Regional Health Areas (RHAs)

Implementation Plan
Draft Paper 20 February 2023
(Not for wider circulation)

This draft Plan is subject to review by the incoming HSE CEO and HSE Board

Contents

1. Executive Summary

The establishment of Regional Health Areas (RHAs) involves the creation of six regional organisations with full responsibility for the planning and delivery of hospital and community healthcare services within their respective areas. These new arrangements will improve the health service's ability to deliver more joined-up, integrated care for patients that is planned and funded in line with regional and local needs. This approach is in line with recommendations made in the Oireachtas Committee on the Future of Healthcare Sláintecare Report (2017).

In April 2022, a Memorandum on next steps, the programme of work, and timelines for RHA implementation was approved by Government. This Implementation Plan outlines the approach to RHA planning and design in line with the overall design principles and objectives of Sláintecare, as outlined in Section 3 of this document, and sets out a high-level programme of work for 2023, with a view to establishing RHAs from 1 January 2024.

This Plan should be read in conjunction with the Business Case for the Implementation of Regional Health Areas (RHAs)[1], and Appendix 1 which sets out in more detail the rationale for the proposed policy direction and its associated change programme, workstreams, and timelines.

The establishment of RHAs represents a major shift in the approach to the planning, funding and delivery of health and social care services. The new arrangements will support a population-based approach to the planning and resourcing of services. RHAs will be better able to understand and respond to changing population needs, identify, and address the root causes of health inequalities, and facilitate the provision of integrated and person-centred services

A central principle throughout this Plan is 'subsidiarity': RHAs will be empowered by ensuring, as far as possible, that the other organisations involved in healthcare planning and delivery – the National HSE and the two Government Departments (the Department of Health, and the Department of Children, Equality, Disability, Integration and Youth) only perform those functions that cannot be carried out effectively by the regions. In this context, the transition to RHAs will have a significant impact on the roles and responsibilities of the National HSE and the two Departments.

The proposed high-level roles and responsibilities within the new RHA arrangements, as outlined within this Plan, were developed in 2022 by staff from the HSE and the two Departments through five programme workstreams, namely: Healthcare Governance; Finance; People & Development; Capital Infrastructure, Digital & ICT; and, Change, Communications & Culture. These workstreams align with the World Health Organisation's (WHO) building blocks of a health system [2].

The key themes and high-level roles and responsibilities proposed for the RHAs, National HSE and the two Departments within the wider national system are as follows:

- RHAs will be central and provide significant input to, and influence over, the "**what**" i.e., the agreed set of nationally consistent integrated services, outputs, outcomes, and objectives that are to be delivered for the patients, service users and families of Ireland

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[1] Department of Health (2022). Business Case for the Implementation of Regional Health Areas. Available from: https://www.gov.ie/en/publication/4eda4-slaintecare-regional-health-areas-rhas/

[2] Everybody's business - strengthening health systems to improve health outcomes: WHO's framework for action. WHO; Geneva: 2007. http://www.who.int/healthsystems/strategy/everybodys_business.pdf

- RHAs will have a very large degree of autonomy over the "**how**" i.e., how the various resources and providers in their area are organised and networked to deliver on the nationally agreed integrated services, outputs, outcomes, and objectives. This will bring decision-making closer to the point of service delivery

- RHAs will also be central and will provide significant input to, and influence over, the agreed framework of nationally consistent standards, guidelines, policies etc. that are required so that the population can have equitable access to quality integrated services regardless of location and other factors

- Full transparency and sharing of all available data within and between RHAs, and with National HSE, and strict compliance with data governance and data standardisation requirements, will be central to ensuring the framework of nationally consistent standards; guidelines and policies can provide the maximum desired appropriate degree of independence and autonomy to the RHAs, and to their front-line teams, in keeping with the important principle of subsidiarity. This will be supported by new legislation

- RHAs will have operational budget autonomy and flexibility, within the framework of nationally consistent standards etc. to manage, and allocate, within their region, the funding assigned to them via population-based resource allocation, in pursuit of the objectives, outcomes and outputs they have committed to

- RHAs will have a large degree of staffing autonomy, within the framework of standards, such that the numbers and types of staff that they can recruit will be a matter for each RHA, provided they operate within their overall budget and deliver the outputs, outcomes, and objectives for which they have been funded

- RHA Chief Executive Officers will be accountable and responsible for all regional health and social care services in all six geographic regions. RHA CEOs will report directly to the HSE CEO on the operation and management of the RHAs. RHA CEOs will form part of the core HSE Executive Management Team, providing regional input into the development of national policies and standards

- National HSE will be accountable and responsible for supporting the RHAs, ensuring consistent national frameworks and models of care and networked care pathways are developed. National HSE will focus on more strategic activities, rather than operational and will devolve responsibility and authority for delivering the vast majority of services from National HSE to six Regions. This will ensure decision making is closer to the patient. National HSE will oversee the delivery of Nationally Delivered Services

- In collaboration with the RHAs, National HSE will define national service requirements and standards and will monitor and assure the performance of the health service delivery system as a whole

- The Department of Health (DoH) will be responsible for setting health policy and will retain an oversight role in ensuring that health service activities are carried out in line with overall policy priorities, achieving agreed-upon national health outcomes and system objectives

- DoH will be responsible for establishing and leading an expert advisory group, which will include reps from HSE and RHAs, to design and the develop the PBRA model which will determine RHA funding allocation based on population need

- The Department of Children, Equality, Disability, Integration and Youth (DCEDIY) will be responsible for the development and clarification of Government policy and legislation for the health and well-being of children and those with disabilities.

The new RHA structures are being designed to ensure the delivery of high quality, integrated care within each region, based on local population needs. Within each region, a number of "Integrated Community Areas" will be established, based on geography, population size, and local needs and services; each Integrated Community Area is expected to typically serve an approximate population of 300k.

The transition to RHAs is planned for 1 January 2024 and will continue to progress throughout 2024. During 2023, the responsibilities and boundaries of the existing six Hospital Groups and nine Community Health Organisations will be changed in line with the new RHA boundaries. By 1 January 2024, the aim is that the six RHA Chief Executive Officers and, as far as possible, their Senior Management Teams will also be in place and fully accountable for the delivery of services and associated resources within their regions. The achievement of this timeline is dependent on early approval from the Department of Public Expenditure and Reform to allow recruitment processes to proceed. During 2024, the existing Hospital Group and CHO structures will be stood down on a phased basis as the new RHA arrangements are established.

This Plan sets out a high-level programme of work for 2023, together with the approach to transition and implementation of RHAs on 1 January 2024 and beyond. The scope of activities that need to be undertaken throughout 2023 to achieve the desired 1 January 2024 transition state and to continue to prepare the system for RHA 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.

This Plan has been developed following ongoing engagement with key stakeholders across the Departments and the HSE and seeks to build on system-wide insights on how the RHAs 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. This Plan has been overseen by a Joint Implementation Team, and ongoing and meaningful stakeholder engagement will be critical as the major change programme progresses.

The priority for 2023 is to continue working in partnership with the health service community to progress detailed RHA design issues, in line with the overall principles and objectives of Sláintecare. This will involve close working with the clinicians and service managers to consider current care pathways and identify the particular factors that are impeding the delivery of safe, high quality, integrated care. Clinical and managerial leaders across Ireland will inform the detailed design and development of new structures, systems, and processes to support the provision of improved health services for patients, their families, and the public.

The remainder of this Plan is structured as follows:

Sections:

- Section 2 outlines the importance of population-based planning and the delivery of integrated care
- Section 3 outlines the vision and objectives for RHAs, together with the key design principles which have been used to underpin their development
- Section 4 outlines the proposed high-level roles and responsibilities for the delivery of key functions across the two Departments, National HSE, the RHAs and other partnerships.
- Section 5 outlines the high-level structure of the integrated service delivery model to be established within RHAs to ensure that services are joined up, organised around the needs of the population
- Section 6 outlines the high-level programme of work for 2023, and the approach to transition and implementation of RHAs on 1 January 2024 and beyond.

Appendices:

- Appendix 1 outlines background and policy context of RHAs
- Appendix 2 outlines the approach which has been taken to RHA planning and design following the Government's decision in April 2022
- Appendix 3 outlines key principles which guide the development of the Integrated Service Delivery Model
- Appendix 4 includes a glossary of terms.

2. Population Health Planning and the Delivery of Integrated Care

This section outlines the importance of population-based planning and the delivery of integrated care.

2.1. What is Population-Based Planning

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 towards holistic assessments of needs, equitable funding, and prioritising health and social care services. This approach addresses root causes of health inequities and supports integrated care. By working together, healthcare providers, public health professionals, and community organizations can create solutions to improve overall health outcomes and address challenges faced by health systems.

