



## **Minister for Health confirms restructuring of health services and delivers key Sláintecare commitment**

### **Questions & Answers**

#### **Q. What are we announcing today?**

The Government is announcing a radical reform in the delivery of healthcare today. At the moment, healthcare provided in the community is planned and delivered separately than that in the hospital setting. This clearly does not work. Today, we are embarking on a significant project to change that, leading to the establishment of six new health regions, which will be responsible for planning and delivering health and social care in their regions. The HSE will continue to be the central executive with responsibility for planning and strategy. Health regions will have greater autonomy to make decisions at a local level.

#### **Q: What will these changes mean in practice?**

These regional bodies will have clearly defined populations and can plan, resource and deliver health and social care services for the needs of its population. It will result in improved accountability and governance in terms of finance and performance. It will also empower frontline staff and allow for the devolvement of decision-making power from the HSE to each local region.

#### **Q: Why are these changes happening now?**

Our health needs are changing. They are more complex, and services are currently not aligned to match those complex care needs. The Oireachtas Committee on the Future of Healthcare recommended this direction and today, we are announcing our intention to proceed with these plans. This will have several immediate impacts. It will provide clarity on the future shape of the system. It will also ensure that other Sláintecare reforms including the implementation of more integrated care pathways and the planning of hospital and community beds are designed around the new geographies as early as possible.

It is important that the intended regions are clarified now in order that these provide a framework for both service planning and organisation design.

#### **Q: Will this mean less staff in the HSE?**

The Current operation of the HSE will continue while a process of collaborative design of the new regional bodies progresses over the coming months. It is important that existing services continue to ensure that our citizens can continue to access and receive health and social care services. The Oireachtas Committee on the Future of Healthcare recommended that the HSE should be a more strategic “national centre” carrying out national level functions, with regional bodies designed on the basis of optimum organisation and regional health resource allocation. Further proposals on the precise details of how this will work in practice will be presented to Government as part of the development and change management process.

**Q: So there won't be more managers?**

No. This will involve a more streamlined national centre and a sharing of expertise. It will also avoid duplication of personnel and support functions between CHOs and Hospital Groups.

**Q. Will there be disruption to delivery of healthcare?**

No, current delivery of healthcare will continue. While giving the community health sector and the hospital sector the same boundaries will not affect patients and staff in the short term, it is a key building block towards the creation of regional care organisations which will enable a better planned and more fairly funded system.

Existing academic links between universities and service providers will also not be affected.

**Q. How will these changes benefit patients/citizens?**

The six health regions will ensure that services are more joined up as well as locally planned and delivered. This will make it easier for citizens to access services; it will make services easier to navigate; and it will ensure that more services are available closer to home.

They will also, in time, provide a basis for equitable funding of services throughout the country. This will aid the management of the health budget.

**Q. Do the health regions mean that you are removing choice for patients? Will they be forced to attend their local hospitals for care rather than make decisions based on quality?**

No. The health regions simply allow for the devolved planning and delivery of health and social care on a local basis, based on the need of that region's population. Patients will not be restricted from attending hospitals around the country.

**Q: What will happen next?**

Immediately, we will begin the process of engaging with stakeholders across the system, including the public and health staff. This will be a key pillar of the development process. At the same time, interim processes for greater collaboration and integrated performance management across hospitals and community will be put in place by the HSE.

## **Q. What will happen to current Community Healthcare Organisation (CHO) and Hospital Group structures?**

The Sláintecare Report called for the establishment of regional bodies based on the alignment of current CHO and Hospital Group structures. It is important to acknowledge the good work done by CHOs and Hospital Groups to date. The process of aligning boundaries and development of regional organisations will build on this good work. The Sláintecare team will work with the HSE and current CHOs and Hospital Groups in the planning of services and organisational structures at regional level and in the interim to put in place processes for improved collaboration and integrated performance management at a regional level.

## **Q. How does this fit with the Sláintecare reform programme?**

At the heart of Sláintecare is development of a more population-based and integrated approach to service planning and care delivery which will facilitate “the right care, in the right place, at the right time, by the right person”. This will have positive implications for patient experience, health outcomes and health system sustainability.

