An Roinn Sláinte
Department of Health

Voluntary Dialogue Forum

Ceantair Sláinte Réigiúnacha

Regional Health Areas (RHAs)

12 September 2022

Output Pack

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Department of Health

Question 1:

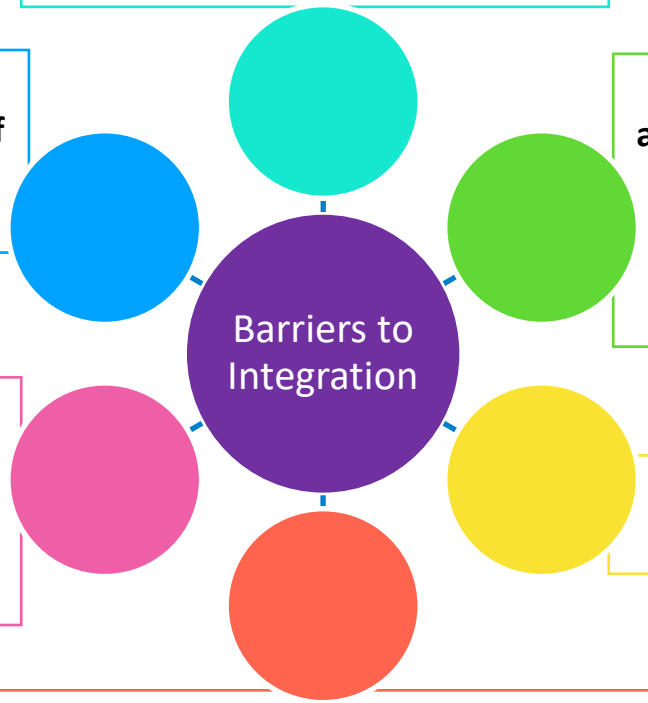
What examples of integration across acute, community, and/or primary care services is your organisation already involved in?

What can we learn from voluntary organisations' successful integrated care initiatives and current governance structures?

Question 1.1: Barriers to Integration

Structural barriers exist that prevent integration.

Vertical siloes created by directorates prevent integrated care through aspects such as **protection of resources**, **agenda setting**, and **fragmentation of the patient journey** between different settings.



Current fragmentation and absence of integration and relationships between relevant leads across the HSE and CHOs has implications for information sharing. Further, the **lack of interaction between CHOs** translates to a lack of standardisation of processes and procedures nationally.

A balance must be struck between **expectations for RHAs and RHA capability**. **Accountable autonomy** can assist this by assigning all included parties the responsibility for delivering what they sign up to deliver.

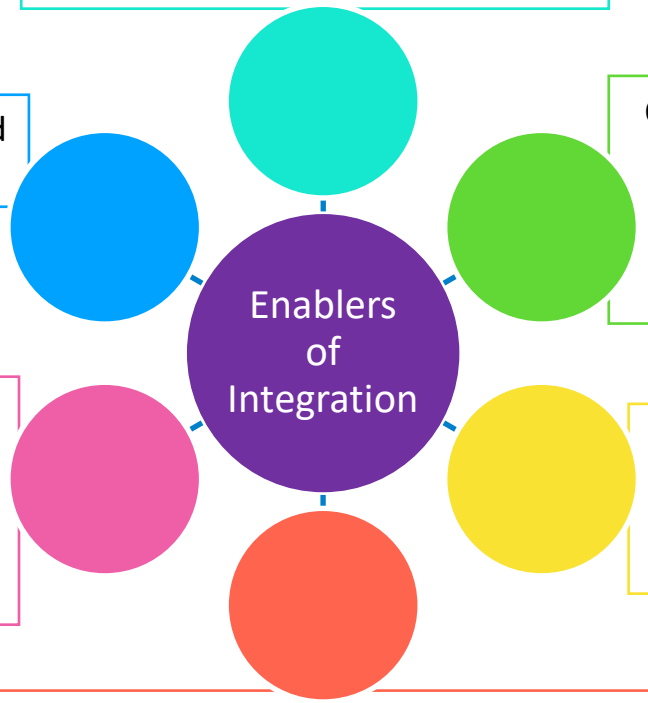
The '**Pilot trap**' – not progressing programmes past the Pilot stage.

