Regional Health Areas Board Update

26 October 2022

Content

1. RHA Background, Current Position Governance and Resourcing

RHA Background

- Following receipt of a draft Business Case for the implementation of Regional Health Areas (RHAs), the HSE Board met in November 2021 to review the contents and provide feedback to the DoH.
- Board members will recall that the draft Business Case considered three organisational options and, following evaluation against a range of criteria, the 'HSE-Local Model' was identified as the preferred way forward i.e. six RHAs established as geographically aligned regionally-integrated sub-divisions of the HSE (each with a population-based budget), replacing the Hospital Groups and Community Health Organisations.
- The aim is to complete high-level design and implementation planning in 2022, with phased implementation in 2023; the target date for go-live with RHAs is January 2024.

RHA Current Position

- In the first half of 2022, preliminary planning for the introduction of RHAs has been taken forward by a joint HSE/Department Implementation Team. The focus of this planning work has included initial thinking in relation to the Vision and Objectives for RHAs, and the identification and scoping of key implementation workstreams:
    - Corporate and Clinical Governance
    - Finance
    - ICT and Capital
    - People and Development
    - Communications, Change and Culture
    - Programme Co-Ordination.
- Key engagements which have taken place in the year to date, including six regional engagement events (Cork, Sligo, Kilkenny, Tullamore, Dublin and Limerick). Attended by over 600 staff members. These took place in September and October to progress the design phase and to inform the implementation plan. Further detail provided in following slides and in Annex 1 and 2
- Detailed stakeholder mapping has been completed with a further schedule of intensive communications and engagement currently being planned. This plan will include dedicated RHA engagement sessions, in addition to integrating with existing forums to maximise stakeholders' time. Existing public and patient fora have been identified; engagement with these groups will form part of the engagement plan. Engagement plans will consider a range of engagement methods including face to face sessions, virtual sessions, submissions, public consultations, online interactions etc.

RHA Programme Governance

As Board members are aware, the joint HSE/Department RHA Implementation team comprises senior representatives from the two Departments and the HSE; the team is responsible for monitoring progress, providing direction and making decisions to support RHA implementation. The team initially focused on the Vision and Objectives for RHAs, and the identification and scoping of key implementation workstreams. They continue to progress RHA planning and design tasks, focusing on the key implementation workstreams. The Implementation Team met most recently on 6 & 20 October to review themes emerging from the regional events to date and to discuss next steps for the RHA Workstreams.

The RHA Implementation Team provides updates to their respective organisational governance lines and to the Sláintecare Programme Board.

Board Members are aware an RHA Advisory Group chaired by Leo Kearns, is an independent forum comprised of representatives with a range of perspectives from across health and social care, who supports and guides the RHA Implementation Team.

The HSE is establishing an RHA HSE Executive Governance forum, including representation from acute, community and social care services in the regions, to support overall Programme governance, design and implementation planning. This Group will report to the HSE's EMT and the Board

RHA Programme Resourcing

The planning and design phase is being led by Dean Sullivan (CSO) supported by Yvonne Goff (ND for Change and Innovation). Liam Woods (ND) has been assigned as RHA Implementation Lead and took up the post on 5 September 2022.

A dedicated Programme Management Team is being established within the HSE with responsibility to take forward the planning and delivery of the Change Programme. Recruitment of the dedicated Programme team is at an advanced stage with interviews complete.

Additional posts including significant change capacity have been submitted as part of the 2023 estimates process to build self-sufficiency within the HSE at national and regional level to support this Programme of change.

Nominations are being sought from the system to bring operational expertise to support each of the Programme Workstreams.

2. Draft Emerging Design Summaries

Draft Emerging Design Summaries

The following slides contain draft relative roles and responsibilities and draft emerging design summaries for the Programme workstreams. Please note the following:

- The slides contain initial working drafts which are being shared for input and discussion, and subject to ongoing deliberation.
- Feedback received during the Regional Events has not yet been reflected in these design summaries.

Draft Relative Roles and Responsibilities

Subject to ongoing deliberation

The role of the RHAs

RHAs are responsible for understanding and using information regarding their populations to plan and deliver services regionally within the context of national policies. RHAs will operationalise policies, guidelines and models of care, etc. as provided by the HSE Centre, within the rulesets and funding provided by the Department of Health and the HSE, to achieve objectives as set by the Department of Health, and is supported by both to do this.

The role of the HSE Centre

The role of the HSE Centre is to support and ensure the effective operationalisation of national policy and to proactively support regions in the delivery of health social care services.

In fulfilling this role, the Centre will seek to promote national consistency in structures, service delivery and clinical processes. The Centre can achieve this via encouraging exchange of good practice between regions, including through the co-development of models of care. Given the roles and responsibilities of the HSE Board, performance management of the regions will also sit with the HSE Centre (and ultimately the HSE Board) in support of performance improvement and in service of their accountability line to the Minister for Health.

The role of the Department of Health

The role of the Department of Health is to set overall strategy, legislation, policy, and funding. The Department retains the Health Vote and is responsible for PBRA governance. This will enable the Department to oversee the health service at a strategic level. Given the legislative roles and corporate governance responsibilities that sit with the Department and Secretary General, high level performance management functions will be a role for the Department.

Workstream 2 – Finance: Summary

Scope: Financial Planning & Analysis, Financial Governance, PBRA, Audit & Reporting

Future State – For Discussion

- **Overarching –** Move towards guidance and frameworks and minimising / streamlining rulesets where practical – development and maintenance of all of above to optimise collaboration between DoH, HSE Centre, RHAs and Voluntary, with the aim of reaching as much of a shared view as practical.
- **DoH:** Sets overall high level financial standards and delivery parameters (the high level "what") for the health and social care system having engaged with regard to what is realistic and achievable. Responsible for the policy development and approval in relation to the PBRA model for RHA funding allocations.
- **HSE Centre:** Focus on guidance, frameworks and, where necessary, rulesets, to ensure consistency and minimum standards. Defines parameters for spending, responsible for ensuring outputs and outcomes (the detailed "what") set are achievable and conditions for success by RHAs are fostered. Responsible for the operation of the PBRA model and/or development of guidance for PBRA methods for RHA decision making about expenditure at community/acute.
- **RHAs:** RHA determines how to achieve outputs and outcomes with allocation (the "how") . Encouraged to save and permitted to reinvest in service of defined outcomes. Transparent access to data permits exception-based reporting. RHAs are responsible for driving cost efficiency, operating within budget and addressing overspends in their area (1st charge).

