Dialogue Forum

Case Study Process

Final Report

Prospectus
creative change

March 2023

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1. Background

Dialogue Forum Background

The Dialogue Forum (DF) was established in 2019 to build a new and more **collaborative relationship** between the HSE, Department of Health and state-funded independently owned and governed not-for-profit organisations (Voluntary Organisations/Vol Orgs) to deliver the transformative reform envisaged by Sláintecare and achieve better quality, people-centred health and personal social services.

The State and Voluntary sectors have become increasingly mutually interdependent over time. The scope of Voluntary Organisations funded under **Section 38** and **Section 39** of the Health Act 2004 has grown significantly in scale and scope. **Section 38 and Section 39 organisations** now account for more than 25% of the total health budget each year.

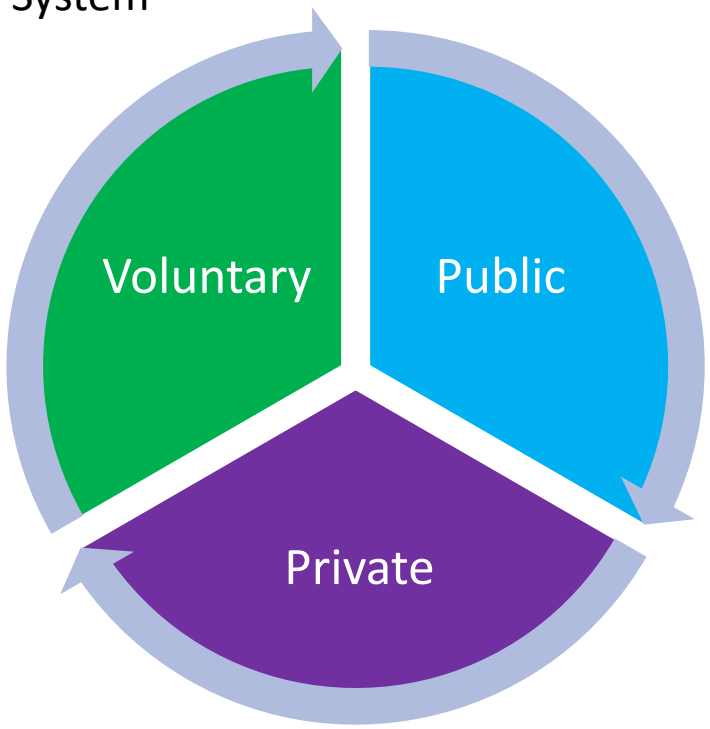
However, various structural reforms and policy changes have resulted in growing dissatisfaction amongst many of the participants, leading to an increased sense that the current arrangement is no longer fit for purpose.

In response to this an Independent Review Group (IRG) which was set up in 2017 to assess the strengths and weaknesses of the hybrid healthcare system and the roles of Voluntary Organisations within it.

The IRG concluded that in order to improve the Irish healthcare system it is imperative that the relationship between Vol Orgs and the State improve. Their final report stated that: *"substantially improving the quality of the relationship between the State and voluntary organisations was critically important to improving the quality-of-service delivery and delivering better outcomes for service users".*

The IRG recommended the establishment of a joint forum comprising representatives from the public and voluntary sectors to progress this agenda and thus the DF was established.

Ireland's Three-strand Hybrid Health & Social Care System



- Voluntary (independently owned and governed, not-for-profit)
- Public (fully State-owned and governed, not for profit)
- Private (for-profit)

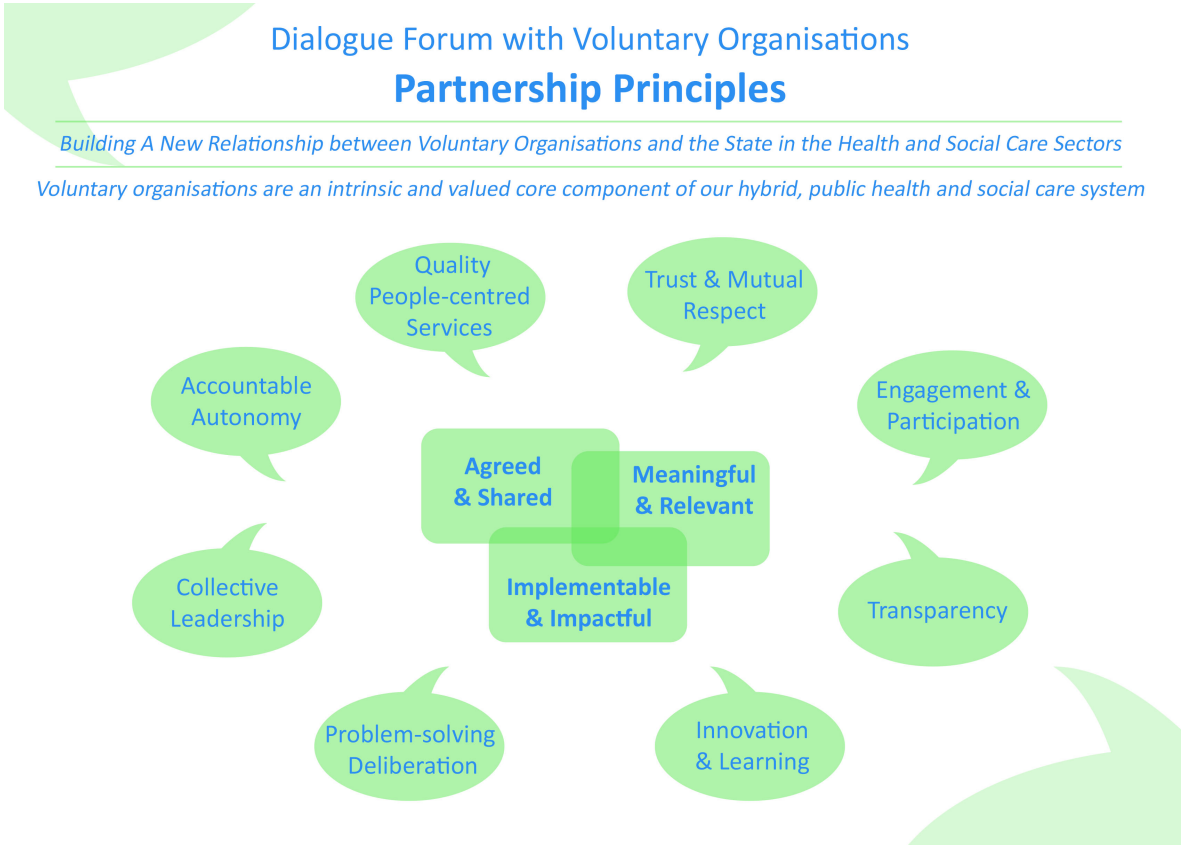
The Partnership Principles

The DF has recently developed and agreed a set of core principles to guide how the statutory and voluntary sector should work together in the future. The purpose of the Partnership Principles are best summed up by the following extract from the document:

