing changes to working hours, rosters, working practices and work location greatly enhanced the capacity of the health system to respond in an agile and flexible manner to the evolving demands posed by the pandemic. These substantial changes were all the subject of discussion and agreement with the relevant public service trade unions. The Forsa trade union for example articulated their commitment to doing whatever was necessary to help contain the virus, protect the health and safety of citizens, and maintain essential services during this unprecedented

emergency.[123] With regards to the voluntary sector per se the relevant trade unions—the INMO, SIPTU, FORSA and UNITE—worked intensively with the HSE and employer groupings within the Health Service National Joint Council to help deliver the flexibility necessary to protect vulnerable individuals and maintain service delivery. This type of sustained consultation enabled trade unions experience and knowledge of what can work best at an operational level to inform key decisions that were taken during this period.[124] Indeed, in a number of instances where staffing challenges emerged suddenly trade union officials responded quickly and worked intensively with the HSE and relevant voluntary bodies to 'work out' pragmatic and effective redeployment solutions to address the need for additional staff in specific crisis-hit organisations. This cooperative partnership-style approach at the national level served to create a supportive environment for individual voluntary organisations to deliver rapid operational and staffing changes during the emergency.

[123] This statement from Kevin Callinan General Secretary of Forsa is indicative of the proactive approach adopted by the healthcare trade unions individually and collectively during the crisis. See B. Sheehan (2020) Trade unions adapt functions to the crisis, focus is on 'critical' workers.' Industrial Relations News, No.11

[124] B. Sheehan (2020a)

Chapter 5. Building a New Relationship and Delivering Better Outcomes

5.1 Introduction

This overview of impact of Covid-19 on the health and social care systems has sought to demonstrate how the voluntary sector, working in close collaboration with statutory organisations, has responded to this unprecedented national health emergency in an agile, flexible and innovative manner. There remains considerable uncertainty over the future trajectory of the global pandemic and it is evident that protecting citizens and in particular the most vulnerable groups will remain a priority for the health and social care system. At the same time, there is also a need to re-establish the full complement of services and supports albeit within the prevailing and evolving public health guidelines and regulations. Indeed the manner in which Covid-19 has impacted on health and social care has served to reaffirm the importance of not only fully engaging with, but indeed hastening the pace of transformative reform envisaged by Sláintecare, and associated sectoral strategies. In essence responding to Covid-19 has been a massive learning exercise in real time for the health system. The Health Dialogue Forum is of the view that harnessing the important lessons and learnings from this shared experience can help to design a new relationship and guide how the state and voluntary sectors collectively address ongoing challenges within healthcare. Indeed the HSE have indicated that there is an opportunity to use the rollout of the 2021 Service Plan as a vehicle to endorse the positive experiences that emerged during the response to the pandemic.

In this context, the Forum needs to consider how it can use the lessons and learnings from the shared experience of the national health emergency to;

- Build a new relationship between the state and voluntary sectors.
- Reinforce the commitment to organisational change and innovation in service provision and
- Embed an increased focus on the providing integrated quality services, enhancing performance and delivering improved outcomes.

5.2 From Problematic To Partnership-Style Relationships

As indicated in Chapter 2, the IRG Report (2019) concluded that given the problematic nature of the relationship between state and voluntary actors and interdependent nature of the healthcare regime, fostering a more productive and collaborative relationship would be

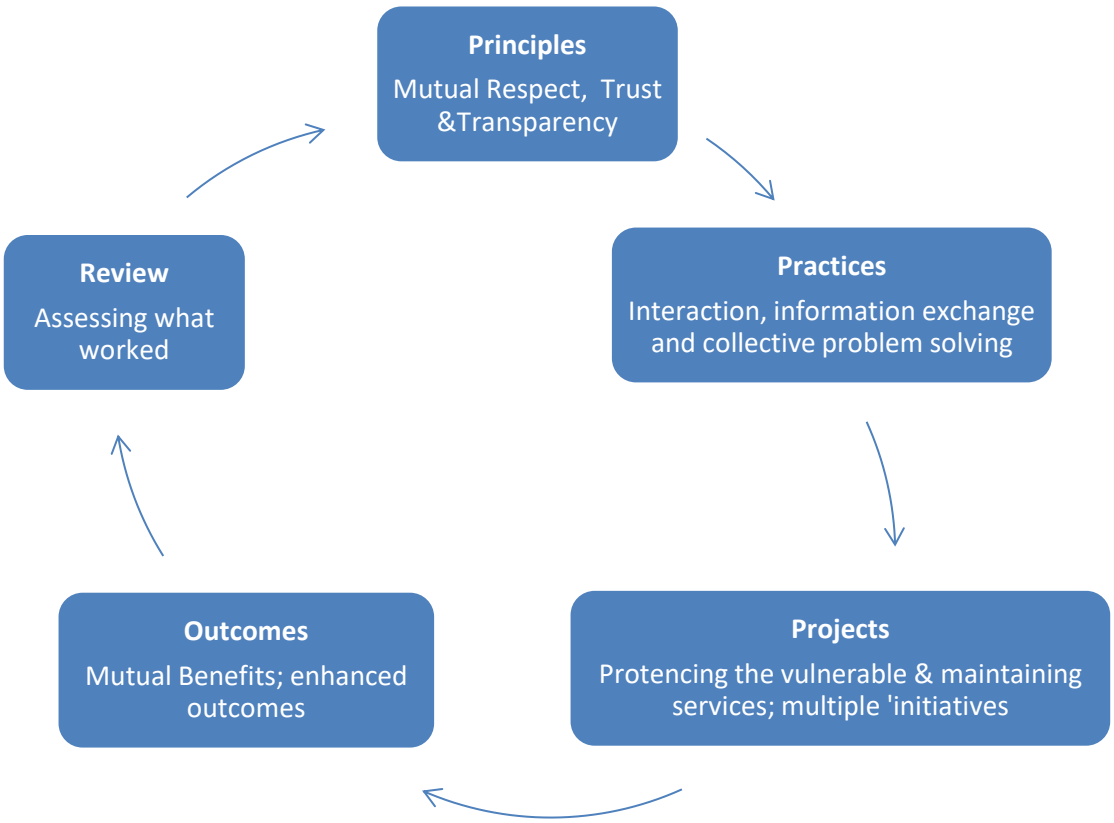
key to any reform strategies that are designed to deliver better quality, person-centric health and personal social services.

This paper has sought to demonstrate that the Covid-19 crisis has created new 'context' in which the seeds of collaboration and partnership-style working that were already in place have not only flourished and grown more quickly than advocates would have expected but also provided tangible evidence of the mutual benefits—for the state, the voluntary sector and for citizens—that can be generated by this way of working. The Disability Federation of Ireland for example contend that the collaborative approach that has emerged in their sector effectively modelled the type of engagement advocated by the IRG report.[125] The state and voluntary sectors response to the unprecedented public health emergency is actually a case study of the proposed framework for building a stronger working relationship (Figure 2.1)—in action, in real time (Figure 5.1).

As was described in previous chapter (section 4.3) a number of new peak level forums were established to drive a collaborative response to the unique circumstances unleashed by Covid-19 (see also Appendix A Box A1, A2, A3 and A4). Within these various forums, there was from the outset an emphasis on transparency and openness while their capacity to develop effective solutions fostered a high level of mutual respect and trust between participants (see 4.6). Importantly the work of these various forums were characterised by intensive engagement, the extensive horizontal and vertical sharing of timely information and a commitment to collective problem solving. From the outset, the overarching focus of this peak level collaboration was the shared goal of protecting vulnerable individuals while continuing to deliver essential services and supports. This ensured that there was a strong focus on identifying and implementing actions (projects) that sought to resolve particular problems and challenges. The capacity of problem-solving deliberation to resolve problems and generate mutual benefits and enhanced outcomes has served to both highlight the potential of more productive relationships and also reinforced participant's commitment to working in this manner. While the HSE and the Department of Health have played a pivotal role in leading the response to the pandemic, Paul Reid (CEO of the HSE) has recognised the critical contribution made by both the voluntary sector and many within the private healthcare system to what has been a collaborative national effort.[126]

[125] Disability Federation of Ireland (2020b).
[126] Dáil Eireann (2020d)

Figure 5.1: Partnership in Action



As indicated in section 4.3 a new partnership-style forum has been (re)established in the disability sector to build on the cooperation that was fostered at the height of the crisis (see Appendix A: Box A5). The terms of reference for the rebranded National Consultative Committee were co-produced by the HSE and voluntary organisations, which is viewed as a signal that the former is clearly committed to deepening dialogue and collaboration. Interestingly, the first meeting of the Committee focused on identifying the values and practices that had worked during the height of the crisis. Although the themes that the Committee will engage with are still being discussed there is definitely a consensus that if it is to be effective then it has to deal with the main issues that will shape the future of the disability sector. Indeed one senior practitioner described it has having the potential to be a space in which difficult but necessary conversations take place.[127]

In contrast the NCCN have been highly critical of what they perceive as a lack of constructive engagement by the state during the crisis. Interestingly, however, meetings have now taken place between senior HSE officials and the NCCN and reflecting on this development the latter have stated that:

[127] Source: Research Interview

> ‘Although early days, the promise of regular interaction between the parties is encouraging. Such a cooperative approach between the statutory and the community providers is seen as the only constructive way forward for the homecare sector and it is very welcome.’ (NCCN, 2020:3).