Historically in Ireland, decisions on health and social care service provision – and the allocation of budgets – have been decided largely based on an annual estimates process as set out by Government, and Ministerial policy priorities in areas such as cancer, trauma and maternity, proposals from hospital institutions and community organisations, rather than being based on a strategic analysis of local population needs. This approach has not resulted in the provision of fair and equitable care, as noted in the Sláintecare Report. To address this, a population-based approach is needed, where RHAs will have responsibility for planning and delivering services based on demographic pressures, prevalence of adverse health outcomes, and geographic differences. This ensures that the health and social care system is responsive to local population needs and aligned with Sláintecare. A population-based resource allocation model will be developed to promote equity in access to health services.

2.2. What is integrated care?

> **Healthcare delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access, and service providers can easily deliver. This is a service which communication and information support positive decision-making, governance, and accountability; where patients' needs come first in driving safety, quality, and the coordination of care**

Integrated care encompasses acute, primary, community and social care services and involves public and private providers; patients 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. Communication between different care areas is made easier.

Integrated care offers a patient-centred approach to healthcare which is more responsive to the needs of its users, or the needs of its defined populations in the case of RHAs.

This has practical implications on the implementation of RHAs. Rather than our system being funded and structured around current system silos – e.g. community care by care group, primary care, or hospital care – services, resources, and governance will be co-ordinated around the needs of patients and local populations across all care settings in each RHA from 2024 onwards. The RHA structures will

enable integrated care however this will require a concerted focus at local, RHA and National level to ensure patient and service user benefits are realised.

Integrated care aims to provide patients with better continuity of care as they transition between services, such as from a hospital bed to rehabilitation centre after or from cancer screenings to mental health support. This requires new and enhanced pathways across care domains. The implementation RHAs aim to clarify and link clinical governance pathways across community and acute sectors, ensuring best practice and reducing variation. This creates a safer, more supportive, and informed care journey for patients and staff. Shared ownership of patient care among healthcare professionals can lead to a more coordinated experience, improving patient satisfaction, supported by technology.

Integrated care offers many benefits to both patients and staff.[3] All health and social care services in each region work together to provide a flexible network of care that is responsive to the changing needs of their respective populations, patients, families, and carers.[4] This will be built upon agile networks of communication between care providers. Integrated care benefits both patients and staff. Multidisciplinary pathways lead to better interprofessional working and an empowered workforce. RHAs are working towards clear roles and accountability for integrated care, reducing duplication of work and improving care quality while making healthcare a better place to work. Integration, coordination, and information sharing within and across RHAs is a key enabler of integrated care, being progressed through the Health Information Bill and eHealth strategy.

2.3. Enabling Integrated Care

The WHO recommends five interwoven strategies that need to be implemented for health service delivery to become more people-centred and integrated[5]: Empowering and engaging people; Strengthening governance and accountability; Reorienting the model of care; Coordinating services and Creating an enabling environment.

Empowering and engaging people in healthcare involves providing the necessary resources, skills, and opportunities for individuals to make informed decisions about their health. It also involves ensuring universal access to healthcare services, especially for marginalized and underserved populations. This goal aims to unlock community and individual resources for action, empowering individuals, and communities to become actively engaged in promoting healthy environments and contributing to healthy public policy.

Strengthening governance and accountability means improving policy dialogue, formulation, and evaluation with input from citizens and stakeholders. It promotes transparency in decision-making, accountability of policymakers and users, and alignment of incentives

Reorienting the model of care means prioritising primary and community care services and shifting towards outpatient and ambulatory care. It also involves investing in health promotion and prevention strategies and working with community organizations and local authorities to address social

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[3] Hazarika R, Purdy S. Integrated care: demonstrating value and valuing patients. Future Hosp J. 2015 Jun;2(2):132-136. doi: 10.7861/futurehosp.2-2-132. PMID: 31098102; PMCID: PMC6460198.
[4] 20 HSE (2022). Integrated Care Programmes. https://www.hse.ie/eng/about/who/cspd/icp/
[5] WHO (2015). WHO global strategy on integrated people-centred health services 2016-2026.

determinants of health. This approach requires inter-sectoral collaboration and partnerships with various stakeholders.

Co-ordinating services involves aligning and harmonising the processes of different healthcare providers to improve the delivery of care, without necessarily merging structures or workflows. The goal is to promote safe and effective care around the needs and preferences of individuals and build networks between health and other sectors. Effective communication and information flow between providers is a key component of coordination

The success of the four previous strategies requires creating an *enabling environment* that brings stakeholders together to undertake transformational change. This involves complex processes and technology to change legislative frameworks, financial arrangements, incentives, and workforce reorientation, including change management, ICT provision, and re.

2.4. 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[6], developed by the 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. RHAs can aid in breaking down outcomes by region and considering specific population needs.

2.Effective Use of Resources: integrated care can result in 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. This can be measured by comparing the costs or population outcomes of care pre- and post-implementation of integrated care.

3. Accessibility: Measuring accessibility of integrated care involves tracking the number of people who can 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 patients 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 satisfaction surveys, clinical outcomes, and other measures of care quality. Regularly measuring these factors will help determine the ongoing effectiveness and impact of integrated care.

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[6] Department of Health (2021). Health System Performance Assessment (HSPA) Framework.
https://www.gov.ie/en/publication/6660a-health-system-performance-assessment-hspa-framework/

3. Vision and Objectives for RHAs

This section outlines the vision and objectives for RHAs, together with the key design principles which have been used to underpin their development.

3.1. Vision for RHAs

The six new RHAs are being implemented internally as formal regional divisions within the HSE. This will see RHAs function as part of a strengthened regional health and social care service with their own budget, their own leadership team, and increased local autonomy and decision-making - RHA Chief Executive Officers will have a legal delegation under the Health Act 2004 for the health services in their region.

RHAs will be empowered and resourced to collaborate and work together, with the support of national services, clinical expertise, interoperable systems, and national frameworks and standards of care. Lessons learned and innovative ideas will be shared across the country, better serving our citizens and the needs of the defined populations of each RHA respectively. RHAs will aim;

To deliver **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**

To **balance national standards** of care and direction with **local decision-making** to ensure people can access the **same quality of care** no matter where they live

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 resources are **fairly allocated and accounted for**

Overall RHAs will have a very large degree of autonomy over how the various resources and providers in their area are organised and networked to deliver on the nationally agreed integrated services, outputs, outcomes, and objectives This will bring decision-making closer to the point of service delivery.

The implementation of RHAs is unlikely to provide an immediate resolution to our present challenges and should not be considered a panacea for all the challenges of our healthcare system faces. RHAs, on the other hand, will play a pivotal role in preventing the structures of our health and social care system from obstructing the achievement of integrated care. They will serve as a foundation upon which we can establish more effective mechanisms and pathways for integrated care. RHAs must be considered in the context of the wider Sláintecare reform programme, and the interdependencies between their imminent implementation and wider system changes.

3.2. Objectives for RHAs

The principle of subsidiarity is a key driver behind the establishment of RHAs, as it advocates for decentralised decision-making and delegation of decision-making power to the lowest level of authority capable of making informed decisions. By aligning hospital and community-based services geographically and devolving key accountabilities and autonomy to RHAs within a coherent national framework, the aim is to implement a comprehensive, community-first health and social care delivery system that is integrated and person-led. The objectives of regionalisation are to:

1. Align and integrate hospital-based and community-based services to deliver joined-up, integrated care closer to the home
2. Clarify and strengthen corporate and clinical governance and accountability at all levels
3. Support a population-based approach to service planning and delivery which aims to address health inequalities
4. Balance national consistency with local autonomy to maintain consistent quality of care across the country and involve patients and service users in the design of future models of health care.

RHAs structures will provide for the alignment and integration of hospital and community healthcare services at a regional level, in a way that is responsive to populations and their local needs. This is key to delivering on the Sláintecare vision of an integrated health and social care service.

3.3. Design Principles

Design principles for RHAs, as approved by HSE and DoH on 23 June 2022, were developed around key themes, aligned to the vision and objectives set out above. These design principles are as follows:

Priority	Theme	RHA Design Principle
1	**Patient-focused integrated care outcomes for service users and patients**	Design will ensure that the introduction of RHAs 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 RHAs.
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.

Priority	Theme	RHA Design Principle
4	**Devolved Decisions and Activities**	Design will support increased, empowered, devolved decision-making in the RHAs and other service delivery entities and will ensure activities are closer to the patient/service user 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, as well as providing opportunities for career progression and skills development.
6	**Clear Interfaces and partnerships**	Design will ensure clear interfaces defined for all Irish health and social care system internal and external stakeholders, enabling transparent communication, enhanced collaboration, and the building of positive trusted relationships, including with, GPS, Pharmacy, the S38/39 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 parameters.
8	**Maximise Data and Information**	Design will ensure the health service and RHAs are set up to leverage and enable the use of health and social care data and information, to drive holistic insight across the system and inform evidenced based decision making. This will be done in line with the relevant regulatory, 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.