"From the outset of the Forum there has been a robust consensus that addressing the integrated set of challenges within the sector in a manner that could ***deliver quality people-centred services necessitated a dramatic step-up in the level, scope and quality of collaboration and integrated working across the system".***

Partnership Principles:

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



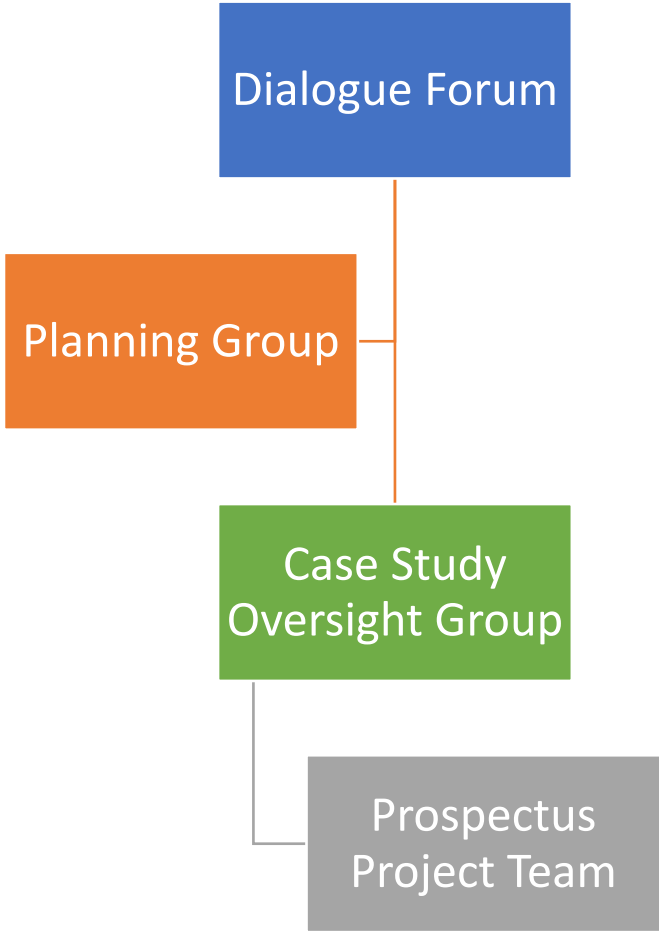
Case Study Process

The Dialogue Forum Case Study process's key purpose is to inform the thinking of the Forum on how to improve relationships between stakeholders as well as informing the SA (Service Arrangement) review.

The overall aim of these sessions was to build an understanding of the key challenges and opportunities which exist as part of the embedding of the agreed Partnership Principles into the structures, process and projects of State and voluntary providers

The objectives as per the RFT (Request For Tender) were to:

- Focus on the funder/provider relationship to examine what's working well and what is not
- Bring forward solutions to support all stakeholders to work effectively and in an integrated way which will improve outcomes and provide enhanced assurances



2. Process Overview

Process Overview & Timelines

This process was completed between August 2022 – March 2023.

01 Initiate

Confirm project scope, process objectives and deliverables

02 Engage

Develop design criteria to help with the selection of Case Study participants.

03 Customise

Circulate a customised template for completion by all participants in advance of workshops

04 Collect

Collate information from templates and outputs from Case Study workshops

05 Review

Analyse findings and develop draft conclusions and recommendations

06 Report

Develop and submit final report to DF for sign-off.

Case Study Process Overview

- The DF Oversight Group (OG), chaired by the Department of Health, oversaw and monitored progress on the development of the Case Study program. Workshops were facilitated by Prospectus Management Consultants
- Section 38 & 39 representatives self-nominated based on a request for participants from the Dialogue Forum. The OG chose 13 s.38/39 organisations, whom they agreed best represented their respective category
- HSE representatives came from Disability Services, Compliance, Acute Operations, Ireland East Hospital Group, Stability & Sustainability & Primary Care
- Each organisation/participant was briefed in advance and completed a detailed template of questions to inform the Case Study workshop (a copy of the template can be seen in the Appendix)
- The workshops had a strong focus on identifying solution-focused actionable items with a one to three-year implementation window. They provided some useful insights which have been shared as part of the Regional Heath Areas (RHA) design process and the Service Arrangement (SA) review process

Case Studies			
No.	**Case Study Categorg**	**Representative Voluntarg Organisations**	**HSE Representation**
1	Small Hospital s.38	Peamount Healthcare	Disability Services, Compliance, Acute Hospital Operations,
2	Large s.38 organisation	Muiríosa Foundation	Disability Services, Compliance, Acute Hospital Operations, Stability & Sustainability
3	Large s.39 organisation (multi-region reach)	Enable Ireland	Disability Services, Compliance, Acute Hospital Operations, Stability & Sustainability,
4	Group of s.39 organisations, multiple service offerings	Shine Mental Health Services	Disability Services, Primary Care, Acute Hospital Operations, Compliance, Stability & Sustainability
		Prosper Fingal *	
		Delta Centre, Carlow (ID Services)	
		SOS Kilkenny (ID Services)	
5	Group of s.39 organisations, multiple service offerings	Epilepsy Ireland	Compliance, Disability Services, Primary Care
		Bluestack Special Needs Foundation Ltd.	
		Cope Galway Homeless Services	
		North Dublin Homecare	
6	Large Acute Teaching Hospital s.38	The Mater Hospital	Acute Hospital Operations, Compliance, IEHG Operations
7	Small Specialist Hospital s.38 (half day)	Rotunda Hospital	Acute Hospital Operations