Current policies and funding models are not facilitating integrated care across care groups – it is important to establish why this is, to identify the roles of all different entities to address this. The Department of Health will need to change as siloes start at the top – **preventing care group funding allocations**, **succeeding with population-based resource allocation (PBRA)** and **facilitating strong leadership** and a **culture transition to one of collaboration and teamwork** will be essential to this.

Question 1.2: Lessons and Enablers of Integration

Integration Forums work well.

Local Needs Assessments need to be perfected and Voluntary Organisations should be involved in this.



Outcome based funding has potential for delivering integrated care. However, defining what outcome-based funding means will be a challenge. Proper definitions of desired outcomes are essential to prevent historical mistakes.

Data sharing across resources will be essential to enable the allocation of services for the patient. However, this must not be hindered by KPIs – RHA leadership teams need to have the data to sufficiently operate across services.

COVID-19 waived **structural barriers** as outlooks shifted from evaluative 'yes/no' to explorative 'how'.

Some specialties have **clear, integrated pathways between the acute sector and primary care**, e.g., ICPOP; these **integration models should be replicated**. Other collaborative agreements, for example that between local authorities and the Department of Housing (PROSPER), may also be useful.

Question 1.3: Identified Risks to Integration

- There is a risk that **further barriers** may be set up for RHAs e.g., through **restrictive governance arrangements** or lack of **accountable authority**. RHAs must be able to drive and facilitate operations rather than be controlled, to have the freedom to deliver the change process.

- Following COVID, there is a risk of **regression/entrenchment** that needs to be addressed.

- There is a risk that RHA directors may **crowd out smaller players**, and that **some personalities may dominate** in a management structure. Therefore, **building relationships** both internally in an RHA and across organisations will be important for inclusivity.

- There is a risk that **existing cultures of services** will not be suitable post RHA implementation. It will important to **build up new cultures and promote responsibility** with a good culture – this will enable people to see through each other's lenses.

- There is a risk that **current structural pitfalls will persist**, leading to the protection of funds within care groups instead of **collaboration focused on the person/person centred approach** – therefore, careful consideration will be needed to prevent this.

Question 1.4: Important Considerations

RHA Structures

- RHA management must not become just another bureaucratic layer; similarly, legacy management must not be allowed prevail
- Reporting structures must promote information sharing outwards and downwards towards communities, similar to the NHS model

Voluntary Organisations

- The Voluntary Organisations can drive integration and identify where barriers to integrated care lie
- The partnership principles should be embedded in the process and the outputs
- Mapping and signposting of RHAs and the role of Section 39s within RHAs may present an opportunity to integrate services and promote Section 39s as hybrid partners

Future Considerations for RHAs

- Future planning, being strategic across care groups and sectors and implementing multi-annual funding are huge opportunities. Joined up thinking and sufficient data will be required for these
- Need to identify what areas need to be addressed, but also what is working well, so it can be kept and built on in the future
- Where is the best place for RHA HQs should be considered
- The possibility of formalising Patient, Carer and Public Involvement (PCPI) within RHAs may be of benefit

Future Considerations for DoH/ HSE

- Avoidance of mechanistic or simplified responses is important
- Facilitate good practice by promoting person-centred care and build up capabilities to include complex care provision
- Innovative response and funding will need to be balanced
- Overall focus on costs may be a reductionist view – it will be important to move away from a ‘how much does it cost’ outlook to a ‘how much will it save’

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Question 2:

