Rialtas na hÉireann
Government of Ireland

Organisational Reform

HSE Health Regions

Implementation Plan

July 2023

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Minister Donnelly's Foreword

Our goal is Universal Healthcare – one of the great, unfinished projects of our Republic – to provide affordable and timely access to high-quality healthcare for all. To this end we have been cutting costs for patients, including abolishing inpatient hospital charges, introducing free contraception, and phasing in hundreds of thousands more GP cards. We have been rolling out new services around the country including in women's healthcare, cancer care, maternity, stroke, diabetes, mental health, obesity, neurorehabilitation, trauma, and much more. We have been strengthening protections for patients through new legislation including the Patient Safety Act. We have been tackling the hospital waiting lists and the scourge of too many patients on trolleys in Emergency Departments.

To achieve all of this, we are pursuing a strategy of two parts. The first part is the unprecedented expansion in healthcare capacity. This includes 21,000 extra healthcare professionals, 1,000 extra hospital beds, new Primary Care Centres, new operating theatres, critical care beds, community beds, diagnostics and more. This is being added to all the time, with several thousand more healthcare professionals to be added this year alone, along with several hundred more hospital beds well progressed, as well as agreement on four new hospitals.

The second part of the strategy is the fundamental reform of how care is delivered. There are many parts to this reform agenda. It includes the new public-only consultant contract, the building of a new community health service to treat patients closer to home, moving to a seven-day service, introducing modern eHealth infrastructure, and focusing on productivity and improved patient outcomes.

A central element of our reform agenda is the restructuring of the HSE into a leaner centre supporting six HSE Health Regions. Right now, the HSE is structured into six hospital groups, many with overlapping geographies, and nine Community Health Organisations (CHOs), which provide community care. The result is a lack of integrated care for patients between hospital and community care, less efficient allocation of resources between hospital and community care, and decisions being made too far from the patient, too far from the health and social care professional, and going through far too many layers of bureaucracy.

The new Health Regions will be responsible for delivering both hospital and community care to six clearly defined geographies. Any restructuring of this kind comes with very real risks, so why do it? Because we want the best outcomes and experience for patients, which comes with integrated care. Because we want patients to have that care provided in their community where possible and in hospital where necessary. Because we want decisions made closer to where the care is provided, by the people providing the care. Because we want our health service running as efficiently as possible, with resources deployed between hospitals and community care in the best way possible. Because we want each Health Region to have a clearly defined geography and population that it serves, and whose local needs it really understands. Because we want balanced investment in health and social care services around the country.

This implementation plan is the result of a big effort by a lot of people. Critically, the work has involved representatives from the most important groups – patients and service users and frontline health and social care professionals. I would like to extend my thanks to all involved in this endeavour for getting us to this point.

1. Executive Summary

The implementation of HSE Health Regions (formerly known as Regional Health Areas or RHAs and referred to as Health Regions hereafter) involves the internal reorganisation of the HSE into six operational regions with responsibility for the planning and coordinated delivery of health and social care services within their respective defined geographies. These new arrangements aim to improve the health service's ability to deliver timely integrated care to patients and service users, care that is planned and funded in line with their needs at regional and local level. One of the core objectives of this reform is to realign the incentives and drivers present within our health and social care system so that it is directed more towards providing care for people closer to home and keeping people healthy and well. This approach is in line with the Government's commitment to universal healthcare as well as recommendations made in the Oireachtas Committee on the Future of Healthcare Sláintecare Report.[1]

In April 2022, a Memorandum on next steps, the programme of work, and timelines for Health Region implementation was approved by Government.[2] This Implementation Plan sets out a high-level programme of work, with a view to standing up the Health Region approach from February 2024, in line with the Programme for Government's Universal Healthcare Mission and the overall design principles and objectives of Sláintecare. A map of the regions is provided on page 9.

Health Regions as Part of Wider Health and Social Care Service Development

A Health Region approach must also be considered in the context of the wider health and social care sector reform and expansion programme, and the interdependencies between their imminent implementation and wider system changes. In 2022 and 2023, central elements of this reform have and are being achieved, including the introduction of the new public-only consultant contract, a new community-based service, Enhanced Community Care, and eligibility expansion measures. At the same time, important new Programme for Government measures – which are also essential to universal healthcare - are also progressing. These include clinical strategies and services, acute and critical care capacity building, and new eligibility measures. We can see the seeds of integrated, universal care being planted in measures such as the Enhanced Community Care programme and introduction of new integrated care pathways, as well as measures that seek to integrate teams of health and social care workers working across different locations. These are aligned with and build upon the direction of travel set by Sláintecare.

However, as much as has been accomplished via these measures, they must now be supported by introducing structures that further merge the governance, management, and funding streams for acute and community services.

The progress being made was underpinned by the highest investment in health and social care in 2022 and 2023 in the history of the State. Through the last three years, we now have an additional 17,298 staff working in our health services, 2,400 healthcare workers recruited to provide more care in the community, 970 additional acute beds, and a 25% increase in critical care capacity. It has enabled investment in innovation and the delivery of integrated services, by investing in people, new care

[1] Committee on the Future of Healthcare (2017). Sláintecare Report. Dublin: Houses of the Oireachtas.
[2] Business Case for the Implementation of Regional Health Areas (2022). Dublin: Government of Ireland.

pathways, new technologies, new facilities, and new ways of working that will enable us to better respond to the growing health needs of our population.

Case for Change

While much work to reform and improve our health and social care services has been done and is in progress, the creation of internal Health Regions within the HSE represents an important improvement in corporate and clinical governance. While this does involve changes in the organisation of services, the organisational change is not the primary objective in itself. The primary objective of this reform is to **help deliver universal and integrated care for people**, providing them with timely access to the care they need, when they need it. This will help to ensure that the needs of people are prioritised by **promoting a culture** that seeks to continuously improve the access to, and quality of, health and social care services. This will be achieved by refining processes and minimising structural barriers to integrated care. This includes waste of patient and service users' time and staff skills, thereby increasing productivity and the consistency, effectiveness, and efficiency of services. The **changes in healthcare governance arrangements are being designed to make our services easier to navigate for people**, and to facilitate more integrated care, stronger accountability, and greater transparency across the sector. This in turn aims to foster change and innovation at a local level to deliver high-quality services to populations based on their needs, making our service a better place to work for our staff.

Organisational change is inherently risky, however. There will always be an opportunity cost involved when time, attention, and resources are diverted away from other competing priorities. International experience would suggest that structural reform alone cannot impact on patients' experience, when the underlying issues are not also addressed as part of the change programme.[3]

Nonetheless, the risk of continuing "as is" outweighs the risks of Health Region reform. Misaligned incentives through siloed structures pose a considerable challenge to integrated care, productivity, and continuous service improvement for the HSE. Our current structures do not sufficiently encourage multidisciplinary ways of working across care settings. Similarly, staff often do not feel empowered to make necessary local decisions to improve care provision consistent with patient needs. As a result, patients and service users experience fragmented care, or cannot access the care they need in a timely manner. Misaligned geographies between acute and community services results in a lack of balanced, equitable regional investment. This impacts the delivery of more integrated care and contributes to the pressures on urgent and unscheduled care.

The move to a regionalised approach, in response to some of these risks and issues, represents a major shift in the approach to the planning, funding and delivery of health and social care services. In line with international best practice – such as experience in New Zealand and Canada – the new arrangements will support a population-based and productivity-focused approach to the planning and resourcing of the geographic delivery of services to improve health outcomes people in Ireland. Health Regions will be better able to understand and respond to changing population needs, focus on prevention and keeping people healthy and well, and provide and coordinate integrated and person-

[3] Quigley *et al.* (2019). *Regional health organisations - an evidence review.* Dublin: Health Research Board (HRB); EY (2020). Considering international best practice to support the implementation of Regional Health Areas (RHAs). Commissioned by the Sláintecare Programme Implementation Office.

centred services. The implementation of Health Regions requires a shift in how we plan health and social care services – one that includes voluntary organisations, GPs and other health and social care professionals not employed directly by the HSE and should facilitate cross sectoral working at regional and national level.

High-Level Roles

A central principle throughout Health Region implementation is the enablement of effective service delivery and continuity of care. Essentially, this means that operational and other relevant decisions are taken as closely as possible to patients and service users. This will be done within the context of national policies, procedures, and priorities on a clear framework of delegation and assignments. This principle sees us examining and removing layers of decision-making that can often frustrate local staff in providing integrated services. The HSE Centre and the two Government Departments (the Department of Health, and the Department of Children, Equality, Disability, Integration and Youth) will perform those tasks which cannot be performed at a regional or local level, and which allow Health Regions to focus on the provision and coordination of integrated services. In this context, the transition to Health Regions will have a significant impact on how the HSE Centre, the Department of Health (DoH) and the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) work together in fulfilment of their roles and responsibilities.

Health Regions will have appropriate operational budget authority, including over their staffing and other resources, within a framework of standard policies and national priorities. This will bring decision-making closer to the point of service delivery. Health Regions will be our core service delivery entities. They will be regional structures which are enabled to plan, manage, and deliver integrated care for people in line with the needs of their regional populations and in partnership with stakeholders.

Governance

Regional Executive Officers (REOs) will be accountable and responsible for regional health and social care services. REOs will report directly to the HSE CEO on the operation and management of the Health Regions. REOs will form part of the core HSE Senior Leadership Team, providing regional input into the development of national policies and standards.

As per the Health Act 2004 as amended, under Part 4, Section 19, the HSE CEO will delegate the authority as described in this plan to the Regional Executive Officers (REOs) in early 2024 within a clearly defined Framework. In keeping with lessons learned from previous health system reforms and international experience, Health Regions will aim to balance the need for national consistency with greater regional autonomy and associated accountability closer to the frontline. REOs will form part of the core HSE Senior Leadership Team and report to the CEO. The future HSE Centre and Health Region management structures will support more streamlined decision-making.

In furtherance of this, the CEO of the HSE is currently undertaking a review of the HSE Centre as a part of the delegation of many aspects of operational decision-making to the Health Regions. The HSE Centre will have responsibility and accountability for ensuring that nationally consistent standards, guidelines, and models of care are developed in a way that is collaborative with Health Regions and that appropriate supports are available to Health Regions. These are important for ensuring that the

population can have equitable access to quality integrated services that support population health improvement and enhance prevention, regardless of location.

The HSE Centre will be focused on activities that are best performed at national level, rather than operational matters e.g. implementation of Government policy and strategies, elements of infrastructure and estates, risk, and national frameworks for research. This means that the HSE Centre will devolve responsibility and authority for delivering the vast majority of services to the six regions. The HSE Centre will oversee the delivery of nationally delivered clinical and supporting services. In collaboration with the Health Regions, the HSE Centre will define national service requirements and standards and will monitor and assure the performance of the health and social care service delivery system as a whole.

The DoH will be responsible for setting health policy and strategy. The DoH will lead on the development of legislation and regulatory policies. The DoH retains its role in overseeing the distribution of Government funding to health and social care services. The DoH will retain an oversight role in ensuring that health service activities are carried out in line with overall Government priorities, and their role in overseeing public investment. The DCEDIY will be responsible for the development and clarification of Government policy, legislation, and funding for specialist community-based disability services. The two Government Departments are committed to working collaboratively with each other and other health and social care stakeholders as this reform progresses.