Future State Alignment to RHA Design Principles

The future state for discussion was reviewed against the 9 RHA Design Principles and the following are most aligned:

- The RHA flexibility to re-allocate funding within guidelines is consistent with *Devolved Decision Making.*
- The standards set at centre and the creation of clear performance goals tied to budget allocation aligns with *Governance and Accountability* and *National Consistency.*

Scale of Change

The following are significant changes from the current state:

- The implementation of the PBRA funding model, which will change how budget allocation is undertaken.
- RHAs are given flexibility within the allocation system to determine how best to achieve desired outcomes but also must address overspend in their area.

Areas to be Challenged

- Does the future state under discussion enable integrated service delivery?
- How should the ruleset be defined for budget allocation such that an RHA has sufficient flexibility to make local decisions to ensure success in reaching objectives?
- How do we ensure a shared understanding of risk within the system so that budgetary decisions are made in a predictable and controlled manner?
- How should the DoH/HSE Centre foster conditions for success when defining desired outcomes during budget discussions with RHAs?

Workstream 3 - People and Development: Summary

Scope: Workforce planning; approval of posts and recruitment; HR Policies & Procedures; Performance Management and Personnel Development; IR, ER

Future State – For Discussion

- **DoH**: Will primarily be at the macro level, with potential involvement for approval of posts at certain levels (TBD). Focus on legislation, policy and monitoring.
- **HSE centre**: Will be responsible for people and development / workforce strategic planning and design, including national resource strategy, as well as setting national standards and national training, ensuring national consistency and liaising with professional bodies. Manage national relationships, develop and maintain centralised approach to IR.
- **RHA:** Will be empowered to make local resourcing decisions to ensure service continuity. Will deliver development and training activities based on local needs – will co-design with HSE centre. Regional workforce plan (identify gaps/needs), informed by best practice set by HSE Centre. Recruitment responsibility for all grades as agreed in recent ROM work. Performance management of staff in line with national framework. Feedback of any possible IR issues to HSE Centre to ensure visibility.

Future State Alignment to RHA Design Principles

The future state for discussion was reviewed against the 9 RHA Design Principles and the following are most aligned:

- The ability of RHAs to make local resourcing decisions aligns with *Devolved Decision Making*.
- National standards and design for training (co-designed between HSE Centre and RHAs) aligns with *National Consistency*.

Scale of Change

- RHA autonomy to make local resourcing decisions, depending on the level of autonomy agreed.
- Decisions made at the regional level will adhere to the guidelines of national strategies and will be informed by regional assessment of population needs.

Areas to be Challenged

- Does the future state under discussion support an appropriate level of devolution?
- Does the future state under discussion enable integrated service delivery?

Workstream 4.1 – Digital: Summary

Scope: Digital Strategy, Roadmap, Architecture & Technical Standards; Digital Procurement & Vendor Selection; Digital Support & User Management, Digital Delivery, Operations & (Cyber)Security; Data Activities (e.g. architecture)

Future State – For Discussion

- **DoH** drives National policy & National strategy and Funding Allocation
- **HSE Centre** retains responsibility for:
  - IT Capital Planning and Prioritisation decisions; Regional investment decisions derive from them.
  - IT Architecture, Standards and Capabilities in conjunction with RHAs.
  - Vendor Frameworks for common applications.
  - Cyber Security and IT Infrastructure.
  - National programmes (full IT lifecycle) standardised and led by National teams.
- **RHA** is responsible for Regional projects (full IT lifecycle) and owns implementation of national programmes.
- **Ownership of innovation** is both regional and national.

Scale of Change

- Standards emanate from the centre, however regional projects are now owned and managed regionally, with the regions responsible for implementation to agreed data and operational standards.
- Innovation is owned both nationally and regionally.

Future State Alignment to RHA Design Principles

The future state for discussion was reviewed against the 9 RHA Design and utilising an ICT capability framework model.
Principles and the following are most aligned:

- In the future state, retaining standards responsibility at the centre is consistent with the principles of *National Consistency* and *Maximise Data and Information,* and the involvement of RHAs in standards definition is consistent with *Collective Leadership and Collaboration in Design.*
- RHA responsibility for all aspects of regional projects is consistent with *Devolved Decision Making.*

Areas to Challenged (Governance and Maximise Data & Information)

- Has the degree of regional financial autonomy been defined (both CAPEX and OPEX)?
- Given the imperative to deliver an integrated architecture (e.g. support a single health record), what expectations do we have for how patient information will be shared and how data will be shared/used to derive insights into how services are/ can be better delivered e.g. how all current settings/actors will be governed in relation to data sharing?
- To factor in the national strategic entity for health information (The National Health Information Authority) under the HIB into the Systems View

Workstream 4.2 – Capital Infrastructure: Summary

Scope: Forward Planning Capital Investment, Portfolio & Capital Projects, Asset Management

Future State – For Discussion

- **DOH:** Similar role, DoH drives Strategic Capital Investment Framework and secure funding Allocation aligned with population health-based methods/policy priorities, develops/agrees capital project prioritisation criteria in conjunction with the HSE, supports the development of HSE Sectoral funding governance guidelines, DoH is the approving authority under the PSC and additionally approves individual projects above €100m on behalf of Govt, approval of annual HSE Capital Plan.
- **HSE Centre:** Acts as a National guidance centre, sets agenda in alignment with clinical strategies, drives policy, strategy, standards, innovation and best practice / develop forward planning capital investment approaches aligned with population health-based methods, clinical programmes, risk analysis & organisational objectives / Oversight of Capital Spend and onward reporting to DoH & Govt. / Develop & maintain Capital & Estates Database to enable data driven analysis, intelligence and inform investment decision making.
- **RHA:** Will work in collaboration with HSE Centre to develop evidence-based regional capital investment plans linked to local needs. Will provide input to end-to-end portfolio, including capital projects, acquisitions/ disposals, energy and sustainability requirements and act as a mechanism through which two-way dialogues are established across the system ensuring local-level requirements are considered within the national agenda.

Future State Alignment to RHA Design Principles

The future state for discussion was reviewed against the 9 RHA Design Principles and the following are most aligned:

- The ability of RHAs to make local resourcing decisions aligns with *Devolved Decision Making* and *Governance and Accountability*
- Utilisation of local information allows for *Maximising Data and Information* to drive holistic insights across the system.
- National standards and design for training (co-designed between HSE Centre and RHAs) aligns with *National Consistency*.

Scale of Change

- In context of scale of change required to healthcare estate and need for plan, prioritised, consistent delivery of same, appropriate degree of central control will be essential.