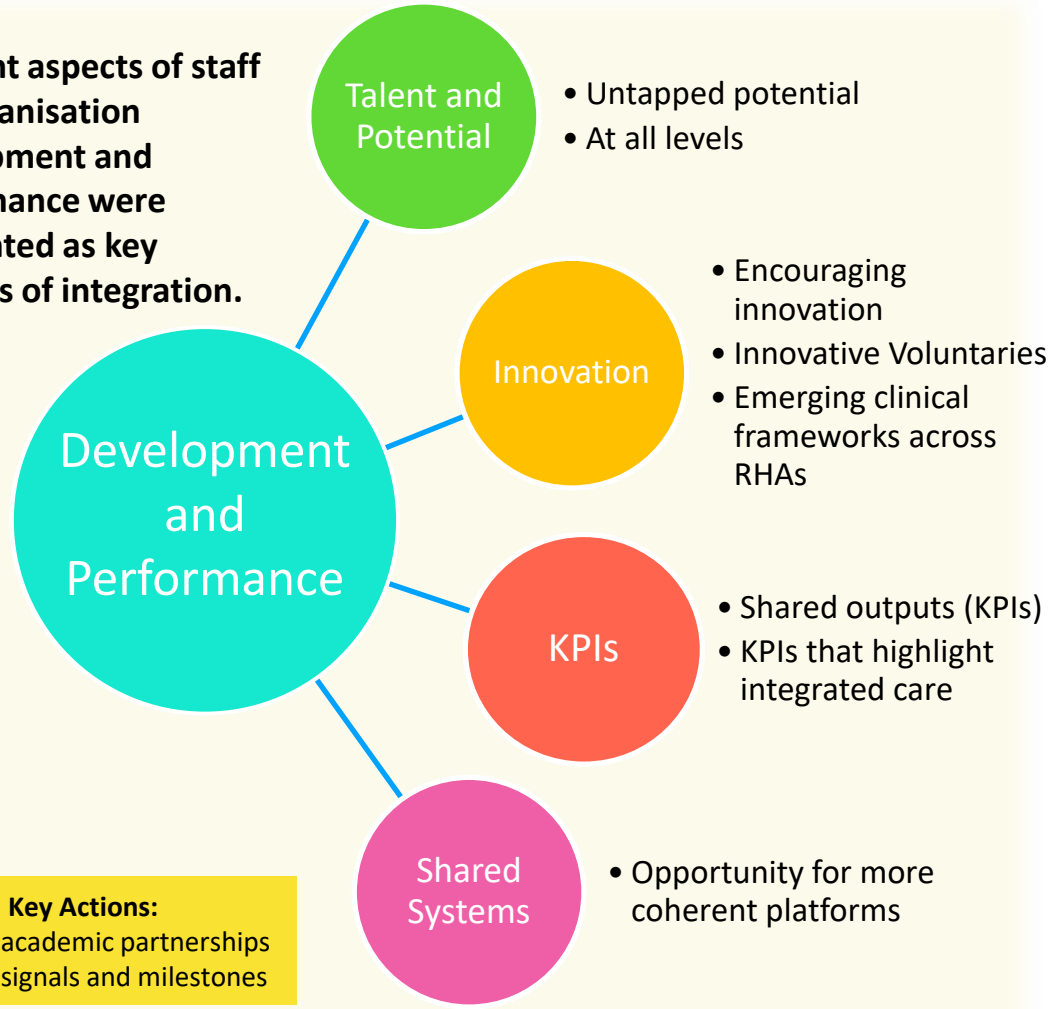
What will help or hinder the new RHAs? Who should we talk to/get involved in this phase/future phases of RHA design and implementation?

Question 2.1: Enablers of RHA Implementation (1/2)

The need for strong, decisive leadership from RHAs was identified, as was the need to seize the opportunity to provide integrated care.

Key Actions:
- Ensure inclusivity
- Match authority with responsibility

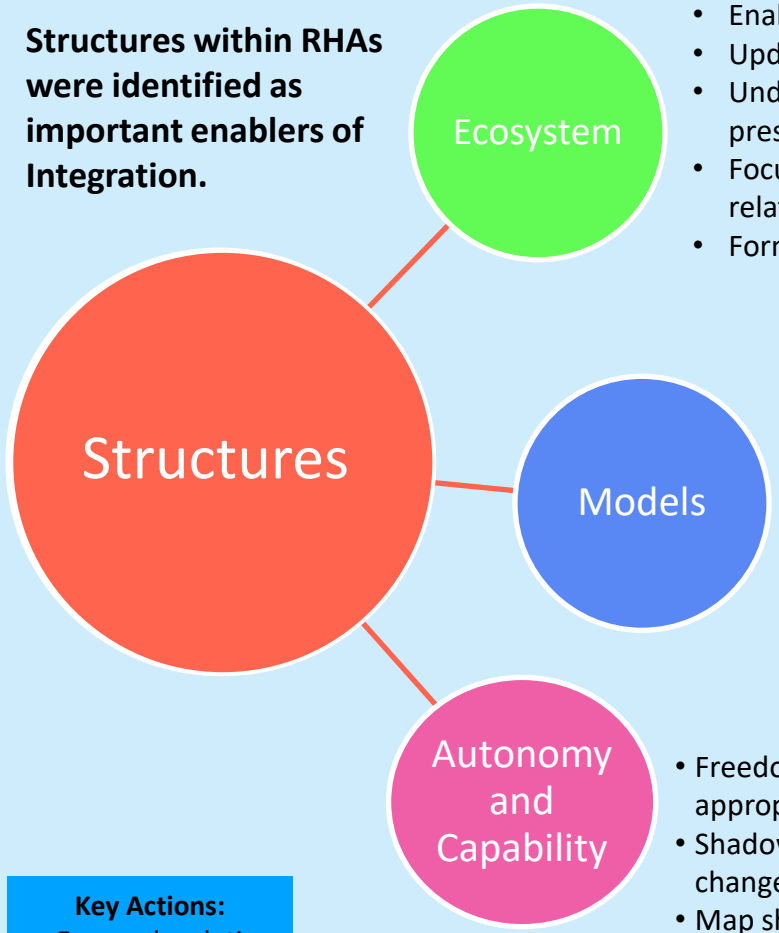
Different aspects of staff and organisation development and performance were highlighted as key enablers of integration.