Transition and Implementation

Although the full implementation of restructuring will be a multi-year journey, the Health Region approach will be stood up from February 2024 and will continue to progress throughout 2024. During 2023, the responsibilities and boundaries of the existing six Hospital Groups and nine Community Healthcare Organisations (CHO) will be brought in line with the new Health Region boundaries. The aim is that the six REOs are in place and will hold accountability for the delivery of services and associated resources from February 2024. CHO and Hospital Group management teams will support and report to the REOs in early 2024 while the Health Region Executive Management Teams are being appointed. By the end of 2024, the existing Hospital Group and CHO structures will be stood down as the new Health Region arrangements are established.

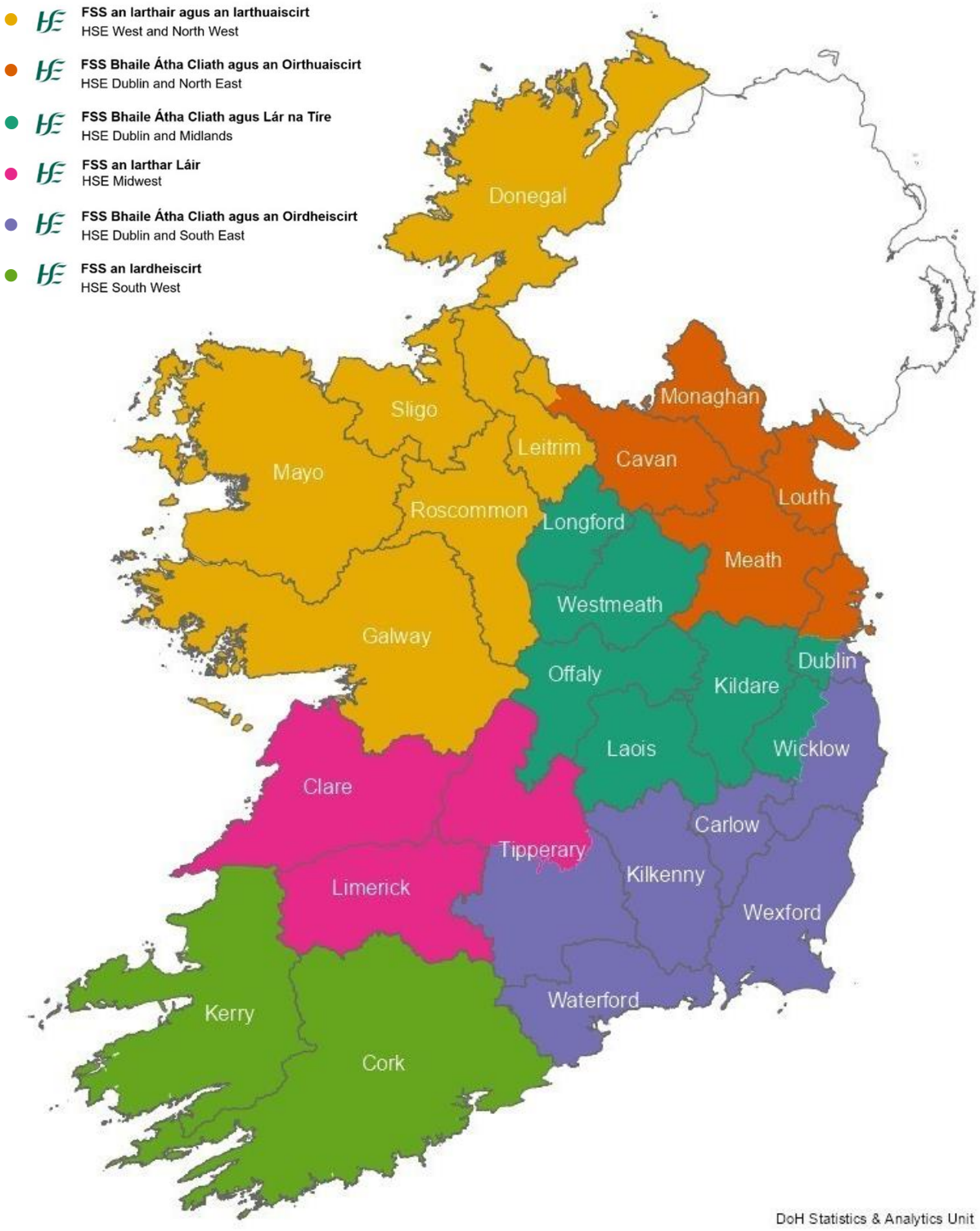
The scope of activities that need to be undertaken throughout 2023 to achieve the desired transition state by February 2024, and to continue to prepare the system for Health Region implementation throughout 2024, has been carefully considered and assessed across four key themes: Leadership, Vision, and People; Model of Integrated Care and Healthcare Governance; Planning and Finance; and Infrastructure, including Capital, ICT and Supports. These changes will have a significant impact on the existing system, but the plan is committed to ensuring continuity in the provision of safe, high-quality services during the transition phase.

As part of the new way in which we envisage health and social care services being delivered, it is currently proposed that planning for each region will be devised on a small areas basis which will take account of varying geographies, population size, local needs, and services for the purposes of service operations. It is broadly intended that each area will serve a population size of up to 300,000 for service planning and delivery. This approach builds on work already undertaken to establish Community Healthcare Networks (CHNs) and specialist hubs. This Plan has been developed following

engagement with key stakeholders, including patients and service users, from across the health and social care services. It seeks to build on system-wide insights on how the Health Regions will be implemented, as well as incorporating lessons learnt from the evolution of health service structures in Ireland over recent decades, and findings from international research. The priority for 2023 is to continue working in partnership with stakeholders to progress detailed Health Region design. This will involve working closely with clinicians, service managers, and patients and service users to consider care pathways, and to identify and address factors that are impacting productivity and the delivery of high-quality, integrated care. Care or referral pathways will change through this process only if clinically agreed.

We know that the implementation of this Health Regions organisational restructuring will not provide an immediate resolution to our present challenges and should not be considered a panacea for all the challenges our health and social care system faces. A Health Region approach will, however, play a pivotal role in supporting the achievement of integrated care and moving toward universal healthcare. The move towards Health Regions provides the optimal basis for the reorganisation and planning of health and social care services in furtherance of Government's priorities of improving timely access to universal, high-quality health and social care.

Map of HSE Health Regions and County Boundaries[4]



[4] West county Wicklow continues to be aligned with Kildare for health services, and a small portion of west county Cavan continues to be aligned with Sligo/Leitrim for health services, in recognition of existing patient flow patterns.

2. Vision for HSE Health Regions

This section outlines the vision, aims and the key design principles which will guide implementation of the Health Region approach and the adoption of whole-of-health-system planning for the delivery of integrated care.

2.1. Vision and Aims

The overall vision for our national health and social care system is universal healthcare, ensuring the Sláintecare objective of the right care in the right place at the right time for all. The organisation of the HSE along clear regional lines aims to facilitate the delivery of integrated health and social care designed around people and planned around communities. Integration will be achieved through the alignment of hospital-and community-based services and through a holistic partnership with GPs, Pharmacists, and the fuller range of health service providers at regional and at national level. This will see Health Regions function as part of a strengthened national health and social care service with their own budget, their own Executive Management Team, and increased local autonomy and decision-making.

Health Regions will be empowered and resourced to collaborate, share lessons and innovative ideas, and with appropriate support from the HSE Centre they will aim to:

To deliver **timely access** to safe, high-quality, integrated care to all patients. This means **person-centred** health and social care services that are **informed by the needs of the people and communities** in each region, better serving people at all stages throughout their lives

To **align** hospital and community-based services in each region so that they can **work together** better and deliver joined-up, **co-ordinated care closer to home**. This will help to ensure that we have a highly productive, transparent service with aligned incentives

To **improve regional investment** and **balance national standards** of care and direction with **local decision-making**. This aims to ensure that people can access the **same quality of care** no matter where they live, and resources are **fairly allocated and accounted for**

To **improve the health and well-being** of people in each region by ensuring that services are **planned around local needs**, people are **well-informed** and supported when accessing services, and **health inequalities** are identified and addressed

2.2. Design Principles

Design principles for the Health Region approach were developed around key themes, aligned to the vision set out above, and updated as the programme progressed. The design principles are as follows:

Theme	HSE Health Region Design Principle
1. Patient-focused integrated care outcomes for service users and patients	Design will ensure that the introduction of Health Regions and associated system reforms enable the delivery of high-quality, integrated health and social care services to meet the needs of the population and deliver positive outcomes for service users and patients.
2. Governance and Accountability	Design will apply the principle of subsidiarity and ensure clear definition and understanding of governance, clarity of mandate, clear lines of accountability and reporting lines for the Health Regions as subdivisions within the HSE.
3. National Consistency	Design will ensure that the model is set up to ensure national consistency in appropriate areas, e.g. models of care and patient safety standards.
4. Devolved Decisions and Activities	Design will support increased, empowered, devolved decision-making in the Health Regions and other service delivery entities and will ensure activities are closer to patients and service users where possible.
5. Our People	Design will ensure that the Irish health and social care system is an attractive place to work, and allows staff to maximise their potential and productivity, as well as providing opportunities for career progression and skills development.
6. Clear Interfaces, partnerships, and aligned incentives	Design will ensure clear interfaces and aligned incentives are defined for all Irish health and social care system internal and external stakeholders. This will support a highly productive, transparent health and social care service that enables transparent communication, enhanced collaboration, and the building of positive trusted relationships, including with GPS, Pharmacy, the Section 38 and 39 voluntary sector, and private providers.
7. Collaborate in Design	Design will ensure the voices of all interested stakeholders are considered, with early and ongoing engagement and a collaborative approach to seeking input on national and local services.
8. Maximise Data and Information	Design will ensure the HSE and wider health eco-system is set up to leverage and enable the better use of health and social care data and information, to drive holistic insight across the system and inform evidenced based decision-making and performance oversight. This will be done in line with the relevant regulatory requirements as well as policy standards and frameworks.
9. Use evidence to inform the design	Design will ensure consideration of evidence from multiple sources, including international learnings, and will be informed by relevant regulatory, policy standards and frameworks.

3. Population Health Planning and Integrated Care

3.1. Population Health Planning and Service Delivery

A population-based approach to planning aims to improve the health and wellbeing of the entire population by considering all determinants of health. It moves toward a holistic assessment of needs, equitable funding, and prioritisation of health and social care services. This approach seeks to address root causes of health inequities and support integrated care.[5]

Population needs will vary both within and between Health Regions. A population-based approach will enable Government to make informed decisions in relation to resource allocation, and to support Health Regions to plan and deliver services based on their specific demographic pressures. While this does not change the total quantum of funding provided through the annual Estimates process in any given year, a population-based approach better enables Government to distribute the funding available through the Health Vote equitably and transparently in line with population need. It also better allows for value-for-money assessments to be made that can link population health outcomes and the productivity of our system to the financial investments made. A population-based approach to service planning and resource allocation seeks to achieve allocative efficiency of available Government funds, greater predictability in health care expenditure, and more informed evidence-based decision-making at the local level.[6] Similar to work undertaken in Scotland and New Zealand, a population-based resource allocation (PBRA) model will be developed to inform the distribution of available healthcare resources according to population need.