This is a positive development which demonstrates how the emergence of new ways of working in one area can influence and shape others as the momentum for seeking to adopt a more constructive relationship would appear to have been driven in part by the limitations of the prevailing approach in this sector and partly by the recognition of the comparative success of a more partnership-style approach in other areas of the healthcare system. Importantly there are also examples of enhanced cooperation and interaction at the local level, particularly where there was already pre-existing positive relationships in place between state and voluntary organisations.

Despite the unprecedented levels of collaboration and the clear evidence of more productive and collegiate relationships, it is recognised that these need to be not only sustained but also deepened and widened. Indeed some interviewees have expressed concern that there is also some limited examples of the ‘command and control’ type approach creeping back in as the severity of the initial wave of infections waned. There is some merit in the view it may be difficult to maintain collaboration and solidarity without the absence of a unifying threat. At the same there as outlined in section 2.5 is no shortage of ‘shared’ problems and challenges for statutory and voluntary organisations to grapple with. Importantly the HSE’s CEO has recently stated that;

> ‘The new ways of working together transcend our current predicament and will set the tone for the future delivery of high quality, integrated healthcare in this country.’[128]

This suggests that a key focus of the Health Dialogue Forum’s ongoing work will be the design of a new and sustainable relationship premised on intensive (inter)action, the open exchange of information and a commitment to problem-solving deliberation.

5.3 Accountable Autonomy

The interdependent character of Ireland’s hybrid healthcare system ensures that it is essential that voluntary and statutory organisations work together within a co-operative model, which fully delivers national health and social care strategies and provides enhanced outcomes for service users while at the same time demonstrating compliance with best practice in terms of governance, quality, safety and financial probity. This paper has noted that the manner in which, particularly at the national level, accountably and autonomy had tended to be viewed as sometimes-oppositional forces had certainly strained relations. As was described in section 4.4 the overarching strategy adopted by the HSE during the crisis

[128] HSE (2021a)

has been based on a combination of a 'tight and loose' approach. This approach enabled the development of clear and strong advice, guidelines and direction at the centre to be combined with greater autonomy at the local level in terms of the scope to deliver organisational change and innovation. Critically interviewees from all sectors agreed that affording greater autonomy to actors at the local level was key to delivering the scale and pace of changes that have occurred since the outbreak of the pandemic. This mirrors the Government's strategy for community and local development that recognises that a renewed partnership underpinned by strong autonomous community and local development structures enable effective interventions for change that the government acting alone could not deliver.[129]

The aforementioned 'Tight and Loose' approach is in effect an example of 'accountable autonomy' in action. Significantly, the HSE has stipulated its support for the latter concept as a way of achieving the right balance between the necessary control by the state over policy and funding and the autonomy and independence of the voluntary sector.[130] This will require further discussion and deliberation between the two sectors in order to forge a shared understanding of what accountable autonomy actually means and how it can be operationalized given the considerable diversity within the voluntary sector in terms of size, structure, ethos and types of services provided. Importantly the HSE recognises that '*now there is an opportunity, and a need, to move on and to do better*.'[131]

There is importantly a genuine commitment on all sides to address this challenge in a partnership-style manner. In this context, Paul Reid's (CEO, HSE) articulation of the need to shift from an overt focus on monitoring costs and outputs towards an emphasis on performance is significant as it has the potential to further embed the concept of accountable autonomy in a manner that could reframe critical debates around the relationship between funding, performance and service innovation. Equally, there is merit in exploring the contribution that the regulatory framework could play in designing a new interdependent relationship between accountability and autonomy.

5.4 A New Approach to Funding?

Although the combined actions of the state and voluntary sector organisations helped to mitigate the major funding challenge facing the latter as a result of Covid-19, the critical issue of how to put in place a sustainable funding model that will enable voluntary organisations to deliver the scale and quality of services that citizens demand remains unresolved. In essence, Covid-19 did not create the funding crisis as such, rather it served to surface, quite rapidly, the deep-seated deficits in the prevailing funding model. In the disability sector, for example there is view, shared by many providers, that the current situation is not sustainable without a fundamental review of the funding of disability

[129] Government of Ireland (2019)
[130] HSE (2021a)
[131] HSE (2021b)

services, including addressing the issue of legacy deficits. Media reports of an internal HSE management report suggest that a combination of underfunding during the austerity period, demographic pressures, the changing needs of people with intellectual, sensory and/or physical disabilities and the cost of meeting and maintaining regulatory standards is creating a situation whereby the provision of disability services by voluntary organisations is unsustainable.[132] The IRG Report (2018) also flagged the lack of a realistic funding model for the provision of services by the voluntary sector. Although the 'parking' of the issue of costs was important in creating some breathing space for action during the crisis it is accepted that there needs to be an open and mature conversation about the level of funding that is required for an agreed level of services and how this relationship can be more effectively managed.

Interestingly there appears to be an emerging consensus among voluntary and state actors that moving to a system of multi-annual funding has the potential to enhance strategic planning and enable the more efficient and effective allocation of resources to meet need. This contrasts with the current system of year-to-year budget allocations which only impedes the HSE's capacity to plan and commission services to meet need.[133] Multi-annual funding would also provide the voluntary sector with the certainty that is required to drive more flexible and innovative approaches to institutional and policy reform. It would also allow voluntary bodies to 'own' the responsibility for the delivery of services and supports. A shift to multi-annual funding if combined with the aforementioned 'tight and loose' philosophy could also create a context that is more conducive to a balanced performance-focused dialogue rather than one that focused primarily on annual 'inputs and outputs'.

Covid-19 has also revealed the extent to which the delivery of public health and social care services are 'subsidised', to varying degrees, by the earned income and fundraising activities of individual organisations. The dramatic fall in revenue over the course of 2020 due to the suspension and/or reduction of such activities calls into question the sustainability of this approach to funding tranches of public healthcare activity.

Another important dimension of this funding dilemma is that 'earned income' functions in a manner similar to the learning and development budget in private companies, in that it enables organisations to actively foster the type of organisational attributes and capabilities that were drawn upon in responding effectively to the crisis. As was argued in the previous chapter the health and social care system needs good, robust and resilient organisations rather than thin and stretched ones (see section 4.12.). Although it is important to be cost-effective, hyper-efficiency can erode the institutional redundancy that agile and resilient organisations rely upon in responding to unexpected and uncertain challenges. This raises the question of how this organisational capacity building will be funded going forward.

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[132] M. Wall (2020) 'HSE says provision of disability services by voluntary bodies is not sustainable.' See https://www.irishtimes.com/news/health/hse-says-provision-of-disability-services-by-voluntary-bodies-not-sustainable-1.4320197

[133] *Ibid.*,

It is also evident that our ambitions for the population as espoused in various healthcare reports will also require necessary funding by other departments outside of health e.g. transport, housing and education.

These various issues suggest that it is time for a more open and honest dialogue about the sustainable funding of health and social care services in which there is a greater focus on performance and outcomes rather than inputs and outputs.

5.5 Improving Access to Quality, Integrated Service Provision

The policy emphasis in the Sláintecare plan on preventative care, the ongoing management of complex conditions and the provision of services closer to home will require moving to a delivery of care model that is coordinated and integrated across organisational and professional boundaries

The onset of the Covid-19 pandemic and the manner in which the healthcare system responded has reinforced the necessity of ensuring that all individual are able to access a suite of quality, multi-disciplinary and relevant services and supports. During the crisis the enhanced levels of collaboration between the state and the voluntary bodies was matched by increased cooperation between organisations within the voluntary sector. This has not only reinforced a strong collective identity but also encouraged a greater focus on the need to enhance service coordination and better harness collective resources. This provides a strong foundation for exploring how best to ensure individuals have access to quality and integrated service provision.