Areas to be Challenged

- How will the requirement for delivering national strategic objectives be balanced with local operational requirements?
- HSE will be Sponsoring Agency under PSC – who is the Client for National Programmes and Regional Only Capital Developments i.e. HSE Centre or RHA ?
- How to ensure, between a corporate centre, regional structures and DoH that when investment planning takes place, it empowers the RHAs to deliver integrated service, but also responds to the framework that the corporate centre had prescribed to them?
- Has the degree of regional financial autonomy been defined? Or looking at another way, who owns minor work/maintenance programmes?
- Will PBRA also apply to capital spending (CAPEX and OPEX), and if so, how?
- How to ensure that an evidence-based and analytic approach underpins strategic investment planning? – SHIF & Property Management Strategy

Workstream 5.1 – Communications: Summary

Scope: Communications guidelines, infrastructure & channels for all groups; campaigns, advertising, media buying and contracts, media relations and crisis communication

Future State – For Discussion

- **DoH:** Provides support where required for the definition of some frameworks, guidelines and standards (e.g. crisis communication) and input on policy. Manages own communications.
- **HSE Centre:** Develops frameworks, guidelines and national standards. Manages comms infrastructure (e.g. HSE website and internal comms infrastructure). Manages national media relations and national crisis comms and campaigns.
- **RHA:** Contributes to the development of communications frameworks and guidelines. Responsible for building their own communications channels and programmes as a core part of a national health and social care service. Manages RHA media channels, RHA section of HSE website, and own media relations. Activates national campaigns locally and identifies needs for new campaigns in their own area.

Scale of Change

- RHAs will have the autonomy to manage their own media relations, and will contribute to national campaigns.
- The RHA will be encouraged to build their own communications programmes and channels within the context of our national health and social care service using national guidelines and standards.

Future State Alignment to RHA Design Principles

The future state for discussion was reviewed against the 9 RHA Design Principles and the following are most aligned:

- Strong alignment of branding/communications to national standards, which is consistent with *National Consistency.*
- The communications roles for the DoH, HSE Centre, and RHA are clearly defined, and consistent with the *Governance and Accountability* principle.
- The RHA is responsible for its own local identity as part of the national health and social care service and media relations, which aligns with *Devolved Decision Making*.

Areas to be Challenged

- Does the future state under discussion support an appropriate level of devolution?
- Does the future state under discussion enable integrated service delivery?
- How is it ensured that the identity of the HSE and each RHA co-exists in a clear and understandable way for the general public?
- How are national comms standards delivered to ensure consistent messaging while allowing RHAs enough flexibility to effectively communicate within their own regions?

Workstream 5.2 – Change and Culture: Summary

Scope: Defining, planning and delivering culture initiatives; Developing change capacity, capability and system leadership

Future State – For Discussion

- **DoH:** Provides research on best practice examples of transformation and culture change to inform and shape desired culture as part of policy and strategy development in collaboration with HSE Centre.
- **HSE Centre:** Sets agreed principles required for a whole system approach to enable people and culture change, support behaviour change and enable integrated ways of working aligned to strategic intent. Develops resources, guidance and tools aligned to agreed national frameworks and organisational policy. Supports establishment of change networks and communities of practice.
- **RHA:** Applies principles for people and culture to local context. Role models and fosters sense of ownership of change and belonging at local level. Collaborates with HSE and DoH on national frameworks and programmes of change. Identifies and integrates existing change capacity, strengthening supports as needed. Responsible for local implementation in line with national guidance and organisation strategy.

Scale of Change

- The main area of change is formal responsibility for RHAs to lead and adapt change and cultural initiatives to local needs and implement accordingly. Need to be resourced to do so and integrate existing development resources locally.

Future State Alignment to RHA Design Principles

The future state for discussion was reviewed against the 9 RHA Design Principles and the following are most aligned:

- The responsibility of the HSE to develop a whole system culture and create frameworks is consistent with *National Consistency*.
- The RHA is mandated to foster a sense of belonging at local level and adapts change and culture initiatives to local nuances. This is aligned with *Devolved Decision Making* and *Our People*.
- RHAs work with HSE Centre to ensure that cultural initiatives match the reality on the ground. This is consistent with *Our People* and *Collective Leadership and Collaboration in Design*.

Areas to be Challenged

- Does the future state under discussion support an appropriate level of devolution?
- Does the future state under discussion enable integrated service delivery?
- How does culture feature in performance management, e.g. to drive incentives to activate desired ways of working?
- How can we collaboratively respond to and communicate emerging change across DoH, HSE Centre and RHAs, with emphasis in the first instance on the high-level vision and intended benefits of RHAs?
- How can we strengthen regional and local capacity to lead and deliver change?

Workstream 1 – Clinical and Corporate Governance (Ongoing Activities)

Workstream	Key Activity
CCGA	Performance Management
CCGA	Transformation and Innovation
CCGA	Audit
CCGA	Service Delivery
CCGA	Research
CCGA	Strategic Planning
CCGA	Planning of Services
CCGA	Quality and Patient Safety
CCGA	Governance & Risk Management
CCGA	Clinical Governance

3. RHA Regional Events

Regional Events – Summary of Locations and Attendance

The following slides provides a summary overview of the 6 Regional Events, further detail provided in Annexe 1 including responses to a number of questions asked on the day using the Menti platform

Event Location	Future RHA Alignment	Attendees (including facilitators)	Total number of breakout discussions
Cork	Area D	92	15
Sligo	Area F	115	15
Kilkenny	Area C	114	15
Tullamore	Area B	94	15
Dublin	Area A	106	18
Limerick	Area E	82	14
Total		599	92

Regional Events Executive Summary

Key Themes from 6 Events across 5 Discussion Areas (further detail provided in Annexe 1 to this pack)