Key Actions:
- Clarify academic partnerships
- Clarify signals and milestones

Question 2.1: Enablers of RHA Implementation (2/2)

Structures within RHAs were identified as important enablers of Integration.



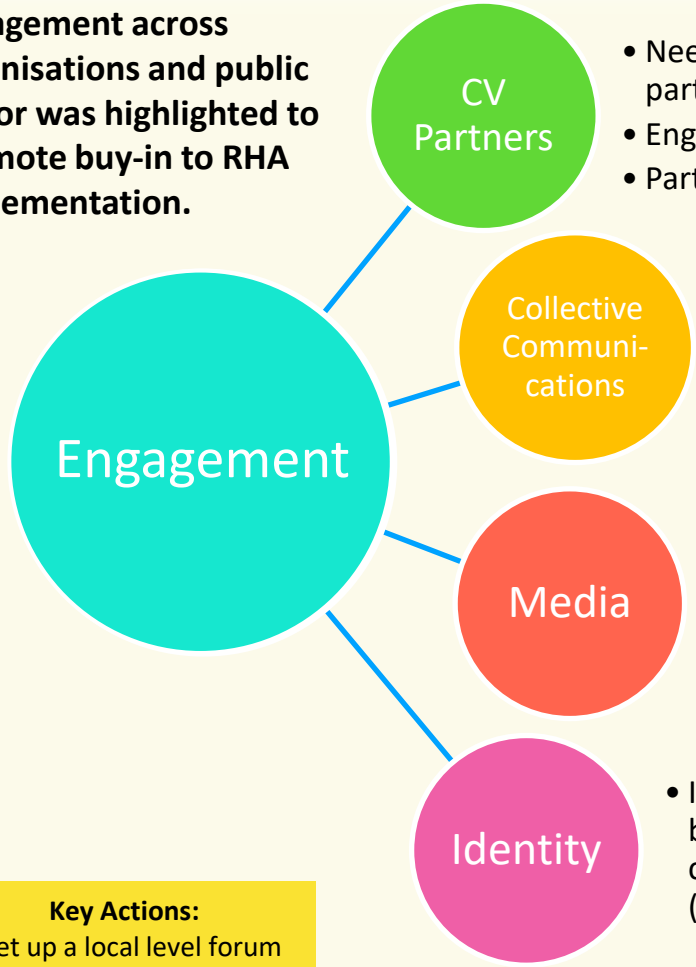
- Enable sharing of information
- Updated service arrangements
- Understand incoming pressures
- Focus on RHAs building relationships
- Formalisation of relationships

- Shared care model
- New model must address current issues
- Incentivise ideal patient pathway e.g., community-first care pathways rather than hospital ED
- Consider existing relationship models e.g., CHO2 and Tusla

- Freedom for RHAs to allocate appropriately as needed
- Shadow structures to enable changeover to RHAs
- Map shadow structures onto voluntaries and onto national, regional, and local services

Key Actions:
- Ensure devolution
- Clarify mandate

Engagement across organisations and public sector was highlighted to promote buy-in to RHA implementation.