4. Proposed Roles and Responsibilities – RHAs, National HSE, and the two Departments

Consistent with the design principles set out in Section 3 of this Plan and informed by the outputs from the detailed engagement with stakeholders set out in Appendix 1, this Section of the Plan outlines proposes high-level roles and responsibilities for the delivery of key functions across the RHAs, National HSE, and the two Departments (DoH and DECDIY). Proposals in relation to how services will be organised, planned, and delivered *within* RHAs are set out in Section 5. The future system, in broad terms, is outlined in the diagram below.
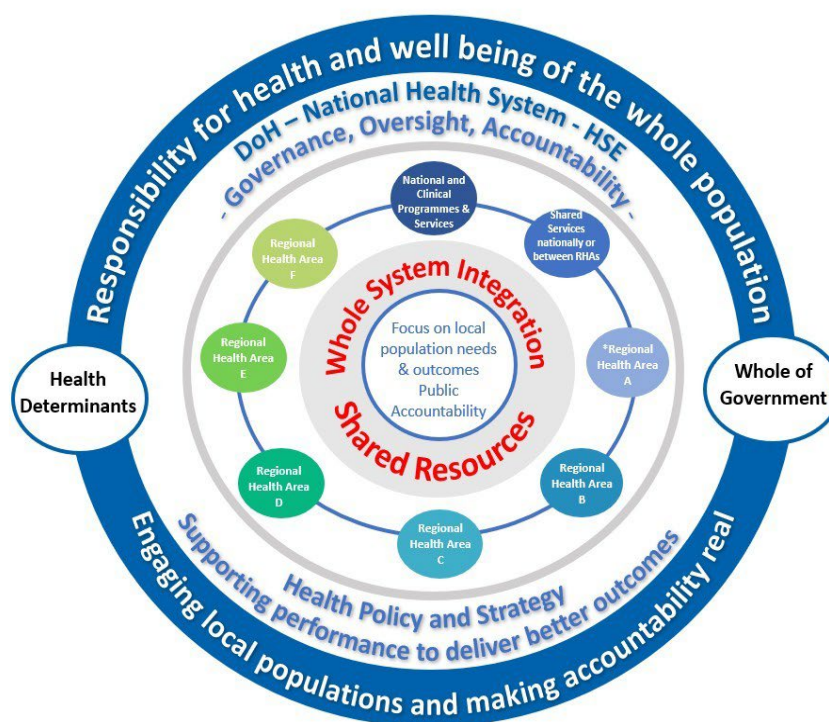
Health Services embedded in the wider system
RHAs influencing and working with a **wide range of people and agencies** i.e. communities and those involved in providing health related services, the public and key agencies whose actions affect the health and well-being of our population

*RHAs inclusive of primary, community and acute services, services provided in partnership with local populations, GPs, Section 38s, 39s and other providers

The proposed roles and responsibilities in relation to each the RHAs, National HSE and the Departments, are set out below.

4.1 Regional Health Areas (RHAs)

Within the new arrangements, RHAs will be accountable for understanding the needs of the populations they serve and for the delivery of effective services in response to those needs. Consistent with this accountability, RHAs will have appropriate authority, autonomy, and control over key resources, with support from the Nation HSE and the two Government Departments. Further details are provided below.

Governance, Service Planning and Delivery: RHAs will be accountable and responsible for the quality and safety of clinical services provided within their region, implementing integrated clinical governance frameworks, and ensuring that appropriate safety and quality systems are in place. RHAs will be central and provide significant input to, and influence over, the "**what**" i.e., the agreed set of

nationally consistent integrated services, outputs, outcomes, and objectives that are to be delivered for the patients, service users and families within their regions. RHAs will have a very large degree of autonomy over the "**how**" i.e., how the various resources and providers in their area are organised and networked to deliver on the nationally agreed integrated services, outputs, outcomes, and objectives. This will bring decision-making closer to the point of service delivery. RHAs will also be central and will provide significant input to, and influence over, the agreed framework of nationally consistent standards, guidelines, policies etc. that are required so that the population can have equitable access to quality integrated services regardless of location and other factors.

RHAs will be responsible for conducting health and social care needs assessments for their populations and will have a deep understanding of local needs and priorities, which will be factored into planning for the region. RHAs will build planning capability to inform estimates and annual service planning process and operational plans for their region. Local planning within RHAs will significantly inform how services are delivered and resourced. RHAs will develop a regional strategic plan in-line with national frameworks, health need assessments and clinical programmes with a three-year view to address their population needs, with this regional strategic context being reflected in the consolidated HSE three-year Strategic plan. With patient outcomes at the forefront, RHAs will be responsible for monitoring performance and identifying areas for further service improvements, embedding a culture of continuous improvement to support the delivery of high-quality services within their region.

RHA Chief Executive Officers will serve as members of the HSE EMT, thereby ensuring direct input into the determination of nationally consistent standards, guidelines, and models of care. This will ensure the emergence of a coherent national approach to the development of health and social care as well as leadership of health service delivery across their regions.

Finance: RHAs will have management authority and accountability at a regional level, operating with a single population-based budget per region. RHAs will have the autonomy to make procurement decisions within national frameworks. Devolving responsibility for budget management to RHAs will promote improved accountability and provide greater oversight at a local level. RHAs will conduct financial planning and analysis to ensure the most appropriate utilisation of funds and will evaluate the financial performance of regional services to better inform strategic decision-making and planning.

People & Development: RHAs will have a large degree of staffing autonomy, within the framework of agreed national standards. Provided they operate within their overall budget and deliver the outputs, outcomes, and objectives for which they have been funded, the numbers and types of staff that they can recruit will be a matter for each RHA, subject to coherence with models of care determined nationally for services. RHAs will develop their regional workforce, conduct regional operational workforce planning, build HR excellence, undertake end-to-end recruitment, promote staff wellbeing, and manage local internal and employee relations.

*Capital and Estates***:** RHAs will work with HSE National to ensure that regional needs and priorities are appropriately reflected in national capital planning arrangements. RHAs will have dedicated capital funds to support business continuity developments and the management of infrastructure risk at regional and local levels, allowing more agile responses to risks and issues that arise. RHAs will be responsible for estates maintenance within their respective areas, together with the associated

staffing and funding. RHAs will manage the delivery of relevant approved projects within their regions, in line with the annual capital plan and within relevant national frameworks (e.g. standardised design and delivery arrangements, etc.).

Data, Digital & ICT: RHAs will deliver and manage digital and ICT systems within their regions, in line with nationally defined standards and guidelines. In addition, RHAs will generate high-quality data for planning, quality improvement, operational management, and performance management purposes. The RHAs will ensure full transparency and sharing of all available data within and between RHAs, with funded bodies, and with the HSE Centre. This will be supported by new legislation, in particular by the Health Information Bill.

Change, Communications & Culture: RHAs will be responsible for all regional communications activity including providing strategic communications support to the RHA CEO, media relations, internal communications, digital, crisis communications, public affairs, and stakeholder engagement within agreed national frameworks. RHAs will work with colleagues in National HSE 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. RHAs will be responsible for driving a culture of openness, transparency, and integration, to ensure successful change and improved service delivery.

Research & Innovation: RHAs will develop plans and deliver research and innovation initiates within a region. RHAs will have the autonomy to prioritise and implement innovation within their region consistent with national clinical and data governance standards.

4.2 National HSE

Within the new arrangements, the nature of the role of the National HSE will change significantly – becoming more strategic, less operational – with a focus on the development of national standards and frameworks and more generally ensuring appropriate supports to the RHAs and providing effective oversight of the regions and the system as a whole. Further details are provided below.

Governance, Service Planning and Delivery: The National HSE will be accountable and responsible for supporting the RHAs, ensuring consistent national frameworks and models of care and networked care pathways are developed. National HSE will focus on more strategic activities, rather than operational and will devolve responsibility and authority for delivering the vast majority of services to the RHAs. In collaboration with the RHAs, National HSE will define national service requirements and standards and will monitor and assure the performance of the health service delivery system as a whole against agreed performance metrics.

National HSE will plan, resource, and deliver a small cross-section of services, namely, national services (e.g., National Ambulance Service) and national shared services (e.g., PCRS, Statutory Home Support Scheme), which would not be appropriate for a single RHA to deliver. The National HSE will proactively seek to avoid unnecessary duplication of national functions in the six new organisations.

National HSE in collaboration with the RHAs will conduct national health and social needs assessment to understand the needs of the overall population. It will co-ordinate and ensure a consistent

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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, National HSE will co-ordinate strategic planning for the HSE every three years, translating governmental policy into national strategy. The HSE National working with the RHAs will co-ordinate the estimates and planning processes for the development of a single national service plan for the organisation on an annual basis. This will be informed by regional plans across the system and national strategy.

Finance: The National HSE, in collaboration with RHAs, will determine service activity levels and associated performance targets to be delivered within allocated funding and will be responsible for monitoring the financial performance of RHAs, in line with nationally defined performance metrics. National HSE will also modify the existing Financial Management Framework and develop a suite of standardised processes to ensure consistency of approach across all regions. A key function of National HSE will be to drive operational efficiencies by delivering process and transaction-led services through a national shared service model.

People & Development: The National HSE will conduct national workforce planning, in collaboration with the RHAs and DoH, and coordinate the development of a resourcing strategy to address RHA and wider HSE resourcing needs. National HSE will continue to be responsible for the rollout of the National Integrated Staff Records and Pay Programme (NiSRP) and will assume responsibility for all pension-related activities.

