

Sláintecare Implementation Advisory Council (SIAC) Meeting

Note of meeting #9

30 March 2021, 3pm – 4:30pm, via Zoom

Attendees

Tom Keane (Chairperson)

Laura Magahy (Executive Director, Sláintecare)

Council members present: Paddy Broe, Sarah O’ Connor, Liam Doran, Ronan Fawsitt, Siobhán Kennelly, Anna McHugh, Gillian O’Brien, Josep Figueras, Eddie Molloy, Mary Higgins, Brendan Courtney, Róisín Molloy and Anthony O’Connor

Apologies: Annette Kennedy, Heather Shearer, Emily O’Connor, Joanne Shear, Brian Fitzgerald and Colm Henry

Invited Participants: Sarah Treleaven, Sarah Gibney, Síne Nic An Ailí, Tiago McCarthy, Ingrid Doyle and Clara Lindenberg, Department of Health, joined for Item 3: Regional Health Areas.

Secretariat: Bob Patterson, Suzanne Lynch

The meeting was held virtually via zoom due to ongoing COVID-19 restrictions.

1. Minutes and Matters Arising

The Chairperson welcomed everyone to the ninth Sláintecare Implementation Advisory Council meeting. Minutes from the previous meeting of 16 December had been circulated in advance. A query was raised as to whether it had been agreed that SIAC would write to the Minister for Health stressing the importance of recruitment and retention of staff in the health service. It was noted that this issue is brought to the attention of the Minister as a matter of course and had been included in the Letter of Approval of the NSP. It was also noted that the view of the Council should be on the record and that a letter would issue to the Minister. The Minutes were deemed adopted, and these will be posted on the website.

The Chairperson outlined that the meeting would start with an update from the Executive Director on progress with Sláintecare implementation followed by a SIAC discussion Regional Health Areas (RHAs). He noted that he had wished to have a discussion on clinical governance at this meeting of SIAC but that time was insufficient and that he would propose to have this discussion at the next meeting.

2. Sláintecare Implementation Strategy and Action Plan 2021-2023

Laura Magahy presented the draft Sláintecare Implementation Strategy & Action Plan 2021-2023 to the Council noting that it was anticipated that it would be approved soon after the Easter recess. Noting that the continued relevance of the 8 Sláintecare principles set out in the 2017 Sláintecare Report, she briefed the Council on the two new Reform Programmes: *Improving Safe, Timely Access to Care & Promoting Health and Wellbeing* and *Addressing Health Inequalities – towards Universal Healthcare*.

She set out details of the 11 projects (7 in Reform Programme 1 and 4 in Reform Programme 2), as well as the continuing stakeholder engagement programme, noting that some represented a continuation of existing work programmes.

Under Reform Programme 1, LM outlined the three workstreams of *Project 1: Implement the Health Capacity Review*. The Healthy Living Pillar was well advanced, with the Healthy Ireland Strategic Action Plan ready to go to Government after the Easter recess. Progress was being made with Healthy Homes, with agreement with Age Friendly Ireland and the appointment of coordinators in every county ready to be announced shortly. On Enhanced Community Care, she referenced the 96 Community Healthcare Networks (CHNs) coming on stream, building on the 9 Learning Networks and that there was a commitment to fully resource these CHNs in 2021 and 2022.

On *Project 2: Scale and Mainstream Integration Innovation* it was noted that the current projects are being evaluated for scaling and mainstreaming. The second phase will see a slight shift in focus to projects enabling safer, integrated care between settings. She noted the establishment of a new ICGP Research Hub supported by the Integration Innovation Funds.

Project 3: Streamline Care Pathways, from prevention to discharge aims to develop integrated care to drive streamlined integration between care settings at a national, regional and local level. A number of examples were provided.

Progress is continuing with *Project 4: Develop Elective Ambulatory Centres*. A Strategic Assessment Report for the 3/4 Elective Ambulatory Care Centres has been completed and approved and a Preliminary Business Case is anticipated to be ready for submission to Government in the next two months. Work on site selection will begin in next two weeks. Consultation is ongoing with Hospital Groups and other key stakeholders.

Project 5: Implement Multi Annual Waiting List Plan aims to achieve the Sláintecare Report waiting list targets. This project will work with the Department of Health, HSE and NTPF and use a LEAN (Leadership, Eliminate waste, Act now, Never ending) approach to reducing waiting lists.

A detailed briefing on *Project 6: Implement eHealth Programme* had been given at the last meeting of the Council.

With regard to *Project 7: Removing Private Care from Public Hospitals* - introducing the Sláintecare Consultant Contract, it was noted that the contract had been agreed by government and that it was expected that it would be rolled out by Government in the short term.

Under Reform Programme 2, Project 1: Citizen Care Masterplan, LM set out the six workstreams of Population profiling and segmentation, population needs assessment and service redesign, development of a Population Based Resource Allocation Funding Model (PBRA), policy proposals and options for achieving universal eligibility, workforce planning and capital planning.

Setting out Project 2: Implement Healthy Communities Programme nationwide, LM noted that 22.5% of the population were exposed to disadvantage. The Healthy Communities was a cross-governmental programme with 12 Government Departments and 12 local authorities signed up. 18 areas were targeted for investment in 2021.

As Project 3: Regional Health Areas was for discussion under Item 3, this was not elaborated.

Project 4: Implement Obesity Policy and Action Plan 2016-2025 had been included as there were clear links between obesity and disadvantage. The Obesity Policy sets out key steps and an agreed set of actions to target obesity.