3.2. The Role of Public Health

Public health and prevention are fundamental principles of Sláintecare. One of the key aims of public health is to ensure the health and wellbeing of the population, and we have clearly seen the important role this played throughout the Covid-19 pandemic. There is ongoing strategic and policy commitment to build an enhanced and strengthened public health function to serve as a foundation for a population health approach. This public health function not only seeks to manage major risks to public health, but to support and inform the continuing development and reform of the health and social care service. This includes delivery of a population-based approach to health planning and resourcing, as well as supporting and enabling integrated care under the four domains of public health, namely health protection; health improvement; health service improvement; and health intelligence. The HSE's public health medicine service – led by consultants in public health medicine and Area Directors of Public Health and supported by multi-disciplinary teams – is already in alignment with the proposed Health Region structures. This service is therefore well-placed to support the Health Region approach and the achievement of their objectives.

3.3. Integrated Care

Integrated people-centred healthcare means putting people and communities, not diseases, at the centre of health systems, and empowering people to take charge of their own health. Evidence shows

[5] Holmes, J. (2022). What is a population health approach? The King's Fund. https://www.kingsfund.org.uk/publications/population-health-approach

[6] McCarthy T. et al (2022). Towards Population-Based Funding for Health: Evidence Review & Regional Profiles. https://www.gov.ie/pdf/?file=https://assets.gov.ie/233689/57e2174e-39da-4474-bd56-87b269375918.pdf#page= null

that health systems oriented around the needs of people and communities are more effective, cost less, and improve health literacy and patient engagement. They are better prepared to respond to health crises, counter health system fragmentation and foster greater coordination and collaboration with organisations and providers across care settings.

Integrated care encompasses acute, primary, community and social care services / local authorities and involves public and private providers; patients and service users, and their families and carers; health and social care professionals; and the voluntary sector. They all work together in a joined-up way around the assessed needs of the person and the population. This requires new and enhanced pathways across care domains.

Integrated care offers many benefits to patients, service users, and staff, such as a more seamless and timely transition between community services, from acute to community services, or vice versa, which will positively impact the patient experience and the delivery of unscheduled and scheduled care.

To support integrated care, the Health Region approach aims to further establish and develop clinical governance pathways across community and acute sectors, ensuring best practice, reducing variation in patient / service user experience and empowering frontline workers to adapt to the changing needs of their patients and service users. The structures to support integrated care will be considered in the Integrated Service Delivery Model section.

3.4. Integrated Information to Support Integrated Care

Digital health and ICT play a critical role to allow health and social care professionals to access and share information quickly and efficiently, improve the accuracy and timeliness of diagnoses and treatment, and enhance the overall quality of care. It is critical that patients and service users have access to their data and shared medical records. Summary Care Records and Shared Care Records are core dependencies for integrated person-centred care.

Information sharing within and across Health Regions will be progressed through the Health Information Bill and the Digital Health strategy. The Health Information Bill will legislate for appropriate data sharing and the Digital Strategy currently in development will aim to address current gaps in the ICT infrastructure to enable joined-up care.

3.5. Measuring Impact

The development of appropriate performance metrics and measures is necessary to monitor the impact and success of population health planning and integrated care. The Health System Performance Assessment framework (HSPA), developed by the Department of Health (DoH) and HSE, supports evidence-informed health policy decisions and effective tracking of key strategies and reforms. Measuring the impact of population health planning and integrated care will consider several different factors, including:

1. **Patient Outcomes:** Patient outcomes will be assessed through changes in measures such as mortality, morbidity, quality of life, and user experience of care. A Health Region approach can facilitate analyses of outcomes by region and considering specific population needs.

2. Effective Use of Resources: Integrated care should result in improved productivity, efficiencies, and cost savings due to improved coordination of care and more effective use of resources; reducing waste and the average unit cost of care. Measurements include hospital length of stay, reduction in delayed transfer of care, hospital avoidances and hospital re-admission rates.

3. Accessibility: Measuring accessibility of services involves tracking the number of people who can and cannot access care, including those from marginalised groups, as well as the length of time they wait for care, and whether they receive the necessary services.

4. Quality of Care: WHO's quality-of-care programme aims to ensure that all people receive the best possible care by meeting seven criteria: safe, effective, person-centred, timely, efficient, equitable, and integrated care. Patient needs will be assessed by considering indicators from HSPA, patient and service user satisfaction surveys, clinical outcomes, and other measures of care quality.

Over time, regularly measuring these factors will help ensure continued health service improvement and improved outcomes from better integrated care as part of service provision.

4. Proposed Roles and Responsibilities

Roles and responsibilities will change as we align all our health and social care services within an integrated structure. This is with a view to enabling more seamless and coherent service delivery for patients and service users, providing a simplicity of structure and a clarity of governance. The organisation of the HSE along regional lines will enable a consistent One Health Service approach nationally and a clear operational and service-delivery focus regionally. The respective roles and responsibilities of HSE Health Regions, Voluntary Organisations, HSE Centre, HSE Board, Government Departments and Regional Health Forums are summarised below.

4.1. HSE Health Regions

At their core, *Health Regions will be the primary service coordination and delivery units for the vast majority of health and social care services* provided across Ireland. They will provide the governance and organisational arrangements to enable planning, management, and delivery of care for people and for communities across their region.

Governance, Service Planning & Delivery

Health Regions will be accountable and responsible for understanding the needs of their regional and local populations. These population health needs assessments will be undertaken in accordance with a national frameworks consistent across regions. They will be empowered to plan services in response to these needs. It is intended that all regions will be required to assess these needs in a uniform way.

Health Regions will have appropriate autonomy over how their various resources and providers are organised to deliver on the nationally agreed priorities. Health Regions will co-design a framework of nationally consistent standards, guidelines, and governance policies with the HSE Centre. Health Regions will build capability to inform estimates and the annual service planning process and operational plans for their region. They will develop a regional plan in line with national frameworks, need assessments and clinical programmes. With patient outcomes at the forefront, Health Regions will embed a culture of continuous improvement to support the delivery of high-quality services.

Regional Executive Officers will serve as members of the HSE Senior Leadership Team (SLT), thereby ensuring direct input into the suite of national standards, guidelines, and models of care. This will support the emergence of a coherent national approach to the development of health and social care delivery across their regions.

Health Regions will function within a national health and social care system. Where clinically indicated, patients may be treated in locations or facilities outside their own local region. It is intended to further develop mechanisms to account for this in governance and financial terms.

Research, Education, Transformation & Innovation

The regionalised approach will build on the closer relations established over recent years between Academic Teaching Hospitals and Hospital Groups to ensure that the benefits of Academic Health Science systems are embedded into the design and the culture of Health Regions. The aim is to foster even closer working relations between health and social care services and the further and higher

education system at regional and at national level, promoting excellence in clinical practice and clinical efficiency, to include a community care focus as well as in acute settings.

Health Regions will be tasked with harnessing the resources and skills available across health service providers in their region to provide for research ethical oversight, governance, management, and support services to promote research, transformation, and innovation within their region. This will be done to ensure that regions operate as part of a strategic national approach and as part of key EU initiatives to strengthen innovation in the health sciences and in health service development.

Finance

Health Regions will have appropriate operational budget authority and flexibility. Health Regions will operate within a budget informed by the population needs of their region and informed by Governmental priorities and policies. Health Regions will lead on making procurement decisions for their regions within co-developed national frameworks. Health Regions will conduct financial planning and analysis to ensure the appropriate utilisation of funds and will manage the financial performance within a region in accordance with national standards and guidelines. As Health Regions develop their approaches to financial and business functions, there will be a focus on ensuring that budgets are managed effectively and in keeping with good governance practices. In time, a nationally agreed formal mechanism will be put in place to allow patients and service users to transfer seamlessly between services offered in different Health Regions. People in all regions will have access to nationally delivered services based on agreed clinical care pathways.

People & Development

We are very fortunate to have so many staff who do their very best in a highly pressurised environment to deliver a high-quality service. Our staff have displayed commitment and exceptional resilience in the face of challenging levels of demand for health and social care. We need to improve the culture in our health service so that we rebuild trust and resilience among staff at all levels. Inherent to this is including staff in the changes that will impact upon them so that they have input and ownership of the new approach to health service delivery.

Health Regions will be empowered to develop their own workforce, including determining hiring needs, within national policy priorities and frameworks and the limits of their budgets. There will be a 'One-Health-Service' approach with nationally determined terms and conditions of employment and engagement for health and social care professionals. Payroll and pensions will be a centrally run service and mobility across regions will be facilitated. These national enablers will support regional management. Clinical and non-clinical leadership is central to the delivery of changes required by our health and social care system and will be an important focus within Health Regions and nationally.

Capital & Estates

Health Regions will work in partnership with the HSE Centre to ensure that regional population needs and priorities are appropriately reflected in national capital planning arrangements. This will include co-development of regional capital master-planning, informed by existing policy and strategic planning, and will collectively work with the HSE Centre to develop a single national capital investment plan. To enable devolved capital investment decision making, Health Regions will have capital and current funding to support business continuity developments and the management of infrastructure

risk at regional and local levels, allowing more agile responses to local operational requirements (clinical needs, infrastructural needs, and others) as well as risks and issues that arise. They will be responsible for estates maintenance within their respective areas, together with the associated staffing and funding. Health Regions will manage the delivery of relevant approved projects within their regions, in line with the annual capital plan and within relevant national frameworks. Each Health Region will have a senior leader in this area.

Data, Digital & ICT

Digital health, data, and ICT play a critical role in our health and social care services in delivering patient-centred integrated care. It will be important to have coherent national approaches to the digitisation of health services in terms of the Data and Technical Standards, and national approaches will be implemented in areas such as Summary and Shared Care Records, ePrescribing and the deployment of Finance, Estates and HR information management systems. Health Regions will support the implementation of national digital health projects. They will also deliver regional technology projects, provide local support, and develop data capabilities locally, while feeding into national health information developments.

Health Regions will administer digital and ICT systems within their regions, working in partnership with the HSE Centre to progress nationally approved frameworks and systems. They will also be involved in the development of architecture, data security, and procurement standards which will be led by the HSE Centre. Rather than seeking to constrict, these standards will act as enablers of innovation at a regional level by being implemented, disseminated, and administered in ways that allow confident action that aligns with the strategic aims of the health system and the needs of services users and front-line staff.

Every opportunity will be progressed to enhance data interoperability and to eliminate information silos within and across Health Regions. Data sharing within and across Health Regions – including voluntary organisations and private providers – is critical to ensuring continuity of care for patients and service users who may receive care across the country as reflected in the Health Information Bill 2023.

Change, Communications & Culture

Health Regions will manage regional communication activities, provide strategic communications support to the Regional Executive Management Teams, and work within agreed national frameworks with the support of the HSE Centre and shared communications infrastructure.

Health Regions will work with colleagues in the HSE Centre to build local change capability and capacity to strengthen each region's ability to lead and drive change to support an integrated culture, focused on delivering quality services for the needs of local populations. They will function as entities that are part of a larger national health and social care system. Health Regions will drive a culture of openness, transparency, and integration, to ensure successful change and improved service delivery.

4.2. Voluntary Organisations

Voluntary organisations, including Section 38 and Section 39 organisations, play a key role in service delivery in the Irish health and social care system. It is therefore crucial that the Health Region approach considers the partnership arrangements with voluntary organisations, the future governance of these organisations, and the process to engage with relevant stakeholders.