- Need to consider all partners
- Engage for buy-in
- Partnership principles

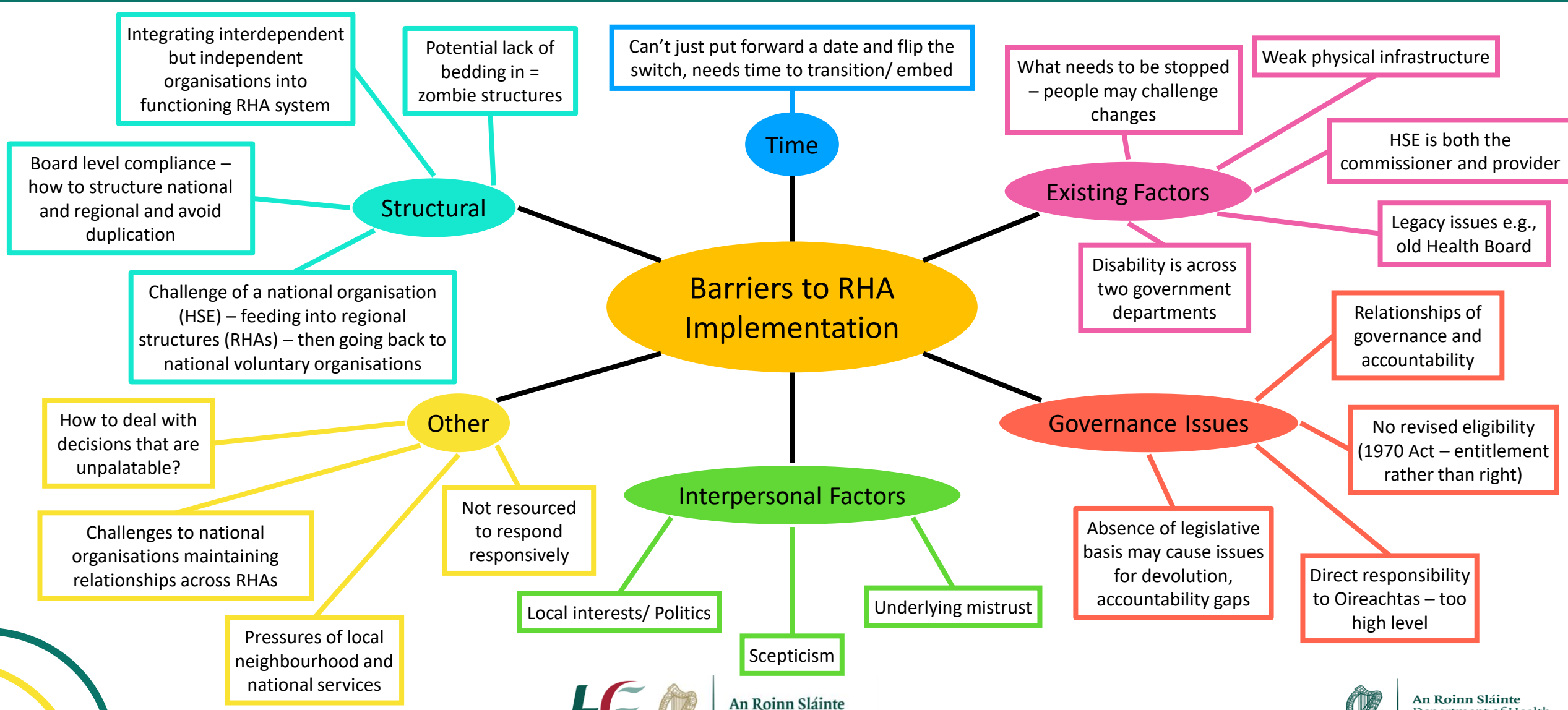
- Who should be consulted?

- Manage the message in the media

- Identify with and build belonging to a common purpose (e.g., Sláintecare)

Key Actions:
- Set up a local level forum
- Establish early partnership

Question 2.2: Barriers to RHA Implementation



Question 2.3: Who should we talk to/get involved in this phase/future phases of RHA design and implementation?

