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

Paper for the Dialogue Forum with Voluntary Organisations

SECRETARIAT PAPER

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An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta
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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 is critically important to improving the quality of service delivery, and to delivering better outcomes for service users (Independent Review Group, 2019). 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—indicated 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. 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, carried out over the period June to September 2020. It seeks to document and analyse the health system's response to Covid-19 with the aim of:

- highlighting the capacity of the healthcare 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, the 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, the 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. Summaries of a number of these are provided in Appendix A.

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

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 (Independent Review Group, 2019). 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 in the public healthcare system. The Department of Health is responsible for overall policy development and providing 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' (Department of Health, 2021). A third key statutory actor is the Health Information and Quality Authority (HIQA), an independent authority focused on improving health and social care services for people, through a combination of standard-setting, providing assurances, monitoring compliance and ensuring enforcement.

As a result of this history, Ireland today has a hybrid, 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 services to people with disabilities (Independent Review Group, 2019). Voluntary organisations are also actively engaged across the spectrum of health and social care services, including mental health, older-people services, palliative care advocacy and working with marginalised groups (ibid.).

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 last four decades), it 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; the Independent Review Group (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, voluntary and private sectors—operate in the same national policy framework. The Government is ultimately responsible for setting public policy across the health and social care system; Sláintecare is the 10-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 essential partners in the delivery of health and social care services, in an increasingly unified and integrated healthcare system (HSE, 2021a).

2.2   The Voluntary Sector

The voluntary sector now comprises a wide range of organisations that vary 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;

- regional non-acute services;

- small community-based support and social care services, and

- advocacy and representative groups.

The State provides funding to an estimated 39 organisations under Section 38 of the 2004 Health Act, and over 2,000 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 (Indecon, (2018).

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 delivering quality health and social care. A particular strength of voluntary organisations, compared to their public-sector counterparts, is 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 in the sector that this particular strength has been gradually undermined by the increased emphasis on standardised operational procedures and process compliance (see Section 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 in the local community enable 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. These are 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.

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 in 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 co-operation 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 in 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).[2]

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, which 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 under which it operates. The HSE has a dual role. First, it needs to support and work with 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 comply 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 that 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 set by 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 and 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

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[2] 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.

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. As well, the HSE is 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 growing consensus that the focus in 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 and giving sufficient autonomy to the voluntary sector. This autonomy would enable 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.

A central conclusion of the IRG report was that the emergence of a problematic relationship between the statutory and voluntary sectors is undermining the collective capacity of the system to deliver necessary improvements to service users. Given the importance of the sectors' mutual dependence for delivering 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 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 the 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 provides an overview 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 co-operative 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, which 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. It 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 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 70 per cent of its response to Covid-19 right, but that there would also be mistakes and ongoing changes (Research interview). Although there was much 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' (Research interview).

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 relation to designing and implementing specific actions (see Section 4.5) (Research interview).

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. There was also widespread disruption to respite and daycare 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, 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 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.

This period also witnessed the widespread adoption of new working practices, and an acceleration of telemedicine and similar technology-enabled practices (HSE, 2021b). 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 (*ibid.*).

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. By providing 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 Department of Health, who was a member of NPHET.[3] 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 about emerging issues.

Among the key issues discussed at this subgroup were:

- communications with vulnerable groups;

- the development of a Community Support Framework;

- long-term care residential settings;

- input into guidance for vulnerable groups;

- the needs of specific groups of vulnerable people; and

- mental health and wellbeing.

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

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[3] NPHET Vulnerable Subgroup, Draft Discussion Paper—Progress to Date, September 2020, unpublished.

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 implementing the preparedness plans remained with relevant departments and agencies, the subgroup played an important co-ordinating 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 establishing 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 (McGauran, 2021). Recognising the importance of communications tailored for vulnerable people, the subgroup supported the Department of 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 led by the public sector, it was 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: HSE, 2021:2).*

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**.**

3.3   The Suspension and Restriction of In-Person Services

Even before the implementation of restrictive public health guidelines in March 2020, frontline 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 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 were 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	Enable Ireland
• Schools closed • 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	• 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 Wheelchair Association	**Prosper**
• 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 training and school leaver services curtailed • Holiday respite service ceased	• Closed day centres • Temporarily closed respite services

In the mental health sector, the majority of organisations—including national bodies such as 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 indicates that, due to the pandemic, 76 per cent of respondents withdrew services they normally provided, amounting to an estimated average of 41 per cent of their normal service provision (Mental Health Reform, 2020a).[4]

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 fundraising events and activities that generate 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 NGOs, carried out by the Charities Institute of Ireland and The Wheel in March 2020, indicated that:

- between 70 and 90 per cent of charities had already cancelled fundraising events and campaigns;

- approximately half of surveyed charities expected fund-raised/earned-income losses of between €100,000 and €1m; and

- the loss of income for individual organisations ranged from 20 to 100 per cent (Coalition of Community and Voluntary Organisations, 2020).

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[4] The sample for this survey was the 75 Mental Health Reform member organisations. A response rate of 56 per cent was achieved (42 organisations).

The Mental Health Reform Survey (2020a) indicates that 55 per cent of respondents had to cancel fundraising 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, generates 80 per cent of its annual income through fundraising. As a result of the pandemic, it was forced to cancel its landmark fundraising event 'Darkness into Light', which raises €6m annually. Given that the organisation was already facing financial constraints, the cancellation of this event raised the possibility of redundancies and a scaling-back of services and supports provided by its centres.

According to the Disability Action Coalition,[5] a new coalition of eight not-for-profit organisations, the biggest impact of the crisis on their sector was the dramatic reduction in earned income, due to the cessation of fundraising activities and social enterprises (see Box 3.1) (Disability Action Coalition, 2020).

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, it estimated that this funding had been reduced by 70 per cent.

- Enable Ireland's postponement of fundraising events, and closure of 21 charity shops, meant that the organisation faced a potential loss of €1.5m in income in 2020, in the context of an existing €3.5m 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 estimated that by mid-year it would have lost over €1m, due to the cancellation of fundraising events and the closing of a number of charity shops.

- The Rehab Group anticipated that its fundraising would fall by approximately €400,000 over the course of 2020. Additional PPE costs alone for the organisation were €116,000 by mid-year.

- MS-Ireland estimated that income from fundraising would 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 after Covid-19 restrictions were announced in late March 2020.

- The CRC was 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. First, there are the 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 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 funding crisis threatened their very existence.

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[5] The Disability Action Coalition is a new coalition of eight not-for-profit disability service providers whose aim is to address the 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.

3.5   A Growing Demand for Services

The escalation in the rate of Covid-19-related 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 increase pent-up demand for treatment.

Although the pandemic is first and foremost a physical health emergency, the WHO has stipulated:

> *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 (Rourke, 2020).*

The pandemic, combined with the social and economic impact of the measures introduced to contain the virus, has the potential to exacerbate existing mental health difficulties and to create new problems. In the Mental Health Reform Survey (2020a), approximately 50 per cent of respondents reported an increase in demand for services and supports in the previous four weeks, while 78 per cent expected demand to increase in the coming months. Pieta, Jigsaw, Aware, Grow Mental Health Ireland, Turn2me and SpunOut have all recorded increased demand for their 'remote' services and increased 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 (*ibid.*). Allied to the fact that there is often an initial lag following major traumatic events before the associated mental health issues become apparent, this suggests considerable pent-up demand for services and supports, which will place increased strain on organisational capacity going forward.[6] Interestingly, Samaritans Ireland reported that, while the number of calls to its helpline did not increase during the height of restrictions, there was a tangible increase in the duration of calls and the levels of emotional stress displayed by callers (Turkington, *et al*. 2020). 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 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, 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. Some had to try to balance continuing to deal with clients in emotional distress while also discharging their own care responsibilities (Mental Health Reform, 2020a). For voluntary organisations, like their public-sector counterparts, this created considerable capacity pressures in providing services and supports, though in some instances internal redeployment from suspended services alleviated this situation. A combination of caring responsibilities, self-isolation and cocooning also reduced the level of volunteering on which so many voluntary organisations depend. For example, volunteering fell by 40 per cent in Samaritans Ireland, with the result that it was difficult for the organisation to operate a full roster on its 24/7 helpline.

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

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: Research interview).*

In responding to this challenge, the CRC established seven multi-disciplinary core teams, each of which was responsible for delivering primarily remote services to their respective client groups.[7] Similarly, many other organisations—such as Enable Ireland and the Rehab Group—put in place internal management structures and associated business continuity plans to manage and co-ordinate their strategic response to the complex set of challenges unleashed by the pandemic (Appendix A: Box E1).[8]

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 involved a number of elements:

- adopting remote working for staff in the organisation;

- investing in extensive infection prevention and control measures;

- keeping open critical residential/accommodation services;

- 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. These included management teams and those employed in administrative and professional support functions such as clerical, HR, IT, finance, procurement, risk management and compliance. Approximately 80 per cent of the respondents to the MHR Survey indicated that the majority of their staff were engaged in home/remote working (Mental Health Reform, 2020a). 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 in the state sector. This flexibility was key to the voluntary sector maintaining its capacity to rethink and reconfigure its business model, in terms of providing core supports and services to clients, supporters and families in a safe and effective manner. In addition to the necessary clinical and healthcare professionals, it is evident that having in place a strong organisational team for administrative and professional services has been vital to the response of voluntary organisations. These administrative and professional support teams have functioned 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, procuring vital equipment, and redesigning and remodelling services and supports.

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

[8] 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 will briefly consider the key outcomes of the voluntary sector's response to the unique challenges posed by this national health emergency.

In the context of the ongoing development and rollout of the national public health strategy for Covid-19, NPHET identified long-term residential facilities as a high-risk area, due to the congregation of vulnerable people. Critically, the HSPC reported that a number of vulnerable groups in various settings (disability, homecare, homelessness and other) recorded relatively low levels of infection, hospitalisation and mortality. These outcomes for vulnerable groups are a major achievement which should be recognised and valued. HIQA also highlighted the collective success of the voluntary disability service providers in limiting infections and managing outbreaks effectively (Research interview; also see HIQA, 2020).

The National Community Care Network (NCCN) comprises 21 homecare providers, who employ 3,000 carers and provide HSE-funded services to approximately 7,000 clients (most of whom are older people). 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.

Next, in the midst of the 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 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 (Section 4.8 and Appendix A: Boxes, B1, B2, B3 and B4). As outlined in Sections 4.9 and 4.11, voluntary organisations also strove to (re)connect with their communities, and their service users, families and carers through the design of new services, and/or the remodelling 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 (Government of Ireland, 2021).

The positive feedback received about 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 (Research interview).

Key aspects of the response to the public health crisis 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 that had been the subject of discussion for a number of years suddenly became a reality and were developed and implemented quickly (Research interview).

> *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 in Dáil Eireann, (2020a).*

The manner in which certain organisations 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: Research interview)*

Importantly, service providers are reporting that many service users enjoyed having more choice around their day, and less structure and routine compared to the traditional centre-based day services (Research interview). The National Incidence Management System (NIMS) reports indicate a substantial fall in the reporting of challenging behaviours, which suggests that certain individuals benefitted from a less structured and more individualised plan of support.

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 regard 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. There are concerns that the burden of responsibility could be shifted onto families if the resources and supports needed for quality integrated community-based services are not forthcoming. Indeed, the Disability Federation of Ireland reports 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 (Disability Federation of Ireland, 2020a).

As 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 have shown their capacity to resolve problems and deliver mutual benefits to stakeholders.

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

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

Table 3.2: Inclusion Ireland Surveys: a Digital Divide

Survey of parents of children with intellectual disabilities (Inclusion Ireland, 2020a)	Survey of daycentre service users and their families (Inclusion Ireland, 2020b)
A small number (11 per cent) had no access to equipment to enable them to access online teaching and supports. 45 per cent did not have access to high-speed broadband.	7 per cent of families indicated that they had no access to any form of technology (smartphone, iPad, computer) that would enable access to online supports. 19 per cent of family respondents stated that the person they supported could not use the technology options due to the level of their disability. 2 per cent of family respondents indicated that the person they supported 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 sending them written material and information packs as an alternative to online activities. The Inclusion Ireland survey of parents of children with intellectual disability indicated that by far the biggest barrier to providing home education was the child's motivation (78 per cent of respondents). 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 (Inclusion Ireland, 2020a). The voluntary disability organisations recognised these challenges, and many supported the provision of summer camps and summer provision. However, harnessing the potential benefits of distance learning for all children will require investment—not just in technology, but in specialist assistive technology, adapted curricula and therapeutic supports.