Theme	Key comments
People	• **RHAs provide an opportunity to further develop regional teams, building regional identities, improve the morale of the people who work in the HSE, and strengthen our resourcing, recruitment and retention strategies**. It is critical that we invest in staff health and well-being, and in work/life balance, as well as attending to the full continuum of staff needs along their career journey. • **Regions need sufficient dedicated resources across all services and functions** (dedicated staff within Human Resources & ICT were highlighted). A lot of staff (for example, in ICT and other business areas) are dedicated to national initiatives and local service providers experience a lack of basic provision because staff are not accountable or often available at a regional level.
Autonomy	• **RHAs can be the regional voice at the national table**. The system appreciated the ability to be heard at the regional events. They want to strongly influence national design and maximise regional autonomy. To advocate for local needs in national discussions so that initiatives that can seem 'minor' at national level get the attention they need. During the RHA programme, local services want to be involved in the redesign of the HSE Centre, not only the RHAs themselves. • National decisions can often seem rigid / disconnected at a regional level, and even minor adjustments to respect local requirements can be difficult to implement. **RHAs present an opportunity to comprehensively plan based local needs** and provide enough flexibility in terms of infrastructure provision, workforce planning (including recruitment), and service planning to best meets the needs of local populations and services.
Planning	• **To deliver population-based Integrated Care, planning must also be integrated**. An opportunity exists to integrate population based decision making, clinical design, capital, workforce, and service planning to ensure that all combine to deliver better outcomes and experiences to meet service user / population needs.
Finance & Capital	• **Collaboration required between HSE Centre and RHAs to determine the standard of care** and the **targeted level of positive patient outcom**es that will be delivered, with **autonomy given to RHAs to determine how these standards and target levels of outcomes will be met**. Budgetary flexibility should be provided to the RHAs to enable the RHA to have sufficient autonomy to find the most efficient and effective way of delivering the required standards and levels of outcomes. • **RHAs should be empowered to reinvest savings to incentivise innovation and efficiencies.** In addition to the extent RHAs overspend their budgeted funding levels for reasons other than exceptional circumstances, the responsibility to address the overspend resides with the RHA through such mechanisms as a first charge on following year funding. This provides the regions with autonomy and flexibility in relation to budget management and encourages accountability. • **Migration from care group budgeting, with access to multi annual budgets/funding required** to enable RHAs to fulfil the patient-centred funding goal and to enable longer-term service delivery and planning to cater for the emerging needs of the impacted population. • **RHAs would wish for a Capital approval process that is transparent, streamlined, and predictable**. The regions find the current processes slow and arcane, and this creates the potential for initiatives to not deliver expected benefits due to the length of time needed to deliver these projects.
Infrastructure	• The **Electronic Health Record** is seen as extremely urgent to streamline the delivery of integrated care. • **Investment is required in Capital and ICT infrastructure to ensure a minimum standard of provision of both across the country**. The lack of basics creates inefficiencies and adversely affects the morale of those working in the HSE. Population-Based Resource allocation cannot "lock-in" the inequity that's perceived in the regions.

4. RHA Programme Plan – Critical Path October to December 2022

RHAs Key Next Steps

October – December 2022

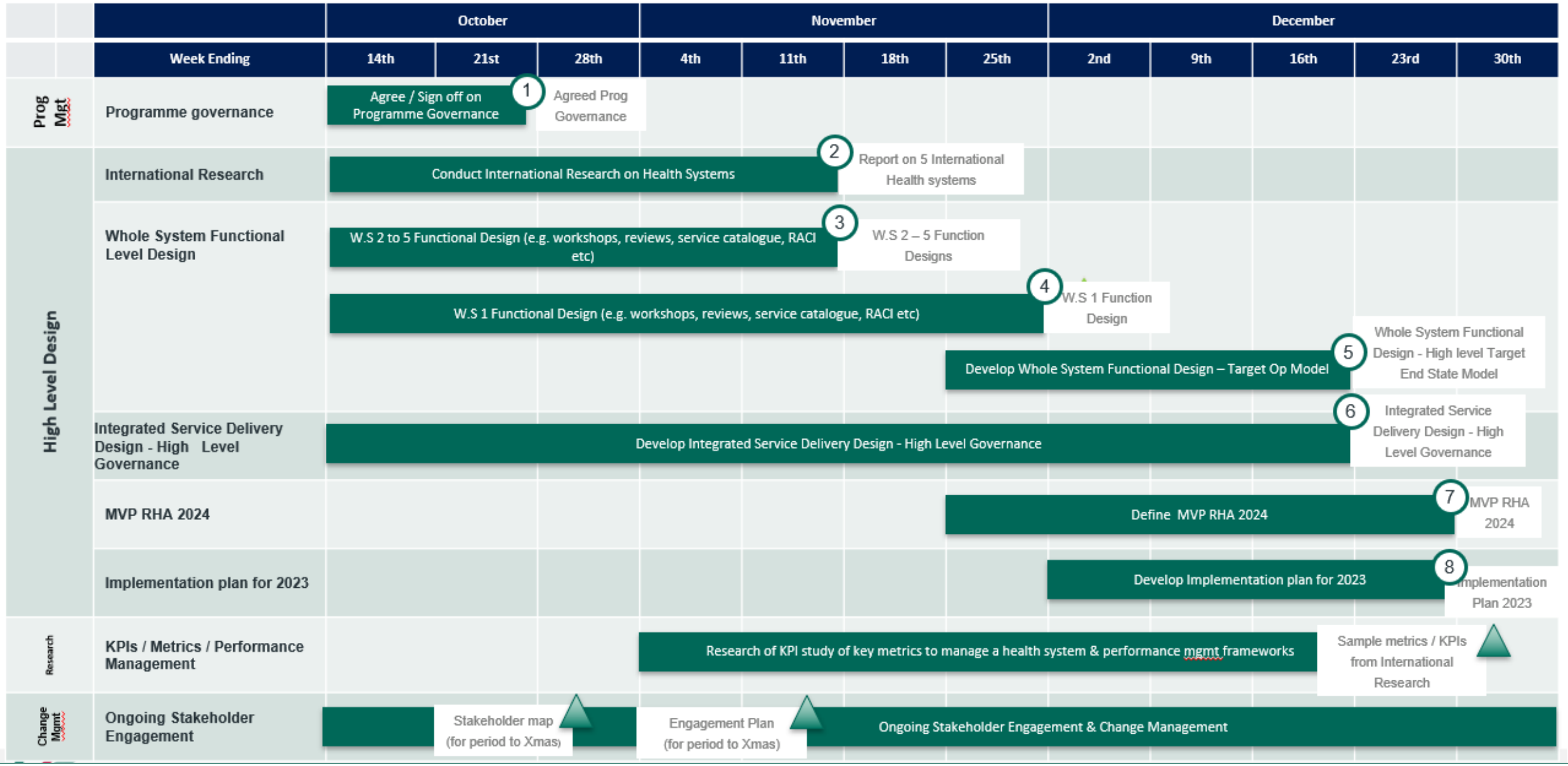
The following are the key next steps in the RHA High-Level Design Phase:

- Conclude the RHA stakeholder communications and engagement plan.
- Analyse outputs from Regional Events and Workstream discussions to inform progress on the functional design; conclude high-level functional design.
- Undertake international research (NZ, Canada, Sweden, Scotland and NI) to identify best practice models, approaches and learnings relevant to RHA design and implementation.
- Develop high-level governance model to support integrated service delivery within RHAs.
- Develop 'Minimum Viable Product' describing all essential structural and process changes for RHA go-live in January 2024.
- Outline RHA implementation plan to be drafted by year end.