* Prosper Fingal replaced Hail Housing Association

3. Case Study Findings

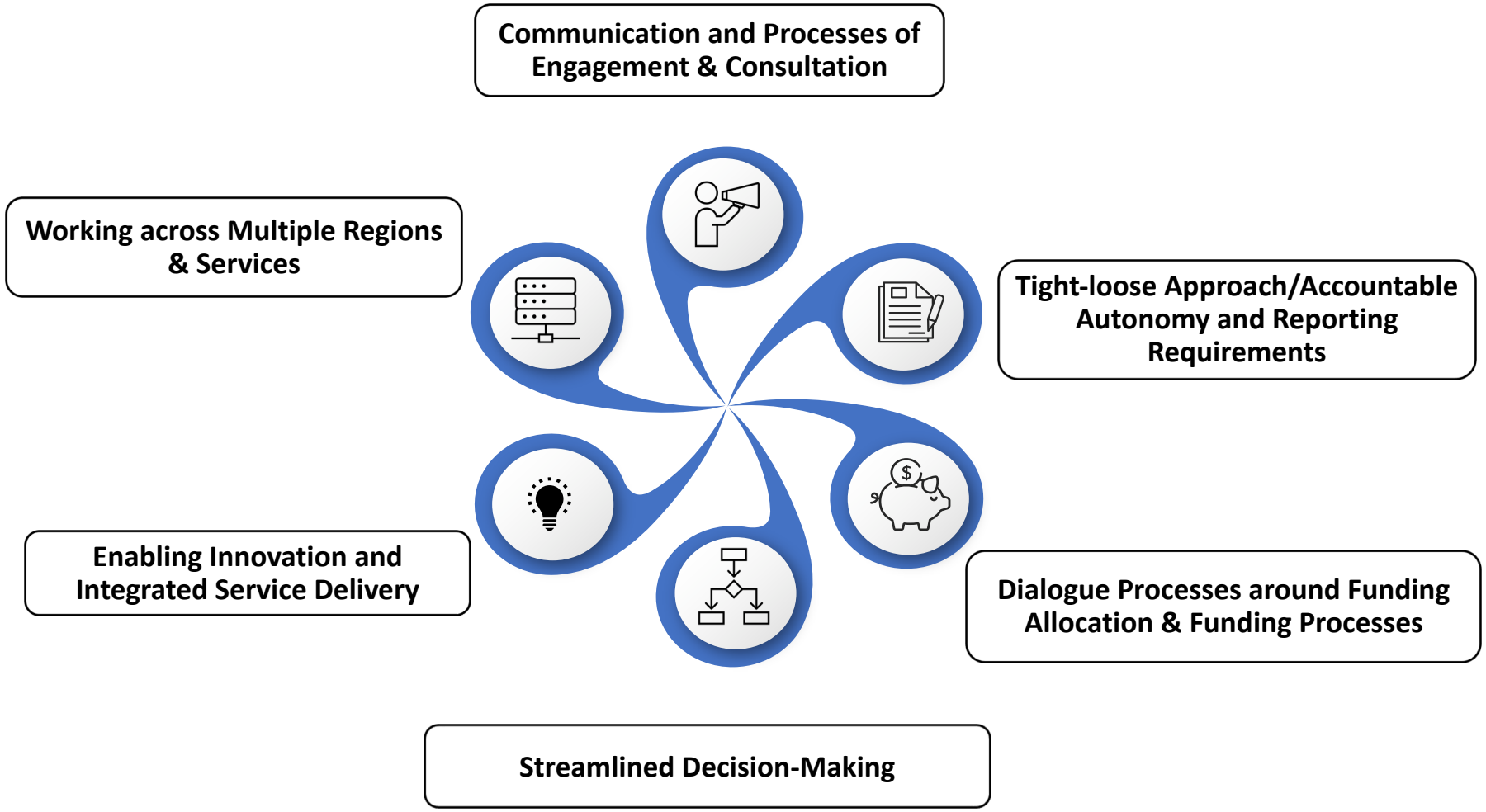
Case Study – Out of Scope Issues Raised

The scope and timing of the Case Study Workshops meant that some important issues raised by voluntary participants were not considered to be part of the scope of this process, however given their importance and the bearing they may have on any future discussions it is essential they are acknowledged at the outset of this report.

1. Funding is the primary concern for all voluntary providers, in particular s.39 providers (including Pay Parity), however, addressing this issue was deemed to be outside of the scope of this exercise.
2. Although there were many positive operational experiences from both statutory and voluntary perspectives during COVID-19, it was made clear that not all organisations shared these positive experiences, in particular some of the smaller s.39 organisations.
3. The emerging stage of the Partnership Principles means they have not yet had a chance to deliver any impact on the ground.
4. The potential for mergers and amalgamations across s.38 (**23** non-acute/community organisations & **16** voluntary acute hospitals) and s.39 organisations (**3,000+** health/community/disability organisations) was raised by a number of participants.
5. Given the spectrum of providers, it is important to recognise the range and type of experiences can differ enormously across each one; as such it was only possible to deal with common issues rather than attempt to address specific organisational challenges. However, where individual issues or experiences were brought to our attention that were felt had wider implications, these were considered.