Inclusion Ireland reported that some parents of adults with disabilities had raised concerns about regression and decline in mobility, speech and language, and physical skills in the absence of essential in-person therapeutic supports (Inclusion Ireland, 2020b). This suggests that re-establishing, if not increasing, the level of therapeutic supports, including greater investment in the potential of e-health services, will be vital in future.

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 served not only to protect staff and service users, but to ensure the continued provision of services and supports in extremely difficult circumstances. At the same time, there is concern about 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 (Research interview). It has been argued that the pandemic has exposed fragilities in 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 (Mental Health Reform, 2020b). Reports from various grassroots forums 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 regard to 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)[9]*

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

It is important to stress that the results of these two surveys did not distinguish between state and voluntary/non-governmental disability service providers of schools or day-centre services.[10] However, the results raise questions about variability in service provision. Indeed, one interviewee remarked that, while their organisation was being innovative and continuing to provide various services and supports, in their opinion others 'did not step up and were not delivering' (Research interview). 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, since the standards of good performance in terms of responding effectively were being set by organisations in 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 stress and anxiety, along with exposure to high-risk situations, have taken their toll on many individuals' mental and physical wellbeing. As 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 skillsets to provide adequate employee wellbeing/assistance programmes. More generally, it is evident

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[9] This survey was carried out between 30 April and 20 May; 1,064 people responded. See Inclusion Ireland, 2020a).
[10] Some schools for children with intellectual disabilities are partnerships between a voluntary body/charity and the Department of Education.

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.

Table 3.3: Inclusion Ireland Survey on Adult Disability Day Services

Family Member Respondents (total: 296)

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

Source: Inclusion Ireland (2020b).[11]

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 experienced increased mental health issues. Additionally, 62 per cent of respondents to the Rare Diseases Ireland survey stated that Covid-19 was having a negative impact on their mental health (Disability Federation of Ireland, 2020a).

A number of interviewees highlighted continued anomalies in the pay of staff in Section 38 and Section 39 organisations. The crisis has focused attention on the value of work by frontline 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 (Fitzgerald, 2020). In the midst of the crisis, there were cases where redeployed workers, doing the same job in the same location, were subject to differing pay and conditions. Aside from its impact on morale, many interviewees saw this as inequitable. However, it is important to note that the Government and the relevant trade unions negotiated a deal in 2019 on restoring pay that had been cut following the economic crash. This deal covered staff in 50 larger Section 39 organisations. A further agreement reached in December 2020 facilitates pay restoration for employees in a further 250 Section 39 agencies (Sheehan, 2020b). Fórsa official Catherine Keogh described the agreement as a 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 an impact —including psychological, emotional and social—on wellbeing. While this study focuses 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) (Government of Ireland, 2019). The unprecedented nature and scale of the Covid-19 pandemic has ensured that its effects have reverberated across the whole of society. The concerted focus from the outset on seeking to protect the most vulnerable groups served to mitigate the levels of mortality and morbidity suffered by these sectors. At the same time, those who were most reliant

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

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.

> *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. 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 underpinning this response, and contributing to the emergence of more productive and collaborative relationships between the statutory and voluntary sectors.

4.2   Unity of Purpose

Ireland and the world have experienced 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 people, particularly the vulnerable, from this deadly virus, while continuing to provide core services and supports where possible. This unity of purpose has provided an overarching framework for all the strategies, actions and initiatives implemented since February 2020. It has also demonstrated that Ireland's hybrid health system has the capacity to function as an integrated national health system, with a 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, 2021a:2)*

In this context, several interviewees commented that the working relationship between the HSE and voluntary organisations during the crisis had 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.

> *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: Research interview)*

The use of digital technology—in this case Zoom—not only created a new communication structure for this particular coalition of voluntary bodies; it also facilitated increased engagement by members and enhanced information-sharing. This helped to reinforce the shared sense of purpose in the group. A senior official in HIQA commented that the existing collective approach among voluntary organisations in the disability sector was reinforced during the crisis. This helped them to engage with the HSE in a co-ordinated and focused manner, particularly around the issue of protecting vulnerable individuals with disabilities in congregated settings (Research interview).

In the mental health sector, the crisis has also fostered an increased level of interorganisational interaction. This led to greater awareness of 'what each other is able to do' and encouraged greater focus on the need to enhance service co-ordination and better harness collective resources (Dáil Eireann, 2020b). Similarly, as a result of their involvement in the Community Call initiative, a number of organisations that 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 vulnerable group (Research interview).

4.3 Intensive Engagement, Information Exchange and Collective Problem-solving

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

New national-level virtual forums or structures, comprising senior decision-makers from both sectors, were established early on in the crisis in the areas of disability, mental health, palliative care and eldercare, in particular. The role of these groups was to oversee the implementation of national public health advice and guidelines, and to address Covid-19-related challenges in their respective sectors (Appendix A: 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: Research interview)*

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 reveal that the work of these forums was characterised by intensive engagement, extensive information exchange and data collection, and a strong commitment to collective problem-solving. Covid-19 is an unprecedented national crisis, and the healthcare system's collective knowledge of this virus and the types of problems it was creating for frontline service providers was constantly changing, almost on a daily basis. These forums enabled regular, structured and intensive engagement between voluntary organisations and senior decision-makers in 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 gave voluntary groups direct access to senior decision-makers and expert policy centres in the HSE. This facilitated the latter in disseminating important guidance and communications in a timely fashion to umbrella member organisations on the ground (Disability Federation of Ireland, 2020b). This was a valuable resource, which had not been available to service providers before.

> *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 in the Voluntary Hospice Group. (A. Houlihan, CEO, Our Lady's Hospice: Research interview)*

The above example shows a second characteristic of these collaborative forums: the extensive two-way flow of information and data. As highlighted in Chapter 2, a central feature of the national response to Covid-19 has been the use of national and international clinical evidence to shape and drive decision-making in an uncertain and rapidly changing environment.

In 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 experience of frontline service providers. In the disability sector, for example, the national umbrella groupings were asked to reach out to their member organisations to identify and collate the key Covid-19-related issues they were grappling with (Appendix A: Box A1). Similarly, the new national helpline, funded by the HSE and operated by Alone, was used to identify the four or five

major issues for older people on a weekly basis during the crisis. These would then be discussed in the Eldercare Forum (Appendix A: Box A2). A senior HSE representative considered the timeliness and quality of the information generated by these processes invaluable for public health policy and guidance (Research interview). It also ensured that issues did not fester, as they could be quickly aired in the decision-making centre. Conversely, in addition to receiving up-to-date guidance and advice, these structures gave voluntary bodies a voice at the centre of the policy dialogue, and a sense that their concerns were being actively listened too.

The emerging problems and issues raised in 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 said:

> *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 (Rogan, 2020a).*

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

> *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: Research interview)*

In this process, disability groups were given responsibility for relaying agreed solutions, and any relevant supporting information, back to their member organisations. Based on this interaction, they worked 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 operated in the other forums in terms of identifying specific actions that voluntary groups would commit to undertake.

There was a strong, pragmatic, action-orientated focus to this collaborative dialogue. Its capacity to identify problems, develop and or seek out potential solutions, and act in a purposeful manner to address issues, helped to foster deeper and more productive relationships between actors. Interviews with individuals from all four forums confirmed that numerous issues, including 'knotty' problems, were either resolved or progressed through collaborative problem-solving deliberation. These included:

- 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 congregated 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 an acceptance that the solution may not be clear at the outset (McGauran, 2021). This capacity to resolve and/or progress issues, in a mutually beneficial way, helped build greater trust between the parties. It also reinforced their commitment to working in a more productive and collaborative manner, and improved the level of co-ordination between groups, including in implementing agreed actions. As one senior decision-maker said:

> *We knew we could do better, and tackling Covid has displayed that we can and that we should. (B. O'Regan, HSE: Research interview)*

The HSE is now seeking to build on the more productive and collaborative relationships that have emerged in the disability sector, by reinvigorating and rebranding the previously ineffective National Consultative Forum—now to be called the National Consultative Committee (Chapter 5 and Appendix A; Box A5). In addition, the national group that prepared the framework to support service providers in resuming day services involved representatives of service users and their families, service providers and the HSE. The framework's approach of providing guidance, while giving individual organisations a degree of flexibility in the resumption of services, was seen as showing the sector's growing influence in the policy dialogue (Research interview). One interviewee suggested that this contrasted sharply with their previous experience of policy issues, where guidance would have been handed down from the HSE without any input from the sector delivering the service (Research interview). Similarly, it has been argued that the response to the current crisis has revealed how the mental health sector can tackle major issues when it works together, despite the scale of the challenges it faces (Rogan, 2020a).

4.4   Regional and Local Level Co-operation

Peak-level collaboration and engagement also provided a supportive framework for partnership working, and for co-operation at 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 local level. A number of interviewees referred to the positive working relationships that had emerged in the Crisis Management Teams established in each CHO area. One respondent described this as 'being where the real action was' (Research interview).

Drawing on the success of the central forum 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. A number of interviewees said that, where state-voluntary relationships were already positive, they were strengthened and enhanced during the crisis. This is important as it suggests that the unprecedented level of collaboration that emerged during the crisis built, to a degree, 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 doing was part of their [HSE] response to the Covid 19 challenge. (P. Reen, Prosper: Research interview)*

Conversely, in other situations pre-existing problematic relationships tended to persist. The National Community Care Network (NCCN) has said that the outbreak of Covid-19 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 (National Community Care Network, 2020). However, this should not detract from the fact that most interviewees felt there had been a discernible improvement in relationships at the local level.

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. 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 (Appendix A: Box D6) (Research interview). On the latter issue, the HSE not only produced an extensive range of very good policies and procedures, but also worked directly with the hospital, which was then able to adapt policies to its particular needs.

Furthermore, state and voluntary actors in certain areas had already been working towards a more co-operative approach, based on the view that all of the key players needed to be involved in the decision-making process, while accepting that they 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: Research interview)*

4.5   Tight and Loose: Towards Accountable Autonomy

There is a perception in the voluntary sector 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 (Broderick, 2018). However, in the context of a national public health emergency, there has been evidence not only of unprecedented levels of co-operation between voluntary and state institutions, but also of a new approach combining strong central guidance and direction with increased autonomy, at the regional and local levels. Paul Reid, the chief executive of the HSE, has described its 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 a broad directional approach, and loose in terms of encouraging people and organisations to get it done (Research interview).*

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, the national response showed a discernible emphasis on freeing up service providers to be innovative in how they implemented guidance and resolved specific challenges. The system was given the resources and freedom to respond rapidly to service needs, while working in the established control environment. This allowed for locally led decision-making, strongly clinically influenced and sensitive to the local infrastructure and capacities. As noted in Section 3.2, staff redeployment was a central element of the HSE's national response. 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. For voluntary hospitals, it was more a case of fully exercising the degree of autonomy they already had.

This recognition by the leadership of the HSE that some mistakes were inevitable, given the uncertain and complex nature of the virus, also provided a safety net that encouraged innovation and underpinned a 'go do' approach among local management and service providers (Research interview). One stakeholder described the new context as 'being allowed to get on with what you are good at' (Research interview).

Senior representatives from the hospice sector said that a tangible devolution of decision-making from HSE headquarters to the local crisis management teams was accompanied by giving individual voluntary organisations greater autonomy for taking action. Critically, interviewees from all sectors agreed that this was pivotal in delivering the scale and pace of changes since the outbreak of the pandemic, in terms of the capacity and confidence to:

- fundamentally redesign the delivery of services;

- 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 has also taken steps to 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 in and across sectors, and 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 suggested in Section 2.4, reconciling the need for both accountability and autonomy in the healthcare system requires this complex problem to be recast as 'accountable autonomy'. It is arguable that the tight and loose approach—albeit fashioned to address a national health emergency—is an embryonic form of accountable autonomy. Organisations had to demonstrate 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 made the case for being given greater levels of autonomy. At the same time as the HSE has been willing to cede some control to the local level, its management of the crisis has seen their standing and authority in the policy system arguably reach an all-time high. Similarly, public trust and confidence in the HSE and national health system has also grown. Importantly, the need to work collaboratively to improve performance and deliver better outcomes has demonstrated how accountability and autonomy can be better reconciled.