Capital and Estates: National HSE, working with the RHAs, will co-ordinate 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. National HSE will be responsible for the planning, initiation and approval of national strategic projects and programmes. It will continue to coordinate the national equipment replacement programme, manage the National Estates database, and manage 'above threshold' property transactions. National HSE will work in partnership with RHAs to develop national guidance and standards to ensure full consistency in relation to the planning, design, and delivery of healthcare estate developments, in line with the HSE Property Strategy.

National HSE will work in partnership with RHAs to ensure that regional needs and priorities are appropriately reflected in national capital planning arrangements. RHAs will be central to developing the capital project prioritisation criteria used to assess individual capital submissions. RHAs will also be a principal stakeholder in the annual capital plan prioritisation process with National HSE, balancing national requirements and regional needs.

Data, Digital & ICT: The National HSE will monitor and address risks of a national scale such as cybersecurity threats. It will establish frameworks for the digitisation of health and social care services for implementation and deployment by RHAs operating at regional level. National HSE in collaboration with RHAs will develop a multi-year Digital Health Strategy and Implementation Plan. This plan will include national consistency and standards, integration of care, and data governance and interoperability.

Change, Communications & Culture: The National HSE will be responsible for all communications activity in relation to national functions. Its national communications function will provide

communications advice to the CEO and EMT of the HSE. The National HSE will work with RHAs to update the HSE's communications strategy, processes, and standards, nationally and regionally. It will develop the HSE communications infrastructure including the HSE website and advertising and third party national medial procurement frameworks, and will co-ordinate media relations, crisis response, public affairs, and stakeholder engagement, as appropriate.

4.3 HSE Board

As the legal structure of the HSE is not changing with the introduction of RHAs, the HSE Board retains its current governance and oversight role. 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 Department of Health for all regional and national service provision in line with strategic priorities. As RHAs will not be separate legal entities, they will not have their own boards and will report to the HSE Board via the HSE CEO.

4.4 Department of Health and DECDIY

The Department of Health and DECDIY will be responsible for the development of Government policy and the delivery of legislation for health and social care. The Departments will retain an oversight role in ensuring that health service activities are carried out in line with overall policy priorities, achieving agreed-upon national health outcomes, and system objectives.

Governance, Service Planning and Delivery: The two Departments will convert governmental priorities into health legislation and policy, which will inform National HSE strategies. The 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 National HSE and RHAs. The DoH will approve the annual service plan via the Minister and oversee the performance of the HSE.

The 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.

Finance: The DoH will co-ordinate the budget and estimates process and engage with Department of Public Expenditure and Reform to agree the overall healthcare budget. The Secretary General of the DoH will remain the Accounting Officer and as such, has responsibility for the approval and safeguarding of public funds which have been allocated under the Health Vote. This also includes ensuring the effective and efficient administration of those funds. The DoH will lead in the development of the population-based resource allocation (PBRA) model with input and advice from a Steering Committee.

People & Development: The DoH 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 resourcing strategy to address workforce gaps including legislative change and working proactively with other relevant Departments of Government.

Capital, Digital & ICT: The DoH will secure annual funding allocations, develop the national digital health strategy framework, contribute to the development of criteria and evaluation framework for capital project prioritisation, approve the annual capital and Digital ICT plans, and sanction investment in projects greater than €100m in-line with Public Spending Code.

Change, Communications, & Culture: DoH will co-ordinate communication services for the Department, including DoH 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 Sláintecare principles, and the associated culture change required at whole-system level, to deliver population-based services based on people's health and social care needs.

# 5. Integrated Service Delivery Model: High Level Design

The purpose of this section is to outline the high-level structure of the integrated service delivery model within a RHA which allows for local variation in geography, services, ways of working and based on the needs of the local population. The next phase of the process in 2023 will involve the development of a detailed design for integrated service delivery that involves key stakeholders in the co-design process. Appendix 3 outlines a set of key principles to guide the development of the Integrated Service Delivery model of care during the detailed design phase.

5.1. Integrated Service Delivery Model

The key focus of the integrated service delivery model will be to ensure that the new RHA organisational arrangements appropriately support the delivery of high quality, integrated care within each of the regions, based on local population needs. This will include the creation of the RHAs as geographic units through the aggregation initially of the Community Health Organisations and Hospital Groups. In the new environment these entities will in due course be fully replaced by the RHA and its integrated care structures.

As the six regions each serve large populations in their own right, it is essential that the structures within each region are organised to provide responsive, population-based integrated care. It is proposed that each region will be sub-divided into "Integrated Community Areas" which will vary depending on geography, population size, local needs and services. Each Integrated Community Area will be supported by the RHA team and national guidance from HSE. Models of care will be implemented on a consistent basis across the country to ensure consistent and safe delivery of services.

The high level ISD model is outlined below.
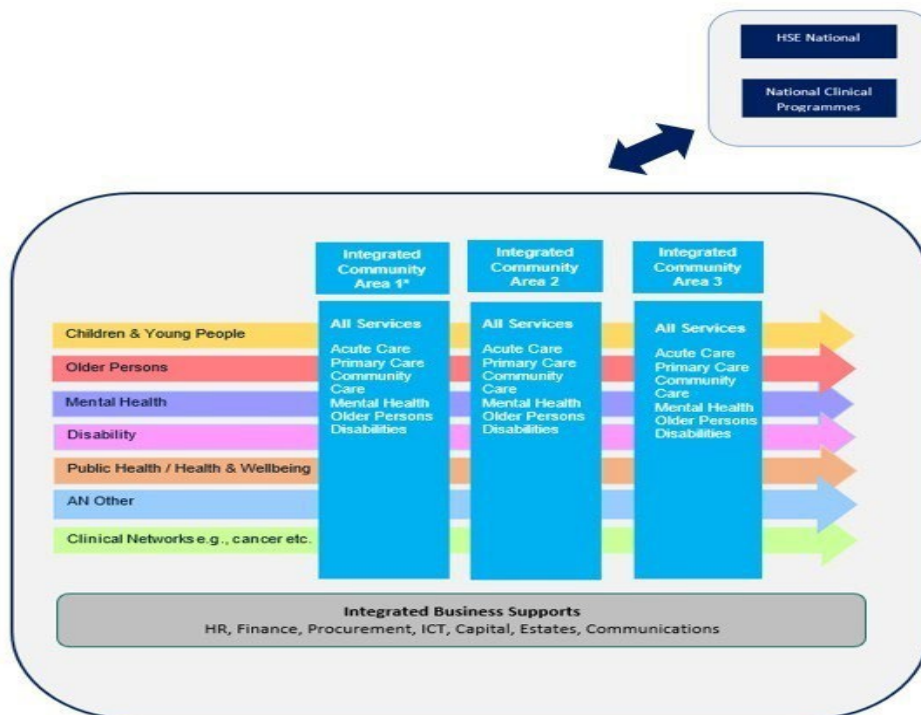
*Integrated Community Area is a working title which may be subject to change.

The term Integrated Community Area denotes all of the services an individual may require in a community, irrespective of setting.

The delivery of integrated care within each RHA will be managed within each Integrated Community Area (vertical). There will also be cross cutting functions that ensure the quality and consistency of care, in line with national frameworks (horizontal). These cross cutting functions are currently categorised as population cohorts, specialist groups based on condition type or clinical networks. The intention is to put in place arrangments at a local level to support the delivery of integrated care across these functions within and between Integrated Community Areas throughout the RHA. There is further work to be done in the detailed design phase on the specific nature of these cross cutting functions, the processes by which they will operate and associated governance arrangements. RHAs will work in partnership with the wider health service including voluntary organisations, GPs, pharmacy, private providers and other stakeholders.

Within each region there will be a number of Integrated Community Areas with a single management lead accountable for all services that are appropriate to be delivered within that area. The existing 96 Community Healthcare Networks (CHNs) will act as the building blocks of integrated service delivery and each Integrated Community Area will be comprised of multiple CHNs. Each Integrated Community Area will have primary access to at least one hospital. The detailed work of implementation will also consider the alignment of these areas, national ambulance service areas, mental health sectors and emergency planning areas.

Existing clinical networks will be maintained through national clinical programmes, and arrangemements will be developed to re-orient networks of Hospitals that cross RHA boundaries, e.g. maternity, trauma, paediatrics and cancer services. Integrated care will continue to be grounded in national models of care including: Integrated Care Programmes, Enhanced Community Care and National Clinical Programmes.

In as far as possible, all existing patient flows will continue to operate within the new structures where feasible and/or viable. The HSE has benefited from strong clinical input into service planning and delivery. This was never more evident than during the pandemic when the connection between evidence and action was a key element of the national response. The work of clinical directors, public health and multidisciplinary leaders at hospital, HG and CHO level will be further supported and developed as we transition to RHAs. The HSE will also further develop the role of clinical programmes in care planning and delivery. The National Cancer Control Programme, the National Women and Infants Health Programme, the Enhanced Community Care programme and the Integrated Care Programme for Older Persons have been key in the planning and delivery of services to date as have a whole range of other programmes. The HSE will seek to harness and action this work in the interests of patients.