The multiplicity and range of voluntary organisations providing health and social services can be a source of value in terms of local connectedness and synergies, the capacity to mobilise volunteerism, agility and the tailoring of services to meet local need. At the same time, this can be quite a complex environment for service users and their families to engage with. Indeed several interviews highlighted the need to provide 'clients' with more help in navigating this complex environment. An unpublished internal HSE document also suggests that there is within disability services, for example, a degree of fragmentation and duplication of organisational delivery models.[134]

A crosscutting theme that has emerged from this paper is the importance of building and fostering robust and resilient organisations across the health and social care regimes. It is also evident that the crisis has refocused attention on the potential benefits that can be realised through enhanced coordination and the harnessing of collective resources and capabilities within the voluntary sector. Indeed it has been argued that delivering 'Sharing

[134] M. Wall (2020) 'Urgent reforms needed for disability service provision, HSE says.' See https://www.irishtimes.com/news/ireland/irish-news/urgent-reforms-needed-for-disability-service-provision-hse-says-1.4320108

the Vision' will require sustainable organisations with the resources and skillsets to provide the type of mental health services envisaged by this ambitious and expansive strategy and as such there is now an opportunity to support rationalization within this sector.[135]

Drawing attention to the diversity and multiplicity of organisations is not to suggest that the answer to these challenges will invariably be consolidation as 'bigger' is somehow better'. Indeed, it will be essential that any future organisational changes are undertaken in a manner that retains the core strengths that give value to the work of voluntary bodies. It is worth noting that Grow Ireland, which operates on a national basis, combines a clear overarching national strategy and agreed objectives with an emphasis on affording each of their eight regions the scope to tailor and customise interventions according to local need and requirements.[136]

What this suggests is the need for a rigorous, informed and inclusive policy dialogue about what types of organisational changes are required to deliver more person-centred, individualised and community-based service. This 'dialogue' should consider the full spectrum of options available to organisations to improve collaboration and partnership working including informal engagement, memorandum of understandings, the co-design of initiatives, collaborative forums, joint partnerships and actual mergers. There will be costs associated with this type of activity and voluntary bodies will need financial support to engage in this process. Similarly, access to expert advice and guidance would also be beneficial in order to facilitate what will be difficult but necessary conversations.

5.6 Maintaining the Momentum for Reform and Innovation

As has been highlighted throughout this paper, the scale of transformative change that has been delivered by statutory and voluntary bodies, in such a limited time and in the midst of a pandemic, has been nothing short of remarkable.

> 'Having worked for thirty years in the private sector and now nine years in the public service, I have never seen such significant and important change undertaken and implemented by so many dedicated people in such a short timeframe'. (P. Reid CEO HSE).[137]

A key challenge as the healthcare system moves out of crisis mode is how to retain the key lessons and learnings from the Covid-19 experience while focusing on delivering the transformative level of change associated with the Sláintecare programme and associated sectoral strategies. For example, while the pandemic provided an opportunity for mental health services to demonstrate extraordinary innovation in terms of adopting new practices,

[135] Dáil Eireann (2020b)

[137] Dáil Eireann (2020d) p.34

services and behaviours,[138] it also exposed fragilities within the current regime in terms of staffing levels, access to ancillary professional supports, adequate IT infrastructure and the response to the mental health needs of particular groups.[139]

Under its Terms of Reference, it is envisaged that the Forum will function as a platform for engaging, involving and consulting with voluntary providers on a regular basis and in a meaningful way, including on Sláintecare and other relevant policy developments. As part of this all members of the Forum will be invited to consider how they can best work together to deliver national strategy and reform.

It should be highlighted that there are already examples of voluntary organisations being directly involved in national policy development, as was the case with the Government's new national mental health strategy, '*Sharing the Vision: A Mental Health Policy for Everyone'*.[140]

> 'Developed in co-production with people who use services, family members, professionals and providers, this policy is ambitious and expansive.' (M. Rogan).[141]

Interestingly in the response to Covid 19 there is arguably the 'green shoots' of the type of institutional reform and policy innovation that will be required to deliver this new ambitious and expansive strategy including:

- The adoption of online modes of service delivery (e-health);
- Increased collaboration between the statutory and voluntary sectors
- Better cooperation between voluntary organisations and an increased awareness of the need for a better coordination of services and effort.
- The increased focus on well-being and mental health promotion and
- A greater emphasis on community and primary services.

This however is only the start, as achieving the goals of *Sharing the Vison,* will require deeper and sustained integration and cooperation.[142]

It is important to recognise that in healthcare, as in other policy domains, it is evident that policy design and policy implementation have become increasingly intermeshed. While national strategy documents set the overall policy direction and highlight particular policy

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[138] Dáil Eireann, (2020c)
[139] Mental Health Reform (2020b)
[140] Government of Ireland (2020) Sharing the Vision A Mental Health Policy for Everyone, available at https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/
[141] M. Rogan (2020b)
[142] Dr. Sinead Reynolds 'HSE Mental Health Services in the Context of Covid-19' presentation to The Irish Context: Impact of Covid-19 on the mental health sector' Webinar available at https://www.mentalhealthreform.ie/coalition-conversations/

objectives and principles, it is very often in the implementation phase that policy is worked out in practice and problems resolved in way that can (re)shape the overall policy design. As part of the Sláintecare Action Plan 2019, for example, a Sláintecare Integration Fund was established to support projects that would test and scale new ways of delivering services with a particular focus on prevention, community care and integration of care across all health and social care settings. As has been highlighted throughout this paper a key characteristic of the response to the crisis was the extent to which frontline organisations were actively driving service innovation and reform, in manner that correlated with overall goals of national healthcare policy.

Since the outbreak of the crisis many voluntary organisations have engaged in an impressive level of change management that has involved redesigning their organisational model, developing new ways of delivering services and supports and adopting new working practices (see chapters 3 and 4). A central feature of the transformative change has been the rapid adoption of remote forms of service delivery with organisations using digital and/or phone-based technology to provide teaching, clinical triage, training to clients and staff, virtual day centres, resources for personal development, health advice and guidance, counselling, psychological and behavioural therapies, social supports and information updates. Significantly, the majority of organisations have committed to retaining and in some instances expanding their remote service provision, in conjunction with the resumption of centre-based services, as part of a transition to a more blended model of service provision (see section 4.8.) Given the potential for remote services to enhance organisational capacity and facilitate easier access to services this trend needs to be actively championed and adequately resourced. This must be done in conjunction with the introduction of measures to overcome the 'digital divide' while recognising that this is a broader societal 'problem'.

The shift to more remote service provision has also supported the 'fast-tracking' of national policy goals during the crisis, in terms of the adoption of more individualised, tailored and community-based service planning. A number of interviewees referred to the fact that initiatives which they had been 'mulling over for quite some time were quickly adopted' while policy moves that would have been taken years to implement were rolled out in a matter of months.[143] There was also a view that notwithstanding the remarkable achievements in protecting service users in residential setting during the crisis, the experience of the last six months has created an opportunity to accelerate the transition of people with disabilities out of institutions and congregated day services towards community based, person-focused services that support their individual needs.[144] In addition to a strong focus on providing a quality and tailored service with appropriate professional supports, it will also be necessary to ensure that this type of transition is managed in a way that does not impose a disproportionate burden on families and/or carers.

[143] Source: Research Interviews
[144] Inclusion Ireland (2020b)

The examples of service change introduced by Cappagh, and Clontarf hospitals to support the national response to the crisis highlights how voluntary bodies in the hospital sector are at the vanguard of organisational reform and innovation (see Appendix A: Boxes D1 and D4). Although the current crisis resulted in these two hospitals undertaking new functions and roles, they both had a well-established culture of embracing institutional reform, organisational change and policy innovation. They also had experience of utilising the autonomy afforded them to develop and manage change and to an extent the space for autonomous decision-making increased during the crisis. This ensures that they are well positioned to take a lead role in implementing type of transformational change that will be required to deliver Sláintecare.

While perhaps not enjoying the same level of autonomy that some of the voluntary hospitals have, many voluntary organisations in other sectors of healthcare have displayed their capacity to respond to challenges in an agile, flexible and innovative manner. It will be important that these same attributes are harnessed to ensure that voluntary organisations are drivers of ongoing policy change rather than passive recipients. This will require organisations with the appropriate capabilities, capacities and resources to take a leadership role, which reaffirms the importance of investing in the development of 'good' and 'resilient' organisations.

Since the onset of the pandemic service providers, both voluntary and statutory, have generally shown high degrees of responsibility and a willingness to take on autonomous decision-making with positive results. The HSE contend that there is now an opportunity to consolidate these gains by assigning a leadership role to certain voluntary organisations in service reform projects which focus not just on the traditional input/output KPIs but also on measures of outcome.[145]

This will require the HSE affording greater 'responsibility' and 'autonomy' to local managers who will then have the scope to engage more collaboratively with local service providers. As the CEO of the HSE has articulated previously the engagement of local management is key to strategic change as in large organisations change and innovation occurs at the front line.

> 'I have a good sense of how big organisations work and a good sense of where change happens…..It happens at the front line. Unless you bring local management into the change process, you will not succeed. Big strategic top-down change plans don't work. You also need a bottom-up approach.'[146]

This emphasis on a 'bottom-up approach' combined with the opportunity for service providers to take a leadership role in the reform process will only serve to reinforce the deepening interrelationship between policy design and implementation. It also highlights

[145] HSE (2021a)

[146] See https://www.irishtimes.com/news/health/paul-reid-has-a-record-of-delivering-big-projects-can-he-tame-the-hse-1.3925978

the active role that service providers can potentially play with regards to policy development.