Partnership Arrangements

The recently published partnership principles will underpin the relationship between voluntary organisations and the Health Regions/HSE Centre. These principles are considered a set of mutually reinforcing elements and were developed by a sub-group within the Voluntary Organisations Dialogue Forum, established by the Minister for Health to provide a platform for regular and structured dialogue between the state and voluntary providers of health and social care services. The partnership principles are based on the experience of collaborative and productive relationships that emerged during the COVID-19 crisis. The principles are included in the diagram below, with further detail in Appendix 2.

Figure 1: Partnership Principles for the Health and Social Care Sectors

Governance

In considering the future governance of voluntary organisations, the organisations can be considered across four categories:

a) Regional voluntary organisations that will operate within a single Health Region, e.g. St Michael's Hospital.
b) Multi-regional voluntary organisations that will operate across regions, e.g. Enable Ireland.
c) Voluntary organisations delivering national specialist services, e.g. Mater major trauma centre.
d) Advocacy and representative groups, e.g. SAGE, Diabetes Ireland.

It is proposed that voluntary organisations will be funded by and will report into the Health Region in which they are located, or the Health Region which leads on the national service they deliver. The Health Region will agree the contractual relationship with the voluntary organisation and define the SLA within agreed national standards. This will allow them to incorporate their own region-specific service delivery needs into the SLA, within the limits of national standards and guidelines. Consideration will be given to having a singular SLA with entities that provide services across multiple Health Regions. In the case of multi-region voluntary organisations, the reporting relationship will be with the relevant Health Regions. Where considered appropriate, some SLAs may be retained nationally.

Engagement with Voluntary Organisations

Engagement with voluntary organisations will continue through the Voluntary Organisations Dialogue Forum to ensure that these stakeholders have a key role in ensuring that the future system is fit for purpose for all entities involved in service delivery for patients and service users. The partnership principles will underpin this work.

4.3. HSE Centre

The nature and role of the HSE Centre will change significantly. The HSE Centre will become strong, lean, and agile, becoming less operational and instead having a greater focus on supporting service delivery at the regional level through the co-development of national standards and frameworks, as well as developing national strategies and implementation plans aligned with national policy. The HSE Centre will have a key role in providing national oversight of the regions and health and social care system as a whole, with a primary focus on *Planning, Enabling, Performance and Assurance*. In addition, the HSE Centre will continue to provide operational delivery of identified specialised services nationally.

Governance, Service Planning & Delivery

The HSE Centre will support Health Regions by ensuring consistent national frameworks and models of care and networked care pathways are co-developed. It will focus on more strategic activities, rather than operational, and will devolve responsibility and authority for delivering the vast majority of services to the regions. Health Regions will collaborate with the HSE Centre to co-design national service requirements and standards, with the HSE Centre enabling and assuring the performance of the health service delivery system as a whole against agreed performance metrics. The Performance and Accountability Framework of the HSE will be revised to reflect the new governance and organisational arrangements.

The HSE Centre will plan, resource, and deliver a small cross-section of services, namely, national services (e.g. National Ambulance Service, National Screening Services, National Environmental Health Service, and the National Office for Suicide Prevention) and national shared services (e.g. PCRS, Statutory Home Support Scheme), which would not be efficient for a single Health Region to deliver. The HSE Centre will proactively seek to avoid unnecessary duplication of national functions in the six Health Regions. The National Ambulance Service will work closely with each Health Region to support patient flow and will have a senior officer available to the REO.

The HSE Centre will co-develop frameworks for conducting population health needs assessments in collaboration with the Health Regions and the Government Departments. It will conduct national health and social needs assessments to understand the needs of the national population. It will coordinate and ensure a consistent approach to strategic planning across the HSE, based on both national priorities and local needs, supporting regions to build this capability over time.

In collaboration with the regions, the HSE Centre will coordinate strategic priority setting for the HSE every three years, in line with Governmental policy. The HSE Centre and Health Regions will coordinate the estimates and planning processes for the development of a single national service plan for the organisation on an annual basis. This national plan will comprise regional chapters, written with the purpose of expressing how services will be delivered in accordance with national priorities and addressing health needs of their regional populations. The HSE Centre will have a key role in monitoring the performance of the Health Regions, in line with their functions in support of the HSE Board.

Learnings, experience, and work completed by the National Cancer Control Programme, National Women and Infant's Health Programme, the National Clinical Programmes (NCPs) and Integrated Care Programmes will be leveraged to ensure that the quality of services provided across the country is high and standardised. These programmes were established with the aim of providing models of care and service design that are based on population health needs, are patient-centred, multi-disciplinary and integrated across all service domains. They have provided the foundation stones for the transformation of healthcare aimed at providing safe, effective, and integrated care using an evidence-based approach. This work will continue and will be done at national level in recognition of the fact that patients and service users often need to access multiple care pathways or models of care at once.

Research, Education, Transformation & Innovation

The HSE Centre will have responsibilities to support strategic workforce planning and to work in partnership with the further and higher education sectors and relevant Government Departments in order to ensure adequate staffing of health services into the future. The HSE will have a critical and clinical input into the determination of future skills needs and will be relied upon to support the practical and placement aspects of initial and continuing training. The integrated care model offers opportunities for shared modules and shared learning among students of health and social professions.

The HSE Centre will ensure that effective supports for health research and innovation are embedded in service development and delivery. As part of implementation, the HSE Centre will put in place a framework to facilitate the engagement of health and social care service providers with commercial and academic partners. The HSE Centre will facilitate and incentivise the performance of research nationally by informing funding agencies of priorities and will use information to inform future national research strategies. The HSE Centre will also be responsible for developing standards and frameworks to support an agile approach to innovation, promoting the sharing of innovation across the health system.

Finance

A key function of the HSE Centre will be to drive operational efficiencies by delivering process and transaction-led services through a national shared service model. With Health Regions and the Departments, the HSE Centre will jointly determine service activity levels and associated performance targets to be delivered within allocated funding and will be responsible for monitoring the financial performance of Health Regions, in line with nationally defined performance metrics. The HSE Centre will also modify the existing Financial Management Framework and develop a suite of standardised processes to ensure consistency of approach across all regions. That framework will support Health Regions to develop their approaches to business functions and financial management and will have a focus on ensuring that Health Regions maximise value for money invested in health and social care services. It will also emphasise the accountability mechanisms in place for monitoring Health Regions' expenditure. This dovetails with the revisions needed to the HSE Code of Governance and Performance Accountability Framework. As a key enabler for this reform, it is critical that the HSE Centre deliver and maintain the Integrated Financial Management System.

People & Development

The HSE Centre will conduct national workforce planning, in collaboration with the Health Regions and DoH, and coordinate the development of a resourcing strategy to address Health Region and wider HSE resourcing needs. The HSE Centre (including HR Shared Services) will continue to roll out the National Integrated Staff Records and Pay Programme (NiSRP) and will have responsibility for all payroll and pension-related activities. The HSE Centre will support the Health Regions with:

1. Population based workforce planning.
2. Selection and appointment of Health Region teams.
3. Centrally managed facility for mobility across HSE nationally.
4. Workforce impacts on transition.
5. Talent attraction and engagement.
6. Targeted professional development.
7. National industrial and employee relations matters.
8. Performance oversight role as is relevant to HR.

Capital & Estates

The HSE Centre, working with the Health Regions, will coordinate input to the estimates and planning processes and will develop a single annual national capital plan for the organisation, together with a longer-term capital infrastructure plan. The HSE Centre will plan, initiate, and approve national strategic projects and programmes as informed by larger Departmental aims and objectives and in line with Government requirements. It will continue to coordinate the national equipment replacement programme, manage the National Estates database, and manage 'above threshold' property transactions. It will work in partnership with Health Regions to co-develop national guidance and standards to ensure full consistency in relation to the planning, design, and delivery of health and social care estate developments, in line with the HSE Property Strategy.

The HSE Centre will work in partnership with Health Regions to ensure that regional needs and priorities are appropriately reflected in national capital planning arrangements. Health Regions will be

central to developing the capital project prioritisation criteria used to assess individual capital submissions. Health Regions will also be a principal stakeholder in the annual capital plan prioritisation process with the HSE Centre, balancing national requirements and regional needs.

Data, Digital & ICT

The HSE Centre will work within the context of the forthcoming Digital Health Strategic Framework and the implementation will include strong engagement with and input from the Health Regions.

Summary Care Records and Shared Care Records are enablers of the integrated person-centred care that the Health Regions are designed to promote. Large national digital health projects such as ePharmacy and ePrescribing will also need national approaches to implementation. The HSE Centre will lead on projects such as this and will serve as a focal point for ensuring that nationally consistent approaches are taken with regard to digital health developments.

Cybersecurity is a critical function that requires an overview of the entire system. It is therefore considered to be a national function; however, security is everyone's responsibility, and should be considered in every decision and activity. The HSE Centre will monitor for cyber threats, manage cyber risks, produce guidance, and deliver security information programmes, with the Health Regions participating in monitoring regional systems, as appropriate. The HSE Centre will also ensure alignment and compliance across the health and social care system with national and EU regulations and directives.

Change, Communications & Culture

The HSE Centre will conduct all communications activity relating to national functions or national communications requirements, including providing strategic communications support to the CEO and leadership of the HSE. The HSE Centre will work with Health Regions to define and implement the HSE's communications strategy, processes, and standards, nationally and regionally. It will develop the HSE communications infrastructure including the HSE website and national content, social media, advertising, media-buying and related procurement frameworks, and will coordinate media relations, crisis response, public affairs, and stakeholder engagement services.

Positive culture is a core enabler to empowering staff in delivering better and more integrated services. The HSE Centre will work closely with Health Regions to enhance change capability and capacity across the regions, building on local strengths and networks.

4.4. HSE Board

In line with the Government Decision in April 2022, Health Regions will continue to be part of the HSE rather than their own legal entities and as such will not have their own boards. Health Regions will report to the HSE Board via the HSE CEO. The HSE Board retains a governance and oversight role as set out in legislation. Therefore, the primary accountability for corporate governance remains with the HSE Board, sub-committees of the Board, and the HSE CEO. The HSE Board remains accountable to the Minister and DoH for all regional and national service provision in line with strategic priorities.

4.5. Government Departments

The DoH and the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) will focus on *Policy, Strategy, Oversight, Legislation and Funding*. They will develop Government policy positions and deliver legislation and regulations for health and social care, with DCEDIY's role pertaining to specialist community-based disability services. The two Departments will retain an oversight role in ensuring that service activities are carried out in line with overall policy priorities, achieving agreed-upon national health outcomes, and system-wide objectives. Joined-up service planning and delivery requires joined-up policy, and other Government Departments and agencies also play an important role in how our health and social care services are supported.

Governance, Service Planning & Delivery

The two Departments will convert Governmental priorities into health legislation and policy, which will substantially and significantly inform the HSE Centre strategies. DoH will provide overall direction, policy, and legislation in relation to health and social care needs assessment, as well as providing strategic guidance and funding to the HSE Centre and Health Regions. DCEDIY will perform this function for specialist community-disability services. The Departments will work in tandem to ensure alignment of governance processes for the HSE and health service providers.