Case Studies – Six Thematic Areas

The Case Study workshops were organised around **six themes** previously identified by the Dialogue Forum



Dialogue Forum – Workshop Process

At each of the workshop's participants were asked to consider each of the six themes under the following headings

Current Situation

Participants were asked in groups to describe what the Current Situation feels like operationally on the ground through the lens of each theme

Ideal World

They were then asked to describe what an ideal operating environment would look like under each theme, described under the heading An Ideal World Scenario

Barriers

Finally, groups were directed to outline the Barriers currently in place which would hinder reaching this Ideal Word Scenario

The following slides provide a summary of the key points that were raised in the workshops across each of the six themes

Communication and Processes of Engagement & Consultation

Current Situation feels like

- Strained, inconsistent communications across CHOs (Community Healthcare Organisations-operated by HSE) Top-down/centre-outwards tendencies at a formal level in CHOs, in places
- Structured meetings with adequate time & space given to key issues at local level work well
- Structured channels for communications such as performance meetings and the Voluntary Health Forum (VHF) work well, though it was said they can differ considerably terms of frequency and approach across CHOs
- Lack of consistent, ongoing engagement opportunities for s.38/39 organisations around SA (Service Arrangement) process is problematic
- Ongoing cascade of information (policy and other) and requests for information from multiple sources, often replicated.
- Insistence from some s.38/39 orgs on engagement around financial resourcing even when solutions/resources are not imminent can be problematic

An Ideal World Scenario

- Closer alignment and engagement, a shared understanding of the decision-making process and service delivery outcomes
- Consistent, transparent, timely budgets and planning processes
- Understanding and acceptance by s.38/39 organisations of requirements of the statutory role of the HSE and necessity for implementation of checks and balances within the system
- Communication and engagement based on mutual respect
- Appropriate consultation, representation and participatory decision-making
- A simple and effective IT-based communications system

Barriers

- Lack of mutual understanding on the current and future vision for services
- Resourcing issues dominate conversations to point of paralysis or communications breakdown
- Lack of opportunities to directly engage with HSE at senior level on key strategic issues
- Communications and IT system are outdated and lacking alignment
- Variations in resourcing of services across CHOs
- Levels of bureaucracy challenging for all at times
- Constantly evolving policy and regulatory requirements is an ongoing challenge for all to resource and integrate

Tight-loose approach/Accountable Autonomy and Reporting Requirements

Current Situation feels like

- A lack of shared understanding and interpretation of what a "Tight/Loose" approach means across all parties has resulted in limited application
- Overly onerous, inconsistent or ineffective systems and processes (e.g. business case process, levels of scrutiny, micromanagement)
- Service Arrangement process considered to be challenging for all parties
- Performance review process is standardised on paper but not reflected in reality e.g., inappropriate KPIs, inconsistent assessment; disproportional focus on money etc
- Output-emphasis rather than outcome-focused process
- Disproportionate attention and oversight demands placed on small s.39 organisations
- Frustration around return to pre-Covid approaches

An Ideal World Scenario

- Simple and direct reporting mechanism which is outcomes-focused with aligned KPIs
- Both sides appropriately resourced to manage the heavy demands of the current contractual framework
- A Service Arrangement and its associated process which have regard to the size and capacity of the organisation, the nature of the service provided, and the amount of funding given
- Data reporting/shared metrics across comparable systems/areas of focus

Barriers

- Insufficient data, lack of appropriate KPIs
- Political understanding of accountability and external drivers (PAC, FOI)
- Volume of legislation and policy and resulting workload not always commensurate with funding. Regional variations exist in their application
- HSE plays multiple roles (funder, commissioner of services, compliance), concerns around perceived conflicts of interest
- Social service provision driven by the requirements of contract law
- Lack of speedy and consistent record of decisions
- Lack of clarity regarding "in-scope" & "out of scope" from both perspectives
- Balancing s.38/39 governance demands between HSE and internal board requirements

Dialogue Processes around Funding Allocation & Funding Processes

Current Situation feels like

- Annual budget structure and associated systems mean s.38/39 orgs cannot forward to plan
- Unilateral funding processes lacking in engagement and consultation
- Limited evidence of budgets and organisations delivering value for money
- HSE supportive but some issues around funding allocation and processes are outside their control (for example funding decisions driven by Department of Public Expenditure & Reform, NPD Delivery and Reform)
- s. 39 organisations losing employees to s.38 organisations and the HSE as they offer better pay conditions

An Ideal World Scenario

- Mutual trust and transparency as key elements of funding relationship
- Multi-annual (3-year), jointly developed, fair budgeting process with greater granular detail
- A national, transparent costing methodology
- Shared agreement and understanding of budget priorities between s.38/38 organisations and the HSE at local, regional and national levels
- Meaningful, direct, honest, structured engagement around budget process between s.38/38 organisations and the HSE
- Short to medium term real needs and real costs discussed without prejudice
- Proper incentivisation to deliver improved outcomes and manage realistic budget

Barriers

- Current systems and structures (one size does not fit all)
- Prevailing culture and mindset in relation to appetites for risk
- Lack of funding beyond service delivery (no funding for administration or compliance costs)
- The HSE playing multiple roles of commissioner of services/ funder of services/ compliance assessor thus resulting in potential conflicts of interest and relationship imbalance
- Unequal knowledge and experience of the delivery system among s.38/39 organisations creating power imbalance
- Absence of engagement around s.38/39 organisations deficits
- Competing funding priorities

Streamlined Decision-Making

Current Situation feels like

- Unilateral, remote, unclear, often confused, decision-making processes
- Challenging and complex environment with multiple competing elements outside the Services Arrangement framework in other legislative contexts
- Dual accountability to both HSE & s.38/38 organisations Boards
- Budget & practice rarely aligned
- Finance-based rather than quality-based decision-making
- Inability of HSE to see the "whole organisation" picture of s.38 & s.39 organisations
- Where autonomy given to s.38 & s.39 organisations around service design, it works well
- HSE responsiveness to service need works well
- Where autonomy at HSE local level exists, decision-making works well
- Systems for non-funding related decisions can be quickly and transparently assessed

An Ideal World Scenario

- Subsidiarity concept at the heart of decision-making
- Autonomy and transparency with appropriate level of accountability
- Equal input for HSE and s.38/39 organisations on decisions which impact the end user
- Decisions made in a timely manner by all
- Efficient, effective, equitable, quality services with clarity on what's required and the agreed rationale
- Robust business case process with timely responses to submissions made
- Consistent, evidence-based data to facilitate decision-making