Similarly, there will need to be a continued focus on staff engagement and participation as this was key to the scale of change achieved during the pandemic. The relevant trade unions also made a positive contribution to the way the healthcare sector was able to flexibly respond to the crisis as demonstrated by the fact that no major industrial relations issues emerged despite the scale and pace of change. This suggests that the sustained consultation with representative bodies that was evident during the crisis needs to be built upon in order to ensure that the reform process is informed by trade unions considerable experience and knowledge. Affording voice to representative bodies can also serve to foster a greater shared understanding of, and buy in to, the reform agenda

5.7 A National Conversation about Health and Social Needs

There is among practitioners and decision makers in the healthcare sector a robust consensus that meeting the health and social care needs of the population, is not just a health and social care issue per se, as it requires a whole of government effort. In particular delivering on the ambitious policy goals articulated in existing disability, eldercare and mental health strategies will require coordinated and progressive action across a number of policy areas including housing, education, employment, welfare, which are the remit of departments and agencies outside of 'health and social care'.

A notable feature of the national response to the Covid-19 crisis has been the degree of social solidarity and the manner in which resources have been collectively garnered to protect the most vulnerable in society. The success of the Community Call programme epitomises this as it involved the rapid mobilisation of a broad range of public, private, voluntary and civic organisations around the shared goal of improving the means of identifying and reaching out to the most vulnerable in society, namely the elderly population. Local authorities have been at the vanguard of this initiative and in addition to a cohort of voluntary bodies who would have been traditionally engaged in this working with older people it has also involved organisations such as An Post, the Gardai, the IFA, the GAA, trade unions and various other civil society organisations.

It is worth considering the extent to which ensuring that all vulnerable groups in society have the opportunity to fulfil their full potential will require a similar 'societal effort'. A number of interviewees from both the public and voluntary sectors suggested that the national emergency has reaffirmed the need for a national conversation about how we meet the health and social care needs of the population in general and the most vulnerable in particular. To an extent, this is already happening with regards to eldercare given the manner in which the crisis has challenged the prevailing policy and associated funding model.

This national conversation will need to explore what are the resource implications associated with national strategies and consider how different public, private and civic actors can contribute to the achievement of agreed national policy objectives. Equally, it may require fundamental changes in our policy approach in particular areas of health and social care, including how services are delivered.

Appendix A: EXAMPLES OF FLEXIBILITY, INNOVATION AND COLLABORATION

A. Interaction, Information Exchange and Collective Problem Solving

Box A1:The Disability Forum: Collaborative Problem Solving

Early in the crisis, the HSE put in place a formal structure for weekly (online) meetings between senior HSE officials and representatives from the disability sector. The purpose of these meetings was to facilitate the early identification and resolution of the key issues affecting front line service providers within the disability sector. These formal weekly meetings were augmented by almost daily contact between the senior officials in both sectors.

The disability groups on the forum were asked to reach out to their member organisations and identify and collate the issues that they were grappling with in the context of Covid-19. These issues were then raised at the meeting and the participants sought to resolve them through problem solving deliberation. If no resolution was possible at this stage, the HSE committed to exploring it further with the relevant statutory bodies and bringing the answer back to a subsequent meeting.

> 'it was like a figure eight with information flowing up and down between organisations at different levels…we would bring a spreadsheet which outlined the issues and tracked progress…, and we would work through the issues together and if it couldn't be solved here the HSE went back to individuals in the appropriate statutory bodies to see if a resolution could be found, and/or additional information provided.'[147]

Disability groups were afforded responsibility for relaying agreed solutions and any relevant supporting information back to their member organisations. Indeed based on this interaction the sector in conjunction with the HSE, started to produce regular FAQ documents that would assist member organisations by providing clear and targeted guidance on specific issues. Among the tricky issues that this group addressed was the procurement, distribution and use of PPE; staff redeployment including insurance related issues (public sector liabilities); the dissemination and customisation of public health guidance; funding challenges and initiatives to improve testing and tracing (see Box 1D).

[147] Source: Research Interviews

Box A2:The Palliative Care Forum: Problem Solving Deliberation

At the beginning of the crisis, the HSE established the Palliative Care Forum comprised of senior HSE officials and representatives of the main service providers. This grouping met on a weekly basis to discuss issues such as accessing PPE, communications and the development and clarification of public health guidelines for their organisations and service users. Importantly irrespective of the origin of the issue, they were treated as 'shared problems' and this served to both facilitate the open exchange of information and also enhance the group's ability to work collectively in devising practical solutions to problems.

> 'The forum provided a much needed space for communication and a support structure for all providers. It created the sense of '*a united front and approach*', where we felt that we were being heard and the group was able to get things done quickly.'[148]

This structured and regular form of engagement provided voluntary groups with direct access to the key decision makers and policy centres within the HSE. This was a valuable 'resource', which hitherto had not been available to service providers. In particular, it afforded direct access to the expertise and guidance of the national Clinical team, which was then disseminated to member organisations.

> 'Our direct access to policy areas such as infection control, occupational health and HR services allowed immediate measures to be put in place with the shared learning disseminated quickly to the organisations within the Voluntary Hospice Group.'[149]

The building of these more collaborative and productive relationships at the centre in conjunction with increased active engagement and involvement in local CHO's also served to enhance the responsiveness of individual organisations in addressing the challenges posed by Covid-19 in the palliative care sector.

[148] Source: Research Interview
[149] Source: Research Interview

Box A3:The Eldercare Group: Information Exchange and Collective Problem Solving

Early in the crisis an Eldercare Group, consisting of senior HSE officials and representatives of relevant voluntary organisations including Age Action, Alone and Dementia Ireland, was established. The purpose of this structured forum, which met weekly, was to exchange information, provide updates and agree actions in relation to the eldercare sector. A key feature of this group was the emphasis on the active collection of data and experiences and the two-way flow of information between the various levels and organisations involved in supporting older people. This enabled voluntary organisations on the group to bring to the HSE's attention the main issues that were arising for their organisations on the ground. The new national helpline funded by the HSE and operated by Alone was a particularly important source of timely information as it was used to identify on a weekly basis the four or five major issues for older people during the crisis. A senior HSE representative considered the timeliness and quality of the information generated by this process to be invaluable in terms of identifying problems and facilitating practical solutions.[150]

Importantly this regular and structured dialogue had a strong action-orientated focus, which served to produce tangible benefits for all participants in terms of resolving issues in a practical and swift manner.

> 'if issues were raised and the fault was on the HSE side, we (HSE) would seek to address it and we would then report back to the group the following week, identifying where we had made progress and also in an open manner what issues could not be resolved…we might also identify actions that the voluntary groups should undertake to help address issues.'[151]

[150] Source: Research Interview
[151] Source: Research Interview

Box A4: Mental Health Services: A Partnership Style Approach

In seeking to achieve the outcomes of '*Connecting for Life 2015–2020*' the National Office for Suicide Prevention (NOSP) works with a broad range of statutory, non-statutory and community partners engaged in suicide prevention.[152] Following the outbreak of the crisis NOSP initiated a dedicated weekly meeting with agencies working in the area of suicide prevention. The HSE also established a similar weekly forum for other non-statutory providers of mental health services and supports. The purpose of these weekly 'calls' was to develop a coordinated approach to the challenges associated with Covid-19 particularly in terms of ensuring a degree of continuity in service provision. These calls, which now take place bi-weekly, enabled the HSE to provide stakeholders with up to date information and guidance on the Government's public health response. Equally, they enabled front line actors to provide feedback on their experiences of the crisis and to directly raise issues of concern with senior decision makers.

A recurring theme at these meetings was the extent to which the collapse in fundraising income within the sector was constraining individual organisations capacity to meet commitments within their respective Service Level Agreements. Although there continues to be serious financial challenges in the sector, the HSE's commitment to underwrite pre-existing funding arrangements did afford the respective voluntary organisations the 'space' and indeed confidence to migrate to remote forms of service delivery.

From the outset, the meetings were characterised by transparency and an open exchange of information and experiences and this served to foster higher levels of trust and cooperation between participants. This formal and structured engagement effectively facilitated a de facto 'disposing of boundaries' as the HSE and non-governmental organisations worked together to address shared problems.[153] This inter-organisational interaction has served to foster a greater awareness of *what each other is able to do'* and is encouraging a greater focus on the need to enhance service coordination and better harness collective resources.[154] It also revealed how the sector can face major issues when they work together.[155]

[152] *Connecting for Life* is Ireland's national suicide prevention strategy, see https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/about/

[153] M. Rogan (2020a) presentation to 'The Irish Context: Impact of Covid-19 on the mental health sector' Coalition Conversations Series, https://www.mentalhealthreform.ie/coalition-conversations/

[154] Dáil Eireann (2020b)

[155] M. Rogan (2020a)

Box A5:The National Consultative Committee: Deepening Dialogue and Productive Relationships

The positive experience of peak level collaboration during the crisis has encouraged the HSE to reinvigorate and repurpose the National Consultative forum, which hitherto lacked a clear function and had become relatively ineffective. Rebranded as the National Consultative Committee, the aim of his 'new' body is to further deepen dialogue and productive relationships in a manner that will help to address key challenges in the sector going forward. The terms of reference for the Committee have been co-produced by the HSE and voluntary organisations, which is viewed as a signal that the former is clearly committed to deepening dialogue and collaboration. Interestingly, the first meeting of the Committee focused on identifying the values and practices that had worked during the height of the crisis.