Sláintecare is about understanding our population’s health needs and delivering the most appropriate care for these needs. This alignment of boundaries will allow us to begin building this understanding. Accurately planning services around the needs of people in defined areas will also allow us to fund the system on the basis of population needs.

This decision is only one part of a much broader reform programme. Sláintecare is not just about reforming structures but reform of structures is an important early step in the reform process.

## **Q. What was the basis for determining these regional areas?**

These boundaries were decided following detailed analysis of patient service usage patterns across the country. This analysis examined patient flows to establish the extent to which hospitals in a given region are serving patients who live in that region. The regions are designed to be as self-contained as possible across the country.

This is critically important if we are to move to a population-based planning and funding model. A number of pieces of research, analysis and consultation were undertaken to support the identification of the optimal boundaries of the new regions.

This included a review of approaches taken internationally, a review of national policy documents on health reform and previous criteria used in determining regional health bodies, a public consultation process and a detailed analysis of service usage patterns.

A range of criteria were also considered including; 1) patient flow/self-containment as mentioned above, 2) critical mass, 3) span of control/manageability, 4) alignment with other Government services, 5) relatability, 6) distance between health services and, 7) academic links.

### **Q. What kind of consultation have you done on the structures of the health service?**

As recommended by the report of the Oireachtas Committee on the Future of Healthcare (the Sláintecare Report), the Department of Health carried out a public consultation on geographical alignment (available: [www.health.gov.ie](http://www.health.gov.ie)) and also further detailed analysis.

The consultation process found that a large majority of respondents are in favour of alignment. The Department's detailed analysis work concluded that the six new geographical regions represent the least change and disruption necessary to achieve optimal alignment of health and social care services at regional level. The Department of Health also consulted with the European Observatory on Health Systems and Policies to learn from the reorganisation of health services in other countries.

### **Q. How much will this cost?**

There is no cost expected for this initial step in the process. The establishment of new regional bodies, in due course, will require an organisational change programme which will require investment. The quantification of these costs will form a key component of the detailed plans, the process for which will commence immediately. These plans will be approved by Government.

### **Q. Who is responsible for making these changes?**

The Department of Health and the HSE will work closely together to design, structure and establish the six new health regions. The Sláintecare Implementation Office has been established so there is dedicated change management expertise available to direct this process. The Sláintecare Implementation Advisory Committee, chaired by Professor Tom Keane, is also providing advice throughout the change management process.

### **Q. Is this not just Health Boards all over again?**

There will be six health regions, there were eleven health boards. While the regions will have devolved responsibility for decision making, they will operate within a national framework, including national policies and strategies, such as the National Trauma Strategy<sup>1</sup> and the National Cancer Strategy and national organisation of certain services such as our screening programmes and ambulance services.

The regions will have a "one budget, one system" approach; improved accountability and governance; equitable resource allocation; and increased clinical governance compliance requirements. They will also be complemented by a lean HSE that will retain responsibility for national services, strategic planning, national systems (e.g. ICT, financial, etc) and ensuring equity and standards are maintained across regions.

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<sup>1</sup> A Trauma System for Ireland: Report of the Trauma Steering Group (2018)

**Q. Why is this plan better than previous restructurings of the health service (e.g. HSE establishment in 2004/5 and the establishment of Hospital Groups and Community Healthcare Organisations in 2013/4)?**

The establishment of the HSE led to an overly centralised command and control model. While the establishment of the HSE corrected some issues in the health system, the centralisation went much further than originally planned. This over-centralisation has made planning and financial accountability at a regional level difficult.

The introduction of the Hospital Groups (2013) and the CHOs (2014) sought to correct this and devolve more decision-making and autonomy to regional and local service delivery, but these entities were not aligned geographically. While the CHOs have defined geographical boundaries, Hospital Groups do not and this inhibits population based health planning. It is clear that to move to regional population-based health planning, alignment of these structures is necessary both to give clarity to staff working in the health system, to service users/patients and also to provide for clear financial and performance accountability.