2023 onwards

High-level plans and timelines are currently being finalised for 2023 to include detailed design and phased implementation in line with the agreed government timeline for the establishment of RHAs in January 2024. Recruitment into RHA senior positions will be progressed as a priority in 2023.

RHA Critical Path Oct to Dec 22



The RHA Critical Path identifies the key tasks and deliverables to be completed during the high-level design phase from October to December 2022, as well as the completion dates for each item. The plan includes time for engagement with the relevant stakeholders to align and agree on the final deliverables, to be signed off according to the agreed governance model.

Annexe 1 – Regional Events Detailed Feedback

1. People and Development – Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
1	Recruitment	• The need for approval processes and recruitment processes to be devolved, streamlined, and simplified was mentioned at all workshops - this would enable RHAs to manage workforce issues and mitigate risks self-sufficiently, responding quicker to population needs. • The need for the current recruitment process to be digitised was emphasised across workshops – this would allow RHA to provide a quicker candidate experience and not lose key people to other areas of the system due to timelines, as many candidates are deterred by the existing lengthy, paper-based process. • Incentivisation to be considered for RHAs where evidence currently indicates it is difficult to recruit (Dublin areas due to cost of living, rural areas etc.) – this would support necessary recruitment in these regions. • More autonomy to make contract decisions for work across community and acute – this would allow regions more flexibility in contracts will incentives for staff to include additional development opportunities and flexible working arrangements, enabling work life balance and ultimately attracting more people to the posts.
2	Workforce Planning	• Workforce planning needs to be more collaborative between national and regional levels – this would allow local issues or intelligence to be fed back into national plan, to effectively identify supply issues and carry out succession planning. • Need to collaborate with the Department of Education and academic partners to address staff supply – this would help address current vacancies across the system and shortages in individuals trained vs numbers needed each year. • Need for flexible contracts – this would facilitate staff to move across the continuum of services in a region and allow the RHA to respond to their population needs in a more agile way. • The benefits of improving and streamlining staff databases were discussed e.g. an accessible database storing the qualifications and experience of staff in the RHA – this would encourage cross system collaboration and skill sharing, it would help patient centred care, and it would facilitate the seamless transfer of individual records across sectors in the case of a staff member engaging in an internal career move. This would empower RHAs to manage their own needs more efficiently and self-sufficiently.
3	HR	• HR expertise needs to be available and sufficiently resourced in RHAs – this would ensure capacity and capability for effective HR activities at a regional level e.g. strategic workforce planning , employee relationship, employee engagement, and learning & development. • Need to professionalise HR grades and how we develop HR staff e.g. CIPD – this would ensure that the region has required skills to manage workforce as HR is a specialised role. • Need to have formal mechanism for more collaboration with RHAs on National policies - this would help ensure they are designed in a way that is implementable at a Regional and local level. • Organisational Development & Design needs to be invested in and expanded to support the change - Organisational Development & Design expertise is a scarce resource which should be developed as this can be very enabling work across many other services and functions.

1. People and Development – Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
4	Staff Training & Development	• It was agreed at all workshops that RHAs need to ensure there is a concerted focus on staff development at regional level and where possible ensure rotations across the region – this would drive better exposure to research, varied experiences, and make positions more attractive which will help staff retention and development. • Clear career trajectories and pathways in RHAs need to be communicated, i.e. opportunities for development and promotion - this would support talent attraction and retention. • Equal access to funding for training purposes needed across RHAs, and training to focus on future skills and integration – this would allow equal opportunity in all regions and would ensure there is strategic investment in the development of staff meet future needs, and not only current service needs. There is also more support required locally to enhance leadership, management development, change management, and mentoring, e.g. training / development supports as well as resources and toolkits. • Regions need to own relationships with academic partners – this will allow regions to create and maintain connections for the RHA as third-level institutions will be dependent on our workforce to train new students and regions will want to create pathways from training into the workforce.
5	Staff Health & Wellbeing and RHA Identity	• A need for increased consideration and investment into protecting the health and wellbeing of staff was emphasised across sessions. RHAs should learn from other organisations and invest in a positive culture by encouraging rapport among colleagues, attending to the basic needs of staff, adding elements of fun to the workplace, and scaling up on creating a welcome an environment for new staff – this would improve the health and wellbeing of existing staff as well as support in a move toward being seen as an employer of choice. • Need for RHAs to develop local identity within the overall HSE brand, naming and fostering their common understanding and identity beyond structural change. This identity should have a focus on staff health and wellbeing with increased employee benefits - this would strengthen psychological contract between staff and the workplace, and increase retention and ability to recruit for local areas. RHAs should have autonomy in how this is delivered, with national guidance to ensure national standards.

2. Finance– Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
1	Autonomy of RHA in service delivery within agreed funding*	• 'What' standard and level of care that will be delivered to each patient (at a minimum) will be developed at national level by the HSE Centre in collaboration with RHAs, however autonomy should be given to RHA's to determine 'how' those standards and levels of care will be met, and the funding structures should enable this – as this will allow flexibility within RHA budgets to prioritise the needs of their patients locally and ensure patients care is not compromised due to limitations of budget. • RHA should have autonomy and budget flexibility to consolidate services that are replicated throughout an RHA – as this will lead to more efficient use of funding and enable better quality of outcome for the service user within their RHA. • Clearly defined roles and responsibilities required – as autonomy should be linked with accountability and responsibility, and RHAs should have a clear understanding of what they are being held accountable for.
2	Incentivising Savings*	• Consensus that a portion of savings should stay with the department that makes the saving (while delivering the required level and quality of service) – as innovation should be rewarded and staff/services which are making cost savings should be incentivised. • RHAs should have autonomy to decide how savings are allocated – as balance needs to be struck between reinvesting the savings to incentivise innovation and reallocating the savings against an RHA deficit in the interest of the greater good. • Savings should not be reallocated to another service if there is a recurring requirement for additional support – as this will impact morale and disincentivise efficiencies. • Collaboration between HSE Centre and RHAs to develop a ruleset in relation to savings – this will enable transparency of allocation of funds and ensure service providers are demonstrating that they are providing the best quality of service possible with the funds they have before additional funding is made available to them. • RHAs should have flexibility to carry forward unutilised portions of the current years budget – as this will reduce unnecessary spending and eliminate the current 'use it or lose it' approach to funding as that is an inefficient use of resources.
3	Budget Overspend*	• Overall agreement that the default position for an RHA is if an overspend/deficit arises due to circumstances which are not exceptional, the associated deficit should be the responsibility of the RHA and carried forward as a first charge to the RHAs following financial period – as this will encourage accountability and innovation within RHAs. The ruleset in relation to first charge principle (definition of 'exceptional circumstance') are to be defined collaboratively between HSE Centre and RHA as this ensures buy-in from RHA leadership. • Alignment between target outcomes and funding allocation required – to ensure that targets can be realistically achieved within limitations of the funding provided. Planning and remediation should avoid deficits, which means that a degree of honesty is required as to what is achievable within the resources provided. • RHA should consider the source of the deficit when balancing the budget. RHA should demonstrate, with evidence, that the overspend was justifiable as overruns may not always be due to inefficiency but instead due to improved patient outcomes. • Year 1 RHA commencing budget is critical – as it is important to ensure adequate resources are available for required level of service and to ensure historical deficits are taken into consideration to enable an equal starting point for all service providers.