The membership of the Committee is also to be broadened to include service providers, family representatives, the HSE and the voice of people with disabilities, reflecting the view that 'if we are serious about collaboration everyone has to be on board…we need to have representation of people with disabilities in this committee.'[156]

The themes that the Committee will engage with are still being discussed however there is definitely a consensus that if the Committee is to effective then it has to deal with the main issues that will shape the future of the disability sector and as such could include;

- Reforms in relation to how services are funded, procured and provided
- The relationship between the state and service providers
- Collaboration, integration and mergers within the sector
- Re-thinking regulation within the sector and
- How to move from a culture of compliance and inspection to a focus on quality and continuous improvement

[156] Source: Research Interview

B. Transitioning to Remote Service Provision

Box B1: Enable Ireland: A Digital Transition

In response to the closure and curtailment of existing face-to-face services, Enable Ireland took the decision to substantially enhance their use of online and digital technology, in order to ensure the continued provision of essential clinical, training and social supports to service users, albeit remotely. This 'digital transition' included the development, in partnership with Microsoft, of a pilot Virtual Service Centre that offered a five-day programme of training, leisure and social activities for adults with disabilities. The adoption of digital technology has allowed Enable to continue to provide support and maintain key connections with their clients, families and carers at a time on heightened anxiety and uncertainty. As a result of the positive feedback from clients Enable are planning to retain the Virtual Service Centre as an integral element of their day service provision even with the full resumption of normal centre-based person to person activities.

Box B2: The CRC: Remote Services and Supports

The CRC have exploited the 'opportunity' presented by the crisis to develop a suite of remote services and supports for adults and children to replace those that have were temporarily suspended and/or restricted as a result of the public health emergency measures. The CRC Adult Training and Development Centre, for example, have put in place a range of accredited and informal online programmes to enable adults with disabilities to both maintain their physical and mental health and also continue to develop personal, social and employability skills. In recognition of the fact that IT is not accessible for all clients, weekly information and learning packs have also been delivered to houses and their families have been provided with additional supports. CRC have signaled their intention to retain a number of these online education and training services as part of a more blended form of service provision

Restrictions on travel and social distancing requirements necessitated CRC scaling back their Adult and Children clinical services with the focus shifting to providing 'virtual' support within individual multi-disciplinary teams. A number of the staff from this service were also redeployed to the HSE during the crisis. The CRC however have maintained a Clinical Triage Team comprising all their clinical services—e.g. medical consultants, social work, dietetics, occupational therapy, physiotherapy, psychology and speech and language—who have provided, in accordance with strict Covid-19 safety protocols, a limited service for cases that cannot be managed virtually. Although their centre-based clinics are now opening up again the CRC intend to continue with the parallel operation of the virtual clinics as it enables the organisation to enhance its clinical capacity.

Box B3 Pieta House: Transitioning from Face to Face to Phone-based Crisis Counselling

Pieta House provide a free professional one-to-one therapeutic service to people who are in suicidal distress, those who engage in self-harm and those who are bereaved by suicide. In response to the Covid-19 public health measures Pieta have transitioned from their well-established face-to-face model of therapeutic support to providing therapy services remotely via the phone. Although they already operated a 24/7 Crisis Helpline, this shift in mode of delivery necessitated an adaption of the Pieta approach and philosophy. This represented a major learning challenge for both the organisation and its national network of professional therapists.

In the first instance a back-office support team developed their own agreed quality standards, operational protocols, guidance and training material, as there was a lack of pre-existing documentation relating to the provision of phone-based crisis mental health services. This internal material focused on highlighting the differences associated with the provision of phone-based therapy, the types of challenges that may arise and options for addressing such issues. It is important to stress that this is a crisis service for high-risk individuals and as such ensuring the safety of the service user and well-being of individual therapists was paramount in Pieta's approach.

Following the initial delivery of training by line managers, weekly meetings with therapists were set up to facilitate the sharing of experience, identify issues of concern and highlight areas where further guidance or advice was required. The support team then reviewed and where necessary revised the training material based on these discussions. This emphasis on monitoring and organisational learning in conjunction with the professionalism of the therapists and their willingness to embrace change has been key to the success of this new service. Additionally Pieta were able to draw upon a professional administrative/back-office team, an established line-manager support structure and ongoing processes for supervising therapists in quickly and effectively managing this change process. Although this initiative has enabled Pieta to continue to provide a key service in very difficult circumstances, some therapists have highlighted the difficulties of providing crisis related therapy within their own homes particularly in terms of being able to maintain emotional boundaries between work and home-life. Pieta are also looking at developing a new online video therapy option as they see remote services as having a key role in complementing face to face therapy in a future blended model of serviced provision.

Box B4: Jigsaw: Providing new ways to 'talk'

Following the decision to temporarily suspend their face-to-face counselling services and postpone all their community work, Jigsaw, the national mental health organisation for young people, immediately put in place phone and video-based services for individuals who were already engaging with their clinicians. Subsequently the organisation has focused on developing a major expansion of its range of online services and supports, as it seeks to respond in an effective and innovative manner to the impact of Covid-19 on the mental health of young people. A key part of this enhanced response has been the development of a range of new in-bound and out-bound options for young people and their parents to access support remotely namely:

- *Jigsaw Live Chat:* direct one to one live chat with trained Jigsaw staff.
- *Live Group Chats:* weekly on line discussion on mental health themes, moderated by a Jigsaw clinician.
- *Ask Jigsaw:* facility whereby individuals can submit a query or question and a weekly selection of responses is posted by a Jigsaw clinician
- *Free Phone support*: individuals can phone, text or email to request a return support call from a clinician.

Box B5: Grow Mental Health(Grow): Building Digital Peer Support Groups

Prior to the imposition of new public health guidelines Grow had 130 active peer support groups. Following the suspension of in-person activity the senior management team decided that it would be detrimental to leave these existing groups without any support and as such, they decided to move to a digital-based service model. This represented a considerable challenge to Grow as they had no experience of providing remote services. Grow's sister organisation in Australia did however have such experience and they agreed to provide training and expert advice to the organisations eight Area coordinators. This 'upskilling' was pivotal to the successful roll out of this initiative as it helped the Area Coordinators become more comfortable with this new model of delivery in addition to providing them with real insights into what made online groups work effectively.

Early on it became apparent that there was a significant group of individuals, particularly from the older age categories, who were not able to go 'online' for various reasons–-poor digital skills, a lack of adequate broadband coverage and/or a difficult home situation. In response, the Area Coordinators decided to establish regular phone contact with these individuals to avoid them becoming isolated and potentially experiencing heightened emotional distress. This was a completely new initiative and although it was resource intensive, it was considered necessary given the need to maintain contact with these individuals. Over time, other group members also began to connect and provide support to those who had not come online, which to an extent is a normal dynamic of a Grow group albeit in a new format. Furthermore, many of individuals, having been supported on a one to one basis, are now connecting via the phone to the online meetings.

As of mid-August, 67 of the original 130 groups had moved online which is a significant turnaround given that pre April the organisation had no remote mental health services. In addition to these pre-existing groups, a number of new 'virtual' peer groups, have now been established. The composition of these groups indicates that this new digital-based form of access is enabling Grow to reach a younger cohort of individuals, which they have actually been attempting to do in recent years with only limited success. Feedback from Area Coordinators is that these new 'virtual' groups, in terms of their group bonding and developmental progress, are moving at a quicker pace than is the norm. Over the course of the crisis Grow eventually moved all of their various training, community education and workplace education programmes online and while they are committed to fully re-establishing their in-person services and programmes these will now operate in tandem with their new digital-based supports, including the online peer support groups.