Following the presentation, the floor was opened for questions and comments. Very positive views were expressed by all speakers. It was noted that the Sláintecare vision was being embedded. The importance of eHealth as a key enabler of Sláintecare was noted. LM noted that the HSE was the primary implementer of the eHealth programme. The eDischarge project was making progress and a meeting on it was planned for the following day (31 March). The emphasis on tackling disadvantage was highlighted and welcomed. The need in particular to tackle disadvantage in traveller, racial and ethnic minority groups was particularly highlighted.

3. Regional Health Areas

The Council received a presentation from Sarah Treleaven of the Sláintecare Programme Implementation Office on the development of a business case for the Regional Health Areas. The session in particular, focussed on the Evaluation Criteria with which a regionalisation model would be selected.

ST set out the background to the RHA project. The impetus has come from the 2017 Oireachtas Sláintecare Report and the proposal to create new regions had been included in the Sláintecare Implementation Strategy. A Government Decision was made in July 2019 on the geographies of the six new RHAs and calling for a business case and change management process to implement the new RHAs. The 2020 Programme for Government reaffirmed the commitment to the RHAs as do the HSE Corporate Plan and new Sláintecare Implementation Strategy & Action Plan 2021-2023.

It was noted that the vision for the Regional Health Areas is to create a structure for the health and social care service that streamlines clinical and corporate governance and enables better performance assessment of the health service. It will support population-based service planning, integration of community and acute care and empower local decision-making.

ST then set the scope of the proposed business case, which would include a roadmap to new systems and structures within the agreed geographies, address new clinical and corporate governance, accountability and reporting lines and high-level cost-analysis. It was not proposed to address already settled issues such as the geographies or regionalisation as a concept, nor would it have full costing of transition or include a fully developed implementation and delivery strategy.

ST advised that at present, three possible models are in development: (1) As is or no change, (2) Administrative, and (3) Legislative. These models are being developed with input from clinicians, HSE, Departments of Health and Public Expenditure and Reform (DPER), as well as and patient representatives. These are not definitive and are subject to change.

The models will be assessed against the agreed Evaluation Criteria to facilitate the selection of a preferred model for decision by Government. The criteria have been developed with input from Department of Health, DPER and the Irish Government Economic Evaluation Service (IGEES) and input was now being sought from SIAC.

4 possible criteria were being put forward for consideration, namely:

1. Governance and Safe Care
2. Population-based Funding & Service Planning and Service Delivery
3. Value-based Health and Social Care Delivery, and
4. Feasibility of Implementation

The Council then divided into three breakout rooms to discuss and provide feedback on the criteria.

Following the breakout sessions, the facilitators of each group reported on the outcomes and there was a wider discussion.

Breakout Room 1 considered the issues of ***Governance and Safe Care***. There was a discussion at the outset around clearly defining whether governance referred to clinical and/or corporate governance and the need to articulate that more clearly. The group also noted the need for an evidence and data-based dimension for safe care to be included to facilitate decision-making. The room also discussed the issue of “culture” of accountability and patient safety and the need to move from a challenging to a constructive culture. The need to clearly define roles and responsibilities across the health service and its various entities was emphasised. The question of national consistency, and retaining that in a regionalisation model, was also discussed. Points were also raised regarding the interface of governance and safe care with delivery of a high-quality care and how regionalisation could facilitate the integration of acute and community services.

Breakout Room 2 focussed on ***Population-based Funding & Service Planning and Service Delivery***. There was a discussion about including flexibility or agility in the health service as part of the criteria. The balance between self-sufficiency/autonomy at the local level and feeding into services provided at the national level was highlighted. The need for a dimension of the criteria to feature equity of access was also noted.

Breakout Room 3 considered both ***Value-based Health and Social Care Delivery*** and ***Feasibility of Implementation***. On the former, discussions centred around efficiency, health outcomes and experience of care. The room felt that the patient-centred component wasn't strong enough. The timing and place of healthcare was important. Reducing duplication and efficiency was not only about financial costs but also about outcomes and effectiveness. On feasibility, there was a discussion around the healthcare professional experience and local pathways of referral, ensuring that we are integrating needs assessment and integrated care to reduce unnecessary referrals. The need to ensure that there is an understanding of the history of the move to regionalisation and buy-in from the Hospital Groups. The question of safety, training and recruitment in relation to Level 3 and smaller hospitals was also raised, as were the connections between the RHA process and other reforms such as tackling waiting lists or ambulatory care. The group also noted that consideration should be given to whether legislation would be required and possible disruption during and costs of transition. The need for the structure to have relevant and required information to allow it to work successfully was also highlighted.

A number of issues were highlighted in the ensuing discussion. A number of contributors emphasised the need to ensure proper clinical governance. Existing gaps in governance, including the lack of managerial accountability and the need to tackle the challenge of conflict between corporate and clinical management with respect to resource allocation and maintaining safe care were raised. The work of Professor Blainaid Clarke, Chair of Corporate Law in TCD, on financial

instruments used in financial services, such as the Senior Managers' Regime and Statement of Responsibilities, which help to clarify where responsibility lies was referenced as potentially useful. The Chair noted that these points highlighted the need for a detailed discussion of clinical governance at SIAC and to develop an understanding of what the Sláintecare objectives are for clinical governance. He intended to put this item on the agenda of the next meeting.

The SIAC feedback will now be incorporated into the Evaluation Criteria and recirculated to SIAC for review and agreement. It was hoped that this could be done within 2-3 days with a week for members for review. In parallel, work on the models will continue. The two streams will then come together with a multi-stakeholder expert panel assessing the models on the basis of the agreed criteria. Stakeholder engagement will continue.

The Chair asked members of the Council to reflect on whether all Evaluation Criteria should be equally weighted. It was agreed that when circulating the updated criteria, a question on weighting would be posed to the group via email.

4. Date of Next Meeting and AOB

No date was set for the next meeting; the Chair noted, however, that given ongoing work, consideration would be given to an earlier date to meet.