4.6   Interdependency and Mutual Respect

The IRG Report (2019) noted a perception in 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 of health and social care services. The sheer scale of the healthcare challenges unleashed by the global pandemic and the manner in which the State has sought to address them have reaffirmed the interdependent character of the Irish healthcare system. As one senior HSE official said:

> *Neither the HSE, the service providers or the families of service users can do it all by themselves, however together they can…(Research interview)*

A greater display of mutual respect for the work and role of the voluntary sector was seen during the crisis. A representative from the voluntary sector noted that somewhat fractious and irregular interactions with senior state officials transitioned into regular, productive and more trust-based relationships during Covid-19 (Research interview). In some respects, this was an example of both parties earning each other's trust. The considerable knowledge and expertise that voluntary organisations could bring to the table as frontline service providers certainly appeared to be more valued during the crisis. As one individual described it, 'They began to see us problem-solvers' (Research interview). One of the strengths of the community and voluntary sector in general is its capacity to intervene effectively in a way that the State, acting unilaterally, cannot achieve (Government of Ireland, 2019). During the crisis the voluntary sector's organic rootedness in the community enabled it to respond in a quick and innovative manner. There is a sense that this particular quality is now more explicitly recognised and appreciated by the State. Equally, the voluntary sector recognises the leadership that the HSE has demonstrated in managing the response to this public health emergency. In particular, the sector has valued the extensive advice, guidance and collaborative support the HSE has provided to individual sectors, and to organisations, in seeking to resolve the various challenges (Research interview).

4.7   A More Balanced Performance Dialogue

The increased level of engagement and co-operative working between statutory and voluntary actors also appears 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 (Research interview). To an extent, the overarching goal of keeping people safe drove most of the decisions taken. It is accepted that this shift will not be permanent, and that it was 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 them, was essentially parked during the height of the crisis. At the same time, the shift suggests the potential for a more balanced

dialogue, in which the issues of costs, organisational performance, service quality and outcomes for users are discussed in a more balanced and integrated manner. This would be a discernible move away from the command and control approach which increasingly characterised the relationship between funders and providers over the last decade or more (Independent Review Group, 2019). As noted earlier, the HSE has a statutory responsibility to manage Exchequer funds in a prudent manner and to 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. The CEO of the HSE has indicated that there should be a move away from how the HSE monitors organisations. The overall focus should not be on costs and outputs *per se*, but on performance and outcomes (Research interview). Moreover, a focus on agreed outcomes can be a galvanising force that creates unity of purpose and space for local innovation (HSE, 2021a).

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

Voluntary organisations have responded to these challenges in a flexible and innovative manner. Central to this 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 of in-centre and face-to-face services. This fundamental shift was indicative of a broader acceleration of telemedicine, 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 rollout of digitally based remote service provision across the sector. National organisations such as Grow Ireland and Jigsaw established online individual and group-based counselling and therapeutic services (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 (Research interview).*

Some organisations, such as Turn2Me.ie and SpunOut.ie, were established to operate solely online. However, for most 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 was challenging, as they had to address issues such as sourcing equipment, upskilling staff and meeting the capital and current costs of investment in IT. For an organisation like Pieta House, the adoption of phone-based counselling involved a fundamental shift in its operating approach, while issues such as privacy, quality control and operational logistics all had to be worked out at pace (Appendix A: Box B3). The success of the initiative, however, has encouraged Pieta House to actively explore other ways of delivering services remotely.

The sector has demonstrated considerable flexibility in overcoming these hurdles quite quickly in practice. The Mental Health Reform Survey reveals that 77 per cent of respondents, who previously had provided services and supports face-to-face, were able to transition to delivering them remotely (Mental Health Reform, 2020a). At the community level, HSE NGO partners have worked hard to support specific population groups across the full life span, to increase their service provision at a national and community level, and to adapt their practices within the Covid-19 restrictions (Government of Ireland, 2021). As part of this, the HSE has actively supported and funded the work of voluntary organisations, e.g. Jigsaw, Alone and the Samaritans.

Additional funding has also enabled the HSE to work with various partner organisations to extend the range of mental health and wellbeing services and supports available to both healthcare staff and the wider population (Appendix A: Box 6). Increased emphasis on quickly designing accessible online quality information and educational resources, tailored to the needs of individuals grappling with mental health issues, has also been a feature of the response to the current crisis (Appendix A: Box B8).

In the space of several months, a virtual digital revolution 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 its use of online and digital technology to provide ongoing clinical, training and social supports remotely to service users (Appendix A: Box B1) (O'Sullivan, 2020). 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 intends to retain this virtual service even when centre-based activities are resumed. The adoption of digital technology has allowed Enable to continue to provide support and to maintain connections with clients, families and carers at a time of heightened anxiety and uncertainty.

Similarly, the CRC has 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 (Appendix A: Box B1). For example, the CRC Adult Training and Development Centre has put in place a range of accredited and informal online programmes. These enable adults with disabilities to maintain their physical and mental health and to continue developing personal, social and employability skills.

Outside 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, daycare, family carer support groups, and dementia cafés—Care Alliance Ireland (CAI) established an online family carer peer support group. This was facilitated by volunteers who had social work and counselling qualifications and moderation experience. Additional support was provided by former and current family carers (Appendix A: Box B9). Since 16 March 2020, 1,550 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 launched a new Online Support Group for Family Carers of People with Dementia, designed to alleviate the increasing pressure experienced by family carers as a result of the public health restrictions (Appendix A Box: B10).

The need to adhere to public health guidelines, including social distancing, has led to very difficult scenarios for end-of-life situations and funeral services. The voluntary hospice sector has mobilised, redesigned and expanded its bereavement services, through the use of phone-based and online services and supports, to meet these changing circumstances (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 service users. The provision of these key services was particularly important in ensuring a degree of service continuity at a time of growing anxiety and isolation (Research interview). This required not only considerable investment in IT equipment and maintenance, and the training of staff, but also work on the design of training material, governance arrangements, operational protocols and quality control.

As highlighted in Section 3.7, the shift to digital services in particular has highlighted a tangible digital divide in society, which will have to be addressed if everyone is to have equal access to publicly funded health and social care services. The ongoing development of digital/remote services will need to be accompanied by increased investment in assistive technology, training and personalised supports.

Despite this key issue, the positive feedback from service users has convinced numerous organisations, particularly in the disability and mental health sectors, to retain and 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. The Rehab Group has indicated that its day and training services will be delivered through a combination of approaches including in-centre, community-based, home-based and remote service delivery/supports (Rehab Group, 2020).

Equally, the increasing emphasis on remote and digital services reflects the potential benefits associated with this type of transformative change. First, it can enable organisations to expand their operational capacity; CRC has cited this as a reason for retaining its virtual clinics. Secondly, it can extend an organisation's geographical reach, which is particularly important for organisations which have been mostly urban-based. Similarly, the adoption of new technology can assist organisations to engage with different cohorts of the population. Grow Ireland has indicated that its new online peer networks are enabling it to reach a younger cohort of people, which it had been attempting to do in recent years with limited success. The provision of remote services and supports—some of which can be accessed 24/7—can also enable

individuals to overcome time or physical constraints that previously would have limited their access to such services. This is one of the advantages of online supports for carers who, as a group, are often time-poor given the nature of their caring responsibilities. Using remote services can give organisations flexibility in virtually redeploying staff to meet variations in geographical demand. Jigsaw has described how using remote services has enabled staff in Galway to provide support to some of its Dublin services, while staff in Offaly are providing similar support to the Meath service (Dáil Eireann, 2020b).

In developing remote and/or digitally based services further, the policy dialogue should not be dominated by a focus on cost savings and operational efficiencies—though these can be a potential advantage of going digital. At the same time, upfront investment in infrastructure, training for staff and users, and the cost of ongoing IT maintenance is needed. Even if issues around digital poverty and low digital skills are addressed, there will always be individuals for whom centre-based, face-to-face services will be more appropriate.[12]

In making the case for the development of a blended network of services, Jigsaw CEO Dr Martin Duffy suggested that it has the potential to deliver a more responsive frontline service, reduce waiting times, enhance community and primary care, and alleviate pressure on specialist services (Duffy, 2020). 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 (Dáil Eireann, 2020b).

> *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: Dáil Eireann, 2020c)*

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 because of its capacity to reduce costs over the medium term, but because of its potential (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 communities. During the crisis they designed new initiatives and strategies, focused on (re)connecting with their communities and providing new forms of support. Following the closure of its day centres, Prosper developed a comprehensive communications strategy which includes day service staff aiming to contact all of Prosper's 700 clients (via phone or online technology). On average, approximately 2,000 calls have been made on a weekly basis since March 2020 (Appendix A: Box C1). These regular one-to-one contacts have enabled Prosper to monitor how its clients are coping during an extremely stressful period. This also enables service users and their carers to raise issues of concern directly. Feedback indicates that service users enjoy the one-to-one engagement, and that both they and their carers/families feel connected and supported despite the suspension of centre-based   services. Similarly the IWA, following the suspension and/or drastic reduction of its 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 (Appendix A: Box C1).

Although there has clearly been a strong emphasis on harnessing the potential of remote services, the IWA has continued to provide direct outreach supports for priority vulnerable clients. Prosper has developed a new community outreach initiative to provide direct person-to-person support to 55 vulnerable individuals in their home or community. The implementation of this initiative involved redeploying day-centre staff and the complete redesign of daily practices

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[12] Jigsaw has 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.

to incorporate social distancing and Covid-19-related measures for managing infection prevention and control—in particular, the extensive usage of PPE.

As indicated in Table 3.1, the CRC had to scale back its Assistive Technology and Specialist Seating Service, though it continues to provide phone-based supports for clients who have problems with their AT equipment or wheelchairs. However, the staff in the service have also been prepared to visit clients informally, 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 (Research interview).

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. Chime continued to provide minor hearing-aid repairs and batteries to people around the country, particularly older people who were cocooning, through its online and outreach services (Chime, 2020). This outreach support was vital in reducing individuals' isolation and ensuring they could continue to communicate with family and friends.

A greater emphasis on providing community-based services has been a key objective of national healthcare policy for a number of years. As suggested above, voluntary organisations are ideally placed to be in the vanguard of this form of tailored service provision. The strategic response to the crisis has accelerated community-based service provision across the health system. Examples are 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 highlighted in Chapter 2, the combination of dramatic falls in income and rising costs exacerbated an already precarious financial situation, with the result that many voluntary organisations had to address a major and immediate funding challenge in the midst of a public health emergency. The sheer scale of this challenge posed a threat, in some instances, not only to voluntary organisations' capacity to maintain existing supports and services, but also to their future existence.

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 procuring PPE and for other safety-related measures;

- cutting costs of non-essential service delivery, and deferral of non-pay fixed costs where possible;

- the hosting of online fundraising events;

- reallocating 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 coalition's success was the collection of hard data on the scale of financial losses in the sector, and its potential impact on service provision and organisational survival. This coalition also, in its submission to government, identified the Dormant Accounts Fund as a

potential source of funding. In early May 2020, the Government used this facility to establish a €35m Emergency Stability Fund (Coalition of Community and Voluntary Organisations, 2020). In addition to the work of the Wheel and the associated coalition, support from the Department of Rural and Community Development was a factor in persuading other relevant government departments of the need to resolve the immediate cashflow liquidity crisis facing the sector.

In addition to that fund, the Government introduced other measures which have helped voluntary organisations to deal with their funding challenges:

- the Temporary Wage Subsidy Scheme;

- the provision of clear assurances around continued statutory funding;

- the decision by the new coalition 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.

As part of the national strategy for dealing with the pandemic, the HSE has made substantial additional funding available for procuring 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 not been a lack of funding as much as a lack of equipment due to the surge in global demand for these products. According to one senior representative from a voluntary organisation, cost was not a major consideration in the dialogue between funders and providers, where the expenditure was related to the safety of service users (Research interview).

The HSE also clearly signalled to organisations that the pre-existing service-level agreements were effectively suspended, as all stakeholders recognised that they were operating in exceptional circumstances. The prevailing view among interviewees from the statutory and voluntary sectors was that the issue of funding the response to Covid-19— in terms of investment to meet safety requirements and the costs of maintaining essential services—was to an extent parked. The availability of additional emergency funding, along with cost-saving measures introduced by voluntary bodies, has helped to mitigate the funding challenge during the crisis. At the same time, as discussed in the next chapter, the question 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.