The leadership role displayed by Grow's Area coordinators and their associated management team's has been pivotal to this 'digital' transformation. Interestingly while the organisation has a clear national strategy with set goals they recognise the importance of affording each of the regions sufficient autonomy to be innovative and to tailor and customise the services and supports to meet the particular needs of their region

Box B6: HSE On-Line Mental Health and Well-being Supports

Over the last two years the Department of Health and the HSE have been working collaboratively to develop more online mental health services. During the current crisis additional funding has enabled the HSE to work with various partner organisations to extend the range of mental health and well-being services and supports available to both healthcare staff and the wider population including;

- *Text 50808:* a free 24/7 text service providing a spectrum of support from a calming chat to immediate support for people experiencing a mental health or emotional crisis
- *MyMind*: free online counselling service for targeted groups.
- *The In This Together Campaign*; an initiative to encourage people to stay connected, active and look after their mental well-being during the current emergency
- Free access for all HSE and public healthcare staff to four self-directed mental health programmes provided by Silvercloud the online mental health service.
- A dedicated phone line for healthcare workers was established to provide staff with information and advice during the health crisis.

These various initiatives are in addition to the existing counselling service that the HSE provides through its employee assistance programme. Additionally, the HSE's website also provides the public with information and signposting to the mental health services provided by a range of voluntary organisations and private providers.

Box B7: The Voluntary Hospice Group: Bereavement Services During Covid-19 :

The need to adhere to public health guidelines including social distancing have created very difficult scenarios concerning both end of life situations and funeral services. Importantly the voluntary hospice sector not only continued to provide a bereavement service but also actually mobilised, redesigned and expanded it to meet these changing circumstances. Social workers are continuing to support people/families via phone assessments and visits to inpatient units and/or the home setting if required. Bereavement services are also provided remotely via a podcast while bereavement support is offered through telephone calls and/or supporting literature. St Francis Hospice chaplaincy team broadcast a weekly reflection via Facebook to support and connect with families. Finally, an online remembrance service has also been implemented for bereaved families.

Box B8: Jigsaw and Aware: Facilitating Access to Quality Information and Educational Resources

An increased emphasis on quickly designing and disseminating quality online information and educational resources tailored to the needs of individual's grappling with mental health issues has been a discernible feature of the voluntary sectors response to the current crisis.

Drawing on their own professional expertise as well as international and national sources, Jigsaw have substantially increased the range of information, guidance and educational content that is available on their website in the form of webinars, videos, support articles and online educational courses/modules. It is recognised that such advice and guidance is not a substitute for direct therapeutic support but rather a 'resource' that young people, parents and individuals who work with young people can draw upon.

The provision of this material has proven to be popular, as highlighted by the substantial increase in website traffic, and the organisation is committed to continuing to develop the range and quality of their resources. For example, 9500 e-learning modules on the subjects of self-care, mental health literacy and promoting mental health have been downloaded by teachers. Jigsaw have also worked with Education Support Centres Ireland to develop webinars designed to support teachers in transitioning back to school and assist them to in supporting pupils.

Aware have also expanded its offering of free online metal health education programmes in response to the Covid-19 outbreak to include;

- A Life Skills Online Programme;
- A Life Skills Group Programme and
- A series of online self-directed programmes focused on managing stress, sleep, resilience and space from Covid-19.

Drawing on the principles of Cognitive Behavioural Therapy, these self-directed educational programmes aim to provide individuals with the tools to cope with anxiety, unhelpful thoughts and common life challenges

Box B9: The Care Alliance Ireland: Online Family Carer Peer Support Group:

In response to the curtailment of support services for family carers such as respite care, day care family carer support groups, dementia cafes etc.,. Care Alliance Ireland (CAI) have established an online family carer peer support group. This online private support group is facilitated by volunteers with social work and counselling qualifications and moderation experience with additional support provided by former and current family carers.

This initiative aims to:

- Mitigate the impact of the sudden withdrawal of face-to-face support services;
- Provide a safe and supportive space for carers to raise issues;
- Facilitate individuals in accessing necessary peer support;
- Encourage the sharing of knowledge and coping strategies; and
- Provide opportunities for socialising.

This project had no dedicated funding allocation and its design and implementation has consumed between 20-30% of staff time. This invariably impinged on the organisation's capacity to deliver other core commitments for which it receives funding. Importantly its core funders Pobal, the Department of Rural and Community Development and the HSE have been supportive and afforded the CAI the autonomy to allocate staffing and financial resources to it. The organisation also bid for funding from three other sources only one of which was successful. Finally, this initiative has relied heavily on the involvement of 12 professional volunteers who have provided approximately 750 hours of volunteer time.

Pre Covid-19 family carers did participate in small support group meetings. By removing constraints in relation to distance, transport and time, this online initiative aims to substantially increase the number of individuals who can avail of the potential benefits of peer support including a shared identity; the development and sharing of skills; increased confidence and improved mental health and well-being. Since March 16, 1550 family carers have joined the online group, engagement levels have been extremely high and it has received positive feedback from participants. CAI contend that the success of this group has been dependent on carer's confidence and willingness to be open about their role and experiences. This highlights the importance of designing robust and transparent rules and protocols that are capable of achieving a balance between the right to privacy for third parties (people being cared for) and the right of carers to seek support and help in undertaking a difficult role. Although it is envisaged that this online support network will continue even when face-to-face services are resumed, this will require securing additional dedicated funding.

Box B10: The Alzheimer Society of Ireland: Online Support Group for Family Carers of People with Dementia

The Alzheimer Society of Ireland have launched a new Online Support Group for Family Carers of People with Dementia that is designed to help alleviate the increasing pressure that family carers are experiencing as a result of the public health restrictions introduced to address the spread of Covid-19. This initiative aims to establish up to ten individual groups, comprised of approximately thirty people each. Each of these ten 'online spaces' will enable family carers to;

- Talk openly and support each other
- Ask questions and discuss topics of interest
- Access Discussion Forums and a weekly live video meeting and
- Get support and guidance from the organisation's Dementia Advisers and expert tutors

Outside of the formal online meetings, that will also involve advisers and tutors, members can also log on 24/7 to their group and as with pre-existing face-to-face support groups, there will be an emphasis on individuals drawing on their own experiences as carers to help and support each other

C. Connecting with their Communities

Box C1: Prosper: (Re) Connecting with the Community

Following the closure of their day centres, Prosper, who provide services and supports to adults with intellectual disabilities in Fingal and Meath, have developed a comprehensive communications strategy that is designed to provide a sense of connection and ongoing support to their vulnerable clients and their families/carers.

The main elements of this communications strategy are;

- Daily personalised contacts with clients and their families via phone or online technology
- A revamped Facebook page
- The adoption of new digital platforms for social supports—Zoom
- A Weekly Dashboard: this provides details of the numbers receiving specific services and a Covid-19 health update (staff; service users; parents/carers)
- An Online Advice Hub providing practical information on Covid-19 to service users and carers
- Establishing a family/carers communication system that will provide immediate information to Prosper clients

Under this initiative day service staff have striven to contact on a daily basis all of Prosper's 700 clients via phone or online technology, and approximately 2000 calls have been made weekly since March. These regular one to one contacts have enabled Prosper to monitor how their clients are coping during an extremely stressful period. It also provides a 'voice' mechanism for service users and their families/carers as they can raise issues directly that are of concern to them. The provision of regular up to date information and advice to the community moreover complements these one to one contacts.

Feedback on this initiative indicates that service users enjoy the one-to-one engagement and both they and their carers/families feel connected and supported despite the suspension of centre based face-to-face services. The new emphasis on engaging through online platforms has also created a vibrant digital community, as service users are now using digital technology to connect and engage with each other.

Box C2: Irish Wheelchair Association's Community Supports Contingency Service

Following the decision to suspend or drastically reduce both their existing centre-based services and their home based services the Irish Wheelchair Association relatively quickly developed a 'Community Supports Contingency Service.' This new initiative incorporates a number of services and supports including:

- Daily phone and text contact with members
- The organisation of home visits to deliver foods, activity packs, information on COVID-19 and general conversation while adhering to social distancing
- The provision of transport on an individual basis to ensure that hospital or other important appointments were kept by an individual member
- The delivery of medication from pharmacies to individual members
- The utilisation of Microsoft teams on a service-by-service basis i.e. School leavers/RTU to promote open sharing of information and peer-to-peer support. And,
- In conjunction with their Assisted Living Service, the IWA are continuing to provide on a priority basis in-home personal care and one-to-one support, in accordance with HSE guidelines on PPE usage

By adopting this new contingency service, the IWA have ensured that 4000 individuals per week continue to receive a service, albeit different from their regular day service, while ensuring adherence to all appropriate HSE clinical guidelines. The IWA have used daily discussions with service users and formal surveys to review the initiative and in particular ensure that it is fit for purpose in terms of meeting the needs of users. A recent Survey on Service User's Preferences indicated that the majority of respondents were in favour of returning to day services while accepting that it would be a more restricted and different offering due to prevailing clinical guidelines.