WHO

- DCEDIY
- National Representative Bodies
- Feedback from National Ambulance Service

HOW

- Media – film, social media, television (e.g., ‘day in the life’ documentaries)
- Patient experience
- Open consultation
- HSE journeys (e.g., Nóra)
- Real life case studies
- Proactively thinking through FAQs/ media queries

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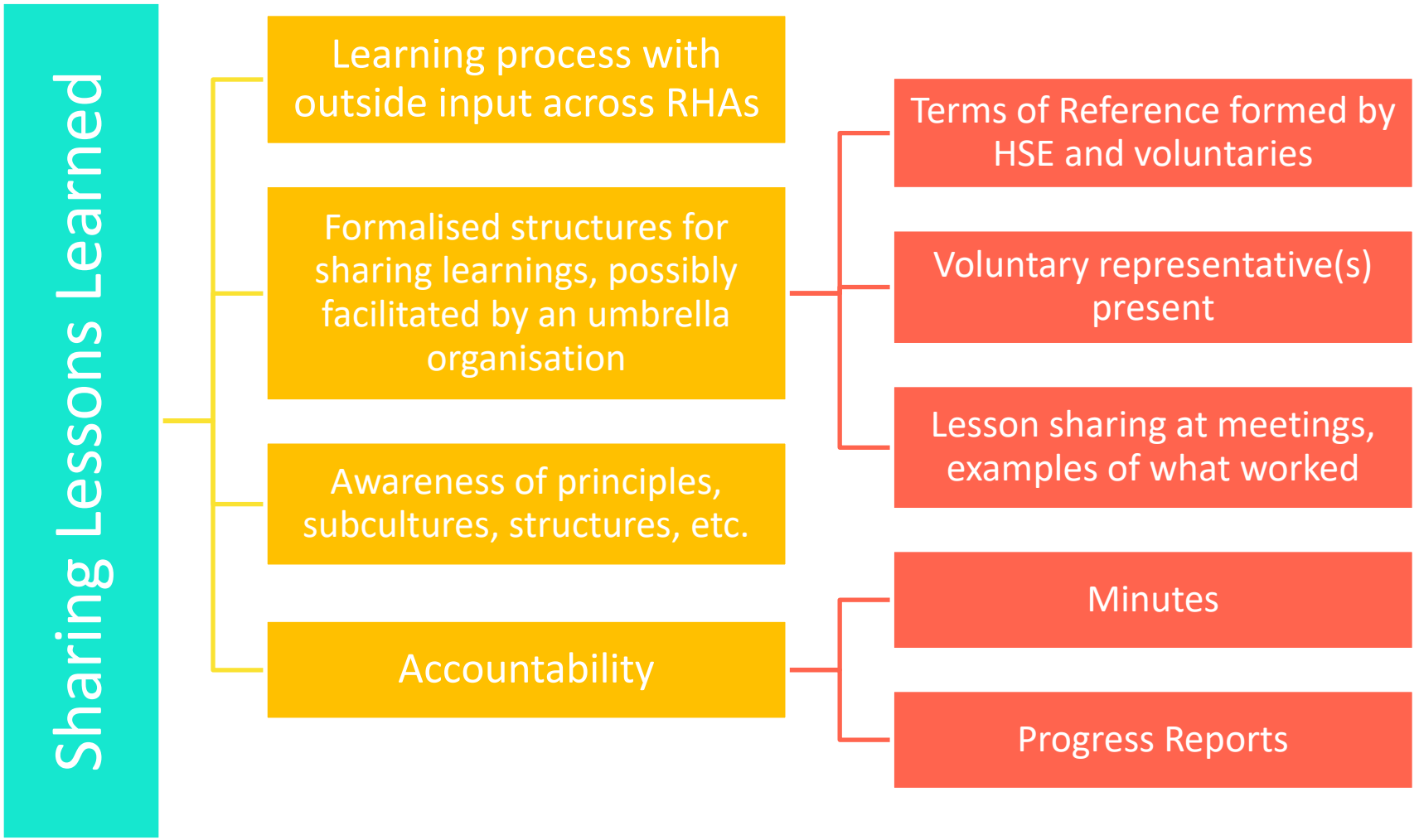
Question 3:

Recognising the interdependence between health and social care actors in the system, how can we best share lessons learned, information, and best practice within and across RHAs and the wider national services?