4.11   Protecting the Most Vulnerable

An emphasis on continuing to serve communities, a strong sense of duty and a commitment to protecting the most vulnerable in society has underpinned the actions and responses of the voluntary sector during the Covid-19 crisis. Similarly, throughout the crisis the HSE displayed its strong public-sector ethos, and the value it places on delivering the highest standard of care to all who need it, and of treating the service user with compassion and dignity. Indeed, it has highlighted that the primacy of the patient and client, and a strengthened focus on vulnerable patient/client groups, continues to be a key driver of its actions and decisions (HSE, 2021b).

Section 4.2 highlighted the unity of purpose evident during the crisis. To an extent this was an expression of the common values and ethos found across the public and voluntary health and social care organisations.

As 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 has attributed this positive outcome to the hard work of disability service providers, their staff and the HSE (Disability Federation of Ireland, 2020b).

HIQA is an integral part of the state apparatus for governance in the health and social care sector, particularly in terms of standard-setting. Despite restrictions imposed by public health guidelines, HIQA continued to undertake institutional

inspections aimed at securing compliance and enforcement with national standards. Given the heightened anxiety and stress caused 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; in these instances, HIQA used its regulatory powers to ensure action was undertaken to improve the safety of residents.

Over the course of the pandemic, HIQA introduced a number of innovative measures 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;

- 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. During 2020, HIQA processed 82 registration applications related to Covid-19.

Disability service providers approached this challenging situation in a collective, engaged and focused manner. It was identified as a risk by boards of management in the relevant organisations early on, and they quickly implemented proactive measures, including the closure of day services, robust infection-control measures, staff training, the use of isolation areas, and an emphasis on ensuring continuity of staff (National Federation of Voluntary Service Providers, 2020). Targeted action plans were developed and the level and regularity of communication with clients, families and carers was increased.

Disability providers benefited from exceptional support from the HSE Social Care team. This enabled them to respond quickly and flexibly to 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 in residential settings, in particular the rigorous use of PPE and investment in associated staff training.[13]

The opening-up of new isolation units—involving tasks such as staff planning, governance procedures, fit-out, training of staff and the repurposing of day facilities—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 its introduction of an expedited registration process, was pivotal to ensuring that service providers were able to quickly put in place high-quality and safe solutions to control infection (Research interview). In part, this reflected HIQA's role in ensuring compliance with national quality standards, while its relationship with service providers continued to evolve, as shown by an increased focus on the co-design of pathways that fostered innovation and resolved problems (Research interview). HIQA has strongly endorsed the voluntary sector's achievements in protecting vulnerable people in residential care settings during the pandemic (HIQA, 2020). Equally, the voluntary sector has highlighted the key role played by HIQA in providing expert advice and guidance, and in working collaboratively with service providers to resolve problems (Research interview).

The professionalism, skills, flexibility and commitment of staff were also central to the successful rollout of plans to control and prevent infection in residential settings:

- There was extensive redeployment of staff from day programmes, both within and between organisations, to support people in residential homes. In particular, many residential settings moved to a 24/7 operating model following the closure of associated day centres.

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[13] *Ibid.*. This was reaffirmed in research interviews.

- 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 sector's focus on providing relationship-based supports, based on a long-term commitment to individuals and their families (Research interview).

Frontline staff are highly committed to service users and they know them, their needs and their families very well (Research interview).

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

The National Community Care Network (NCCN) managed to ensure a relatively low level of infections among employees and clients, most of whom are older and fell into the high-risk category. The NCCN believes 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 (National Community Care Network, 2020). In contrast to the disability sector, the NCCN contends that the level of support provided by the HSE and the various CHOs was minimal for most of the crisis period, and that essentially it was left to its own devices (*ibid.*).

4.12 The Quality of Staff: Committed, Flexible and Engaged

The quality of staff in voluntary organisations has been pivotal to the sector's capacity to respond in an innovative, flexible and dynamic manner. Throughout this national health emergency, staff across all sectors have displayed high levels of commitment, engagement, flexibility and professionalism. This has been key to ensuring the safety of service users and the continued delivery of services. The skills and competencies of staff in the voluntary sector have been demonstrated by their 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 wellbeing of vulnerable individuals and their families.

This performance was matched in the statutory sector as public-sector employees showed similar levels of professionalism, flexibility and commitment in the face of the unprecedented adversity. From the outset, HSE management placed a strong emphasis on effective communication and ongoing consultation and engagement with staff and their representative bodies. 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 of 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 front line of the national response. Combined with the fact that many staff also experienced major changes in their working practices and/or were redeployed, this meant it was a period of considerable stress and anxiety. Section 3.5 showed that voluntary organisations faced ongoing staff absenteeism and shortages over the course of the crisis. Mitigating this has required staff engagement, creativity and proactive leadership. In some instances, professional staff such as physiotherapists and occupational therapists were redeployed as care assistants to address staff shortages. Along with the redeployment of day staff, this helped to plug gaps in residential settings, for example. However, the downside was that the critical support therapies that these professional staff normally provided were not available.

As is outlined below (Section 4.17), the willingness of staff to be redeployed to other voluntary, public and private organisations was pivotal in helping the HSE address staff shortages and contain the spread of the virus in high-risk situations. In some cases, 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' (Research interview).

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 changes to their overall strategy. A number of senior managers stressed the role played by their boards of management in providing not only expertise and advice but also strong backing, especially when undertaking major organisational change (Research interview).

The scale of the changes associated with the fundamental remodelling and redesign of services and supports needed the full engagement and commitment of staff. Although many organisations already had a strong culture of employee engagement, some bodies set up new virtual forums to facilitate input by employees, and to give them 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 employees' voices in the decision-making process. This reinforced the importance of ramping up the quality and regularity of communication. In organisations such as the NOHC, Prosper, CRC and the Rehab Group, an array of mechanisms was 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 (Research interview). A feature of this enhanced information flow was the lead role that the CEOs in many organisations took in communicating directly and regularly with staff to outline changes. There was a similar emphasis on increasing the level of communication with service users, their families and their carers.

Senior management have 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 in the organisation. (Stephanie Manahan, CRC: Research interview)*

This collaborative and engaged leadership style extended beyond organisational boundaries. There was increased co-operation between organisations operating in the same sector (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 co-operative relationships that were forged with the HSE also relied on a collaborative and engaged leadership style (Section 4.3.)

Naturally, this required a reciprocal approach from statutory bodies. The willingness of the HSE to establish the various collaborative forums demonstrated the emphasis it placed on building a strong, inclusive and collective response to the crisis. As shown in Section 4.5, the HSE's emergence as a more authoritative leader in the policy system has, in part, been based on a willingness to 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 a strong and collaborative leadership style, as shown by its work on the funding challenges facing many community organisations (Section 4.10). This highlighted The Wheel's 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. It pointed 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 delivering quality services and well-developed corporate and clinical governance models.

It is clear 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—came to the fore and drove the manner in which it responded to the 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 they serve. This ensures that their actions are driven by a concerted focus on the needs of service users and their families/carers. This was critical in the context of Covid-19, when the primary aim was to protect vulnerable individuals. A number of interviewees commented that the willingness of staff to 'go the extra mile' for their clients was in part driven by the fact that 'they know them and understand their needs' (Research interview). This reach into the community also enabled needs to be identified and responded to relatively quickly, as demonstrated by the following examples:

- the communication programmes that the CRC and Prosper put in place to ensure that service users and families remained connected to the organisation (Appendix A: Box C1 and C2);

- the CRC and Chime outreach initiatives to fix essential equipment for people with disabilities;

- the customising of public health messaging by the Rehab Group, Chime and Cheshire Ireland to make it more appropriate for certain groupings (Appendix A: Box D7); and

- establishing online peer networks for carers (Appendix A: B9 and B10).

As outlined in Section 4.3, Alone gained key information on issues facing older people through the operation of the national Covid-19 helpline, which was channelled upwards to the national-level eldercare group. Through the organisation's existing helplines, Alone volunteers were alerted to the increased number of older people experiencing high levels of distress, including 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 (Appendix A, Box C3) (Moore & Hamra, (2020).

The decision-making process in voluntary organisations has traditionally been less bureaucratic than that of their public-sector counterparts, thus enabling them to respond more quickly to emerging situations (Independent Review Group, 2019). This flexibility and agility was evident in the rapid and early decisions many organisations took to redesign operational models to facilitate the remote delivery of a range of services and supports, in line with social distancing requirements (Section 4.8). At the same time, in the context of managing the response to the crisis, the HSE and Department of Health have delivered an unprecedented level of change and innovation in a remarkably short period (Dáil Eireann, 2020a).

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 (Appendix A: Box D1 and D6). It was also important that the HSE was confident that both organisations could deliver these major change projects.

Similarly, (Dublin) Northside Home Care's ability to fundamentally redesign its meals-on-wheels service into an expanded core service—going from providing 1,000 hot meals over four days to 2,700 chilled meals over seven —was based on the fact they had 'the knowledge, structure and linkages in the community to make it happen' (Research interview).

4.15   Resilient and Robust Organisations

The capacity of many voluntary bodies to oversee extensive and fast-paced operational change shows that they are resilient organisations, as evidenced by their ability to absorb stress, re-establish critical functions, work effectively and, in some cases, thrive in altered circumstances. Many of the characteristics 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. Such organisations did not become good or resilient organisations overnight. As 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 (Research interview).*

Effective organisations in the voluntary sector have actively fostered and invested in organisational capabilities and competencies such as 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 a person-centred approach. The crisis created a context in which organisations were able to mobilise and harness these capabilities to develop and implement strategic and innovative responses. However, some bodies, which were in a difficult position before the crisis, lacked the organisational capabilities required to respond in a more flexible manner, and have continued to struggle.

As outlined above, the quality of staff has been a key factor in the performance of voluntary organisations. This reflects voluntary bodies' emphasis on investing in workforce development, including building strong teams (not just of clinical and healthcare professionals, but also critical business and organisational support functions, where possible), administration, corporate governance, compliance and risk management, finance, procurement, HR, marketing and fundraising. As referred to earlier, the business and administrative support teams have functioned as the engine rooms of organisational activity since early March 2020 (Section 3.6). A number of interviewees highlighted the pivotal role played by their heads of procurement in sourcing PPE in difficult and stressful situations. Strong management teams also played a central role in the rapid development and effective implementation of 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 (Research interview).*

A strong focus on workforce development continued throughout the crisis, as organisations invested extensively in areas such PPE training and the expansion of digital skills. The transition of the National Orthopaedic Hospital, Cappagh (NOHC) to an orthopaedic trauma centre necessitated theatre staff acquiring new clinical skills. 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. For many organisations this was a case of stepping up or redesigning such activities.

A key factor in the successful transition of NOHC to a trauma centre was the interdisciplinary huddles which met each morning to discuss the daily schedule of surgeries, and reconvened in the evening to review performance, with the aim of applying any lessons and learning to support continuous improvement and enhanced clinical outcomes (Appendix A: Box D1). The NOHC views the crisis as a learning experience that can augment its capacity to deal with future public health emergencies. It is actively exploring whether 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 additional operational capacity and increased flexibility for staff. Northside Home Care Services have documented their performance during Covid-19, and are using this to develop a five-point strategic plan for the future. Weekly meetings to review experience, monitor performance and highlight issues that require additional advice and guidance were key factors in Pieta House's successful rollout of its new phone-based crisis counselling service (Appendix A: Box B4). These are all examples of a strong culture of organisational learning and monitoring in the voluntary sector, which has underpinned extensive organisational changes during the crisis.

A number of organisations introduced initiatives designed to support their employees' wellbeing and health. Measures introduced by the Rehab Group include resilience workshops led by an in-house psychologist, toolkits and tips for minding 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) 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 recognising their effort and providing them with space to decompress, as in some cases they had been working in high-risk situations (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 way 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 the health and social care sector. It is important to stress that voluntary organisations' earned income has in part worked in the same way as the learning and development budgets of private companies. It was used to foster organisational learning, innovation and workforce development—the very attributes and capabilities drawn upon in responding effectively to Covid-19. Although cost-effectiveness is important, hyper-efficiency can erode the institutional redundancy that agile and resilient organisations rely upon in responding to unexpected and uncertain challenges. While this section has focused on voluntary organisations, it is clear 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 was the provision of high-quality and regular public health guidance on controlling and preventing the spread of infection. Drawing on the latest national and international research and knowledge, the HSE constantly updated and disseminated its expert advice on issues such the use of PPE, social distancing, hygiene measures, testing and tracing, dealing with virus outbreaks, deep cleaning, etc.