There will be one annual National Service Plan (NSP) which is approved by the Minister for Health and Government. This plan will include separate sections for specialist community-disability services which will be signed off by the Minister for Children, Equality, Disability, Integration and Youth. Similarly, there will be one capital plan which DoH will approve via the Minister for Health, again with separate sections for specialist community-disability services (which will be signed off by the Minister for Children, Equality, Disability, Integration and Youth).

DoH will be responsible for overseeing the performance of the HSE. This includes developing strategy, setting standards and policy, and monitoring and evaluating progress against strategic priorities and agreed high-level indicators. DCEDIY will be responsible for overseeing the performance of the HSE with respect to specialist community-based disability services.

Research, Education, Transformation & Innovation

DoH will develop national health and social care research legislation and policy and will identify health strategic research priorities both as part of the overall national research strategy and specific departmental research priorities in alignment with DoH health policy needs. Similarly, DCEDIY will perform these responsibilities as they pertain to their area of responsibility.

DoH and DCEDIY will continue to liaise with other Government Departments to ensure that the skills that the health service needs within its workforce are met in the long term.

Finance

DoH and DCEDIY will coordinate the budget and estimates process and engage with Department of Public Expenditure, NDP Delivery and Reform (DPENDR), to agree the overall health sector budget and budget for disability services, respectively. The Secretaries General of DoH and DCEDIY will remain the Accounting Officers and, as such, have responsibility for the approval and safeguarding of public funds

which have been allocated under the Health Vote and the DCEDIY Vote. This also includes ensuring the effective and efficient administration of those funds. This takes the form of value for money assessments of funding allocated to via the Health Vote and spent by Health Regions and the HSE Centre. DoH will lead in the development of the population-based resource allocation (PBRA) model for its funds with input and advice from an Expert Group.

People & Development

DoH, in collaboration with the HSE, will conduct long-term strategic workforce planning for the health system as a whole (private and public) and provide a clear view on macro supply and demand and future skills requirements. It will implement relevant actions in the resourcing strategy to address workforce gaps, including legislative change and working proactively with other relevant Departments of Government.

Capital, Data, Digital & ICT

DoH and DCEDIY will secure annual funding allocations, develop the longer-term national health capital plan and national digital health strategy framework informing the National Development Plan (NDP). They will also contribute to the development of criteria and an evaluation framework for capital project prioritisation, approve digital ICT plans, and sanction investment in projects greater than €200m in line with the Public Spending Code. There will be one annual capital plan which DoH will approve via the Minister for Health. This plan will include separate sections for specialist community-disability services which will be signed off on by the Minister for Children, Equality, Disability, Integration and Youth.

Change, Communications, & Culture

DoH will coordinate communication services for the Department, including Governmental media relations, public affairs, and crisis responses, internal, digital, social, Freedom of Information requests (FOI) and Parliamentary Questions (PQs). The two Departments will continue to promote improvements and reforms within our sector that are in line with Government's commitments to universal healthcare. This includes the associated culture change required at whole-system level to deliver population- based services based on people's health and social care needs.

4.6. Regional Health Forums

There are currently four regional health forums which will be developed to align with the Health Regions. The four Regional Health Fora were established in 2006 to promote democratic representations and feedback from people on the range and operation of health and personal social services in their area. As part of this work, the current Regional Fora arrangements will be aligned to the Health Regions.

5. Integrated Service Delivery

Integrated care is foundational to ensure that everyone in Ireland can access the right care, at the right time, in the right place, with the right team. Designed first and foremost around the needs of the person, integrated care has the dual aim of improving both system efficiency and service user experience and outcomes.[7, 8, 9, 10, 11]

5.1. Integrated Service Delivery Model

In order to deliver integrated care, it is necessary to design a model of integrated service delivery for the Irish health and social care system. At its core, this will be the operational model for the Health Region approach and national services. In order for form to follow function, we are considering how best the operational management of hospital- and community-based services will be structured from the ground up to provide an integrated experience for people using them, taking learnings from the implementation of Hospital Groups and CHOs and ensuring that the associated benefits achieved are maintained.

We acknowledge the multiplicity of contracted services and voluntary organisations who work alongside our statutory services, delivering a very significant proportion of care. To this end, the HSE and the Department are committed to engaging with the relevant partners across the system in developing the Integrated Service Delivery Model.

Learnings and experience from the National Clinical Programmes (NCPs), and Integrated Care Programmes will be leveraged to develop this integrated service delivery model and facilitate the provision of integrated care, acknowledging that patients and service users often need to access multiple care pathways or models of care at once. The NCPs were established with the aim of providing models of care and service design that are based on population health needs, are patient-centred, multi-disciplinary and integrated across all service domains. The NCPs have provided the foundation stones for the transformation of healthcare aimed at providing safe, effective, and integrated care using an evidence-based approach.

The evidence base of integrated care in Ireland and internationally has also been considered. We completed an International Research review to examine six international health systems which are currently undergoing reform. In addition, structures of health systems abroad were the subject of a Health Research Board Evidence Review. This has also informed thinking regarding the future form of Health Regions.[12]

For integrated care to be effective, we recognise that all levels of our health and social care system must be integrated.[13] Building on the progress to date in the context of the Community Healthcare

[7] HSE (2014). Community Healthcare Organisations: Report & Recommendations of the Integrated Service Area Review Group - Frequently Asked Questions, p. 3. https://www.hse.ie/eng/services/publications/corporate/cho-faq.pdf
[8] Committee on the Future of Healthcare (2017). Sláintecare Report, pp. 18 and 72. https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf
[9] Dr Catherine Darker (2013). Integrated Healthcare in Ireland – A Critical Analysis and a Way Forward. An Adelaide Health Foundation Policy Paper: Trinity College Dublin. www.tara.tcd.ie/handle/2262/75958
[10] Darker, 2013, cited by Donnelly, S., Allen, C., McGrath, K., Barry, S. and Burke, K. (2021). Evaluation from the implementation of Community Healthcare Networks Learning Sites: Lessons from early and pre-implementation. Dublin, Ireland: The Centre for Effective Studies, pg. 99 – 101.
[11] HSE. Integrated Care Programmes. https://www.hse.ie/eng/about/who/cspd/icp/
12 Quigley et al (2019). Regional Health Organisations: Evidence Review. Dublin, Ireland: Health research Board.
[13] Donnelly, S., Allen, C., McGrath, K., Barry, S. and Burke, K. (2021). Evaluation from the implementation of Community Healthcare Networks Learning Sites: Lessons from early and pre-implementation. Dublin, Ireland: The Centre for Effective Studies, pg. 99 – 101.

Organisations (CHOs), Hospital Groups (HGs), and Community Healthcare Networks (CHNs), Health Regions are expected to support and enable integrated care at a number of levels:

- Integration between different parts of our primary and community health and social care services including GPs, Pharmacy and other non HSE partners;
- Integration between the totality of community health and social care services, primary health and social care services, and acute hospitals; and
- Integration with wider public services organisations in recognition of the wider social determinants and effects of health, e.g. local authorities, TUSLA, educational bodies, An Garda Síochána, local voluntary organisations, transport and housing bodies, and others.

It is acknowledged that structural change in and of itself will not ensure the successful delivery of integrated care, but neither must it be a barrier to integrating care. It is essential that the structures clarify how the frontline will link to the Health Regions and onwards to the HSE Centre, extending across acute and community services and encompassing the spectrum of health and wellbeing from prevention through to diagnosis, treatment, and survivorship.

The work of clinical directors, public health and multidisciplinary leaders at hospital, Hospital Group and CHO level will be supported and developed as we stand down the existing structures and transition to Health Regions. Clinical leadership will be critical to the success of the Health Regions and integrated care.

Clinical links will be maintained through existing hospital and community networks. Integrated care will continue to be grounded in national models of care including Integrated Care Programmes, Enhanced Community Care, and National Clinical Programmes.

5.2. Progressing Integrated Service Delivery Design

In order to progress detailed design for integrated service delivery (ISD), an Integrated Service Delivery Workstream Group has been established. This group is progressing the detailed design for ISD and will propose a preferred set of organisational arrangements to underpin, enable and support the provision of integrated care, i.e., the operational model of reporting and accountability at local, regional, and national level. The group is comprised of multi-disciplinary representatives from across health and social care services including patients/service users, academics, healthcare staff and managers, and policymakers.

The first step in detailed design has commenced to define the most appropriate structure to deliver integrated care within the HSE Health Regions, in line with the ISD design principles included in Appendix 3. This work is due to be complete by August 2023. Further work will be required throughout 2023, including agreement regarding how clinical networks, care pathways and service planning and delivery processes will underpin integrated care.

5.3. Integrated Health Areas

As the six regions each serve large populations in their own right, it is recognised that a sub-structure within each region will be required and must be designed from the ground up.

It is currently proposed that these sub-structures will be called **Integrated Health Areas (IHAs).** They will serve a population of up to 300,000**,** will take account of varying geographies, population size, local needs, and services. The existing 96 Community Healthcare Networks (CHNs) and the Community Specialist Teams (CSTs) will act as the building blocks of integrated service delivery, and each Integrated Health Area will be comprised of multiple CHNs / CSTs and will have primary access to at least one hospital.

Integrated Health Areas will also partner with local social services, non-governmental organisations (NGOs), local authorities, and other public bodies involved in broader determinants of health to reach patients and service users impacted by exclusion, disability, and/or poverty.

Further detailed design work will consider the alignment of proposed IHAs with national ambulance service areas, and emergency planning areas, as well as how national service providers will fit within the new structures. More work is required to finalise the approach to SLAs given the multiple different scenarios involved.

5.4. Senior Leadership Teams

Informed by early engagements with stakeholders, initial work has commenced on the design of the senior leadership team structures, both in the HSE Centre and in the Health Regions. Senior leadership is central to ensuring that there is early ownership of the change programme within the system. Their input in the design of future governance and service delivery structures for which they will be accountable is considered fundamentally important. In line with the bottom-up nature of Integrated Service Delivery Model development process, it is planned to allow time for that to conclude before the Health Regions Executive Management Team structure is finalised.

The Regional Executive Officers will serve as members of the HSE Senior Leadership Team and will report directly to the HSE CEO on the operation and management of the Health Regions. Regional Executive Officers will form part of the core HSE Senior Leadership Team, providing regional input into the development of national policies and standards. It is planned to undertake this reform on a headcount neutral basis with respect to senior level posts, with the exception of posts which have already been provided for in Estimates 2023, e.g. the Regional Executive Officers. This will be important in terms of ensuring efficiency, clear lines of reporting, and a strong lean HSE Centre.

6. Implementation Path for 2023 and Beyond

The full internal reorganisation of the HSE into Health Regions is a multi-year journey. The purpose of this chapter is to outline the extent to which the new Health Region arrangements are expected to be in place by February 2024, depending on the appointment of REOs, and the key preparatory activities required to achieve this in 2023 and beyond.

Due diligence for the safety of health and social care services during the transition to the Health Region approach will be critical. A detailed process of transition planning will be undertaken at a national level and within each region followed by phased implementation to allow for robust due diligence and risk management to mitigate against any quality and patient safety risks and disruption arising from the changes. A change management strategy will be developed and will be implemented in parallel to support staff across the system.

Given the complexity of the large-scale, system-wide transformation envisaged, and in the context of the current challenges faced by our health and social care services, it is vital that the organisational restructuring to Health Regions proceeds on an appropriately planned and phased basis to minimise service disruption and mitigation of risk, while ensuring momentum. The integration of all care services will be iterative but progressive and will be informed by the ideas of health and social care professionals across all levels of the HSE and the wider health and social care sector.