An integrated approach to business supports (HR, Finance, ICT, Capital, Communications etc) will also be fostered as part of the ISD model to enable the system to deliver agreed performance outcomes.

The configuration of Integrated Community Areas within a sample RHA can be seen below for illustrative purposes. The sample RHA is comprised of three Integrated Community Areas each of

which contains between three and four CHNs and a hospital. Where possible, each Integrated Community Area will be aligned with at least one hospital.

The configuration of Integrated Community Areas within a sample RHA is outlined below:
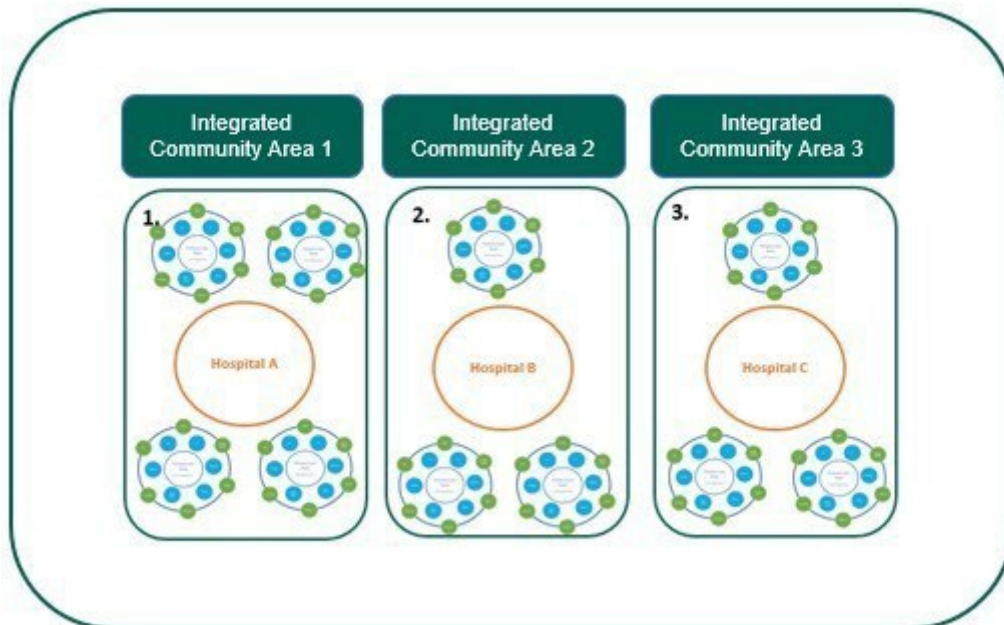
5.2. Key Considerations for Detailed Design

During high-level design, a number of items have been identified for futher consideration. These will be progressed during detailed design as the model is further refined and described.

Some of the priority items for consideration are:

- Healthcare Governance: Clarification of healthcare governance arrangements and accountabilities within RHAs in a matrix structure, i.e. service delivery within Integrated Community Areas (vertical) and cross cutting functions that ensure the quality and consistency of care for each Care Group/Clinical Programme (horizontal).
- Governance and structure arrangements within each "Integrated Community Area" including:
  - Community Healthcare Networks (CHN)
  - Specialist Community Services
  - Acute hosptials
- Acute hospital alignment and networks: Alignment of hospitals across Integrated Community Areas to include improved way of working across the patient pathway from acute hospital specialists to primary care clinicians.
- Hospital / Clinical Networks: Continued support for hospital networks in the new structures e.g. supporting clinical networks within and between RHAs
- Management of regulated / inspected entities: Management of these entities within RHAs to ensure compliance with legal obligations / delegated authorities, e.g. disability, older persons and mental health settings.

- Engagement from all key stakeholders including patients, clinicians and leaders in the co-design of the model during the next phase of detailed design
- Strategic engagement with and governance of Voluntary Bodies: Clarification regarding the role of voluntary bodies and other partner organisations and associated governance arrangements. The RHA implemenation process will have regard to the outputs of the Dialogue Forum sponsored by the Department of Health. i.e. trust, space for dialogue, room to manoeuvre, differing perspectives, understanding, common purpose, leadership, timing and opportunity
- Governance of National Services: Clarification on governance for national services to ensure integrated care.
- Relationship and arrangements beween RHA functions and national functions.
- Accountability: Public accountability arrangements in the context of RHAs
- Alignment with the public health model re health protection, health improvement (health and wellbeing), health intelligence and health service improvement.

5.3. Functions within the RHA

Each RHA will deliver a range of functions that will enable the RHA CEO and Senior Management Team to make evidence informed and timely decisions and to best support the delivery of the desired Integrated Service Delivery Model for the local population. RHAs will be enabled by integrated business supports, e.g. finance, procurement, human resources, communications, estates, capital, and digital/business intelligence.

Outlined below are three main functional groups to be included in the RHAs. The organisation structure and roles to deliver these functions within the RHAs will be defined and agreed during 2023 detailed design.
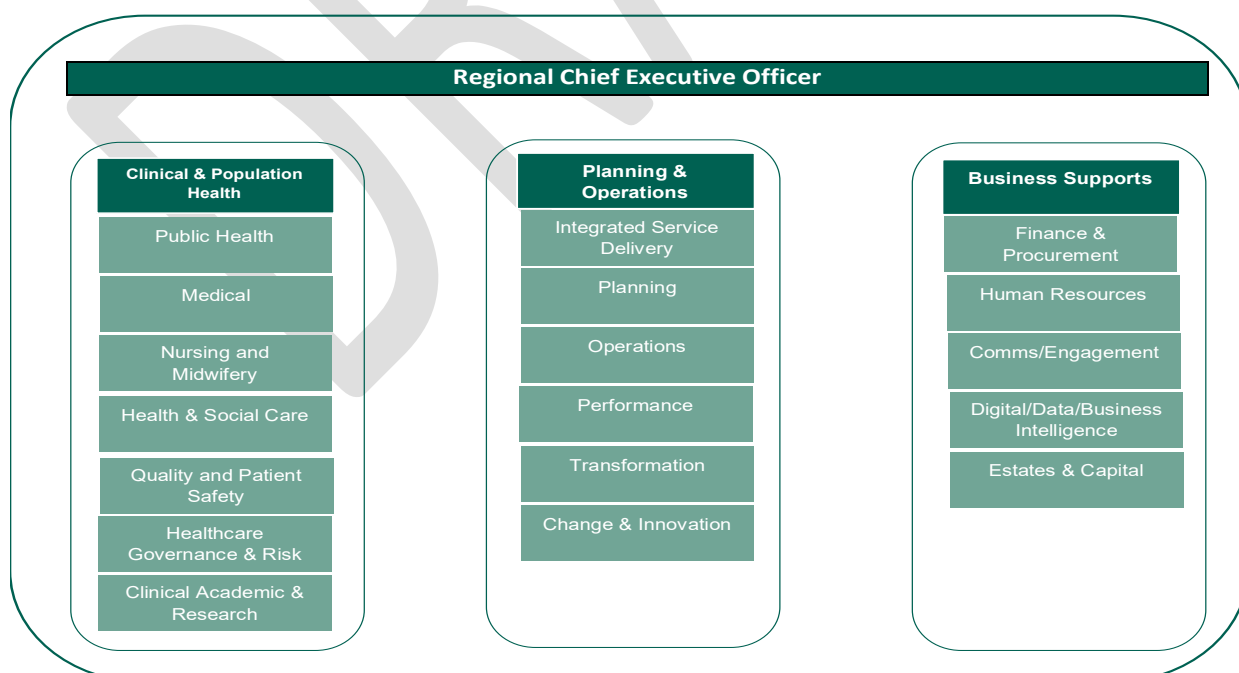
5.4. Functions within National HSE

As outlined in section 4, it is expected that National HSE will be required to deliver key functions including Clinical & Population Health; Strategy, Planning & Performance; Business Enablement & Support. The expectation is that the National HSE will be significantly reduced in terms of its functions and size as the system moves to the new RHA environment.

Some services and supports will continue to operate nationally including the national ambulance service, PCRS, Fair Deal etc. These will be fully scheduled as part of the implementation process and will be be designed to support RHAs in achieving their objectives.

The organisation structure and roles to deliver these National HSE functions and national services will be defined and agreed during 2023 detailed design.

6. Transitioning to Regional Health Areas

The full implementation of RHAs will be a multi-year journey. The purpose of this chapter is to outline the extent to which the new RHA arrangements are expected to be in place by January 2024, and the key activities in 2023 to achieve this. Implementation of Regional Health Areas will be a significant change, most importantly on the people who deliver and receive our services, impacting on structures, but also on organisational boundaries, care processes and pathways, and governance. These changes also come after a period of significant disruption to health and social care services, as services seek to emerge from the additional pressures of the Pandemic and cyber-attack, coupled with the escalating impact of a rapidly growing and ageing population on health service demands.