Procuring and distributing sufficient quantities of PPE was a major challenge for the HSE, and one it shared with other health systems, given the dramatic increase in global demand. 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. In the home care sector, for example, a mini-consortium of six service providers was established to address their procurement challenge. Overall, given the evolving and complex nature of the challenge, the prevailing view among interviewees was that the HSE's centrally co-ordinated procurement approach had worked very well.

Section 4.3 indicated how peak-level collaborative structures gave voluntary groups direct access to expert advice, which could then be disseminated quickly to member organisations. There was also a strong collaborative side to this engagement, as service providers worked with the HSE to customise and tailor guidelines to their particular needs. Based on NPHET's initial advice on the use of PPE, a joint working group was established to co-produce more tailored guidelines for situations where individuals with an intellectual disability were living in their own home (Appendix A: Box D8). This partnership-style approach was also evident in the HSE's engagement with individual organisations, helping them to draw on its expertise and advice in adapting guidelines to their needs. This was the case for Clontarf Hospital among others (Section 4.4). Similarly, as shown in Section 4.11, the crisis witnessed the emergence of more collaborative problem-solving relationships 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, Cheshire 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 helped service users to digest and better understand the public health information around hand-washing, social distancing, cough etiquette and testing (Rehab Group, 2020).

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 2020, the individual and collective actions of voluntary organisations have supported the national effort to protect staff and vulnerable individuals while continuing to provide essential services and supports.

Voluntary organisations have also displayed a willingness and capacity to go beyond their organisational mandates and boundaries, by undertaking actions and initiatives contributing to the national public health strategy for preventing and controlling the spread of the virus, and caring for those infected. While more detail on selected initiatives is provided in Appendix A, these actions and initiatives include:

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

- The CRC developed a comprehensive redeployment programme under which 109 staff have provided approximately 12,000 hours of care in 12 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 (Appendix A: Box D2).

- Prosper redesigned and repurposed buildings to provide additional designated residential spaces for HSE patients recovering from Covid-19 or other crisis situations (Appendix A: Box D3).

- The Irish Wheelchair Association provided transport assets and buildings to the HSE to support and enhance testing and tracing operations (Appendix A: Box D4).

- A Step Down Rehab facility for Covid-19 patients was established in Clontarf Hospital (Appendix A: Box D5).

- Enable Ireland signed over part of its Kildare service building to the HSE for six months for use as a Community Assessment Hub.

- Hospice providers provided nurses to upskill and educate staff in HSE nursing homes in the provision of palliative care.

As outlined in Chapter 3, staff redeployment has been a core element of the HSE's response to the pandemic. In particular, the enhanced capacity to reassign staff quickly has been 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 CRC's comprehensive programme, many voluntary organisations from across the health and social care sectors have played a key role during the crisis in facilitating extensive redeployment within and 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 has been achieved without any significant industrial relations issues. This highlights the positive partnership-style role played by trade unions. Extensive staff redeployment—along with ongoing changes to working hours, rosters, working practices and work location—greatly enhanced the health system's capacity to respond in an agile and flexible manner to evolving demands. These substantial changes were the subject of discussion and agreement with the relevant public service trade unions. The Fórsa trade union stated early in the crisis its 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.[14] With regard to the voluntary sector *per se*, the relevant trade unions—the INMO, SIPTU, Fórsa and UNITE—worked

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[14] This statement from Kevin Callinan, general secretary of Fórsa, is indicative of the proactive approach adopted by the healthcare trade unions individually and collectively during the crisis. (See Sheehan, 2020a),

intensively with the HSE and employer groupings in the Health Service National Joint Council to 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 taken during this period (Sheehan, 2020a). 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 for crisis-hit organisations. This co-operative partnership-style approach at the national level served to create a supportive environment that enabled individual voluntary and public organisations to deliver rapid operational and staffing changes during the emergency.

Chapter 5

Building a New Relationship and Delivering Better Outcomes

5.1   Introduction

This overview of the 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. Considerable uncertainty remains over the future trajectory of the global pandemic. It is clear that protecting citizens, in particular the most vulnerable groups, will remain a priority for the health and social care system. At the same time, there is a need to re-establish the full complement of services and supports, albeit within the prevailing and evolving public health guidelines and regulations. The way Covid-19 has affected health and social care has reaffirmed the importance of fully engaging with and hastening the pace of transformative reform envisaged by Sláintecare and associated sectoral strategies. Responding to Covid-19 has been a massive real-time learning exercise for the health system. The Health Dialogue Forum believes that harnessing the important lessons from this shared experience can help to design a new relationship, and to guide how the State and voluntary sectors collectively address ongoing challenges in healthcare. The HSE has 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 (HSE, 2021a).

- In this context, the Forum needs to consider how it can use the lessons from the shared experience 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 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 the interdependent nature of the healthcare regime, fostering a more productive and collaborative relationship would be key to any reform strategies 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 a new context in which the seeds of collaboration and partnership-style working already in place have not only grown more quickly than advocates would have expected but provided tangible evidence of the mutual benefits—for the State, the voluntary sector and citizens—that can be generated by this way of working. The Disability Federation of Ireland contends that the collaborative approach that has emerged in its sector effectively modelled the type of engagement advocated by the IRG report (Disability Federation of Ireland, 2020b). The State and voluntary sector's 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 described in 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 (Appendix A: Boxes A1, A2, A3 and A4). These forums emphasised transparency and openness from the outset, while their capacity to develop effective solutions fostered a high level of mutual respect and trust between participants (Section 4.6). The work of these forums was characterised by intensive engagement, extensive horizontal and vertical sharing of timely information, and a commitment to collective problem-solving. From the beginning, 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 a strong focus on identifying and implementing actions (projects) to resolve particular problems and challenges. The capacity of problem-solving deliberation to resolve problems, and generate mutual benefits and enhanced outcomes, has highlighted the potential of more productive relationships and reinforced participants' 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, HSE CEO Paul Reid has recognised the critical contribution made by the voluntary sector, and by many in the private healthcare system, to a collaborative national effort (Dáil Eireann, 2020a short timeframe).

Figure 5.1: Partnership in Action
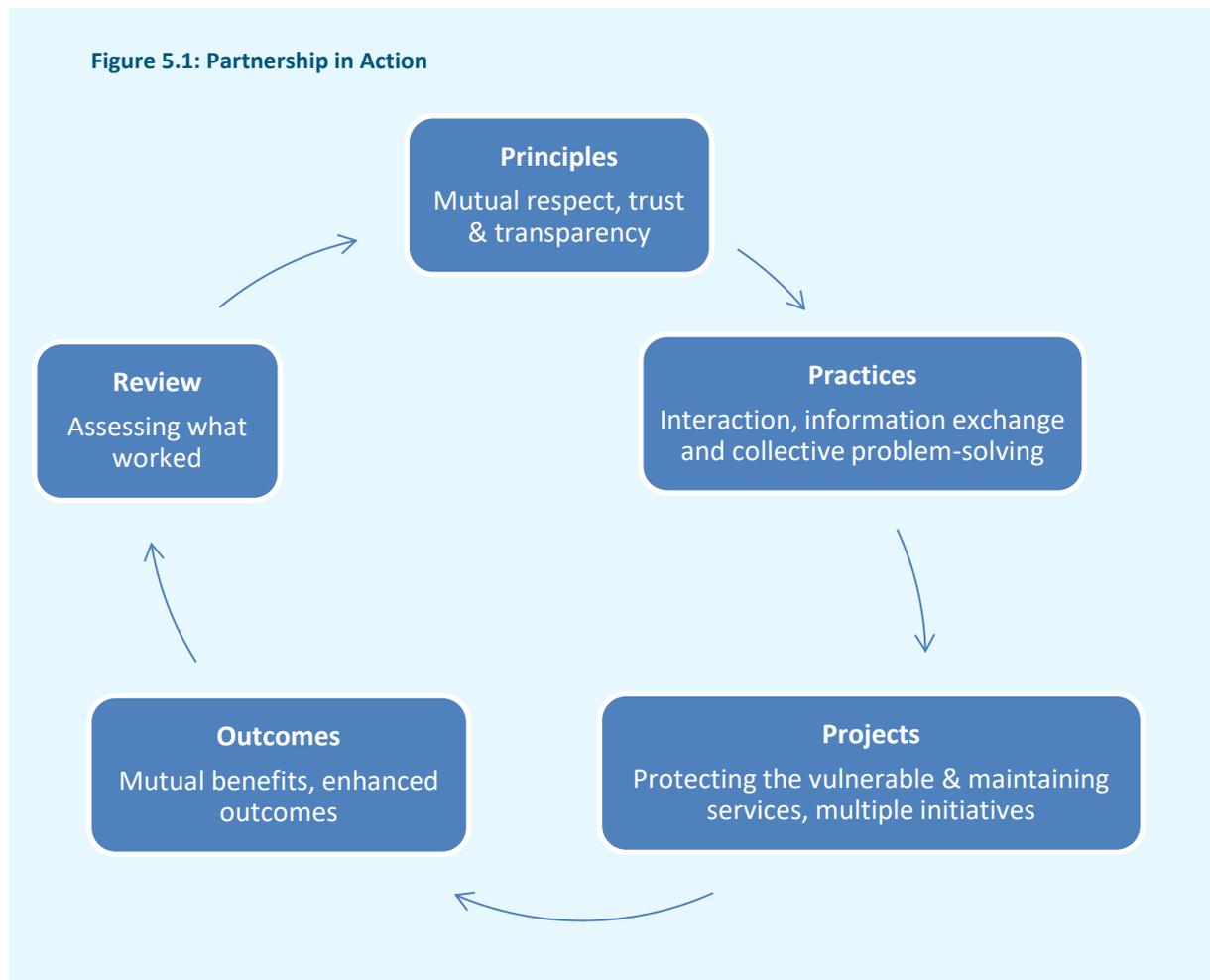
As indicated in Section 4.3, a new partnership-style forum has been (re)established in the disability sector to build on co-operation fostered at the height of the crisis (Appendix A: Box A5). The terms of reference for the rebranded National Consultative Committee were co-produced by the HSE and voluntary organisations, which is viewed as a signal that the former is clearly committed to deepening dialogue and collaboration. 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 consensus that to be effective it must deal with the main issues shaping the future of the disability sector. One senior practitioner described the committee as having the potential to be a space in which difficult but necessary conversations take place (Research interview).

In contrast, the NCCN has been highly critical of what it perceives as a lack of constructive engagement by the State during the crisis. However, meetings have now taken place between senior HSE officials and the NCCN; reflecting on this development, the NCCN has stated:

> *Although early days, the promise of regular interaction between the parties is encouraging. Such a co-operative 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 positive development shows how the emergence of new ways of working in one area can influence and shape others. The momentum for adopting a more constructive relationship appears to have been driven in part by the limitations of the sector's prevailing approach, 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 examples of enhanced co-operation and interaction at the local level, particularly when pre-existing positive relationships were already 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 sustained, deepened and widened. A number of interviewees were concerned about some limited examples of the command-and-control approach returning as the severity of the initial wave of infections waned. It may be difficult to maintain collaboration and solidarity without the absence of a unifying threat. At the same time, as outlined in Section 2.5, there is no shortage of shared problems and challenges for statutory and voluntary organisations to grapple with. The HSE's CEO recently stated:

> 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 (HSE, 2021a).

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 makes it essential that voluntary and statutory organisations work together in a co-operative model, which fully delivers national health and social care strategies and provides enhanced outcomes for service users , while demonstrating compliance with best practice in governance, quality, safety and financial probity. This paper has noted that the way in which accountability and autonomy tended to be viewed as sometimes oppositional forces had strained relations, particularly at national level. As described in Section 4.4, the overarching strategy adopted by the HSE during the crisis 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, combined with greater autonomy at the local level in the scope to deliver organisational change and innovation. Interviewees from all sectors agreed that affording greater autonomy to local actors 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, which recognises that a renewed partnership, underpinned by strong autonomous community and local development structures, enables effective interventions for change that government acting alone could not deliver (Government of Ireland, 2019).

The tight and loose approach is an example of accountable autonomy in action. The HSE has supported this 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 (HSE, 2021a). 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 operationalised, given the considerable diversity in the voluntary sector in terms of size, structure, ethos and types of services provided. The HSE recognises that 'now there is an opportunity, and a need, to move on and to do better'(HSE, 2021b).

There is a genuine commitment on all sides to address this challenge in a partnership-style manner. In this context, Paul Reid's (CEO of the 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 could embed further 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. While Covid-19 did not create the funding crisis, it brought to the surface, quite rapidly, the deep-seated deficits in the prevailing funding model. In the disability sector, many providers feel that the current situation is not sustainable without a fundamental review of the funding of disability 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 (Wall, 2020a). The IRG report (2019) also flagged the lack of a realistic funding model for the provision of services by the sector. Although parking 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 needed for an agreed level of services, and how this relationship can be managed more effectively.