Implementation resources, infrastructure, and expertise will be required to support leaders – at all levels – as implementation progresses, building on and maximising existing capability as well as drawing on external resources. We plan to utilise internal resources who have the required substantial knowledge and skills to support the implementation programme supplemented externally where required, to successfully move to a Health Region approach.

This chapter also outlines some key Health Region programme processes that are in place to manage the restructuring – governance, change management and risk and dependency management.

6.1. Where we will be by February 2024

In considering the multi-year journey and implementation pathway for a Health Region approach, the actions for 2023 and 2024 were considered in line with the:

- Impact on achieving Health Region objectives.
- Ease of implementation and what can realistically be implemented by February 2024.
- Impact on services and operational performance day-to-day during the transition.
- Impact on staff roles, responsibilities, reporting lines or working arrangements.
- Pace of Health Region implementation to progress required changes with appropriate momentum.

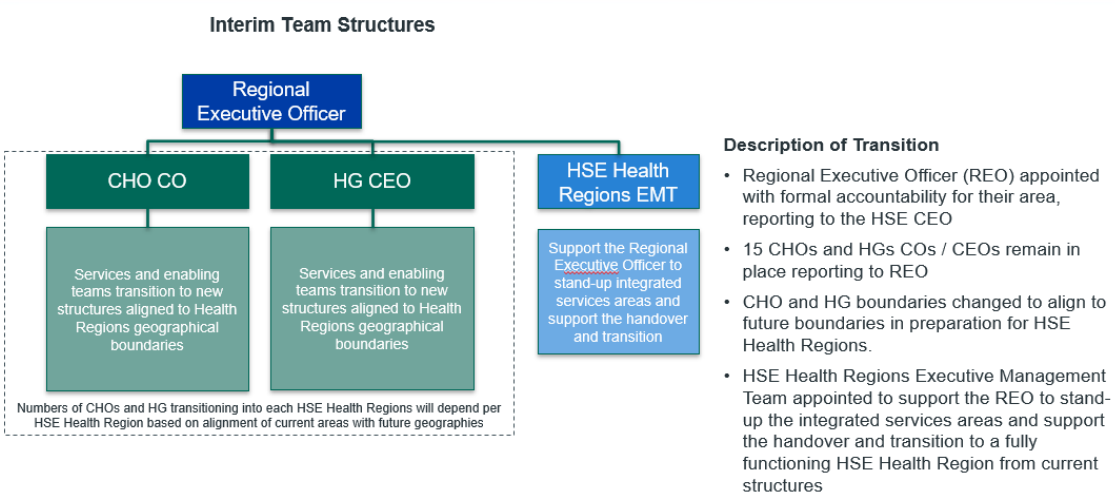
By February 2024, we aim to have:

1. Realigned geographical and operational boundaries of the existing CHOs and Hospital Groups consistent with the agreed Health Region boundaries.

2. Appointed the six REOs, with these officers fully accountable for the services and associated resources within their respective regions.
3. Developed revised staffing requirements/allocation, governance structures and processes within the HSE Centre to ensure appropriate supports are in place for the newly established Health Regions, consistent with their stated responsibilities.
4. Parallel engagement with voluntary organisations and non-HSE providers on aligning wider health and social care services to Health Regions to ensure a whole-of-system approach to implementation is adopted.

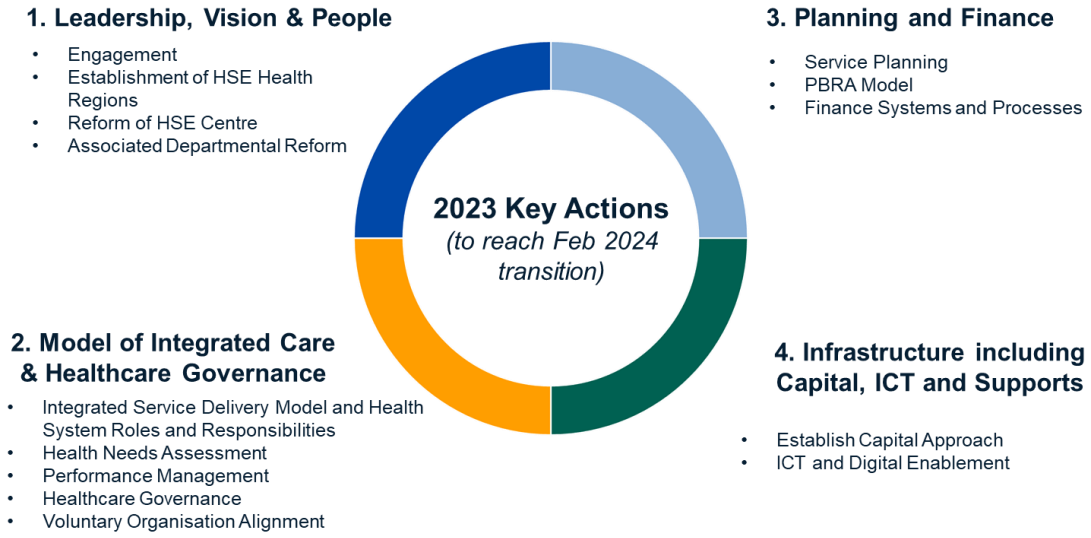
The existing CHOs and Hospital Groups organisational structures will remain initially in place, reporting to the new REOs; these structures will be stood down during 2024 as responsibilities are moved to the new Health Region Executive Management Teams. As neither Hospital Groups nor CHOs are currently legislated for, no legal changes are necessary to do this. As an interim arrangement, Hospital Groups and CHOs are currently grouped into regional pods.

These key actions were assessed as providing the best balance between mitigating the risk of impact on services and staff, while still making meaningful progress towards Health Region implementation. The proposed transition is outlined below:



6.2. Key Actions in 2023

To get to where we aim to be by February 2024 requires a decisive move to operations organised within the regions, the HSE Centre, and in the wider health and social care sector. The key actions for 2023 are grouped into four themes: 1) Leadership, Vision, and People; 2) Model of Integrated Care and Healthcare Governance; 3) Planning and Finance; and 4) Infrastructure, including Capital, ICT and Supports below. These will be enabled by a strong focus on engagement and communication throughout the transition phase. This is not exhaustive of all the activities that will be required to fully transition to a Health Region approach successfully.



Further information on each of these activities can be seen under each of the four headings below with a full list provided in Appendix 1.

Leadership, Vision & People

Senior leadership is considered central to ensuring that there is early ownership of the change programme within the system. The organisational design of Health Region team structures and associated roles and responsibilities will be finalised, with the involvement of new REOs, once appointed, along with development of key workforce processes to underpin this. The input of the REOs in the design of future governance and service delivery structures for which they will be accountable is considered fundamentally important. As mentioned in the Executive Summary, the REOs will serve as members of the HSE Senior Leadership Team and will report directly to the HSE CEO on the operation and management of the Health Regions. As part of the core HSE Senior Leadership Team, REOs will provide regional input into the development of national policies and standards. Each REO will serve as the head of each of the six Regional Executive Management Teams.

Work will continue to finalise the job specifications for the REOs and develop those for Executive Management Teams, referencing both the transition state (i.e., where we aim to be by early 2024) and the end state. The recruitment process for REO roles will be completed, with CHO and Hospital Group management teams supporting and reporting to the Health Region in early 2024 while the

Health Region Executive Management Team is being appointed. As an interim step, Hospital Groups and CHOs are already meeting in regional pods that are reflective of the Health Region structures, and the associated interim HSE senior leadership arrangements has been established. This included a revision of the membership of the HSE Senior Leadership Team and the establishment of a wider senior leadership team reflective of the decisions of the HSE CEO.

Structures and roles within the HSE Centre and the DoH will be reviewed to reflect changes required to support Health Regions to best deliver integrated care into the future. Work will also continue on the workforce transition approach and principles to fill these structures at both Health Region and HSE Centre level, ensuring consultation with key stakeholders including staff representative groups and regulators.

Leadership, Vision, and People	
Activity	**Timeline**
Define the structure of the HSE Centre	September 2023
Conduct geographical impact analysis	July 2023
Agree staff appointment transition approach for Health Regions	September 2023
Define the structure of the Health Regions	September 2023
Align geographies to Health Regions	From September 2023
Progress integrated care pathways	Ongoing from September 2023
Health Region leadership – Appoint REOs	From October 2023
Health Region leadership – Agree EMTs	From October 2023
Conduct training needs analysis to support and upskill staff transitioning to Health Regions	From December 2023
Develop a phased learning plan for Health Regions and HSE Centre	From December 2023
Deliver required training programmes to leadership and staff	From February 2024
Clarify the Department of Health's role to enable Health Regions	March 2024
Engage with stakeholders	Ongoing

Model of Integrated Care including Healthcare Governance

Ensuring consensus and buy-in to a common purpose is critical to successfully transition to a Health Region approach. Central to this will be regular and meaningful engagement and consultation with staff representative groups in line with the nationally agreed change process. Staff and wider stakeholder groups will receive communications and briefings to ensure they understand the key changes associated with the organisational restructuring leading into February 2024 and beyond. Targeted professional development will also be delivered to leadership and staff to support the successful internal reorganisation.

Each region will have their own identity, consistent within national guidelines and understanding that each is part of the wider national health and social care system. An exercise will be completed with

the Communications function, working in partnership with patient and service user representatives and others to consider naming and branding for the Health Regions.

During 2023, we will seek to finalise the model of health and social care delivery to be adopted within each of the six regions. This model will seek as far as possible to follow a geographical approach with a view to best support delivery of integrated care to the relevant populations. The future roles and responsibilities of each entity in the context of healthcare governance will also be clearly defined ensuring absolute clarity in accountability and key handoffs or interfaces.

It will be essential to the effectiveness of the integrated service delivery model that high-quality and robust detailed design is completed for healthcare governance in the context of Health Regions, including engagement with patients and service users and multi-disciplinary clinical, public health and wider stakeholders (including the Health Regions Advisory Group). Work will also progress to define and agree the governance approach and partnership arrangements with Section 38 and Section 39 voluntary organisations.

Recognising the importance of effective clinical governance, it will be critical during 2023 that the national clinical governance framework is reviewed and updated, along with defining the approach to clinical governance within each region. This will also include the approach to increasing integration across community and acute services and the further development, alignment, and implementation of models of care. Additionally, in preparation for transition in 2024, the Code of Governance, governance policies and standards will be reviewed, and updated as appropriate, to reflect changes in accountability and authority.

As the Health Region approach seeks to move to a population focus, the process to conduct and complete regional health needs assessments will be agreed. These will be central to successful implementation of a population-based approach. Work will also progress to agree appropriate performance metrics and measures, informed by the health system performance assessment (HSPA) framework that has recently been developed by the DoH and HSE.

Model of Integrated Care including Healthcare Governance	
Activity	**Timeline**
Develop framework for health needs assessments	July 2023
Agree integrated service delivery model for Health Regions	August 2023
Conduct health needs analysis	From September 2023
Update HSE Code of Governance	November 2023
Agree Health Regions governance approach and partnership arrangements for non-HSE providers	December 2023
Undertake baseline analysis of resources by Health Region	December 2023
Agree performance accountability framework	December 2023
Agree baseline KPIs for Health Regions	December 2023
Implement integrated service delivery model for Health Regions	From June 2024

Planning & Finance

Given the complexity and scale of the health system, it will be critical that there is focus throughout 2023 on establishing clarity around planning and finance in the context of the future Health Region arrangements.