Barriers

- A lack of strategic engagement and discussion around the development of key themes across parties
- Multi-layered decision-making structures and overall low-risk appetite and fear of exposure within HSE
- Current IT systems and paper-based systems, but the lack of data is very restrictive
- Perception amongst s.38/39 organisations that the current monitoring and reporting arrangements are excessive
- s.38/39 organisations working within inadequate budgets
- HSE emphasis on costs and outputs rather than outcomes, which is largely driven by reporting requirements placed on them
- Varying approaches taken by multiple regulators
- Challenges arising from the multiple roles the HSE has to play e.g., funder, commissioner, regulator etc
- Legislative inconsistencies and varied interpretation of policy across CHOs

Enabling Innovation and Integrated Service Delivery

Current Situation feels like

- No clearly-defined, structured approach to innovation and learning
- Approach to innovation funding varies across CHOs
- Innovation is permitted within the requirements of the Services Arrangement process
- s.38/39 organisations driving innovation, but they want more recognition of this role and the value it brings
- Levels of innovation across disability services can be restricted by compliance requirements
- s.39 organisations currently in position to develop alternative funding streams and fundraise for innovation purposes
- Current dearth of IT structures limits opportunities for integrated service delivery

An Ideal World Scenario

- Fund allocated for sole purpose of innovation e.g. percentage of budget for activity-based funding model put towards innovation
- Open, collaborative environment and structural process across all agencies that allows providers and end users to share and discuss innovations
- Integrated service planning to meet defined needs
- IT structures which facilitate integrated service delivery
- Better links around innovation between Community and Acute services to facilitate service improvement

Barriers

- Competitive environment and siloed thinking in s.38/39 organisation restricts innovation
- The volume of active s.38/39 organisations represents a significant management challenge for HSE
- Risk aversion and overly burdensome reporting requirements as disincentives to innovate
- Policies to embed innovations require strengthening
- Annual funding cycle can restrict innovation
- Quantity of administration linked to governance and compliance
- Standardised approaches can restrict opportunities for integrated service delivery

Working across Multiple Regions & Services

Current Situation feels like

- Multiple or disjointed systems, structures and processes across CHOs can limit potential to work across multiple regions and services
- Competitiveness across CHOs creates a challenging environment for integrated service delivery across regions
- Competitiveness across s.38/39 organisations limits potential to work across multiple regions and services

An Ideal World Scenario

- Strong network for development of collaborative structures and processes for all parties
- Seamless service provision and integrated service delivery across regions
- Consistency in approach and reporting across CHOs
- Ownership of decisions within regions including budgetary control
- Common IT platform for all working across regions and services

Barriers

- Current operational structures and processes do not facilitate cross-region/cross-service working
- IT systems do not facilitate cross-region and cross-service operations
- Siloed culture and services across CHOs and s.38/39 organisations
- Inconsistency of approach in some s.39s
- Lack of regional planning at CHO level
- Funding allocation models do not facilitate cross-region and cross-service operations
- Multiple reporting lines, duplication of tasks, and multiple formats across CHOs complicate reporting processes
- Huge variation in size, capacity and interests of voluntary organisations which can limit ability to work across region and services regardless of potential to do so

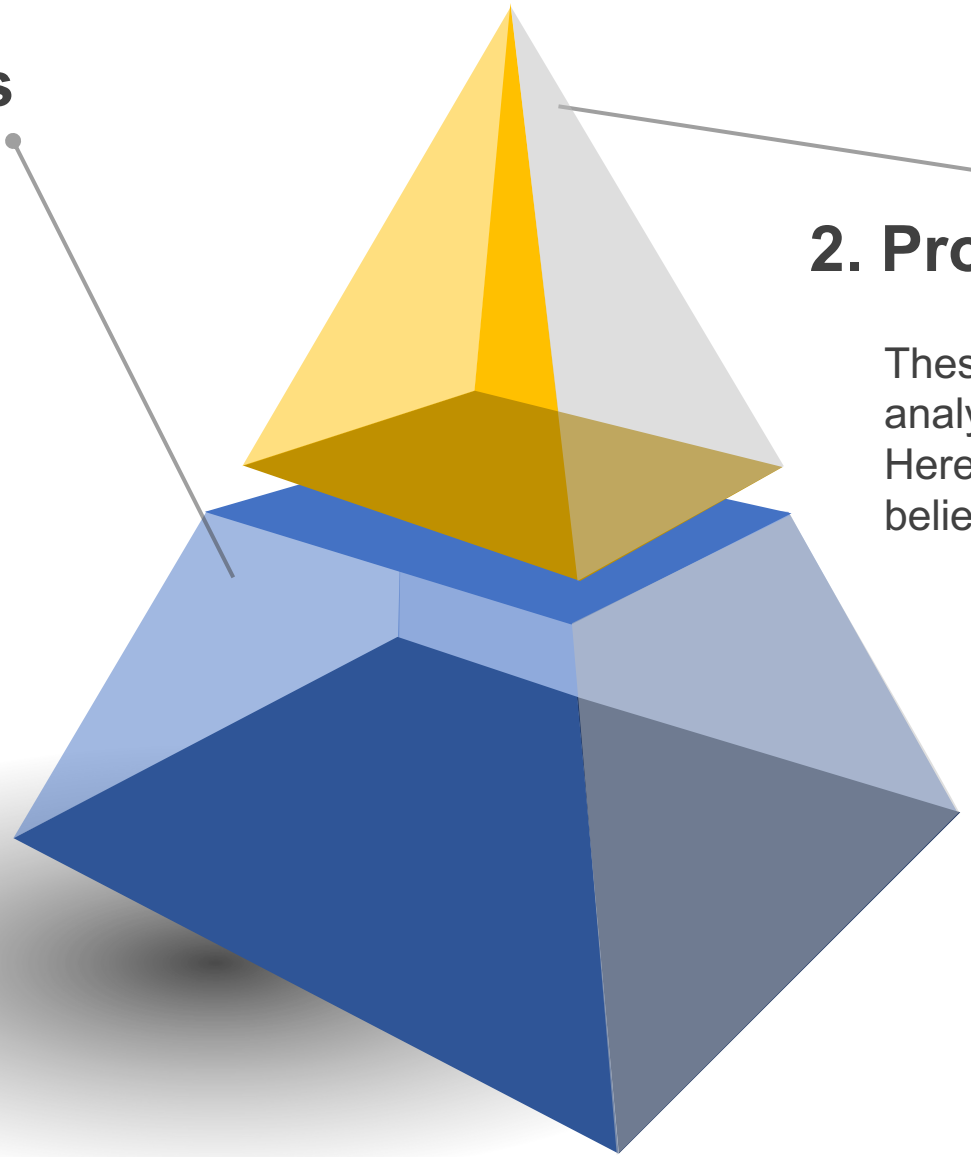
4. Conclusions

Our conclusions are divided into two categories:
1. Thematic Conclusions 2. Prospectus' Conclusions