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 to 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 impedes the HSE's capacity to plan and commission services (*ibid.*). Multi-annual funding would also provide the voluntary sector with the certainty needed 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 tight and loose approach, could create a context that is more conducive to a balanced performance-focused dialogue rather than one that is 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 is 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 argued in the previous chapter, the health and social care system needs organisations that are good, robust and resilient rather than thin and stretched (Section 4.12.). Although it is important to be cost-effective, hyper-efficiency can erode the institutional redundancy that agile and resilient organisations rely on in responding to unexpected and uncertain challenges. This raises the question of how this organisational capacity-building will be funded in the future.

It is clear that our ambitions for the population as espoused in various healthcare reports will also require necessary funding by government departments other than the Department of Health such as Transport, Housing and Education.

These issues suggest that it is time for a more open and honest dialogue about the sustainable funding of health and social care services, with 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 co-ordinated and integrated across organisational and professional boundaries.

The onset of the pandemic and the manner in which the healthcare system responded have reinforced the need to ensure that everyone is able to access a range of quality, multi-disciplinary and relevant services and supports. The enhanced levels of collaboration between state and voluntary bodies during the crisis was matched by increased co-operation between organisations in the voluntary sector. This has reinforced a strong collective identity and encouraged a greater focus on enhancing service co-ordination and better harnessing collective resources. It also 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 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, it can be quite a complex environment for service users and their families to engage with. Several interviewees highlighted the need to provide clients with more help in navigating this complex environment. An

unpublished internal HSE document also suggests that in disability services, for example, there is a degree of fragmentation and duplication of organisational delivery models (Wall, 2020b).

A crosscutting theme emerging from this paper is the importance of building and fostering robust and resilient organisations across the health and social care regimes. The crisis has refocused attention on the potential benefits of enhanced co-ordination and harnessing of collective resources and capabilities in the voluntary sector. It has been argued that delivering Sharing 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. There is now, it is suggested, an opportunity to support rationalisation in this sector (Dáil Eireann, 2020b).

Drawing attention to the diversity and multiplicity of organisations is not to suggest that the answer to these challenges will invariably be consolidation on the basis that bigger is somehow better. Any future organisational changes must be undertaken in a way that retains the core strengths 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 giving each of their eight regions the scope to tailor and customise interventions according to local need and requirements.

This suggests the need for a rigorous, informed and inclusive policy dialogue about the types of organisational changes needed to deliver more person-centred, individualised and community-based services. This dialogue should consider the full spectrum of options available to organisations to improve collaboration and partnership working, including informal engagement, memoranda of understanding, 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 difficult but necessary conversations.

5.6   Maintaining the Momentum for Reform and Innovation

As highlighted throughout this paper, the scale of transformative change delivered by statutory and voluntary bodies, in such a limited time and in the midst of a pandemic, has been 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; Dáil Eireann, 2020a: 34)*

A key challenge is how to retain the main lessons and learnings from the Covid-19 experience as the healthcare system moves out of crisis mode, 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, services and behaviours, (Dáil Eireann, 2020c) it also exposed fragilities in 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 (Mental Health Reform, 2020b).

Under its terms of reference, 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. All members of the Forum will be invited to consider how they can best work together to deliver national strategy and reform.

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 (Government of Ireland, 2020).

> *Developed in co-production with people who use services, family members, professionals and providers, this policy is ambitious and expansive.' (Rogan, 2020b)*

The response to Covid-19 arguably shows the green shoots of the type of institutional reform and policy innovation needed to deliver this ambitious and expansive strategy, including:

- the adoption of online modes of service delivery (e-health);

- increased collaboration between the statutory and voluntary sectors;

- better co-operation between voluntary organisations and an increased awareness of the need for a better co-ordination of services and effort;

- the increased focus on well-being and mental health promotion; and

- a greater emphasis on community and primary services.

However, this is only the start, as achieving the goals of Sharing the Vison will require deeper and sustained integration and co-operation (Reynolds, 2020).

It is important to recognise that in healthcare, as in other policy domains, policy design and policy implementation have become increasingly intermeshed. While national strategy documents set the overall policy direction and highlight particular policy objectives and principles, it is often in the implementation phase that policy is worked out in practice and problems are resolved in ways 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 highlighted throughout this paper, a key characteristic of the response to the crisis was the extent to which frontline organisations actively drove service innovation and reform, in a manner that correlated with the 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 (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. Most 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 (Section 4.8.) Given the potential for remote services to enhance organisational capacity and facilitate easier access to services, this trend should be actively championed and adequately resourced. This must be done in conjunction with 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 adopting more individualised, tailored and community-based service planning. A number of interviewees referred to the fact that initiatives that, as one of them put it, 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 (Research interview). There was also a view that, despite the remarkable achievements in protecting service users in residential settings 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 (Inclusion Ireland, 2020b). 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.

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 (Appendix A: Boxes D1 and D4). Although the 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 using the autonomy given them to develop and manage change and, to an extent, their space for autonomous decision-making increased during the crisis. This ensures that they are well positioned to take a lead role in implementing the type of transformational change required to deliver Sláintecare.

While perhaps not enjoying the same level of autonomy as some of the voluntary hospitals, many voluntary organisations in other healthcare sectors have shown they can respond to challenges in an agile, flexible and innovative manner. These attributes should be 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. This reaffirms the importance of investing in the development of good, resilient organisations.

Since the onset of the pandemic, voluntary and statutory service providers have displayed high degrees of responsibility and a willingness to take on autonomous decision-making, with good results. The HSE believes there is now an opportunity to consolidate these gains by assigning a leadership role to certain voluntary organisations in service reform projects focusing on measures of outcome as well as the traditional input/output KPIs (HSE, 2021a).

The HSE will need to afford greater responsibility and autonomy to local managers who have the scope to engage more collaboratively with local service providers. As the CEO of the HSE said 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 (McGee, 2019).*

This emphasis on a bottom-up approach, combined with the opportunity for service providers to take a leadership role in the reform process, will reinforce the deepening interrelationship between policy design and implementation. It also highlights the active role that service providers can potentially play in policy development.

Similarly, there will need to be a continued focus on staff engagement and participation, which 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 shown 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 evident during the crisis needs to be built on, to ensure that reform is informed by trade unions' considerable experience and knowledge. Giving a voice to representative bodies can also 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 a robust consensus among healthcare practitioners and decision-makers that meeting people's health and social care needs is not just a health and social care issue *per se*, but requires a whole-of-government effort. In particular, delivering on the ambitious policy goals in existing disability, eldercare and mental health strategies will require co-ordinated and progressive action across a number of policy areas—including housing, education, employment and welfare, which are the remit of government 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 way in which resources have been collectively garnered to protect the most vulnerable. 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 identifying and reaching out to the most vulnerable in society, the elderly population. Local authorities have been at the vanguard of Community Call which, in addition to those voluntary bodies traditionally working with older people, involved organisations such as An Post, the Garda, 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 can fulfil their potential will require a similar societal effort. A number of interviewees, from both the public and voluntary sectors, suggested that the pandemic reaffirmed the need for a national conversation about how we meet people's health and social care needs, particularly those of the most vulnerable. To an extent, this is already happening with eldercare, given the way the crisis has challenged the prevailing policy and associated funding model.

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

Appendix

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 frontline service providers in 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 matters 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 (Research interviews).*

Disability groups were afforded responsibility for relaying agreed solutions and any relevant supporting information back to their member organisations. Based on this interaction, the sector and the HSE started to produce regular FAQ documents to assist member organisations by providing clear and targeted guidance on specific issues. Among the tricky issues this group addressed were: 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.

Box A2: The Palliative Care Forum—Problem-solving Deliberation

At the beginning of the crisis, the HSE established the Palliative Care Forum, which comprised senior HSE officials and representatives of the main service providers. This group 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, which helped the open exchange of information and enhanced the group's ability to work collectively in devising practical solutions.

> *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 (Research interviews).*

This structured and regular form of engagement gave voluntary groups direct access to the key decision-makers and policy centres in the HSE. This was a valuable resource, which had not been available to service providers. In particular, it gave 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 in the Voluntary Hospice Group (Research interviews).*

Building more collaborative and productive relationships at the centre, along with increased active engagement and involvement in local CHOs, enhanced the responsiveness of individual organisations to addressing challenges in the palliative care sector.

Box A3: The Eldercare Group—Information Exchange and Collective Problem-solving

Early in the crisis an Eldercare Group was set up, consisting of senior HSE officials and representatives of relevant voluntary organisations including Age Action, Alone and Dementia Ireland. This weekly forum's aim was to exchange information, provide updates and agree actions in relation to the eldercare sector. A key feature was the emphasis on the active collection of data and experiences, and the two-way flow of information between various levels and organisations. This enabled the voluntary organisations to bring the main issues arising on the ground to the HSE's attention. 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 weekly the four or five major issues for older people. A senior HSE representative considered the timeliness and quality of the information generated by this process invaluable in identifying problems and facilitating practical solutions (Research interviews).

This regular and structured dialogue had a strong action-orientated focus, which produced tangible benefits for all participants in 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 (Research interviews).*

Box A4: Mental Health Services—a Partnership-Style Approach

The National Office for Suicide Prevention (NOSP) works with a broad range of statutory, non-statutory and community partners engaged in suicide prevention to achieve the outcomes of Connecting for Life 2015–2020 (HSE, undated). Following the outbreak of the crisis, NOSP started a dedicated weekly meeting with agencies working in this area. The HSE 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 co-ordinated approach to the challenges associated with Covid-19, particularly in ensuring continuity in service provision. These now bi-weekly calls enabled the HSE to give stakeholders up-to-date information and guidance on the Government's public health response. Equally, they enabled frontline actors to provide feedback on their experiences and raise concerns directly with senior decision-makers.

A recurring theme at these meetings was the extent to which the collapse in fundraising income in the sector was constraining organisations' capacity to meet commitments in their service-level agreements. Although serious financial challenges continue to exist in the sector, the HSE's commitment to underwrite pre-existing funding arrangements gave organisations the space and 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. This fostered greater trust and co-operation 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 (Rogan, 2020a). The interorganisational interaction has fostered greater awareness of 'what each other is able to do', and is encouraging a greater focus on the need to enhance service co-ordination and better harness collective resources (Dáil Eireann, 2020b). It also revealed how the sector can face major issues when it works together (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 had lacked a clear function and become relatively ineffective. Rebranded as the National Consultative Committee, the aim of this new body is to further deepen dialogue and productive relationships to help address key challenges in the sector. The committee's terms of reference were co-produced by the HSE and voluntary organisations. This is viewed as a signal that the former is clearly committed to deepening dialogue and collaboration. 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 to be broadened to include service providers, family representatives, the HSE and the voice of people with disabilities. This reflects 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' (Research interviews).

The themes the committee will engage with are still being discussed. However there is a consensus that, to be effective, it must deal with the main issues shaping the future of the disability sector. These 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 in the sector;

• rethinking regulation in the sector; and

• how to move from a culture of compliance and inspection to a focus on quality and continuous improvement.

B: Transitioning to Remote Service Provision

Box B1: Enable Ireland—a Digital Transition

In response to the closure and curtailment of face-to-face services, Enable Ireland decided to substantially enhance its use of online and digital technology 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 clients, families and carers at a time of heightened anxiety and uncertainty. As a result of the positive feedback from clients, Enable is planning to retain the Virtual Service Centre as an integral element of its 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 exploited the opportunity presented by the crisis to develop a suite of remote services and supports for adults and children, to replace those temporarily suspended and/or restricted. The CRC Adult Training and Development Centre, for example, put in place a range of accredited and informal online programmes to enable adults with disabilities to maintain their physical and mental health and 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 been delivered to houses, and their families have been provided with additional supports. CRC has signalled its 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 its adult and children clinical services, with the focus shifting to providing virtual support in individual multidisciplinary teams. A number of staff from this service were also redeployed to the HSE during the crisis. However, the CRC has maintained a Clinical Triage Team comprising all of its clinical services—e.g. medical consultants, social work, dietetics, occupational therapy, physiotherapy, psychology and speech and language. They have provided a limited service for cases that cannot be managed virtually, in accordance with Covid-19 safety protocols. Although its centre-based clinics are now opening up again, the CRC intends 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 provides a free professional one-to-one therapeutic service to people in suicidal distress, those who engage in self-harm, and those bereaved by suicide. In response to the Covid-19 public health measures, Pieta transitioned from its well-established face-to-face model of therapeutic support to providing therapy services remotely by phone. Although it already operated a 24/7 crisis helpline, this shift in mode of delivery necessitated an adaptation of the Pieta approach. This represented a major learning challenge for both the organisation and its national network of professional therapists.