Box C3: ALONE, Dublin Samaritans and Samaritans Ireland: Collaborating to support older people

As the Covid-19 crisis unfolded and the associated public health guidance regarding 'cocooning' for vulnerable groups remained in place for an extended time period, ALONE volunteers became acutely aware of the increased number of older people who were experiencing high levels of distress including expressing very negative emotions and suicidal ideation when they 'called' the organisation's existing helpline. The desire to ensure that these high-risk individuals received appropriate support and counselling led to the development of a formal Memorandum of Understanding between Dublin Samaritans, Samaritans Ireland and ALONE given the formers in experience in working in the area of suicide prevention. Under this MOU, ALONE have agreed to directly refer individuals who had contacted them and who were displaying extreme levels of emotional distress to the Samaritans so that they could avail of more specialised crisis-based counselling. Up until mid-July ALONE had referred twenty-five clients directly to the Samaritans for support.

Box C4: Northside Home Care Services: (Re) Designing and Expanding A key Service

Prior to the outbreak of Covid-19 Northside Home Care operated a Meals on Wheel service for elderly clients. The combination of the loss or reduction in home support and the increased isolation due to 'cocooning' highlighted the importance of a regular meal service both in terms of nutrition and regular social contact. In response Northside Home took the decision to fundamentally redesign and expand its existing service going from the provision of 1,000 hot meals over a 3-4 day period to proving 2,700 chilled meals per week over seven days. In this regard it became more of an essential service for clients. The expansion of this service was facilitated by the recruitment of additional volunteers from the local community as well redeployed staff from other community organisations in the area in particular Empower and Northside Partnership. The organisation had actually been thinking about this type of change for a while based on their experience of previous flu seasons and the outbreak of Covid-19 provided an opportunity to put their ideas into action. The relative speed with which they were able to successfully manage this major redesign and expansion of an existing service was a reflection of the fact that they had the knowledge, structure and strong linkages in the community to actually make it happen.

D: A National Response to the Public Health Crisis

Box D1: Cappagh Hospitals Transition to a Trauma Centre

In early March, the National Orthopaedic Hospital Cappagh (NOHC) suspended all non-essential elective procedures and outpatient appointments in order to transition into an Orthopaedic trauma centre for patients who would normally be treated in major acute settings. This initiative was designed to alleviate the growing pressure acute hospitals were facing as a result of Covid-19 infections by freeing up beds, staff and resources to deliver vital care for Covid-19 patients. This was a major change for the hospital as in contrast to elective procedures, which are precisely planned in advance, trauma presents unforeseen challenges and uncertainties. Three senior consultants led the process, on the clinical side, in close cooperation with colleagues in the 'feeder' hospitals. New pathways and algorithms had to be developed and the use of the Siilo App, a secure medical messaging platform, supported the coordination of care across institutions by enabling real-time exchange of patient data, collaboration and decision making while complying with social distance protocols

The hospital's Senior Management Team provided vital support to the clinical team through the development of a comprehensive operational strategy designed to deliver this transition in a safe and effective manner. This included addressing multiple issues for example; procuring PPE and medical equipment; developing protocols for Covid-19 testing; managing staff; implementing public health guidance; infrastructural investments; introducing changes in work practices; responding to Covid-19 outbreaks and securing additional staffing and bed capacity. A senior interdisciplinary Covid-19 Strategy team also met on a weekly basis to discuss any emerging issues and to make any necessary changes to policy, direction and/or strategy. The evolving nature of this unprecedented crisis ensured that the Senior Management team had to respond quickly and flexibly to changing circumstances and new information and to an extent it was a case of 'learning by doing'.

Although this transition was challenging, NOHC is characterised by a strong culture of innovation and staff fully engaged with the process including embracing new ways of working; new rosters and shift patterns and the acquisition of new skills. The overarching context of Covid-19 invariably created anxiety amongst staff and as such, the CEO and senior management teams placed a strong emphasis on both extensive communication with staff and also ensuring a safe working environment, physically and mentally, for all staff. A key factor in the successful transition to Trauma Centre were the interdisciplinary huddles which met each morning to discuss the daily schedule of surgeries and then reconvened in the evening to review performance with the aim of applying any lessons and learning to support continuous improvement and enhanced clinical outcomes.

The NOHC also view this as a learning experience that has augmented their capacity to deal with future public health emergencies. Furthermore, they are actively exploring if a number of changes introduced—new staff rosters; extended theatre hours and weekend working—can be retained as they have the potential to provide both increased operational capacity and increased flexibility for staff.

Source: A. Lee (2020) and author's research interview.

Box D2: The CRC's Redeployment Programme

In response to requests from the HSE, the CRC put in place a comprehensive staff redeployment programme to support the national response to the Covid-19 crisis. This has resulted in 109 staff providing approximately 12,000 hours of care to the national system in twelve different locations including private and voluntary nursing homes, voluntary hospitals, hospices, HSE Contract Tracing Centres, the Croke Part Testing Centre and the new City West Self-Isolation Facility.

In a number of situations CRC staff displayed considerable bravery and commitment in going into nursing home settings in which their own health was at risk due to a very high incidence of Covid-19. The establishment of the City West Self-Isolation Facility was a key innovation in the Government's response to the national health crisis and while the nursing and management staff came from the HSE the majority of the other support personnel came from the CRC's clerical and social care and support worker teams.

A number of factors have underpinned the success of this redeployment programme**.**

- The programme was voluntary and the CRC management ensured that different options were available in terms of both back-office support functions as well as more front line health and caring roles.
- The flexibility, commitment and strong sense of public ethos displayed by staff was pivotal to this redeployment activity.
- Although there were opportunities to undertake tasks similar to their existing roles in many instances CRC health professionals volunteered to take on clerical, administration and/or caring roles if that was what was needed in particular settings.
- The CRC stepped up its level of communication and engagement with staff in order to ensure that staff were informed of organisational strategy and ongoing developments including the redeployment programme.
- A debriefing week-off for staff in between their redeployment and resuming normal work was introduced. This was both a way of recognising staff's efforts and providing them with space to decompress. It also served as an infection control measure.
- Throughout this programme there was a strong emphasis on protecting the well-being and health of staff and redeployed staff have reported that they felt supported, connected and valued during this period.

Box D3: Prosper and the HSE: Regional Level Collaboration

The contingency plan that Prosper developed in response to the closure and/or reductions in service provision in both Fingal and Meath, including plans to repurpose residential centres and temporarily reallocate them to the HSE, were effectively incorporated into the HSE's regional strategy for responding to Covid-19.

As part of this contingency plan Prosper have collaborated with the Daughters of Charity and the HSE to repurpose a new residential centre, that they had acquired, into an emergency centre for people who were recuperating post Covid-19 or who had a crisis within their home. This service was to be for all people in the region rather than clients of Prosper. Under this collaborative arrangement, the Daughters of Charity were to provide the nursing resources while Prosper agreed to manage the facility and redeploy a number of day staff to this centre. Prosper were also responsible for ensuring that this 'repurposed' residence complied with HIQA regulations and standards in order to be approved and registered as a designated centre. Equally, they had to ensure operational practices adhered to social distancing requirements and other Covid-19 related measure for managing infection prevention and control. This project, which is one of a number, is indicative of how existing cooperative relations were enhanced during the crisis and as one senior official from Prosper remarked:

> 'We always had a good working relationship with the HSE and once we drew up the contingency plan and that was incorporated into their regional response it ensured at this stage we were now working on shared ground…what we were doing was part of their (HSE) response to the Covid 19 challenge.'

Box D4: The Irish Wheelchair Association: Enhancing Covid-19 Testing Capability

The temporary closure of the IWA's day centres resulted in their extensive fleet of 117 buses, which normally transported clients to and from day facilities effectively lying idle. In response, the IWA took the innovative decision to make these buses available to the HSE to enhance their Covid-19 testing capability outside of designated HSE testing centres. Following initial discussions within the weekly national meeting between the HSE and disability groups, the HSE and IWA signed a Memorandum of Understanding to govern this innovative initiative. Under this arrangement, the IWA's bus fleet was made available to transport testers and/or testing kits to and from HSE testing centres to various locations across rural Ireland including individual homes and residential facilities such as Nursing Homes. Subsequently the IWA also signed two separate MOUs with the HSE to enable their buildings and car parks in Cork and Leitrim to operate to an agreed standard to support HSE Test Centre activities in these two counties.

Box D5: Clontarf Hospital: Establishing a Step Down Rehabilitation Facility for Covid 19 Patients

Clontarf Hospital provides both post-acute orthopaedic rehabilitation treatment and an active rehabilitation service for older people. During the crisis, the hospital took the decision to support acute hospitals in the region by establishing a step-down rehabilitative facility for patients severely impacted by the Covid-19 using a combination of physiotherapy, occupational therapy and psychological support. Aside from providing patients with quality-integrated care, this initiative also served to relieve pressure on beds and resources in acute facilities.