2. Finance– Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
4	Budgeting*	• Agreement that collaborative decision making between HSE Centre and RHA's is required, with earlier bottom up input regarding the allocation and management of available funding – as this enables lower levels of RHA to influence budget based on local experience and insight and promotes equity of fund management. • Budgets should be devolved to a local level with increased accessibility and accountability for budget management and financial reporting sitting within more local levels of the RHA, and flexibility to reallocate/repurpose funding and integrate budgets - as this will enable more detailed review of historic spending and trend analysis and allow RHA's to fulfil the patient centric funding goal. Considerable investment in finance systems and data analytics is required to enable this • Earlier visibility/transparency of budgets is required - as this will enable better utilisation of funds if RHA's are aware of the limitations of their budget upfront. • Multi annual funding for base funding and long term development plan suggested – this will provide future certainty on funds available, and will ensure emerging needs are identified and accounted for in RHA budget. • Alignment between Finance and HR and Procurement – as this will strengthen workforce and strategic planning and ensure there is alignment between future budgets and the strategic objectives of the RHA over time.
5	Performance Management*	• An element of performance-based allocation of budget suggested, where funds are allocated to services that can demonstrate their efficiency with data (to the extent data is available) compared to services which cannot, and by evidencing with data that they are providing the best quality of care possible with the funding that has been made available to them – as it is expected that this will promote better management of funds/resources and drive efficiencies. • Investment required in real time data – as data collection/management is currently under resourced and underutilised and can be used to inform budgets, allocation of funds and identify where efficiencies can be created. • Development of integrated and patient centric KPI's required not just financial KPI's – this will ensure that KPI's are in the best interest of the service user and can be monitored throughout the entire patient journey.
6	Integrated Budgets and Integrated Care*	• The patient journey should be the paramount consideration and need to ensure patients are treated in most appropriate place for them (e.g. community care rather than hospitals) – as funding and the provision of services should follow the patient regardless of the budgetary constraints of the RHA in which they are based. Need to create a more streamlined pathway for patient experience. • Consensus was that care group budgets currently act as a barrier to integrated care and migration from the care group budgeting required to include a portion of funding designated for integrated care was deemed necessary – this will enable RHA's to fulfil the patient centric funding goal. • Agreement that RHA's should have flexibility to share/merge care group budgets, buy services from other RHA's, and promote collaboration across care groups – as this will accommodate patients that move between multiple care groups and enhance quality of patient outcome.
7	National Specialities*	• Clarity on national programs in the context of RHA funding required. Broad agreement that national specialities located within RHAs should be funded outside the PBRA model, through a "super RHA" or national top slice of health budget – because all RHA patients stand to benefit from national services and suggestion is that their budget should standalone and protected without the risk of being absorbed by other RHA priority services.
8	S.39 Organisations*	• The current usage level of S.39 organisations should be factored into RHA service delivery and future planning – as there is an over reliance on S.39 services due to lack of capacity within public system. Insourcing should be incentivised within new RHA structure in order to reduce reliance on S.39. • Lack of pay parity between HSE and S.39 organisations needs be addressed – as this will help to attract and retain resources.

2. Finance– Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
9	Estates	• RHA input into Estates required to ensure alignment between capital funding and RHA budget – as limited coordination between revenue and capital budgets leads to misalignment between services available and the infrastructure required to deliver the service (and vice versa). • Agreement that PBRA should apply to capital budget as well as revenue budget and also take into account historical investment levels – to ensure equality in level of capital investment.
10	PBRA Model	• The rurality of the West and the Islands should be given due weight when developing equalisation factors for PBRA – this will take into account the greater cost involved in bringing services to the patient. • Flexibility of funding to develop the provision of additional services in the West and Islands is required to enhance professional experience - as challenges exist in attracting and retaining resources and remuneration is not always a key driver. • The socio-economic status of the population of the mid West (e.g. lowest level of 3rd level education, highest population classed at disadvantaged) should be given due weight when developing equalisation factors for PBRA – this will ensure equity of population based funding and will ensure that the RHA is equipped to service the needs of its population. • PBRA model and the equalisation factors that determine budget allocation should be flexible and adjustable – this will ensure that the nuanced and emerging needs of the population are accounted for when funding is being allocated.
11	Workforce Planning	• Flexibility required within RHA budget to provide a moving allowance to attract and retain resources – particularly important for Dublin, where cost of living is greater than other areas within the RHA. • Enhance the skillset of appropriate staff and extend their roles (where capacity allows) – this will enable more effective budget management, help achieve end-to-end provision of services and ensure resources are fully utilised.
12	Non-Health Related Funding	• Co-ordination between the RHAs and local authorities is critical – as this will help ensure efficient use of funding provided for non-health related services which may be categorised as social protection expenditure (e.g. housing, transport).
13	Preventative Care	• RHA should have autonomy and budget flexibility to safeguard a portion of RHA budget for preventative care and wellbeing – as early detection and prevention will reduce pressure placed on hospitals and community care in the longer term.
14	Political and Public Perception	• Link between RHA and political system to be considered – as RHA's should have autonomy to make decisions that benefit the population they serve whilst considering the impact on political and public perceptions. • RHA should be as transparent as possible – as this will ensure that there is both public endorsement, and endorsement from staff as potential service users, in how the health system is governed and how money is spent. • If RHA's are expected to provide integrated care, the approach to integration needs to flow from the top down – as current challenges exist when political influence favours a siloed approach. Approach to integration needs to apply consistently to all in order to be successful.