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 implementation of the RHAs proceeds on an appropriately planned and phased basis to ensure minimal service disruption and mitigation of risk, while at the same demonstrating appropriate pace and momentum. The integration of all care services will be iterative but progressive and learnings from each region will be shared across the system to advance the progress.
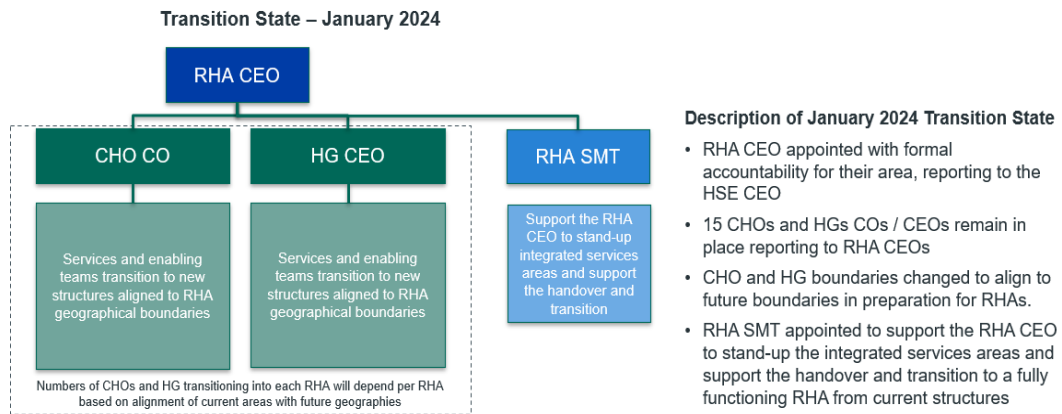
6.1. Where we aim to be by January 2024

To determine how far along the implementation journey we should aim to be by January 2024, a range of options for transitioning were developed and assessed. These options outlined different paces of progress towards the desired full implementation and were each assessed in the following context:

1. Impact on Achieving RHA objectives – extent to which the option would progress delivery of the stated objectives for RHAs i.e. joined-up care organised around patients and communities.
2. Ease of Implementation – extent to which the option could realistically be implemented by January 2024
3. Impact on Services and Operational Performance – extent to which the option would disrupt the delivery of day-to-day services provision
4. Impact on Staff – extent to which the option would impact on staff roles, responsibilities, reporting lines or working arrangements
5. Pace of RHA establishment – extent to which the option would progress the required changes to staffing, structures, processes etc.

Following consideration of the transition options identified, the conclusion was agreed that, by January 2024, we should aim: (i) to have appointed the six RHA CEOs, with these officers fully accountable for the services and associated resources within their respective regions, (ii) to have fully or substantially completed the appointment of the six RHA Senior Management Teams, and (iii) to have realigned geographical and operational boundaries of the existing CHOs and Hospital Groups consistent with the agreed RHA boundaries. Timing of recruitment is dependent on early sanction from DPER. With this option the existing CHOs and Hospital Groups organisational structures remain in place, reporting to the new RHA CEOs; these structures would be stood down during 2024 as responsibilities are moved to the new RHA Senior Management Teams. In parallel with the changes to be made within the regions, significant changes would also take place to staffing, structures and processes within National HSE to ensure appropriate supports are in place for the newly established RHAs, consistent with their stated responsibilities.
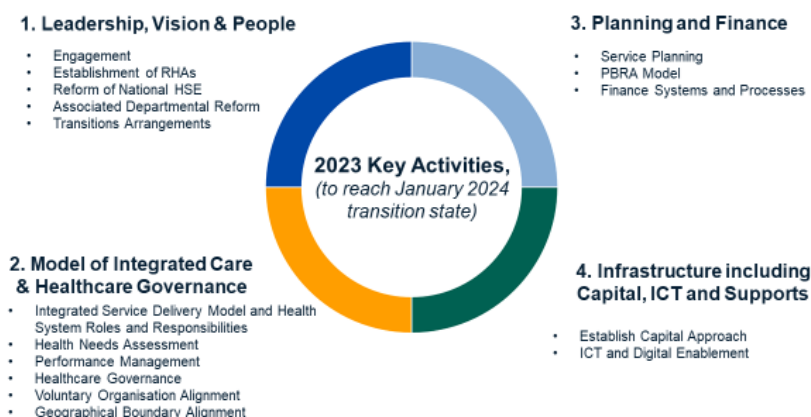
The option outlined above was assessed as providing the best balance between mitigating the risk of impact on services and staff, and ensuring continuity, while at the same time making meaningful progress towards RHA implementation. The proposed option for January 2024 transition state is outlined below:

Transition State – January 2024

Description of January 2024 Transition State

- RHA CEO appointed with formal accountability for their area, reporting to the HSE CEO
- 15 CHOs and HGs COs / CEOs remain in place reporting to RHA CEOs
- CHO and HG boundaries changed to align to future boundaries in preparation for RHAs.
- RHA SMT appointed to support the RHA CEO to stand-up the integrated services areas and support the handover and transition to a fully functioning RHA from current structures

6.2. Key activities in 2023 to achieve the January 2024 Transition State

The achievement of the desired January 2024 transition state will require a significant level of change, both within the regions and in National HSE. The high-level activities to be progressed in 2023 are outlined in the section below, noting that there is an additional level of detail below each of these to successfully achieve this transition state.

For ease of reading, the key activities are grouped into four themes as below and will be enabled by a strong focus on engagement and communication throughout the transition phase:

1. Leadership, Vision & People
- Engagement
- Establishment of RHAs
- Reform of National HSE
- Associated Departmental Reform
- Transitions Arrangements

2. Model of Integrated Care & Healthcare Governance
- Integrated Service Delivery Model and Health System Roles and Responsibilities
- Health Needs Assessment
- Performance Management
- Healthcare Governance
- Voluntary Organisation Alignment
- Geographical Boundary Alignment

3. Planning and Finance
- Service Planning
- PBRA Model
- Finance Systems and Processes

4. Infrastructure including Capital, ICT and Supports
- Establish Capital Approach
- ICT and Digital Enablement

2023 Key Activities, (to reach January 2024 transition state)

Details of the key activities to be progressed in relation to each of the above areas during 2023 is provided below, together with additional details on key tasks to be undertaken in 2024. This is not exhaustive of the activities that will be required to fully transition to RHAs successfully.

Leadership, Vision & People	Key Activities 2023 Preparing the system for RHAs	Transition State - January 2024 RHAs Established	Key Activities 2024 Developing Emerging RHAs
	Engagement		
	• Refine and deliver a detailed communications and engagement plan for both internal and external stakeholders across the health and social care system, including service users and public • Communicate vision, objectives and build common purpose across all stakeholder groups • Ensure staff representation engagement and consultation in line with nationally agreed change process • Communicate key changes and ensure all stakeholder groups understand how they will be impacted with achievement of January 2024 transition state.	• Common purpose understood and stakeholder groups bought in to case for change • Staff representatives and unions engaged and consulted in line with nationally agreed process • Feedback and insights incorporated into design and implementation planning • Key changes and impacts on January 2024 understood by staff and other key stakeholders	• Continue to build common purpose and make progress visible • Continue meaningful engagement across community and acute sectors, with voluntary agencies and service users and the public
	Establishment of RHAs		
	• Finalise and secure approval for job specification for RHA CEOs (including reference to both transition state and end state) • Complete recruitment process and appoint RHA CEOs • Develop and secure approval for job specifications for RHA SMT roles (including reference to both transition state and end state) • Agree process and progress recruitment/appointment for RHA SMT roles as far as possible • Conduct change impact assessment for transition of existing CHO and HG staff and services to align with new RHA boundaries • Agree approach for the transition of existing staff and services to align with new RHA boundaries e.g. approach to data/system update requirements, contracts, ways of working/culture etc • Transition existing CHO and HG staff and services to align to new geographical boundaries • Define team structures and responsibilities for RHAs • Complete development of key workforce processes e.g. approvals of posts to resourcing • Agree workforce transition approach and principles for fulfilment of future structures in RHAs • Establish baseline RHA workforce and develop population based workforce planning model (strategic and operational) • Progress Talent Attraction and Engagement to support RHA establishment and maintain service continuity • Deliver targeted professional development to leadership teams and staff to support the successful introduction of RHAs • Develop and agree branding for RHAs	• RHA CEOs appointed with formal accountability for their areas, in line with new RHA geographical boundaries • CHOs and HGs COs / CEOs remain in place reporting to RHA CEOs, with new geographical boundaries • Existing staff aligned to new RHA Boundaries • Transition principles and role mapping approach agreed for all levels • RHAs each to have their own brand and name within a new HSE brand architecture • RHA SMT appointed to support CEO to prepare for transition to fully functioning RHA	• Appoint/ establish all teams within an RHA • Stand down (as appropriate) existing CHO/HG teams
	Reform of National HSE		
	• Review and co-design National HSE functions and structures in the context of the RHA design and Integrated Service Delivery Model • Define team structures and responsibilities for National HSE • Develop and agree Job Specification for any changing EMT/leadership roles and agree process for recruitment/appointment • Agree workforce transition approach and principles for fulfilment of future structures in National HSE • Agree readiness activities to support any changes e.g. data/system update requirements, contracts, ways of working/culture etc	• Future state HSE National EMT in role and HSE National leadership established	• Stand down (as appropriate) existing teams
	Associated Departmental Reform		
	• Finalise the function and role of the DoH in the context of the new RHA structure and functional breakdown	• Clarity on the relationship between RHAs, DoH and HSE National agreed • DoH key changes in place	• Stand down (as appropriate) existing teams