A back-office support team developed agreed quality standards, operational protocols, and guidance and training material, as there was a lack of documentation relating to providing phone-based crisis mental health services. This internal material highlighted the differences associated with the provision of phone-based therapy, the types of challenges that might arise, and options for addressing such issues. It is important to stress that this is a crisis service for high-risk individuals, and ensuring the safety of the service user and the wellbeing 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 needed. 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 was able to draw on 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 providing a key service in difficult circumstances, some therapists have highlighted the difficulties of providing crisis-related therapy in their own homes, particularly in being able to maintain emotional boundaries between work and home-life. Pieta is also looking at developing a new online video therapy option, as it sees remote services as playing a key role in complementing face-to-face therapy in a future blended model of service provision.

Box B4: Jigsaw—Providing New Ways to Talk

Following the decision to temporarily suspend its face-to-face counselling services and postpone all of its community work, Jigsaw, the national mental health organisation for young people, immediately put in place phone- and video-based services for individuals already engaging with its clinicians. The organisation then focused on developing a major expansion of its range of online services and supports, as it sought 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 online discussion on mental health themes, moderated by a Jigsaw clinician;

- Ask Jigsaw: a 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

Before 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 groups without support and so decided to move to a digital-based service model. This was a considerable challenge for Grow as it had no experience of providing remote services. However, Grow's sister organisation in Australia did have such experience, and agreed to provide training and expert advice to the organisation's eight area co-ordinators. This upskilling was pivotal to the successful rollout of the initiative, as it helped the area co-ordinators to become more comfortable with this new model of delivery, in addition to providing them with 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. The area co-ordinators decided to establish regular phone contact with these individuals to avoid them becoming isolated and experiencing heightened emotional distress. This was a completely new initiative and, although resource-intensive, it was considered necessary given the need to maintain contact. 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 the people supported on a one-to-one basis are now connecting by phone with the online meetings.

As of mid-August 2020, 67 of the original 130 groups had moved online. This is a turnaround given that before April 2020 the organisation had no remote mental health services. In addition to the existing groups, a number of new virtual peer groups have been established. The composition of these groups shows that this digital-based form of access is enabling Grow to reach a younger cohort of people, which they had been trying to do in recent years with only limited success. Feedback from area co-ordinators is that these new virtual groups are moving faster than the norm, in terms of group bonding and developmental progress. Over the course of the crisis, Grow eventually moved all of its training, community education and workplace education programmes online. While Grow is committed to fully re-establishing its in-person services and programmes, these will operate in tandem with the new digital-based supports, including the online peer-support groups.

The leadership displayed by Grow's area co-ordinators and their management teams has been pivotal to this digital transformation. While the organisation has a clear national strategy with set goals, it recognises the importance of giving each of the regions enough autonomy to be innovative and to tailor and customise services and supports to meet the particular needs of their region.

Box B6: HSE Online Mental Health and Wellbeing Supports

Over the last two years the Department of Health and the HSE have been working together 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: a 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 wellbeing 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 to provide staff with information and advice during the health crisis.

These initiatives are in addition to the existing counselling service that the HSE provides through its employee assistance programme. Additionally, the HSE's website 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, created very difficult scenarios concerning end-of-life situations and funeral services. The voluntary hospice sector not only continued to provide a bereavement service but also mobilised, redesigned and expanded it to meet the changing circumstances. Social workers continue to support individuals and 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's chaplaincy team broadcast a weekly reflection via Facebook to support and connect with families. Finally, an online remembrance service was 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 individuals grappling with mental health issues, has been a discernible feature of the voluntary sector's response to the crisis.

Drawing on its own professional expertise, as well as international and national sources, Jigsaw substantially increased the range of information, guidance and educational content available on its website, in the form of webinars, videos, support articles and online educational courses/modules. It recognises 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.

This material has proven to be popular, as highlighted by the substantial increase in website traffic. Jigsaw is committed to continuing to develop the range and quality of its resources. For example, 9,500 e-learning modules on self-care, mental health literacy and promoting mental health have been downloaded by teachers. Jigsaw has also worked with Education Support Centres Ireland to develop webinars designed to support teachers in transitioning back to school and to assist them in supporting pupils.

Aware has 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 give individuals 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, daycare, family carer support groups, dementia cafes, etc. Care Alliance Ireland (CAI) established an online family carer peer-support group. This online private group is facilitated by volunteers with social work and counselling qualifications and moderation experience, with additional support from 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 peer support;

• encourage the sharing of knowledge and coping strategies; and

• provide opportunities for socialising.

This project had no dedicated funding and its design and implementation consumed between 20-30 per cent of staff time. This invariably impinged on the organisation's capacity to deliver other core commitments for which it receives funding. Its core funders Pobal, the Department of Rural and Community Development and the HSE have been supportive, and gave the CAI autonomy to allocate staffing and financial resources to the project. CAI bid for funding from three other sources, only one of which was successful. 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 participated 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. These include a shared identity; the development and sharing of skills; increased confidence; and improved mental health and well-being. Since 16 March 2020, 1,550 family carers have joined the online group, engagement levels have been extremely high, and it has received positive feedback from participants. CAI contends that the success of this group has depended on carers' confidence and willingness to be open about their role and experiences. This highlights the importance of designing robust and transparent rules and protocols, 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 launched a new online support group for family carers of people with dementia, designed to help alleviate the increasing pressure that family carers are experiencing as a result of the public health restrictions. This initiative aims to establish up to ten individual groups, comprised of approximately 30 people each. Each of these 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, which will also involve advisers and tutors, members can 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 Communities

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

Following the closure of its day centres, Prosper, which provides services and supports to adults with intellectual disabilities in Fingal and Meath, developed a comprehensive communications strategy designed to give a sense of connection and ongoing support to its 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, which 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; and

• a family/carers communication system that will provide immediate information to Prosper clients.

Under this initiative day-service staff have striven to contact Prosper's 700 clients via phone or online technology daily. Around 2,000 calls have been made weekly since March 2020. These regular one-to-one contacts have enabled Prosper to monitor how its clients are coping during an extremely stressful period. It also enables service users and their families/carers to raise concerns directly. The provision of regular up-to-date information and advice to the community complements these one-to-one contacts.

Feedback on this initiative indicates that service users enjoy the one-to-one engagement, and 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 its centre-based services and home-based services, the Irish Wheelchair Association developed a Community Supports Contingency Service relatively quickly. 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 food, activity packs, information on Covid-19 and general conversation, while adhering to social distancing;

- the provision of individual transport to ensure that hospital or other important appointments were kept by individual members;

- the delivery of medication from pharmacies to individual members;

- the use of Microsoft teams on a service-by-service basis, e.g. School leavers/RTU, to promote open sharing of information and peer-to-peer support; and

- in conjunction with its Assisted Living Service, the IWA is continuing to provide in-home personal care and one-to-one support on a priority basis, in accordance with HSE guidelines on PPE usage.

By adopting this new contingency service, the IWA has ensured that 4,000 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 has used daily discussions with service users and formal surveys to review the initiative and, in particular, to ensure that it is fit for purpose in meeting users' needs. A recent survey on service users' preferences indicated that most 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 public health guidance on cocooning for vulnerable groups remained in place for an extended time, ALONE volunteers became acutely aware of the increased number of older people experiencing distress. These included very negative emotions and suicidal ideation when they called the organisation's helpline. The desire to ensure that these high-risk individuals received support and counselling led to the development of a memorandum of understanding with Dublin Samaritans and Samaritans Ireland, given their experience of working on suicide prevention. Under this MOU, ALONE agreed to refer individuals, who contacted them displaying extreme levels of emotional distress, directly to the Samaritans. In this way they could avail of more specialised crisis-based counselling. Up to mid-July 2020 ALONE had referred 25 clients directly to the Samaritans for support.

Box C4: Northside Home Care Services—(Re)Designing and Expanding a Key Service

Before the outbreak of Covid-19, Northside Home Care operated a meals on wheels 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 in terms of nutrition and regular social contact. In response, Northside Home decided to fundamentally redesign and expand its existing service. It moved from providing 1,000 hot meals over a 3–4 day period to providing 2,700 chilled meals over seven days, becoming an essential service for clients. This expansion was facilitated by the recruitment of additional volunteers from the local community, as well as redeployed staff from other local community organisations, in particular Empower and Northside Partnership. Northside Home Care had been thinking about this type of change for a while, based on its experience of flu seasons. The outbreak of Covid-19 provided an opportunity to put its ideas into action. The relative speed with which it was able to manage this major redesign and expansion of an existing service successfully was a reflection of the fact that it had the knowledge, structure and strong linkages in the community to make it happen.

D: A National Response to the Public Health Crisis

Box D1: Cappagh Hospital's 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 become an orthopaedic trauma centre for patients who would normally be treated in major acute settings. This initiative was designed to alleviate the growing pressure that acute hospitals were facing as a result of Covid-19, by freeing up beds, staff and resources. This was a major change for Cappagh 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 co-operation with colleagues in the feeder hospitals. New pathways and algorithms had to be developed. The use of the Siilo App, a secure medical messaging platform, supported the co-ordination 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 by developing a comprehensive operational strategy, designed to deliver this transition in a safe and effective manner. The strategy addressed multiple issues, including 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 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 the crisis ensured that the senior management team had to respond quickly and flexibly to changing circumstances and new information. To an extent it was a case of learning by doing.

Although this transition was challenging, NOHC has a strong culture of innovation, and staff fully engaged with the process. They embraced new ways of working, new rosters and shift patterns, and the acquisition of new skills. The overarching context of Covid-19 created anxiety among staff, and the CEO and senior management team placed a strong emphasis on extensive communication and ensuring a safe working environment, physically and mentally, for staff. A key factor in the successful transition was the interdisciplinary huddles which met each morning to discuss the daily schedule of surgeries, and reconvened in the evening to review performance, with the aim of applying any lessons to support continuous improvement and enhanced clinical outcomes.

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

Source: Lee, 2020; and 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 12 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 homes 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. While the nursing and management staff came from the HSE, most of the other support personnel came from the CRC's clerical and social care and support worker teams.

A number of factors underpinned the success of this redeployment programme:

- The programme was voluntary and the CRC management ensured that different options were available in terms of back-office support functions, as well as more frontline 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 needed in particular settings.

- The CRC stepped up its level of communication and engagement with staff to ensure they were informed of organisational strategy and ongoing developments, including the redeployment programme.

- A debriefing week off for staff between their redeployment and resuming normal work was introduced. This was a way of recognising staff 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 wellbeing and health of staff. 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 reduction in service provision in both Fingal and Meath—including plans to repurpose residential centres and temporarily reallocate them to the HSE—was effectively incorporated in the HSE's regional strategy for responding to Covid-19.

As part of this contingency plan, Prosper collaborated with the Daughters of Charity and the HSE to repurpose a newly acquired residential centre into an emergency centre for people recuperating post Covid-19, or who had a crisis in their home. This service was 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 was 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, it had to ensure that operational practices adhered to social distancing requirements and other Covid-19 related measures. This project, which is one of a number, is indicative of how existing co-operative relations were enhanced during the crisis. 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 its extensive fleet of 117 buses, which normally transported clients to and from day facilities, lying idle. In response, the IWA took the innovative decision to make these buses available to the HSE to enhance its Covid-19 testing capability outside of designated HSE testing centres. Following initial discussions in the weekly national meeting between the HSE and disability groups, the HSE and IWA signed a memorandum of understanding to govern this initiative. Under this arrangement, the IWA's bus fleet was used 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 signed two separate MOUs with the HSE to enable their buildings and carparks in Counties 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, Dublin provides post-acute orthopaedic rehabilitation treatment and an active rehabilitation service for older people. During the crisis, the hospital decided to support acute hospitals in the region by establishing a step-down rehabilitative facility for patients severely affected by Covid-19, using a combination of physiotherapy, occupational therapy and psychological support. Aside from providing patients with quality integrated care, this initiative relieved 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; procuring 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 created a stressful and intensive working environment; 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 rollout of operational plans throughout this change process. The overall project was overseen by a senior management team comprising the leads from the main areas in the hospital. Meeting initially on a daily then weekly basis, the team addressed emerging issues and received 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 hospital's 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, the HSE produced an extensive range of very good policies and procedures, and worked directly with the hospital, which was able to adapt these policies to its particular needs.