The lack of geographical alignment between Hospital Groups (HGs) and Community Healthcare Organisation (CHOs) creates an impediment for the health system to deliver on its integrated care objectives. The new health regions will be responsible for the delivery of most primary, acute and social care in their region with a single budget. This will allow regions to plan, fund and monitor their own health services and also allows regions to deliver integrated care in the most effective manner for their region.

The development of an effective implementation structure for this reform is an integral part of this programme to ensure that clear, tangible health outcomes are achieved for the population of each region.

**Q. Would it not be easier to redraw the boundaries of the CHOs and maintain the existing hospital groups (HGs)?**

No; the majority of health and social care services<sup>2</sup> are provided outside of hospitals and delivered locally, closer to people's homes. The nine CHOs have clearly identified catchment areas, whereas most of the Hospital Groups do not. Redrawing CHO boundaries to fit unclear hospital catchment areas would have proven disruptive.

New Community Healthcare Networks (CHNs) are being developed to support the move toward primary care and community-based service provision. These geographical based units will provide a framework for local integrated care within the regional organisation of services, delivering primary and community services to an average population of 50,000 people. They will support and strengthen multi-disciplinary team working and bring decision making closer to the point of care, ensuring that services are targeted and coordinated based on the identified needs of the local community. It is intended that there will be 96 networks across the country, and work is already underway to establish nine learning sites to inform the implementation of the CHN model.

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<sup>2</sup> E.g. disability services, community Mental Health, palliative, health and wellbeing, social inclusion, screening, vaccination

In addition, the proposed regions are primarily based on county and local authority boundaries<sup>3</sup> as far as possible<sup>4</sup> which supports cross-sectoral cooperation. The CHOs already map to county boundaries in almost all cases, so as to underline local identity and instil a sense of community involvement and ownership. Given the importance of 'health in all policies' and the increasing value of cooperation with other government services at regional level, attention was paid to the potential for supporting cooperation across sectors and the identification of regions for which national statistical information is available to support national and regional planning.

Furthermore, as noted in *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group*, the ability of a service users to relate their healthcare delivery mechanisms is important. Aligning around current (sometimes non-contiguous) structures has the capacity to cause confusion for those trying to access services and therefore, it is hoped to avoid this.

**Q. There has been no mention of the new children's hospital with regard to these regions - why?**

The Children's Hospital Group, as it was previously called, is now Children's Health Ireland. Together with its paediatric satellite centres, the new national children's hospital at the St James' site, will operate as a national and in fact all-Ireland service, not a regional one and therefore is not a part of any of these regions. However, acute paediatric services are available in each of the new areas, as well as nationally through Children's Health Ireland.

**Q. How will the accountability/governance line be formally amended for those CHOs and HGs that are realigning on an interim basis?**

One of the aims of this decision is to improve accountability and governance within our health system. That does not mean immediate changes to Community Healthcare Organisations or Hospital Groups in advance of the further work which is now being initiated.

**Q. Will this have an impact on waiting lists?**

We know that the acute hospital system is currently operating under significant pressure, a situation that will become more challenging as our population ages. The Health Service Capacity Review has highlighted the need for some 2,600 additional hospital beds over the next 15 years. Expanding capacity, however, is only part of the answer. System improvements are also key.

A more integrated system will enable more services to be provided in the community, as well as in hospitals. Alongside that, existing hospital services need to be planned and managed in a more coherent way to make the best use of available resources and to ensure the delivery of high-quality, safe care. The new model will support and enable

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<sup>3</sup> Local Authorities, Child & Family Agency (Túsla), Education, Housing, An Garda Síochána, Local Voluntary Organisations, etc

<sup>4</sup> Any necessary deviation from county boundaries (in Dublin, Wicklow and Tipperary) was done in favour of current boundaries associated with the delivery of community services.

these reforms and will contribute to tackling some of the capacity pressures the system faces today.

**Q. Has it not been shown before that structural change does not improve patient outcomes?**

We know that changing structures alone is not a panacea for problems in the health service. This realignment is one of the first steps in a 10-year journey. The delivery of Sláintecare reforms supported by more appropriate health structures and accompanied by improvements in capacity will enable significant improvement in planning and delivery of health and social care services. Ultimately, the health regions will be a critical enabler of better outcomes and a more sustainable health service.