3. Capital – Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
1	Processes	• During the sessions it was mentioned that the process of applying for approval for capital projects is unclear, and the length of time required to complete means that the delivery can be inappropriate by the time it's finished. • Capital approval process was discussed during all workshops. It was felt that it should occur at regional level as part of a transparent and predictable process – as fewer layers of approval would accelerate the process and make it more agile. • Bringing decision-making into the regions should make it possible to make more joined-up decisions around capital infrastructure - this will mitigate issues such as different health settings within the region procuring incompatible systems. • Some projects are national in nature, and it was expressed that RHAs should bring a regional voice to those discussions – ensuring that smaller, regional considerations were integrated into national planning.
2	Infrastructure and Procurement	• It was noted that RHAs should contribute directly to national strategic planning around capital expenditure at a minimum, but ideally should be entirely responsible for capital decisions within their region – as this would ensure that regional proprieties are considered with less bureaucracy around procurement and fund allocation. • To deliver an Integrated Care Model, the Estates service needs to take a holistic view on *where* services take place – the current approach is to create buildings for each new function, whereas buildings could serve multiple (and therefore, more integrated) uses, and some services could take place in the community with the right investment. In general, we should be using patient journeys and care pathways more explicitly when designing estates and allocating capital budgets. • Capital Infrastructure doesn't sufficiently consider transport – in providing for the population, capital planning needs to incorporate how patients (in particular, those with extra mobility needs) travel to care settings, or if they can be treated in their home. We cannot assume that everyone can be driven, so all modes of transport should be taken into account. This is obviously important in relation to equity of access to health and social care.
3	Service Planning	• Strategic priorities must inform how capital will be spent – this will ensure infrastructure aligns to agreed standards and is suitable in terms of standards of care. Regardless of where it sits in terms of capital allocation, it must be corrected if it is not fit for purpose. • The capital approvals process needs to be integrated with service & workforce planning - this will support a more future-focused view. • It was noted that a new RHA-based approval process may improve the alignment of service planning and capital planning – and therefore ensure that capital projects are made operational, and that staff will get necessary approval for infrastructure. It was noted, that alignment of capital and service planning is essential to the delivery of integrated care. • Autonomy around service planning was also mentioned. Participants noted that approval for capital projects below an agreed threshold should be owned by RHAs – this will increase the decision-making ability of regions and reduce waiting periods for funding.

3. Capital – Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
4	Maintenance	• Maintenance and capital should be considered together – this would prevent regions not having the budget to maintain and repair systems which essentially puts them out of use. • National projects often produce unusable infrastructure in regional settings. RHAs need to ensure that regional requirements are incorporated into systems – this would help ensure that they are usable once delivered.
5	Regional Prioritisation & Decision-making	• Throughout the sessions it was highlighted that RHAs should retain a level of autonomy around decision making and prioritisation. RHAs should have the ability to prioritise regional-specific capital projects and have a voice in national capital project prioritisation – as this would ensure that important projects are approved. Several participants noted that oftentimes that vital capital projects get pushed down the list in favour of more explicitly clinical projects (e.g., the provision of education and training facilities for staff). • RHA proximity to the regions can enable a discussion about a better use of existing assets – there is a feeling that assets have the potential to be used for more purposes than at present.

4. ICT – Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
1	Resourcing	• RHAs need to ensure that the regions have sufficient staff and equipment to support ICT and capital needs – while centralisation of ICT systems may standardise methodologies and processes, there are fears that a pool of ICT skilled staff will be further pulled from regional areas. To ensure that RHAs can resolve their own challenges, ICT experts need to be present locally and a point-of-contact must be identified.
2	Digital Baseline	• The introduction of ICT should bring with it a baseline of minimum digital provision. Across all workshops it was alluded that the current ICT environment varies across regions and also between health settings. • More importantly, almost all participants noted that the very basic technical provision is not available (both hardware and software) which affects the delivery of services – therefore, there is an opportunity to understand the current digital and ICT baseline within the new RHAs and provide the necessary infrastructure as requites. This would reduce clinical risks, enhance information sharing and decrease operational waste. • The lack of a single electronic health record makes the efficient operation of care pathways more difficult – every hand-off requires information to be inefficiently transferred and re-entered. The is exacerbated when processes are paper-based.
3	Standards and Regional Operations	• The consensus was that the HSE Centre should remain as the leader of standard setting and the owner of big technology projects – to ensure system wide interoperability, consistent standards and consistency from the patient perspective. However, RHAs should be involved in that process to ensure sufficient flexibility to implement effective solutions within the regions. • The HSE Centre should have a lead role in standardisation, interoperability and best practices for technology, however prioritisation, procurement, implementation, and operations should happen in the regions within national standards and guidelines – this would ensure that technology/ICT projects are implemented at pace without a risk that challenges in one RHA will impact on implementation in other areas. Additionally, this approach would also ensure that infrastructure is context specific and hence more suited to the environment in which it operates.
4	Innovation	• Throughout the Covid-19 pandemic, local innovation and timely implementation were possible due to increased autonomy and reduced regulations from the Centre - some of these innovations should be implemented as "easy wins for RHAs“ to increase morale and to demonstrate best practice. • For RHAs to innovate, share ideas and best practice, they require clear guidelines on "innovation project journeys". To innovate, RHAs will also require a clarity around information governance. RHAs would also like to have a point of contact with knowledge of regulations (like an innovation commissioner), who would navigate the environment and accelerate the innovation process. • ICT systems should take a more active role in helping health professionals determine the next step for a service user - The current approach relies too much on staff being aware of next steps and who to contact. In repeatable situations, ICT systems should be employed to make it easier to efficiently and safely move a service user along a care pathway. In general, it was felt that ICT had the potential to make significant financial savings for the HSE due to efficiency gains and easing the burden on staff, and this should be recognised in budget discussions.

4. ICT – Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
5	Data Use and Quality	• Data capture is currently time consuming and is error-prone. Participants mentioned that data is currently stored using stand alone Excel spreadsheets which do not feed into the national system limiting research, monitoring and baselining opportunities. Going forward, the RHA should collect and utilise data in accordance with national standards – which will enable high quality data, better decision making, improved research impact and accurate monitoring, reporting and baselining. • Additionally, it was mentioned that RHAs should be equipped with working systems that decrease the workload of staff – by eliminating paper reporting, "finger counting" and job duplication ensuring that staff are focusing on their primary jobs (e.g. comments were made that reporting is a significant additional task for frontline staff). • Going forward, it was suggested that RHAs must create regional-appropriate solutions, and delivery better use of data that is already collected – this would enable date informed decision making (e.g. better use of data collected by the Ambulance Service to optimise systems). • Patient data, and single patient identifier were frequently mentioned during the workshops. It was noted that whilst this may be outside of the remit of RHAs, it will nonetheless improve patient experience especially as they move across the RHAs. • A patient portal should be introduced in the new RHA structure – this will allow information to be reviewed and updated by the patient, increasing transparency. This will also ensure accuracy of records that are available across systems.