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

Throughout the crisis, the HSE and other public health bodies have collated and disseminated a wealth of up-to-date information and guidance to voluntary organisations seeking to protect their staff and vulnerable clients. Given the sheer amount of information and the evolving nature of the advice, some organisations in the disability sector 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 can help service users to understand better the public health information around hand-washing, social distancing, cough etiquette and testing. Cheshire Ireland has tried to assimilate the information and create accessible formats for the people it supports. Chime has 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. A working group was set up to co-produce more appropriate PPE guidelines for the disability sector. This 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.

E: Business Continuity Planning

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

The early establishment of a Covid-19 Response Committee comprising the CEO and senior managers who held appropriate oversight, governance and decision-making capabilities enabled the Rehab Group to respond quickly to the pandemic. This included activating various business continuity plans and designing a Covid-19 Preparedness Plan to guide its 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 a Quality and Governance Team. The remit of the latter involved providing ongoing support and guidance to operations and frontline staff on Covid-19 preparedness, risk management, continuity planning, health and safety, infection prevention, control and isolation, testing, social distancing and compliance with government and HSE protocols.

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

Research Methodology

A series of qualitative interviews were conducted with senior decision-makers in voluntary and statutory organisations in the health and social care sectors. Most interviews took place between 30 June and 17 September 2020. The final report benefited from comments and feedback on earlier drafts from the Dialogue Forum Planning Group, and individual member organisations on the Dialogue Forum. The HSE Senior Management Team also provided a detailed submission that informed the findings of the final report.

Interviews Undertaken

Interviewee	Organisation
Patricia O'Doherty	Director, Voluntary Healthcare Forum
Pat Quinlan	Chair, Voluntary Hospices Group, and CEO, Milford Care Centre
Audrey Houlihan	Vice-Chair, Voluntary Hospices Group, & CEO, Our Lady's Hospice and Care Services, Harold's Cross, Dublin
Michael Fitzgerald	Head of Operations and Service Improvement, Services for Older People, HSE
Susan Cliffe	Deputy Chief Inspector of Social Services—Older Persons, HIQA
Finbarr Colfer	Deputy Chief Inspector—Disability, HIQA
Ivan Cooper	Director of Public Policy, The Wheel
Sarah Monaghan	Campaigns Manager, The Wheel
Paul Reid	CEO, HSE
Kathleen MacLellan	Assistant Secretary, Social Care Division, Department of 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	Clinical Director, Pieta House
Emma Dolan	Pieta House
Rosemary Keogh	Chair, Not-for-Profit Association and CEO, Irish Wheelchair Association
Angel Cullinane	Project Manage (M.CO)
Alison Hartnett	Interim Manager, National Federation of Voluntary Service Providers (NFVSP)
Sean Abbott	Chair, NFVSP and CEO Cope Foundation
Liam O'Sullivan	Executive Director, Care Alliance Ireland
Zoe Hughes	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	Spokesperson, National Community Care Network & Head of Operations, Northside Home Care
Eamonn Dunne	CEO, Northside Home Care
Trevor O'Callaghan	CEO, Dublin Midlands Hospital Group
Dr Trevor Feeley	Clinical Director, Dublin Midlands Hospital Group
Alllen Dunne	Deputy CEO, Disability Federation Ireland (DFI)
Joanne McCarthy	Director of Policy, Advocacy & Engagement (DFI)
Ríona Morris	Policy and Research Officer (DFI)
Robert Murtagh	Advocacy (Policy) Co-ordinator, Inclusion Ireland
Mark O'Connor	Community Engagement Manager, Inclusion Ireland
Michele Kerrigan	CEO, Grow Ireland
Liam Bernie	Industrial Officer (ICTU)—ICTU Voluntary Bodies Group
Aidan Kane	SIPTU—ICTU Voluntary Bodies Group
Damien Ginley	SIPTU—ICTU Voluntary Bodies Group
Catherine Keogh	Fórsa—ICTU Voluntary Bodies Group
William Quigley	Unite—ICTU Voluntary Bodies Group
Albert Murphy	INMO—ICTU Voluntary Bodies Group

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Council Reports					
No.	**Title**	**Year**	**No.**	**Title**	**Year**
1	Report on the Economy in 1973 and the Prospects for 1974	1974	14.	Population Projects 1971-86: The Implications for Social Planning—Dwelling Needs	1976
2	Comments on Capital Taxation Proposals	1974	15.	The Taxation of Farming Profits	1976
3	The Economy in 1974 and Outlook for 1975	1974	16.	Some Aspects of Finance for Owner-Occupied Housing	1976
4	Regional Policy in Ireland: A Review	1975	17.	Statistics for Social Policy	1976
5	Population and Employment Projections: 1971-86	1975	18.	Population Projections 1973-86: The Implications for Education	1976
6	Comments on the OECD Report on Manpower Policy in Ireland	1975	19.	Rural Areas: Social Planning Problems	1976
7.	Jobs and Living Standards: Projects and Implications	1975	20.	The Future of Public Expenditure	1976
8.	An Approach to Social Policy	1975	21.	Report on Public Expenditure	1976
9.	Report on Inflation	1975	22.	Institutional Arrangements for Regional Economic Development	1976
10.	Causes and Effects of Inflation in Ireland	1975	23.	Report on Housing Subsidies	1976
11.	Income Distribution: A Preliminary Report	1975	24.	A Comparative Study of Output, Value-Added and Growth in Irish and Dutch Agriculture	1976
12.	Education Expenditure in Ireland	1976	25.	Towards a Social Report	1977
13.	Economy in 1975 and Prospects for 1976	1975	26	Prelude to Planning	1976

87	A Review of Housing Policy	1989	102	Population Distribution and Economic Development: Trends and Policy Implications	1997
88	Ireland in the European Community: Performance, Prospects and Strategy	1989	103	Private Sector Investment in Ireland	1998
89	A Strategy for the Nineties: Economic Stability and Structural Change	1990	104	Opportunities, Challenges and Capacities for Choice: Overview, Conclusions and Recommendations	1999
90	The Economic and Social Implications of Emigration	1991	105	Opportunities, Challenges and Capacities for Choice	1999
91	Women's Participation in the Irish Labour Market	1992	106	Review of the Property Proofing Process	2001
92	The Impact of reform of the Common Agricultural Policy	1992	107	Benchmarking the Programme for Prosperity and Fairness	2002
93	The Irish Economy in a Comparative Institutional Perspective	1993	108	National Progress Indicators	2002
94	Association between Economic Growth and Employment	1993	109	Achieving Quality Outcomes: The Management of Public Expenditure	2002
95	Education and Training Policies for Economic and Social Development	1993	110	An Investment in Quality: Services, Inclusion and Enterprise, Overview, Conclusions and Recommendations	2002
96	A Strategy for Competiveness, Growth and Employment	1993	111	An Investment in Quality: Services, Inclusion and Enterprise	2003
97	New Approaches to Rural Development	1995	112	Housing in Ireland; Performance and Policy	2004
98	Strategy into the 21st Century: Conclusions and Recommendations	1996	113	The Departmental Welfare State	2005
99	Strategy into 21st Century	1996	114	NESC Strategy 2006: People, Productivity and Purpose	2005
100	Networking for Competitiveness Advantage	1996	115	Migration Policy	2006
101	European Union: Integration and Enlargement	1997	116	Managing Migration in Ireland: A Social and Economic Analysis	2006

147	Climate-Change Policy: Getting the Process Right	2019
148	Transport-Orientated Development: Assessing the Opportunity in Ireland	2019
149	Addressing Employment Vulnerability as Part of a Just Transition in Ireland	2020
150	Housing Policy Actions to Deliver Change	2020
151	The Future of the Irish Social Welfare System: Participation and Protection	2020
152	Grounding the Recovery in Sustainable Development: A Statement from the Council	2021
153	Shared Island: Projects, Progress and Policy Scoping Paper	2021
154	Digital Inclusion in Ireland: Connectivity, Devices & Skills	2021
151	The Future of the Irish Social Welfare System: Participation and Protection	2020
152	Grounding the Recovery in Sustainable Development: A Statement from the Council	2021
153	Shared Island: Projects, Progress and Policy Scoping Paper	2021
154	Digital Inclusion in Ireland: Connectivity, Devices & Skills	2021
155	Ireland's Well-Being Framework: Consultation Report	2021

Secretariat Reports					
No.	Title	Year	No.	Title	Year
1	Ireland's Economic Recovery: An Analysis and Exploration	2011	15	Cost-Benefit Analysis, Environment and Climate Change	3018
2	Understanding PISA and What it Tells us About Educational Standards in Ireland	2012	16	Multistakeholder Agreements in Climate Governance and Energy Transition: The Dutch Energy Agreement	2018
3	Towards a New Climate Change Policy	2012	17	The Framing of Climate Action in Ireland: Strategic Considerations	2019
4	Ireland and the Climate Change Challenge: Connecting 'How Much' with 'How To'. Final Report of the NESC Secretariat	2012	18	Urban Structure, Spatial Planning and Climate Emissions	2019
5	Review of Developments in Banking and Finance	2013	19	The Transition to a Low-Carbon and More Digital Future: Supporting the Needs of Vulnerable Workers and Enterprises	2020
6	Employment and Enterprise Policy	2013	20	Approaches to Transition	2020
7	Greening the Economy: Challenges and Possibilities for Integrating Sustainability into Core Government Policy	2013	21	Shared Island Consultation: Climate and Biodiversity Challenges and Opportunities	2021
8	Activation Policy	2012	22	Community Call: Learning for the Future	2021
9	Consumer Prices	2012	23	Shared Island: Projects, Progress & Policy The Good Jobs Agenda	2021
10	Review of Irish Social and Affordable Housing	2014	24	Housing and Urban Development Policy Priorities	2021
11	Financing of Social Housing in Selected European Countries	2014	25	Shared Island: Projects, Progress & Policy The Island Economy	2021
12	Reflections on Infrastructure Policy and Institutional Developments in the UK	2017	26	Building a New Relationship between Voluntary Organisations and the State in the Health and Social Care Sectors. Paper for the Dialogue Forum with Voluntary Organisations	2021
13	Land Value Capture and Urban Public Transport	2018			
14	International Approaches to Land Use, Housing and Urban Development	2018			

Research Reports					
No.	Title	Year	No.	Title	Year
1	Cluster in Ireland: The Irish Dairy Processing Industry: An Application of Porter's Cluster Analysis	1997	15	Four Case Studies on Just Transition: Issues for Ireland	2020
2	Cluster in Ireland; The Irish Popular Music Industry: An Application of Porter's Cluster Analysis	1997	16	Modelling the Zero-Carbon Transition: International Approaches and Lessons for Ireland	2020
3	Cluster in Ireland: The Irish Indigenous Software Industry: An Application of Porter's Cluster Analysis	1997	17	Energy Transition Pathways and the COVID-19 Pandemic; An analysis of the 'green recovery' responses in Denmark and Ireland	2020
4	Profit Sharing Employee Share, Ownership and Gainsharing: What can they Achieve?	2000	18	The Impacts of COVID-19 in Ethnic Minority and Migrant Groups in Ireland	2021
5	Sustaining Competitiveness Advantage: Proceedings of NESC Seminar	1998	19	Economic Resilience in Sustainable Communities: Innovative Approaches in Public Spending to Maximise Local Benefits	2021
6	Ireland's Child Income Supports: The Case for a New Form of Targeting	2007	20	Challenges and Opportunities for Rural Ireland and the Agricultural Sector	2021
7	State of Play Review of Environmental Policy Integration Literature	2015	21	Gender and COVID-19 in Ireland	2021
8	Socially Integrated Housing and Sustainable Urban Communities: Case Studies from Dublin	2016	22	Building Long-Term Resilient and Sustainable Cities	2021
9	The Burren Life Programme; An Overview	2016			
10	Nature's Values; From Intrinsic to instrumental	2017			
11	Valuing Nature; Perspectives and Issues	2017			
12	Low Work Intensity Households and the Quality of Supportive Services: Detailed Research Report	2018			
13	Advancing the Low-Carbon Transition in Irish Transport	2019			
14	Transport-Orientated Development: Assessing Opportunity for Ireland Background Case Studies	2019			

An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta
National Economic & Social Council