Also, it would not be appropriate for the Government to invest in new capacity and make tangible reforms to our model of healthcare delivery as outlined in the Sláintecare Implementation Strategy, the NDP and the Capacity Review, when the underlying delivery structures do not align.

**Q. What does this mean for staff of the health service?**

Staff have indicated that the current healthcare delivery structure of seven Hospital Groups and nine Community Healthcare Organisations is not fit for purpose and hinders the delivery of fully integrated healthcare.

The creation of the six health regions will enable and empower staff to provide patients with care that is integrated, locally planned and delivered.

**Q. Does this proposal mean staff redundancies and/or redundancy schemes?**

The early work of engagement with stakeholders is focused on building an integrated service regionally. No decision has been made in terms of the output of this work, nor the final structure of regional care organisations.

**Q. What does this mean for the HSE?**

Alongside this new model of six health regions which are aligned geographically, and that take a population-based approach to the planning of health and social care services, the HSE will evolve to form a national centre with responsibility for national planning and strategy.

The HSE has recognised the need for a better balance between national and regional authority and that is why since 2013, much progress has been made in developing regional structures of Hospitals Groups and Community Healthcare Organisations.

However, the fact that Hospital Groups and Community Healthcare Organisations are not geographically aligned impedes the kind of integrated planning and care delivery that underpins the Sláintecare vision.

**Q. What about the impact on links between hospitals and their neighbouring GPs?**

Existing links between hospitals and their neighbouring GPs will continue and not be affected. There will be no restriction on GPs in terms of onward referral to hospitals.

**Q. What about the impact on service collaborations between hospitals?**

Collaborations between hospitals will not be affected. There is no intention for any geographical realignment to adversely impact existing clinical service collaborations. Any changes would have to be informed by the future approach to the planning of services in a health region.

**Q. What does this mean for Voluntary Organisations?**

Voluntary Organisations will be involved in the service planning development of the six health regions.

The valuable role that voluntary organisations play has been acknowledged by the Minister and he has committed to better dialogue especially on policy initiatives such as a new forum. Additionally, the proposals to develop a population approach to health service planning and delivery on a regional basis are in line with recommendations of the Day Report<sup>5</sup> and should have benefits for providers as well as patients.

**Q. Why are you in a process of appointing new Hospital Group CEOs when you are about to embark on this structural change?**

These changes will not happen overnight and the existing Hospital Groups and CHO CEOs have an important job to continue to deliver services within budget. We will now begin a process of collaboratively designing the precise remit, structure, organisational design and operational model of six health regions with stakeholders.

We need to work closely together to get these changes right, and therefore it is only right and proper that we fill gaps in Hospital Group and CHO senior management teams where they exist, while we plan the new regions in parallel.

**Q. How will the six health regions help to control health expenditure?**

Building on the work done to date on implementing and expanding activity based funding in the acute setting, the six health regions will, in time, have a population-based funding model to compliment the population-based service planning approach. Funding for regions will be determined by a population-based resource allocation formula which will take into account a variety of demographic and geographical factors. This will provide for equitable and transparent funding allocation throughout the country as well as providing greater clarity and oversight of expenditure.

The six regions will be informed by, and enablers of, the financial reforms outlined in the Sláintecare Action Plan.

**Q. What about the impact on academic links?**

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<sup>5</sup> Report of the Independent Review Group established to examine the role of voluntary organisations in publicly funded health and personal social services (2018). Available [www.health.gov.ie](http://www.health.gov.ie).

Academic links between academic partners and hospitals, hospital groups and CHOs will remain. It should be and is possible for a Hospital Group to have more than one academic partner for research and education purposes, subject to any specific arrangements in place for the organisation of training, such as Intern Training Networks. Where existing partnerships are in place which benefit patients, there should be sufficient flexibility around these.

Under Sláintecare, there will be an additional focus on these academic links in terms of broadening their coverage to include more emphasis on the non-acute areas, especially with regard to research and innovation.