1. Thematic Conclusions

These are derived from analysis of the findings from each of the six thematic areas previously outlined:

1. Communication and Processes of Engagement & Consultation
2. Tight-loose approach/Accountable Autonomy and Reporting Requirements
3. Dialogue Processes around Funding Allocation & Funding Processes
4. Streamlined decision-making
5. Enabling Innovation and Integrated Service Delivery
6. Working across Multiple Regions & Services



2. Prospectus' Conclusions

These are derived from our summary analysis of the thematic conclusions. Here we identify eight core areas we believe now need to be prioritised

1. Thematic Conclusions

Communication & Engagement

- The quality and consistency of communications and relationships overall are not yet at the level required to develop a genuine partnership approach as detailed in the Partnership Principles
- Where relationships are strong and consistent, multiple examples were given of challenges being addressed up front using structured approaches or informal contacts
- Evidence would suggest there is a basis for open, trust-based consultation which benefits service users
- s.38/39 organisations see direct engagement with the HSE at a senior level as key to foster ongoing quality service development and delivery. The current system does not always facilitate this
- Where s.38/39 organisations cannot or will not move conversations beyond budgets, this stance can drive paralysis or a breakdown of communications

Tight Loose Autonomy

- The definitions of a "tight/loose approach" and "accountable autonomy" remain unclear and as a result inconsistently understood and applied by all parties. This is inhibiting the required levels of trust across HSE/DoH/s.38/s.39 processes and relationships
- Experience during Covid-19 suggests that the concept of "tight/loose" can work in a single focus/crisis environment but more recent evidence points to the reinstatement of a more traditional "command and control" approach
- The SA's "one document to meet all eventualities" format and associated processes places a large burden on all involved (time, expertise, cost, focus) although the engagement framework can work well where applied meaningfully
- Ever increasing levels of compliance reporting and statutory requirements are taking focus away from planning, sustaining and delivering quality people-centred services, especially for small s.39 orgs
- Quantitative outputs often emphasised over qualitative outcomes in the reporting process which s.38/39 orgs see as forcing them to compromise in the delivery of their organisation's mission

Dialogue & Funding Allocation

- The limited experience of a substantive two-way dialogue process around the annual budget cycle breeds a large degree of frustration for both parties in terms of expectations of achievement
- The lack of a substantive two-way dialogue process around the annual budget cycle also limits the ability to have a conversation around value
- The lack of a community costing mechanism is a barrier to progress

Thematic Conclusions continued

Streamlined Decision-making

- The opportunity exists to practice subsidiarity in decision-making, but there is little evidence of its widespread application
- The number and variety of s.38 and s.39 organisations means that a “one size fits all” approach to decision-making is creating challenges across the system
- Current IT systems are not meeting the needs of the HSE and s.38 and s.39 organisations to work quickly and effectively with regard to streamlined decision-making

Innovation & Integrated Delivery

- s.38 and s.39 organisations generally insist that innovation is an added value item/distinctive feature of their offer
- A greater emphasis could be placed on innovation by funders in terms of models of care for service delivery. Without innovation finding a place in the SA, or elsewhere, there is measure or evaluate or scale up where appropriate
- Structural and budgetary silos and competitive pressures (s.38 and s.39 organisations) are inhibiting the extent to which integrated care approaches can be developed and implemented

Working Across Regions

- The health and social care system is vast and complex. It is also subject to constant churn in terms of personnel and structure. Working across multiple regions and organisations adds another layer of complexity to already burdened parties
- Navigation of the health and social care system, even for the largest players (HSE or s.38/39s), is very challenging and in many cases there is a lack of understanding as to who the key players are and their precise roles. This makes working even across regions or individual service lines difficult

2. Prospectus' Conclusions

The following six conclusions have been identified based on our analysis of the various thematic conclusions previously identified.

Reimagined Ways of Working- There is a definite need to build further **trust and mutual respect** between all parties if the Partnership Principles are to play a fundamental role in underpinning how all engagements and work is done in the future. It would seem **current approaches and ways of working can actually militate against a collaborative approach rather than facilitate it**

Common Perspectives – Given reporting demands placed on them some HSE funders feel compelled to manage their relationship with s.38/39 providers in a way that is largely transactional, and output driven. This contrasts with many s.38/39 orgs who typically expect that the relationship should be more collaborative, and more outcome-focused

Collective Leadership – If the ambition and objectives of the Partnership Principles are to be realised it will require a whole system approach, where both the statutory and voluntary sectors recognise and proactively support the benefits of a diverse delivery system. This will invariably challenge the entire system and specifically how both statutory and voluntary organisations typically do their business, but this will need to be tackled and brave decisions made if improved outcomes for service users are to be achieved

Clear Decision-Making – There are considerable gaps between participants as to respective operational imperatives. These gaps in understanding, result in frustration, poor communication, and lost opportunity

Shared Vision – The positive experience felt by many during COVID, but not all, was built around a singular focus; "we're all in it together". There is little evidence that this has continued as we revert to "normal business". Given the degree of interdependence, it seems that mechanisms to involve voluntary organisations in shaping a shared "Vision" for health and social care services is now required

Timing & Opportunity – the establishment of RHAs offers a unique opportunity to do things differently. However, if the same structures, processes, approaches and culture are relabelled and rolled out on all sides it will be a missed opportunity. It's incumbent upon all DF participants to openly embrace this change opportunity