5. Population Based Service Delivery – Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
1	Need for RHA autonomy	• There should be regional flexibility, but within national guidelines. The RHA is best placed to adapt service delivery to the particular needs of its population, while the Centre should play a key supporting role – issuing frameworks, developing models of care, communicating best-practice. Broad agreement that the Centre should play an enabling and support role, rather than adopting a 'command and control' approach. • Standard pathways of care set out centrally, while maintaining flexibility around implementation locally, with RHAs having autonomy to flex based on local population health needs. • Agreement across groups that there is a need for the Centre to shrink and for the RHAs to take responsibility – commitment is required from both to make RHAs a success. • RHAs need to have one structure with the autonomy to manage their own resources. Leadership within each region need to be empowered to establish a vision and identity. • Regional tailoring of any model of care for RHAs needs to be evidence-based, and align with the National Model of Care, however RHAs need to allow freedom for local innovation.
2	Coordinated care provided by integrated RHAs	• Planning and delivery of services needs to be better coordinated across the care continuum and professions, in order to enable a multi-disciplinary approach and to prevent silos. • Regions should have the freedom to invest in networks that align all parts of the RHA, providing consistent care across all settings. RHAs are an opportunity to better integrate the community and acute sectors, establish cohesive teams with linkages between services. Collaboration should be encouraged through implementation of peer to peer networks. • There is a need for integrated accountability and governance right across the RHA. Voluntary organisations need to be included as an integral part of Regional Health Areas. Legislative changes may be required to ensure that voluntary organisations are aligned on RHA priorities and are brought within unified governance structures. • Patients or service users with complex needs (e.g. Disability) require more services and budget however this needs to be balanced with those who have a lesser need – the RHA performance management framework will need to have KPIs which can measure quality of care for more complex patients. • It was felt that HSE Centre and RHAs should be more patient-centric when designing and delivering services - while policy developments, models of care and standard setting have aimed to achieved integrated care, that is not something which service users currently experience when they interact with the system. • There is a strong concern that existing links between service providers may be broken because of their allocation on either side of an RHA boundary.
3	Budgets and Funding	• The current 12-month funding cycle is not conducive to effective long-term planning. The shared budget concept will need to be understood across the RHA and allocated on a multi-annual basis, so that population needs can be effectively managed from one source in a sustainable way. • Strong agreement across groups about the need to steer away from overly hypothecated funding. RHAs need to be able to decide how to conduct service planning for their own region. This cannot be done effectively if the Centre is consistently 'badging' resources for allocation – the RHA needs the flexibility to allocate funding for services according to its population needs. This is true for capital and estates, as well as for service development. • Processes should be in place to recycle savings and reward good practice within individual RHAs.

5. Population Based Service Delivery – Key Themes

Consolidated Outputs from across all Regional Events

	Theme	Key comments from Participants
4	Staffing Flexibility	• Major challenges with current staffing processes reported across several groups, particularly around approval processes and rigid job posts – these need to change under RHAs. • Clear desire for flexibility in staffing, with enhanced autonomy to recruit according to the needs of the RHA, so an allowance for regions to adapt and reprofile posts. Agreement that this should be done within the context of maintaining consistency with national outcomes. • Greater flexibility on staff contracts and IR relationships is required so that staff can be deployed in more agile manner – potential for rotational posts with contracts held by the RHA. Lack of movement of staff is a constraint to service reconfiguration.
5	External environment	• There was widespread agreement among many groups that RHAs need to be enabled to effectively engage with complex stakeholders such as trade unions and political representatives – this includes provision of robust support from the Centre. It was noted that each RHA will have varying challenges dependent on social and geographic factors. • Learning lessons from other initiatives and previous experiences will improve the effectiveness of the implementation of RHAs – many lessons learned during Covid should be factored in, as should other learnings, e.g., from ISAs and ECCs.

6	Important role of enablers	• Digital enablers are key if the RHAs are to be set up for success. Current systems are not fit for purpose and do not allow caregivers to follow the patient digitally, which is a barrier to the provision of integrated care. There is waste and duplication across the system as a result. Coordinated IT systems can also promote collaboration and innovation within RHAs.
		• RHAs need to deliver access to good quality data - automated and self-service data access are important enablers for service delivery.
		• There needs to be a system that people can use to bring their innovative ideas. If you curtail people to be innovative you miss the opportunities to drive change – staff need to have the opportunity to innovate to develop services.
		• Each RHA should be empowered to create a strong brand and identity in order to drive integration across the RHA and between all services. Public relations capability is a key component of this.
		• It was felt that RHAs should enable better access to business analysts, target operating model (TOM) design, transformation and change skillsets to support TOM design based on best practice and to implement that design –
		  • Needed in order to constantly update service delivery and to design innovation models to support evolving population needs
		  • Enables self-sufficiency and supports transformation within the RHA.

Snapshot of Menti Feedback from Attendees – Question 1

What did you find most valuable about today?

*"Workshops were **open** and **engaging,** given the **chance to design the future** of the health service"*

*"Listening to **different perspectives, diverse opinions**"*

"Networking"

***"Presence** of senior leadership"*

*"**Engagement across disciplines –** a lot of similar issues across services"*

*"**Exposed** a lot of **difficulties**"*

Snapshot of Menti Feedback from Attendees – Question 2

After today, what is the most urgent topic to discuss on RHAs?

*"**Line of Governance** from MoH to DoH to HSE Centre to RHAs. **Models and structure**"*

*"**ICT** systems implementation and integration. Corporate, clinical and financial governance for **integrated service**"*

*"**Modernising** the services and systems"*

"Developed budget and innovation opportunities"

"Structural change only!"

*"**Equity** across hospital and community"*

"Data strategy"

*"**Accountability** and decision making. Clarity on **authority** and **leadership**"*

*"Practicality of **population based funding** VS **strategic investment**"*

*"**Timeframe for key milestones** on road to delivery"*

Snapshot of Menti Feedback from Attendees – Question 3

What are your main concerns with the implementation of RHAs?

*"**Failure to integrate** between community and acutes"*

*"Implementation of authorities that are **too far removed** from what is happening on the ground"*

*"Another layer of **bureaucracy**"*

*"**Nothing will change** to improve patient's outcomes, reduce waiting lists or provide speedy access to services"*

*"Meaningless without **buy-in** and **sustained investment**"*

*"Rural areas **lose autonomy**, becomes urban centric leadership"*

"Timeframes for implementation"

Snapshot of Menti Feedback from Attendees – Question 4

How could these sessions be better in future?

"Focus and clarity of how findings will be used"

"Separate workshop around key services e.g. children, mental health"

"More sessions as progress is made and more time"

"Invite clinicians and front line stakeholders"

"Discuss how we move from current status to RHA"

"Separate IT & Capital"

"More specific questions"

"Smaller group sizes"

Sligo Regional Event Photos