Focus will be given to developing a clear future process for service planning activities, including clarity on roles of different parts of the system, ensuring an emphasis on how best to ensure regional needs are considered. Future processes will also be defined for the development of the HSE corporate plan, service plan, capital plan and IT plan, including the roles at both Regional and National level.

The approach for allocating funding to Health Regions will be agreed, along with its associated governance mechanism. During 2023, a DoH-led PBRA Expert Group will be established, including representatives from the Departments, HSE Centre, Health Regions, Central Government, health economists and researchers in the area of resource allocation. The outputs of this Expert Group will support and inform Government decision-making as regards resource allocation.

Planning and Finance	
Activity	**Timeline**
Approve revised process for service plans	July 2023
Establish PBRA Expert Group	July 2023
Approve revised process for HSE corporate plans	June 2024

Infrastructure including Capital, ICT & Supports

During 2023, work will be progressed on a number of core infrastructure activities to ensure regions will be set-up for success, both by February 2024 and in the longer term.

A key priority for 2023 will be to define the critical Digital and ICT requirements for Health Regions, including necessary data requirements for both the February transition, and the medium- to long-term success of Health Regions. Particular focus will be given to supporting successful implementation of safe integrated service delivery pathways and needs of both workforce and patients and service users. It will also be critical to consider data and information governance and reporting to allow information led decision-making and KPI measurement for the regions.

From a process and governance perspective, the future approach for capital arrangements will be finalised and agreed, taking account of any implications of the Public Spending Code. This will include capital funding arrangements, capital planning, capital projects and management of estates and assets. In addition, the future approach to procurement will be designed and developed, supported by a single set of nationally defined and standardised procurement processes. Consideration will also be given to the physical infrastructure needs of each Health Region, including identification of the physical location of Health Region headquarters or main offices.

Infrastructure including Capital, ICT and Supports	
Activity	**Timeline**
Identify Health Region 'headquarters'	September 2023
Define critical Digital, ICT, and data requirements for regions	October 2023
Agree future approach to business functions for Health Regions	December 2023
Address critical digital, ICT, and data requirements for regions	January 2024
Agree future approach for capital arrangements in line with Public Spending Code to include capital funding, capital planning, procurement and delivery of capital projects, and management of estates and assets	January 2024
Complete branding exercise for Health Regions	February 2024

6.3. Key Actions in 2024 and Beyond

The Health Region Advisory Group has highlighted the importance of avoiding a leadership vacuum by the early appointment of core leadership teams to each Health Region, to take ownership of the implementation from the perspective of the Health Region as soon as possible. In line with best practice and the *Design Principles for Government in Ireland*[14], the detailed design of Health Regions will be co-created with users as part of an iterative process. This co-design process will include those ultimately responsible for the Health Region approach, i.e., the Health Region Executive Management Teams themselves, as well as patients and service users, staff, voluntary organisations, and other service providers. Once appointed, the Health Region leadership teams will be charged with driving the change management programme for the transition to a Health Region approach, working with system stakeholders in both the Department and the HSE. Empowering the Health Region service delivery teams to make continuous improvements in response to new insights and user needs will be key to the success of the Health Region implementation and ongoing evolution.

While there is a high-level plan for the organisational restructuring, a detailed plan for 2024 and beyond will be completed during 2023 and will be further informed by the REOs once they are appointed.

6.4. Health Region Programme Governance

As the Health Region Programme moves out of high-level design and into implementation, it is important that a robust governance pathway exists with input across a wide range of impacted stakeholders and service areas. This is with a view to ensuring that the decisions, challenges, scale of change, risks and dependencies associated with the implementation of Health Regions are fully understood, and appropriately assessed, in order to reach a well informed and considered position for the benefit of our patients, service users, and staff.

Two groups are currently being mobilised to govern the implementation of Health Regions:

[14]Department of Public Expenditure and Reform (2022). Designing our Public Services: Design principles for Government in Ireland. Dublin: Government of Ireland.

1. **The Health Region Implementation Planning Group**
   This is a dedicated governance structure, chaired by the Health Region Implementation Lead for the HSE, that will drive implementation of organisational restructuring at regional, national and Department levels, and monitor the progress of associated change activities.

2. **The Health Region Oversight Group**
   Chaired by the HSE CEO, the Health Region Oversight Group will be established to further oversee the successful management and coordination associated with the implementation of Health Regions. The Health Region Oversight Group will review and approve key decisions made by the Health Region Implementation Planning Group, and recommendations and outputs of the Health Region Oversight Group will be reported to and governed by the HSE Board and the Sláintecare Programme Board.

6.5. Change Management

The Health Region approach will require change to every aspect of our health and social care system including governance, structures, processes and systems, behaviours, culture, relationships, and how services are planned, funded, and delivered. Key to achieving this will be engaging with staff at all levels to co-develop a clear vision of the new shared values and behaviours expected for Health Regions, encouraging innovation, promoting collaboration, and fostering a culture of continuous service improvement.

The approach to change underpinning Health Region implementation is based on international evidence and learning from previous reform and reorganisation.[15] Our planning and transition approach will utilise the HSE Change Management approach as set out and agreed with the health sector unions. Briefings will continue with the National Joint Council of Unions, and we will work directly with relevant unions as required.

[15] DoH (2023). *Regional Health Areas Advisory Group Thematic Summary of Advice 2022*. Dublin: Government of Ireland. Barry, S., Stach, G., Thomas, S. and Burke, S. (2020). *Understanding Service Reorganisation in the Irish Health & Social Care System 1998 to 2020*. Dublin: Centre for Health Policy and Management, TCD; Donnelly, S., Allen, C., McGrath, K., Barry, S. and Burke, K. (2021). *Evaluation from the implementation of Community Healthcare Networks Learning Sites: Lessons from early and pre-implementation*. Dublin: The Centre for Effective Studies. Heslin, C. and Ryan, A. (2018). *People's Needs Defining Change – Health Services Change Guide*; HSE (2013). *Community Healthcare Organisations: Report & Recommendations of the Integrated Service Area (ISA) Review Group*; Quigley, J., Coyle, C., O'Dwyer, C., O'Brien, D., O'Nolan, G., Farragher, L., and Long, J. (2019). *Regional health organisations - an evidence review*. Dublin: Health Research Board.

We are taking a systems approach to the Health Region change programme, starting first and foremost from a patient and service user journey perspective. Critical to the provision and delivery of fully joined up and integrated care for our patients and service users, however, is constructive engagement and effective partnerships with and between all service providers across the health and social care system. People support the change they help to create, reinforcing the importance of early and sustained engagement to ensure that the needs of local communities and staff are central to the design and implementation process. The HSE Change Framework connects all of the elements that are needed to create the conditions for change with a particular focus on the people impact of change. It is intended to complement and align development interventions across the system to enable patient and service user engagement, quality and service improvements, and culture change in line with our values and public service ethos.

Ensuring change and improvement is resourced and supported at regional level will be key to the Health Region approach building on relationships and networks across the system.

6.6. Risk and Dependency Management

The Health Region Programme team tracks, monitors and manages key programme risks and dependencies that could impact the strategic, programme, and/or operational objectives on an ongoing basis. This is with a view to early intervention and mitigation where necessary, including escalation to the programme governance forums, and to the Sláintecare Programme Board as appropriate. A comprehensive risk register is maintained and is a live document where risks are added, updated, and removed as required. It is understood that with a change of this size and scale, risks and issues will inevitably emerge and will be mitigated as they come to surface.

Among these risks is the potential of duplicating functions or duties, particularly corporate functions, as we stand up the Health Region approach. As we make decisions regarding the new organisational structures for the regionalised approach, we will be particularly conscious of this risk. At the same time, we should also be conscious that our current system has 15 service delivery entities that we intend to stand down– nine Community Healthcare Organisations and six Hospital Groups (plus Children's Health Ireland, which will not be stood down). These provide services and some corporate functions. So, while we will be very conscious of the need to avoid unnecessary duplication of functions, we will be combining a number of teams performing key functions, thereby minimising duplication.

Another key risk is that of effective budget management and financial accountability as we seek to reorganise and transition the way in which services are funded. As new approaches to corporate and business functions are implemented, building systems that enable sufficient visibility on budgets and expenditure in Health Regions will be key and will be managed carefully through the transition. In as far as is possible, the transition of budgets to Health Regions will be done in line with our annual budget cycles to help maintain line of sight on allocations.

Key programme risks in the following categories have been identified and are currently being managed and mitigated against by way of a risk action plan:

- Governance, leadership, and timely decision-making.
- Complexity, scale, and impact of the Health Region implementation.
- Stakeholder engagement.
- Enablers, e.g. digital health, ICT, and data; PBRA model.
- Governance/Partnership with voluntary organisations/non-HSE service providers.
- Patient safety/Service disruption.

An initial list of key dependencies has been identified, both within the Health Region programme and with other critical national reform programmes, including but not limited to:

- The Health System Performance Assessment (HSPA) framework
- The Health Information Bill
- Digital Health strategies
- Waiting list reform
- Strategic workforce planning
- Public Health reform
- The rollout of the Integrated Financial Management System (IFMS)
- Strategic Healthcare Investment Framework (SHIF)
- Capital Plan (longer-term and annual)
  The development of models to support resource allocation informed by population health needs (PBRA)

This list of dependencies will be expanded as the programme progresses and, similar to risks, these dependencies are monitored and managed on an ongoing basis and associated issues are escalated to the appropriate governance forums if required. To ensure that Health Regions are integrated and aligned with other ongoing changes, the Health Regions programme teams are working in partnership with colleagues across the HSE and the DoH.