5. Recommendations

Prospectus' Recommendations

Based on our previous conclusions the following six recommendations are proposed:

Prioritise s.38/39 consultation on and engagement with the RHA design and implementation process

Exemplar projects focusing on the implementation of the Partnership Principles need to be confirmed and progressed as a priority. Learning from these projects then needs to be captured and disseminated in a structured manner across the voluntary and statutory systems to inform wider ways of working

Voluntary organisations should be given structured and regular access through Umbrella Bodies to senior decision-makers to allow input to the development of a shared understanding of how future decisions will be made under the RHA structure

Building on the learning from the exemplar projects jointly –led regional fora need to be established to drive the wider roll out of new ways of working and act as a forum for addressing issues and sharing good practice. It is impetrative that this is sustained and continually adapted to reflect ongoing learning and system needs.

s.38/39 organisations should be provided with an opportunity to input into national service planning on an annual basis, with the option of exploring a multi-annual work plan in the future

A structure and process for s.38/39 organisations to contribute towards the development and roll-out of a shared vision for health and social care services should be established

Recommendation 1: Reimagined Ways of Working

Conclusion

Reimagined Ways of Working

There is a definite need to build further trust and mutual respect between all parties if the Partnership Principles are to play a fundamental role in underpinning how all engagements and work is done in the future. It would seem current approaches and ways of working can actually militate against a collaborative approach rather than facilitate it

Recommendation

Recommendation #1

Exemplar projects focusing on the implementation of the Partnership Principles need to be confirmed and progressed as a priority. Learning from these projects then needs to be captured and disseminated in a structured manner across the voluntary and statutory systems to inform wider ways of working

Explanation

Why this is important

The Partnership Principles have the potential to drive significant change around how the statutory and voluntary sectors work together. Shared, practical examples with defined outcomes are essential in order to progress the Principles from a working document to a Reimagined Way of Working. This will be an ongoing process of learning and constant change. It will be critical to ensure that the ongoing learning from the rollout of projects is continually informing and progressing the effectiveness of the Partnership Principles

Recommendation 2: Collective Leadership

Conclusion

Collective Leadership

If the ambition and objectives of the Partnership Principles are to be realised it will require a whole system approach, where both the statutory and voluntary sectors recognise and proactively support the benefits of a diverse delivery system. This will invariably challenge the entire system and specifically how both statutory and voluntary organisations typically do their business, but this will need to be tackled and brave decisions made if improved outcomes for service users are to be achieved.

Recommendation

Recommendation #2

Building on the learning from the exemplar projects jointly–led regional fora need to be established to drive the wider roll out of new ways of working and act as a forum for addressing issues and sharing good practice. It is impetrative that this is sustained and continually adapted to reflect ongoing learning and system needs.

Explanation

Why this is important

The Dialogue Forum process comes at a time where a strong opportunity exists to embrace the opportunity to innovate across the statutory and voluntary sectors in the delivery of improved outcomes for service users. This is a dual responsibility. Collective Leadership requires an acceptance across *all* statutory and voluntary participants that everyone has a role to play in achieving future change and success.

Recommendation 3: Shared Vision

Conclusion

Shared Vision

The positive experience felt by many during COVID, but not all, was built around a singular focus; “we’re all in it together”. There is little evidence that this has continued as we revert to “normal business”. Given the degree of interdependence, it seems that mechanisms to involve voluntary organisations in shaping a shared “Vision” for health and social care services is now required

Recommendation

Recommendation #3

A mechanism for S38 and S39 organisations to contribute towards the development and roll-out of a shared vision for health and social care services should be established

Explanation

Why this is important

A shared vision for services, developed on a consultative basis with the DoH, HSE and s.38/39 organisations is a foundation for future collaboration, aligned with the Partnership Principles. This could include supporting the roll-out of Slaintecare.

Recommendation 4: Common Perspectives

Conclusion

Common Perspectives

Given reporting demands placed on them some HSE funders feel compelled to manage their relationship with S38/39 providers in a way that is largely transactional, and output driven. This contrasts with many S38/39 organisations who typically expect that the relationship should be more collaborative, and more outcome-focused.

Recommendation

Recommendation #4

S.38/39 organisations should input into national service planning on an annual basis, with the option of exploring a multi-annual work plan in the future

Explanation

Why this is important

The limited knowledge and understanding amongst voluntary providers around how annual funding processes e.g. Estimates, the NSP (National Service Plan) work has undoubtedly contributed to the frustration often felt by voluntary providers when funding requests are denied or ignored. It is thought through increasing awareness around funding decision-making processes that this will at least dispel suggestions that all fault lies with the HSE and it will provide a greater appreciation of the challenges faced by the HSE around the allocation of finite resources on an annual basis.

Recommendation 5: Clear Decision-Making

Conclusion

Clear Decision-Making

There are considerable gaps between participants as to respective operational imperatives. These gaps in understanding, result in frustration, poor communication, and lost opportunity

Recommendation

Recommendation #5

Voluntary organisations should be given structured and regular access to senior decision-makers through Umbrella Bodies to allow input to the development of a shared understanding of how decisions will be made under the RHA structure.

Explanation

Why this is important

The RHA design and rollout offers a unique opportunity for the DF to bring experienced based learning and insights to the process. The positive, constructive approach demonstrated by all parties in the DF process to date, shows the appetite and openness to participate and contribute to positive change.