	Key Activities 2023 Preparing the system for RHAs	Transition State - January 2024 RHAs Established	Key Activities 2024 Developing Emerging RHAs
Model of Integrated Care and Healthcare Governance	**Integrated Service Delivery Model and Health System Roles and Responsibilities**		
	• Agree new roles and responsibilities of each entity in the system in the future state for healthcare governance (detailed design), including defining the integrated service delivery model	• Integrated service delivery model designed • Detailed design of RHAs, National HSE and DOH	• Monitor implementation of Integrated Service Delivery model and refine if necessary
	Health Needs Assessment and Performance Management		
	• Agree Health Needs assessment process and how this will be completed for each region • Develop National and RHA Performance and Accountability framework to include KPIs, to include appropriate consideration of the RHA Integrated Service Delivery Model to support integrated care pathways (including year 1 view)	• Health Needs assessment process agreed outlining how this will be completed for each region • New RHA Performance and Accountability framework defined, communicated and understood, including clarity on which activities need to operate in year 1 • Interim KPIs for year 1 tracked and monitored for existing CHOs and HGs per Region	• Use available national and local data to understand population health and care needs • Health Needs assessment completed for each region in 2024 • New RHA Performance and Accountability framework commences operation based on agreed principles for year 1
	Healthcare Governance		
	• Engage multi-disciplinary clinical, service and wider stakeholders on the approach to detailed design of healthcare governance, in the context of RHAs • Finalise National and RHA healthcare governance framework • Revise the code of governance and update relevant governance policies and standards as needed to reflect changes in accountability and authority (e.g., delegation office policies)	• Agreed approach for healthcare governance for RHAs • National and RHA healthcare governance framework defined • Proposed changes to healthcare governance policies and standards drafted • Any governance changes required to operate safely in transition state January 2024 implemented	• Proposed changes to healthcare governance policies and standards approved for use in year 2
	Voluntary Organisation Alignment		
	• Agree governance approach and partnership arrangements with Section 38s and 39s	• Any changes to governance arrangements with Section 38s and 39s communicated and understood, including clarity on which activities need to operate in year 1	• Governance approach and partnership arrangements with Section 38s and 39s operational including performance management framework for Year 1

	Key Activities 2023 Preparing the system for RHAs	Transition State - January 2024 RHAs Established	Key Activities 2024 Developing Emerging RHAs
Planning & Finance	**Service Planning**		
	• Agree and document the process for development of the Corporate Plan, Service Plan, Capital plan and IT prioritisation, and clarify roles and responsibilities at national level and across RHAs • Agree the approach to allocate funding for RHAs and the associated process to govern same	• Process for development of the Corporate Plan, Service Plan, Capital plan and IT prioritisation defined	• RHAs, via RHA CEOs and existing CHOs and HGs, included in prioritisation process for annual Corporate Plan, Service Plan, Capital Plan and IT plan
	PBRA Model		
	• Establish a process to realign financial budget allocation and reporting to RHAs • Establish DoH-led expert advisory group, including representatives from HSE National and RHAs, to agree objectives and contribute to design of the PBRA model (with agreed timelines/process) • Commence a data mapping exercise to understand current inputs, activity, outputs and outcomes by geographic area • Agree PBRA criteria that need to be considered, based on population need • Commence development of the PBRA model • Test PBRA model outputs to understand level of alignment with current position based on data mapping	• Financial allocation and reporting aligned to new boundaries • PBRA development underway • Data mapping exercise complete outlining key variances between proposed PBRA budget and current actual budget	• Continue refinement of the PBRA process informed by the data mapping exercise
	Finance Systems and Processes		
	• Continue the development of IFMS in preparation for deployment across all regions • Design and develop national financial shared services with a single set of nationally standard finance processes	• Role of national finance shared services agreed including single set of nationally standard finance processes	• Continue the development of IFMS in preparation for deployment across all regions • Operation of national shared service centre
Infrastructure including Capital, ICT and Supports	**Establish Capital Approach**		
	• Agree the process for capital allocation and capital programmes, including understanding any implications of Public Spending Code • Design and develop national procurement shared services with a single set of nationally standard procurement processes • Agree RHA Head Office and other locations	• Capital allocation and capital programme delivery underway across RHAs, via existing CHOs and HGs • RHA Head office locations identified	
	ICT and Digital Enablement		

	• Agree data governance and reporting processes to support measurement of KPIs for RHAs
	• Assess and identify RHA Critical ICT requirements for:-
	  • RHAs to enable the emerging functions and processes defined & progressed
	  • Supporting the implementation of integrated service delivery/ care pathways
		• Common data definitions and reporting standards and cadences agreed
		• Data gathering and reporting processes in place to support measurement and tracking of KPIs for RHAs as agreed
			• Define ICT requirements for RHAs
			• Build out RHA KPI dashboard and analytics

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Appendix 1 - Background and Policy Context for RHAs

RHA implementation is grounded in the Sláintecare Report recommendation to organise the national health and social care services in a manner that is fully coherent and aligned at regional level; and that encompasses the full range of health and social care services across acute and community. The Sláintecare Report calls for the RHAs to have authority and "devolved responsibility for the provision of services in accordance with national policy" to ensure that their defined populations have "timely access to integrated healthcare services".

The commitment to establish RHAs was reaffirmed in the Sláintecare Implementation Strategy and Action Plan 2019, the Sláintecare Action Plan 2021-2023, the HSE Corporate Plan 2021-2024, and the Department of Health's Statement of Strategy 2021-2023. This reaffirmation of commitment reflects the cross-party 10-year consensus on the long-term policy direction for Ireland's healthcare system.

In July 2019, the geographies of six new regional health areas were approved, and the Government directed the development of a detailed business case and change-management programme outlining proposals for HSE reconfiguration to align with the regional geographies. The Programme for Government 2020 committed to bring forward detailed proposals on the six regional health areas to enable delivery of local services for patients that are safe, of high quality, and fairly distributed. A Memorandum on next steps, programme of work, and timelines for RHA implementation was approved by Government in April 2022.

Key elements of the RHA model, as set out in the Government-approved business case, are as follows:

- The six RHAs are to be set up as geographically aligned regional integrated sub-divisions of the HSE which will replace the nine Community Health Organisations, six Hospital Groups (excluding Children's Health Ireland), and other existing reporting structures
- RHAs will have management authority and accountability at a regional level operating with a single population-based budget per region
- RHAs will not have their own independent boards and will not be established as separate legal entities
- RHAs will have primary responsibility for health and social care service delivery and will have one leadership team and will derive their authority and fulfil their accountabilities through clear integration into the wider HSE governance framework.
- As well as being direct employers of existing HSE staff, the RHAs and National HSE will have responsibility for the delivery of integrated care in partnership with all health service providers across the regions (GPs, Pharmacies, Disability Services, Social Care)
- The model will include a strong, lean, and agile National HSE team responsible for national programmes and standards-setting and will seek to avoid unnecessary duplication of national functions in the six new organisations.

Appendix 2 - Approach to RHA Planning

Detailed below describes the approach which has been taken to RHA planning following the Government's decision in April 2022.

Key areas of focus have been: to outline the respective roles and responsibilities of the RHAs, National HSE, DoH and DCEDIY within a regional arrangement; and outline the appropriate delivery arrangements within the six RHAs.

Programme Governance Arrangements

To oversee the design and planning for the RHAs an **RHA Advisory Group** has been established by the Minister as an independent forum to provide the Implementation Team with support and guidance to RHA planning and implementation. They also have a role in keeping the Minister updated on their assessment of the reform's progress.

To take forward the planning and design of RHAs, a **Joint Implementation Team** comprising senior representatives from the DoH and HSE has been established. The Implementation Team provides updates to the respective organisational governance lines and to the Sláintecare Programme Board. A **dedicated programme support team** has also been appointed to support the planning and design processes, together with implementation.

As part of the Implementation Team structures, **five programme workstreams** were set-up to progress high-level functional design work. The workstream groups comprised membership including representatives from services, National HSE and DOH and are as follows:

1. Healthcare Governance
2. Finance
3. People and Development
4.1 Capital Infrastructure
4.2 Digital and ICT
5. Change, Communications and Culture.

As we move from the current design and planning phase into implementation there is an opportunity to augment the internal HSE approach, including the governance of same.

Stakeholder Engagement

A programme of engagement underpinned the approach adopted throughout the high-level planning phase. Outputs have been co-designed with a diverse group of stakeholders to ensure that system-wide insights have been gathered to inform the proposed way forward.