Question 3.1: Sharing Lessons Learned



Question 3.2: Sharing Information

Sharing Information

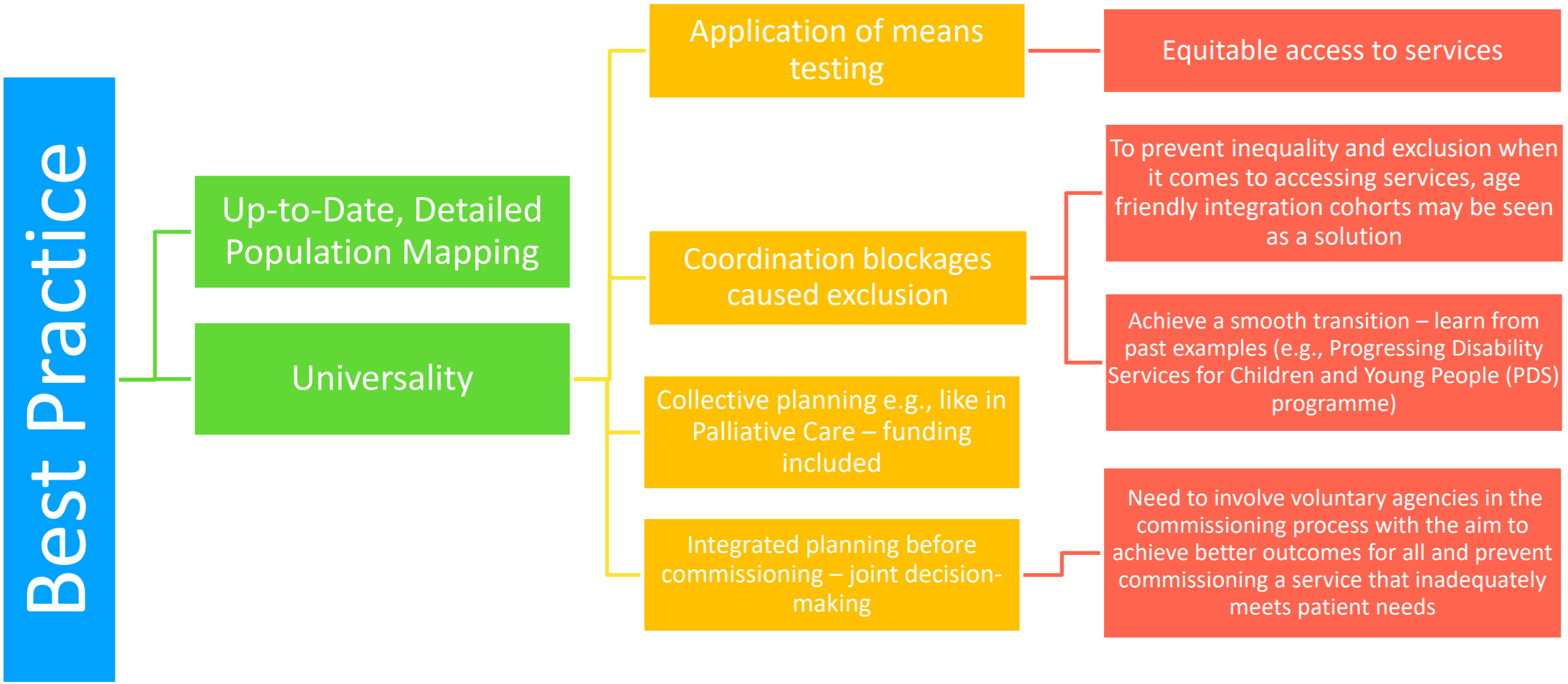
Capture patient and user experience

- Disparate buckets of information
- Evidence informed, funding linked to action
- Partnership working
- Different perspective national vs regional

Information sharing across RHAs

- Top-down?
- Committee (budget dependent) at sub regional levels
- Care needed around division of budget - geography based or service budget?
- Should sub-regional advise RHAs in terms of budget?
- Peer learning as a mechanism to maintain standards before implementat-ion
- Local integrated care communities need clout to work

Question 3.3: Sharing Best Practice



Question 3.4: Sharing within and across RHAs and the wider national services

Include Voluntary Organisations at the Table

- Shouldn't just be HSE
- Untapped networks e.g., the Wheel, Disability Federation of Ireland, etc.
- Regular meetings, wide membership
- Robust integrated care providers need influence

Statutory and Voluntary Forum

Regional fora

- Quarterly meetings with devolved working groups to deal with own issues and report back

Formal consultative processes with appropriate membership from all aspects of health sector

- Avoid silo-ing, think of high-level values

Enhancing / widening the partnership programme

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Go raibh míle maith agaibh | Thank you for your input!