Recommendation 6: Timing & Opportunity

Conclusion

Timing & Opportunity

The establishment of RHAs offers a generational opportunity to do things differently. However, if the same structures, processes, approaches and culture are relabelled and rolled out on all sides it will be a missed opportunity. It's incumbent upon all DF participants to openly embrace this change opportunity

Recommendation

Recommendation #6

Prioritise s.38/39 consultation on and engagement with the RHA design and implementation process

Explanation

Why this is important

The RHA design and implementation process provides an opportunity to shape elements of the decision-making process at RHA level and implement fit for purpose, transparent processes and protocols that are aligned with the Partnership Principles. The process also provides another opportunity to put the Partnership Principles into practice

6. Action Planning

Recommendations & Actions For Consideration

Reimagined Ways of Working

Recommendation 1

Exemplar projects focusing on the implementation of the Partnership Principles need to be confirmed and progressed as a priority. Learning from these projects then needs to be captured and disseminated in a structured manner across the voluntary and statutory systems to inform wider ways of working

Actions

1. DF representatives to participate in a review of the Service Arrangement and the RHA design processes. These processes will serve as tests cases or exemplar projects for the application of the Partnership Principles
2. Using these exemplar projects develop a suite of evidence-based KPIs/outcome measures to track progress against the delivery of the Partnership Principles. These measures can then be used to assess the impact of the Partnership Principles on other relevant projects.
3. Develop a reporting structure to capture progress against the agreed KPIs/ Outcome measures and ensure progress reports and learning are disseminated across the delivery system

Collective Leadership

Recommendation 2

Building on the learning from the exemplar projects jointly–led regional fora need to be established to drive the wider roll out of new ways of working and act as a forum for addressing issues and sharing good practice. It is impetrative that this is sustained and continually adapted to reflect ongoing learning and system needs.

Actions

1. Terms of Reference for the fora to be agreed with the Dialogue Forum at a national level and then rolled out locally at RHA level
2. Mechanisms to allow locally identified issues to be escalated to the Fora for consideration need to be put in place as quickly as possible
3. Communications channels to disseminate outputs from fora need to be established so that learning can be shared quickly across the statutory and voluntary delivery system

Shared Vision

Recommendation 3

A structure and process for S38 and S39 organisations to contribute towards the development and roll-out of a shared vision for health and social care services should be established

Actions

1. s.38/39 organisations to engage and input to the development and dissemination of a shared vision for services
2. s.38/39 organisations to actively participate in the roll-out of Sláintecare through participative fora
3. s.38/39 organisations to participate in the roll-out of outcome measures associated with the shared vision / Slaintecare outlined above

Recommendations & Actions For Consideration

Common Perspectives

Recommendation 4
s.38/39 organisations should be provided with an opportunity to input into national service planning on an annual basis, with the option of exploring a multi-annual work plan in the future

Actions

1. A structured programme to be devised and rolled out across s.38/39 organisations to increase understanding around the annual estimates and NSP (National Service Planning) processes
2. Opportunities for s.38/39 organisations to input into the NSP process should be examined
3. Undertake an assessment of the possibility of introducing multi-annual budgeting and funding commitments to facilitate better financial plaaning and management

Clear Decision-Making

Recommendation 5
Voluntary organisations should be given structured and regular access to senior decision-makers through Umbrella Bodies to allow input to the development of a shared understanding of how decisions will be made under the RHA (Regional Health Area) structure

Actions

1. DF to prepare a short, concise charter to recognise the value of s.38/39 organisations to the State and their role as partners.
2. An assessment of the multiple roles of the HSE e.g. Commissioner/Funder/Regulator, should be undertaken to determine how any perceived conflicts of interest can be reduced
3. Clearly define what “Tight/loose approach” and “accountable autonomy” means within the RHA construct and share practical insights with all voluntary organisations

Timing & Opportunity

Recommendation 6
Prioritise s.38/39 consultation on and engagement with the RHA design and implementation process

Actions

1. s.38/39 organisations to be plugged into all RHA design workstreams to provide voluntary insights on design issues
2. Consider the appointment of HSE Senior Relationship Managers (SRM) at RHA level to liaise with voluntary representatives around implementation issues.

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Appendix

Appendix 1 – Case Study Template

Dialogue Forum - Template for Case Studies					
Overarching Theme	**Key Considerations for Case Study Group Participant(s)**	**Response** (100 word limit per response)	**Example(s) - What has worked and why?** (100 word limit per example)	**Example(s) - What hasn't worked and why?** (100 word limit per example)	**Proposed Solution(s) & Rationale** (100 word limit per solution and rationale)
Communications and processes of engagement and consultation	How would you describe the communication and engagement process between your organisation(s) and the HSE?				
	What is typically the focus of these engagements e.g. Service requirements and patient / client care? Arriving at shared agreement on how services are to be delivered? Defining reporting and regulatory commitments? Others?				
	How did COVID impact on the communications and engagement process between voluntary organisations and the HSE?				
	Other? Please insert any other question or statement you think relevant under this heading.				
Tight-loose approach / accountable autonomy and reporting requirements	How would you describe the balance between service focus and reporting requirements in your engagements?				
	How might it be possible to achieve budgetary/ regulatory control and flexibility at the same time?				
	How well did reporting and accountable autonomy work during COVID?				
	Should "one-size-fit-all" in terms of the SA and associated processes regardless of the size and complexity of the voluntary organisation?				
	Other? Please insert any other question or statement you think relevant under this heading.				
Enabling innovation and integrated service delivery	To what extent is the need for innovation reflected in the relationship between the HSE and voluntary providers?				
	How well is integrated service delivery encouraged and supported?				
	What learning or innovative experiences around service delivery can be taken from the COVID period?				
	Other? Please insert any other question or statement you think relevant under this heading.				
Streamlined decision making	How would you describe current decision-making processes, particularly within the SA process?				
	How speedy and timely are decision-making cycles?				
	What are the decision-making implications of having to sometimes negotiate and sign multiple SAs across different HSE regions?				
	Other? Please insert any other question or statement you think relevant under this heading.				
Working across multiple regions	How do approaches and engagment processes differ across regions and/or organisations?				
	How do these differences manifest themselves in terms of service delivery?				
	Other? Please insert any other question or statement you think relevant under this heading.				
Dialogue processes around both funding allocation and funding approaches	What takes greater priority: service delivery requirements or funding obligations?				
	Are funding discussions during the SA process typically a unliteral or bi-lateral discussion?				
	What difference would it make to service delivery and the SA process if funding could be arranged on a multi-annual basis?				
	Where do quality of service and outcomes (as opposed to volume of activity) feature in the funding approach?				
	Other? Please insert any other question or statement you think relevant under this heading.				
Additional themes / issues	Note: the issue must directly relate to the interactions between the HSE and Voluntary Organisations				