Appendix 1: Implementation Pathway

No.	Summary Action	Detailed Actions	Timeline
Leadership, Vision & People			
1.	**Define the structure of the HSE Centre**	HSE CEO to define the future structure of the HSE Centre to support the implementation of Health Regions	*September 2023*
2.	**Align geographies to Health Regions**	Conduct geographical impact analysis. Align the geographies of the existing Hospital Group and Community Healthcare Organisations. *(Date is dependent on the outcome of the impact analysis)*	*July 2023* *From September 2023*
3.	**Agree staff appointment / transition approach for Health Regions**	Develop and agree a staff transition strategy for Health Regions as structural changes are being implemented.	*September 2023*
4.	**Define the structure of the Health Regions**	Define the structure of the Health Regions.	*September 2023*
5.	**Progress integrated care pathways**	New integrated pods to continue to progress integrated care pathways and improved ways of working between hospitals and communities in 2023 and 2024.	*Ongoing from September 2023*
6.	**Appoint HSE Health Region leadership**	Appoint new Regional Executive Officers. Agree HSE Health Region Executive Management Team with a view to recruitment in early 2024, once REOs are in place.	*From October 2023* *From October 2023*
7.	**Support and upskill staff transitioning to Health Regions**	Conduct training needs analysis. Develop a phased learning plan for Health Regions and the HSE Centre. Deliver required training programmes to leadership and staff.	*From December 2023* *From December 2023* *From February 2024*
8.	**Clarify the Department of Health's role to enable Health Regions**	Clarify the Department of Health's continuing role in the context of the introduction of Health Regions and reform of the HSE Centre.	*March 2024*
9.	**Engage with stakeholders**	Implement a schedule of engagement and consultation with internal and external stakeholders including HSE staff, patients and service users, voluntary organisations, GPs, and others.	*Ongoing*

No.	Summary Action	Detailed Actions	Timeline
Model of Integrated Care including Healthcare Governance			
10.	**Develop framework for health needs assessments**	Develop a national framework for the conduct of regional and local health needs assessments.	*July 2023*
11.	**Agree integrated service delivery model for Health Regions**	Further develop and finalise the Integrated Service Delivery Model.	*August 2023*
12.	**Conduct health needs analysis**	Conduct regional and local health needs analysis.	*From September 2023*
13.	**Update HSE Code of Governance**	Update Revised HSE Code of Governance to include Health Regions (corporate and clinical), taking into account wider health system including GPs, patients and service users, Section 38 and 39 organisations, and others.	*November 2023*
14.	**Agree Health Region governance approach and partnership arrangements for non-HSE providers**	Define and agree the governance approach and partnership arrangements with Section 38 and Section 39 voluntary organisations and other non-HSE providers.	*December 2023*
15.	**Undertake baseline analysis of resources by Health Region**	Undertake baseline analysis by Health Region available in each region, broken down by current function, e.g. capital, financial and human resources.	*December 2023*
16.	**Agree performance accountability framework**	Agree updated performance accountability framework to reflect new structures and be informed by the Department's Health Systems Performance Assessment framework as appropriate.	*December 2023*
17.	**Agree baseline KPIs for Health Regions**	Agree KPIs for February for Health Regions, the HSE Centre and DoH, aligned to HSPA.	*December 2023*
18.	**Implement integrated service delivery model for Health Regions**	Establish the agreed integrated service delivery structure. *(Dependent on Health Region Senior Team appointment and staff transition strategy)*	*From June 2024*

No.	Summary Action	Detailed Actions	Timeline
Planning & Finance			
19.	**Approve revised process for service plans**	Develop and approve the process for the development of the 2024 annual service plan and capital plan including the development and inclusion of regional specific chapters. (*Interim plan for 2024, new process to include statutory and voluntary, GPs, other HSCPs going forward for future years)*	*July 2023*
20.	**Establish PBRA Expert Group**	Establishment of a PBRA Expert Group to be chaired by the Department of Health.	*July 2023*
21.	**Approve revised process for HSE corporate plans**	Develop and approve the process for the development of the multiannual HSE corporate plan in the context of changing national and regional structures.	*June 2024*
Infrastructure including Capital and ICT Supports			
22.	**Identify Health Region 'headquarters'**	Identify location of Health Region 'headquarters' for each Health Region.	*From September 2023*
23.	**Define critical Digital, ICT, and data requirements**	Define the critical Digital and ICT requirements including necessary data requirements to establish Health Regions (recognising the need for a wider Health Region digital health strategy).	*October 2023*
24.	**Agree future approach to business functions for Health Regions**	Design, develop, and agree future approach to business functions and processes for Health Regions.	*December 2023*
25.	**Address critical Digital, ICT, and data requirements**	Address critical Digital, ICT, and data requirements to establish Health Regions (recognising the need for a wider Health Region digital health strategy).	*January 2024*
26.	**Agree Capital Planning and Prioritisation Approach**	Agree future approach for capital arrangements in line with Public Spending Code to include capital funding, capital planning, capital projects, management of estates and assets and the future approach to procurement supported by a single set of nationally defined and standardised procurement processes.	*January 2024*
27.	**Complete branding exercise for Health Regions**	Branding exercise to be completed to name each Health Region, Integrated Health Areas and the HSE Centre in consultation with stakeholders.	*February 2024*

Appendix 2: Partnership Principles

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

Delivering Quality, People-centred Services

Ireland has a hybrid public health and social care system. One of the defining features of this hybrid system is the mutual interdependence between the state and voluntary sectors in providing a diverse range of health and social care services to citizens. The collective national response to the challenges posed by Covid-19 crisis served to reaffirm mutual interdependence as a defining characteristic of Ireland's hybrid health and social care system. The crisis also served to demonstrate the mutual benefits for the state, voluntary organisations, and patients/service users that can be generated by a commitment to collaboration and integrated working.

Voluntary organisations, which are independent legal entities, are an intrinsic and valued core component of Ireland's public health and social care system. It is recognised however that achieving the transformative reform associated with Sláintecare and delivering quality, people-centred services require the building of more collaborative and partnership style relationships between the state and voluntary organisations.

Developing more cooperative, productive, and sustainable relationships between the State and voluntary organisations was at the heart of the decision to establish the Health Dialogue Forum. To support this work the Forum have published an agreed statement of partnership principles that seeks to guide and inform the evolving relationships between the State and voluntary organisations across the health and social care sectors. This set of partnership principles is set out in the figure below.

An Agenda for Change

It is essential that the aforementioned set of partnership principles are owned by all stakeholders, are relevant and are implementable and impactful. These agreed set of principles, and associated practices and behaviours have to be 'lived' rather than 'laminated'. That is to say, this form of high-level agreement has to be embedded in the practical action, and in particular, it should contribute to maximising effectiveness and delivering improved outcomes for patients/service users.

The fact that the principles outlined in Figure 1 reflect the actual experience of collaborative and productive relationships that emerged in response to the COVID-19 crisis, suggests that they potentially represent a powerful agenda for change in how things are done in the sector. The national response to this national health emergency crisis was characterised by an unprecedented level of collaboration between the statutory and voluntary sectors. The development of more productive and partnership-style relationships underpinned a remarkable level of change and innovation, at pace, across the health and social care system. In part this was driven by organisations being supported and facilitated to get on with what they are good at. Significantly, this experience of partnership in action, in real time, served to surface the very principles and associated practices that should inform the ongoing evolution of more collaborative and productive relationships and integrated ways of working across the health and social care sectors.

Figure 1: Partnership Principles for the Health and Social Care Sectors

To be effective, this agenda for change has to be owned and embraced. This will necessitate a commitment by all state and voluntary organisations to changing their behaviours and relationships and to focus on embedding partnership principles into their structures, processes, and projects. In other words, partnership, collaboration, and integrated working has to become the way we do our business in the health and social care sectors.

Adopting, championing, and owning this set of partnership principles provides stakeholders with an opportunity to maintain the momentum for change and to build the type of collaborative relationships that are necessary to deliver better quality, people-centred health, and personal social services.

Appendix 3: Principles for the Development of Integrated Service Delivery

In order to define the national model of Integrated Service Delivery (ISD), a set of national principles were identified to guide the development as outlined below.

Principle 1: Patient and Community Focus

The ISD model will be person-centred, building care around individual needs rather than the needs of the system. It will be co-designed through meaningful partnerships with patients and service users, carers, and staff, building on what is currently working well within existing care pathways and service user experiences.

Principle 2: Population Health and Local Context

The ISD model will enable the provision of joined-up health and social care to individuals within the context of a distinct population cohort which is geographically defined. This approach will be greatly facilitated by the Public Health leadership in each of the Health Regions. The population-based approach to service planning and delivery will be fully inclusive of all communities in the region and will, as required, take account of the needs of specific populations cohorts / groups. A population-based approach encompasses the entire range of determinants of health and wellbeing and will compliment the work of Healthy Ireland and the Sláintecare Healthy Communities Programme. It aims to shift towards models that incorporate a more holistic assessment of needs at individual and population level, with an emphasis on prevention and early intervention, rather than focusing on addressing specific diseases, healthcare settings or services.

While services will be planned and delivered in an integrated, devolved way at Health Region and local level, taking into account national strategies, clinical pathways, and models of care, it is recognised that certain specialist services will continue to be planned and delivered nationally, for example the National Cancer Control Programme (NCCP). The NCCP will partner with the Health Regions on the implementation of the national cancer strategies, ensuring equitable access to cancer services, and will work with clinical leaders within the Health Regions in the development of guidelines, protocols, referral pathways, national cancer networks and workforce planning, which in turn will support the Health Regions in the delivery of cancer services within their region.

It is recognised that the integrated model of service delivery will need to be designed within strong national frameworks but be sufficiently flexible to adapt to local need. A model which facilitates local autonomy will be essential to enabling the innovation and creativity required to respond to the unique profile of the population in each region.

Principle 3: Continuum of Care

The ISD model will be essential to delivering right care, right place, right time across the full continuum of care with an emphasis on providing integrated care at the lowest level of complexity. The ISD model will provide care and support at, or near, home where appropriate and ensure hospital stays are minimised.

Principle 4: Healthcare Governance and Leadership

The ISD model will be underpinned by an agreed model of healthcare governance, which includes both clinical and corporate governance underpinned by the principle of subsidiarity. This governance model will be designed to:

- Increase accountability through increased engagement with local populations.
- Increase connectivity and collaboration between services, enable collaboration and facilitate co-operation at both national and local Health Region level.
- Enable decision making to take place as close as possible to the front line.

The provision of services will be underpinned by robust governance structures with clear accountability building upon the work of CHOs, Hospital Groups, Community Health Networks, and the National Clinical Programmes in this area.

Community Health Networks (CHNs) will support the HSE and other providers in the delivery of integrated care across care groups and between primary care, community, acute and social care services. Acute hospitals will be aligned with the local geographic areas to enhance integration with community services, while also continuing to work across networks in maintaining the benefits achieved through Hospital Groups. Public health and clinical governance will be aligned around a shared population health needs assessment promoting a focus on prevention and early intervention, addressing inequalities in access to and outcomes from healthcare provision with a strong multi-disciplinary ethos.

Principle 5: Implementation and Evaluation

ICT systems will be essential to support effective integrated care and the HSE will continue to support the development of local and national solutions to link care providers in the interests of patients and service users. A comprehensive measurement and evaluation system, underpinned by a robust data infrastructure, incorporating indicators to measure outcomes at different levels will be developed to monitor progress towards achieving agreed objectives of integrated care. The HSE is committed to implementing the new KPIs detailed in the Irish Health System Performance Framework (Department of Health, 2021).

Creating the culture and conditions for integration will require a dedicated focus on building change and innovation capacity and capability at local level and will be supported by the HSE Centre.

Appendix 4: Glossary of Terms

CEO	Chief Executive Officer
CHN	Community Healthcare Network
CHO	Community Healthcare Organisation
CST	Community Specialist Team
DCEDIY	Department of Children, Equality, Disability, Integration and Youth
DoH	Department of Health
DPENDR	Department of Public Expenditure, National Development Plan Delivery and Reform
ECC	Enhanced Community Care
EMT	Executive Management Team
HG	Hospital Group
HSE	Health Service Executive
ICPOP	Integrated Care Programme for Older Persons
ICT	Information and Communications Technology
IGEES	Irish Government Economic and Evaluation Service
IHA	Integrated Health Area
ISD	Integrated Service Delivery
NAS	National Ambulance Services
NCCP	National Cancer Control Programme
PBRA	Population-Based Resource Allocation
PCPI	Patient, Carer and Public Involvement
PCRS	Primary Care Reimbursement Service
REO	Regional Executive Officer
SCDS	Specialist community-disability services
SLA	Service level agreement
SLT	Senior Leadership Team
WHO	World Health Organisation