In September and October, **six regional engagement events** were held to obtain critical input from senior leadership and delivery staff across the services. This involved attendance by over 600 staff from across a blend of clinical, operational, and enabling functions. In November a RHA Clinical Governance workshop was held. The outputs from these events were collated and shared with the HSE, DCEDIY and DoH and fed into the high-level design and workstream considerations.

A number of sessions were also held with international subject matter experts to share insights, provide guidance and review high level outputs.

In addition, more than 25 briefing sessions took place throughout the high-level design phase with various HSE and external stakeholder groups to provide updates on project progress and emerging high-level design. Categories of stakeholder briefing groups include, Patient Fora Representatives, Staff Representatives and Unions, Professional Bodies, Voluntary Organisations, Chief Academic Officers and Government representatives. Two dedicated sessions with members of the Joint Committee on Health were held. More than 200 attendees were reached through the various sessions that took place from April to December 2022.

It is recognised that ongoing and meaningful stakeholder engagement will be critical at every stage throughout this major change programme. The programme team will work closely with all key stakeholders to ensure this engagement and that key stakeholders remain fully informed and involved at all stages.

Learning Nationally and Internationally

In taking forward the planning of RHAs, consideration has been given to the lessons learnt from the evolution of health service structures in Ireland over recent decades, from the establishment of the Health Boards in the 1970s, the Health Boards Executive (HeBE) in 2001, through to the establishment of the HSE in 2005 and the subsequent organisational approaches to the management of primary and community and acute services. This included reflection on lessons learnt from the establishment of four regional management teams, the Integrated Services Directorate area model, and the Integrated Service Areas in 2010, and the subsequent development of Community Healthcare Organisations and Hospital Groups. In addition, more recently, 96 Community Healthcare Networks have been established across the country – these Networks will be a key building block for service planning and delivery going forward within the RHA model.

In addition to Irish learning, international research has been conducted on a range of countries – New Zealand, Canada, Sweden, Northern Ireland, and Scotland – to identify best practice models, approaches, and learning that may be relevant for RHA implementation in Ireland. In New Zealand, a regional reform programme went live in July 2022. This country has many similarities to Ireland: their population is approximately five million; their health budget is approximately $24 billion per year; and they have recently disbanded 20 district health boards and now has one central authority with four regions. In 2019, Ontario similarly disbanded 14 Local Health Integration Networks (LHINs) and centralised its health system into one body called 'Ontario Health' with six regions. Sweden has had a more gradual move to allow local regions to design their own integration care networks. NHS Scotland has 14 territorial NHS Boards and has 31 Integration Authorities, the structure of which will help inform the Integrated Service Delivery model for Ireland. This research, its key findings and learnings fed into the whole system design and the integrated service delivery design. A key lesson evident from the research conducted was that the main driver of successful transformation is putting people at the centre. Transformation requires a major mindset and culture shift, and this 'emotional' side of the journey should be recognised and planned for.

The research focus areas included:

1. Health system framework (organisations and roles within the system)
2. Service level model (what is centralised versus what is devolved to the region)
3. Integrated service delivery model within the region
4. High-level structure / organisation design in each organisation within the system (evolution of / transition to including timeline)
5. Structure (population, hospitals, community, and primary care)
6. Healthcare Governance (incorporating Clinical and corporate governance).

Delivering Change

The approach to change that underpins RHA implementation is based on international evidence and learning from previous reform and reorganisation. It is signed off as organisational policy by the Trade Unions (National Joint Council and JICF) and the HSE Executive. (Health Services Change Guide –www.hse.ie/changeguide).

 "People support the change they help to create" reinforcing the importance of early and sustained engagement ensuring the needs of local communities and staff are central to the design and implementation process. The 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 / 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 RHA implementation building on relationships and networks across the system.
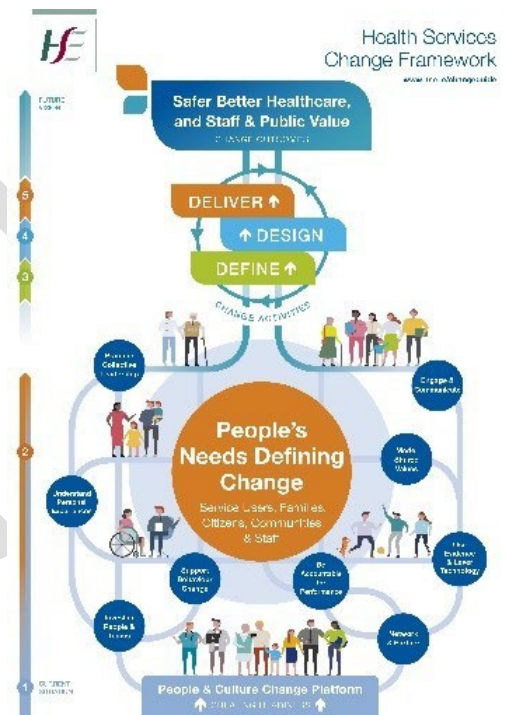
Appendix 3 – Key Principles to guide the development of ISD

Detailed below are a set of key principles to guide the development of the Integrated Service Delivery model of care.

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.
- The ISD model will be co-designed through meaningful partnerships with patients, carers, citizens 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 Leads in each of the RHAs. 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.
- While services will be planned and delivered in an integrated, devolved way at RHA and local level, taking account of national strategies, it is recognised that certain specialist services will continue to be planned and delivered nationally.
- 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 and demonstrates parity of esteem between acute and community services will be essential to enabling the innovation and creativity required to respond to the unique profile of the population in each region.
- Community healthcare networks will be the foundational building blocks for the ISD model - building on multi and inter disciplinary teamwork for integrated service delivery.
- Involvement with key partner organisations and communities at RHA level will be embedded as part of the ISD model to ensure a balanced approach on the wider determinants of health and with regard to primary and secondary prevention, early intervention and self-management across health and social care in the community.

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 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 public accountability through increased engagement with local populations
  - Increase connectivity and collaboration between services, enable collaboration and facilitate co-operation at both national and local RHA level
  - Enable decision making to take place as close as possible to the front line
- The provision of high-quality, safe care will be an integral component of integrated care underpinned by robust governance structures with clear accountability building upon the work of Community Health Organisations (CHOs) and Hospital Groups (HGs) in this area. RHAs will undertake an active risk management process and build upon the work done both centrally in the HSE and by HGs and CHOs. The work of the quality and patient safety functions will be further developed and enhanced. This will include the continued implementation of funded Antimicrobial Resistance and Infection Control recommendations and the excellent work done on infection management during the pandemic.
- While the lead role in each of the sub geographies within the RHA will be critical to facilitating integrated care across services and settings, integrated care will be the responsibility of everyone within the region and will require commitment at all levels. It is also recognised that some care is specialised and will be managed and overseen by the RHA. A separate process for consideration of a small number of truly national specialties will oversee the continued planning and delivery of such services, examples include transplant and neurosurgery.
- Community Health Networks will align 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. As a general principle, existing clinical networks that currently operate across hospitals / hospital groups will be maintained and will not be disrupted by revised administrative arrangements. This is a core component of maintaining safe, quality care, and reducing patient risk between model 4, 3 and 2 hospitals. Maternity networks are a good example of this and are embedded in the existing maternity strategy. The work done by Hospital Groups in planning and delivering care will be maintained and further enhanced based upon clinical input.
- Commissioning and contracting of services including associated governance arrangements with key service providers will be addressed at RHA level within national frameworks.
- Care group, clinical programme, clinical network, and public health leadership will be essential within the RHA to provide clinical oversight and support for planning and evaluation of each care group service.
- Public health and clinical governance will be aligned around a shared population health assessment promoting a focus on prevention and early intervention, addressing inequalities in access to and outcomes from healthcare provision and a strong multi-disciplinary ethos.
- The ISD model will be informed and enabled by research and by clinical programmes, pathways of care and care group requirements. This will include shared care arrangements and other networked approaches to the provision of high quality, safe services.
- ICT systems will be essential for effective integrated care by supporting better, more efficient, person-centred care which enhances information provision, communication, and service user

experience. This will also be core to innovation in primary and secondary prevention, assessment, diagnostics, treatment, monitoring and self-management. 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

Principle 5: Implementation and evaluation

- 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.
- Creating the conditions for integration will require a dedicated focus on building change and innovation capacity and capability at local level.
- The HSE is committed to implementing the new KPIs detailed in the Irish Health System Performance Framework (Department of Health, 2021)

Appendix 3 - Glossary of Terms

RHA	Regional Health Area
HSE	Health Service Executive
DoH	Department of Health
DCEDIY	Department of Children, Equality, Disability, Integration and Youth
NAS	National Ambulance Services
PCRS	Primary Care Reimbursement Service
ISD	Integrated Service Delivery
HG	Hospital Group
CHO	Community Health Organisation
CEO	Chief Executive Officer
PBRA	Population Based Resource Allocation
ICT	Information and Communications Technology
DPER	Department of Public Expenditure and Reform
WHO	World Health Organisation