Establishing this step-down facility was a major clinical and logistical exercise that involved; establishing and agreeing new clinical pathways; introducing changes to working practices and rosters; undertaking the procurement of PPE; redesigning internal facilities to support social distancing; acquiring new clinical skills; establishing comprehensive testing and contact tracing procedures; developing protocols for dealing with virus outbreaks; managing ongoing staff issues (recruiting staff and dealing with absenteeism) and introducing a range of other measures to support the prevention and control of the virus. This served to create a stressful and intensive working environment and the success of this major project was dependent on the collective engagement and participation of all staff—health professionals, business and administrative services and ancillary staff.

Strong leadership from the nursing and administrative teams was pivotal in the design and roll out of operational plans throughout this change process. The overall project was overseen by a senior management team comprised of the leads from all the main areas in the hospital. Meeting initially on a daily then weekly basis, this senior management team sought to address any emerging issues and were provided with real time updates on testing and contract tracing; infection control; procurement and waste management.

Over the course of this project there was a tangible improvement in the hospitals working relationship with the HSE as they collaborated closely on the design of clinical pathways; staff recruitment; procurement particularly of PPE and the implementation of public health guidelines and advice. On the latter issue, for example the HSE not only produced an extensive range of very good policies and procedures but also worked directly with the hospital, who were then able to adapt said policies to their particular contextual needs.

Box D6: Rehab; Chesire Ireland and Chime: Customising Public Health Information

Throughout the current crisis, the HSE and other public health bodies have been to the fore in collating and disseminating a wealth of up to date information and guidance to assist voluntary organisations in seeking to protect both their staff and vulnerable clients. Given the sheer amount of information and the evolving nature of the advice, some organisations in the disability sector have recognised the importance of filtering, customising and disseminating information in formats suited to their service users. The Rehab Group has ensured that psychologists and behaviour therapists are available to assist their service users to digest and better understand the public health information around hand washing, social distancing, cough etiquette and testing. Chesire Ireland have attempted to assimilate the information and create formats that are more accessible for the people it supports. Chime have also engaged extensively with the HSE to ensure that the needs of individuals with hearing difficulties are considered when providing public health information and advice.

Box D7: The Disability Forum : Co-creating Public Health Guidelines:

Following NPHET's issuance of guidelines on the use of PPE it became apparent to participants in the national level Disability Forum that these were designed for application to a hospital setting and were not suitable for individuals with an intellectual disability living in their own home. This resulted in the formulation of a working group to co-produce PPE guidelines that were more appropriate to the disability sector. This working group included family advocacy groups, service providers, procurement professionals and outreach services. The new guidelines were accompanied by a FAQ document for service users and their families, in which the information was presented in an easier to understand and more digestible manner.

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E: Business Continuity Planning

Box E1: The Rehab Group—Managing the Response to the Crisis

The early establishment of a Covid-19 Response Committee comprised of the CEO and senior managers who held appropriate oversight, governance and decision-making capabilities enabled the Rehab Group to respond quickly to the ever-changing landscape posed by the pandemic. This included activating various business continuity plans and designing a COVID-19 Preparedness Plan to guide their response, including identifying which critical services had to remain open. The work of the Covid Response Committee was supplemented by other intra-organisational management structures including a Serious Incident Management Team and Quality and Governance Team. The remit of the latter involved provided ongoing support and guidance to operations and front line staff on C19 preparedness, risk management, continuity planning, health and safety, infection prevention, control and isolation, testing, social distancing and compliance with Government and HSE protocols.

Appendix B: **DIALOGUE FORUM WITH VOLUNTARY ORGANISATIONS: MEMBERS**

Organisation	**Name**	**Position**
	Peter Cassells	Chair
Department of Health	Colm O'Reardon	Acting Secretary General
	Kathleen MacLellan	Assistant Secretary, Social Care Division
	Patrick Creedon	Principal Officer, Acute Care Division
HSE	John Kelly	Head of Corporate Affairs
	David Walsh	National Director, Community Operations
	Angela Fitzgerald	Deputy National Director, Acute Operations
	Brendan Lenihan	HSE Board Member
	Fergus Finlay	HSE Board Member
HIQA	Susan Cliffe	Deputy Chief Inspector of Social Services—Older Persons
	Finbarr Colfer	Deputy Chief Inspector of Social Services—Disability
Mental Health Commission	Rosemary Smyth	Director of Standards & Quality Assurance
	Elena Hamilton	Senior Regulatory Manager
The Wheel	Ivan Cooper	Director of Public Policy, The Wheel
	Jacquie Horan	CEO, COPE Galway
Mental Health Reform	Fiona Coyle	, CEO Mental Health Reform
	Michelle Kerrigan	CEO, Grow and Board Member of Mental Health Reform
Disability Federation Ireland	Allen Dunne	Deputy CEO, DFI
	Joanne McCarthy	Senior Executive Officer Policy & Research, DFI
Not for Profit Association	Rosemary Keogh	Chair NFPA and CEO Irish Wheelchair Association
	John O'Sullivan	Board Member NFPA and CEO, Enable Ireland
National Federation of Voluntary Service Providers	Alison Harnett	Interim Manager, NFVSP
	Sean Abbott	Chair NFVSP and CEO Cope Foundation
Voluntary Healthcare Forum	John Gleeson	Chair VHF and Chair Coombe Women & Infants University Hospital
	Patricia O'Doherty	Director VHF
Voluntary Hospices	Pat Quinlan	Previous Chair, Voluntary Hospices Group,

Group		and former CEO Milford Care Centre
	Audrey Houlihan	, Chair Voluntary Hospices Group, and CEO Our Lady's Hospice and Care Service, Harolds Cross
National Community Care Network	Noel O'Meara	CEO, Crumlin Home Care Services
	Fiacre Hensey	Chair NCCN

Appendix C: **RESEARCH METHODOLOGY**

A series of qualitative interviews were conducted with senior decision makers in voluntary and statutory organisations within the health and social care sectors. These interviews began on the 30th June and the last one was undertaken on the 17th of September. In addition to these interviews, the research has also drawn on relevant secondary material and submissions from individual organisations.

Interviews Undertaken

Interviewee	**Organisation**
Patricia O'Doherty	Director, Voluntary Healthcare Forum
Pat Quinlan Audrey Houlihan	Chair, Voluntary Hospices Group, and CEO, Milford Care Centre Vice- Chair, Voluntary Hospices Group, and CEO, Our Lady's Hospice and Care Services, Harold's Cross
Michael Fitzgerald	Head of Operations and Service Improvement, Services for Older People, HSE
Susan Cliffe Finbarr Colfer	Deputy Chief Inspector of Social Services -Older Persons, HIQA Deputy Chief Inspector- Disability, HIQA
Ivan Cooper Sarah Monaghan	Director of Public Policy, The Wheel Campaigns Manager, The Wheel
Paul Reid	CEO, HSE
Kathleen MacLellan	Assistant Secretary, Social Care Division, D/Health
Bernard O'Regan	Head of Strategy and Planning, Disability Services, HSE
Cathal Morgan	Head of Disability Operations, HSE
Jacquie Horan	CEO, COPE Galway
Kate Mitchell	Senior Policy and Research Officer, Mental Health Reform
Dr Samuel Gower Emma Dolan	Clinical Director, Pieta House Pieta House
Rosemary Keogh Angel Cullinane	Chair Not-for-Profit Association and CEO, Irish Wheelchair Association Project Manage (M.CO)

Alison Hartnett Sean Abbott	Interim Manager, National Federation of Voluntary Service Providers (NFVSP) Chair, NFVSP and CEO Cope Foundation
Liam O'Sullivan Zoe Hughes	Executive Director, Care Alliance Ireland Policy & Research Officer, Care Alliance Ireland
Derek Greene	CEO, National Rehabilitation Hospital
Angela Lee	CEO, National Orthopaedic Hospital
Michelle Fanning	CEO, Clontarf Hospital
Stephanie Manahan	CEO, Central Remedial Clinic
Pat Reen	CEO, Prosper Group
Maria Jackson Eamonn Dunne	Spokesperson, National Community Care Network & Head of Operations, Northside Home Care CEO, Northside Home Care
Trevor O'Callaghan Dr. Trevor Feeley	CEO, Dublin Midlands Hospital Group Clinical Director, Dublin Midlands Hospital Group
Alllen Dunne Joanne McCarthy Ríona Morris	Deputy CEO, Disability Federation Ireland (DFI) Director of Policy, Advocacy & Engagement, (DFI) Policy and Research Officer, (DFI)
Robert Murtagh Mark O'Connor	Advocacy (Policy) Co-ordinator, Inclusion Ireland Community Engagement Manager, Inclusion Ireland
Michele Kerrigan	CEO, Grow Ireland
Liam Bernie Aidan Kane Damien Ginley Catherine Keogh William Quigley Albert Murphy	Industrial Officer (ICTU)—ICTU Voluntary Bodies Group SIPTU—ICTU Voluntary Bodies Group SIPTU—ICTU Voluntary Bodies Group Forsa—ICTU Voluntary Bodies Group Unite—ICTU Voluntary Bodies Group INMO—ICTU Voluntary Bodies Group

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