

## **Opening Statement by Mr Leo Kearns, Chair of the Regional Health Areas Advisory Group to the Joint Oireachtas Committee on Health, 26<sup>th</sup> October 2022**

Firstly, I would like to I would like to thank the Chair and Committee for your invitation to attend today.

In late December 2021, the Minister for Health established the Regional Health Areas Advisory Group and appointed me as Chair of this Group. The membership of the Group includes people of great experience from right across the health and social care system. It is important to note that the role of the Group is to provide advice. Responsibility to draft the plan and to implement RHAs rests with the HSE and the Department of Health. An implementation team has been established under the joint leadership of the Secretary General of the Department of Health and the CEO of the HSE.

### **Background**

The six new Regional Health Areas (RHAs) are in line with recommendations made in the Oireachtas Committee on the Future of Healthcare Sláintecare Report (2017), that regional bodies should be responsible for the planning and delivery of integrated health and social care services.

Integrated care is where services, funding, and governance are co-ordinated around the needs of the patient, encompassing both acute and community care.

RHAs will ensure the geographical alignment of hospital and community healthcare services at a regional level, based on defined populations and their local needs. This is key to delivering on the Sláintecare vision of an integrated health and social care service.

As well as enabling the integration of community and acute care, RHAs aim to empower local decision-making and support population-based service planning. This will ultimately strengthen our health service and lead to improved patient experience as well as access to healthcare closer to home.

Since formation, the Advisory Group has met on a number of occasions and some of the key advice provided are as follows:

### **Ensuring clarity of purpose**

The core vision driving RHA implementation is to improve care to patients by enabling a joined-up, integrated approach to service planning and delivery; and to empower those who deliver that care. There is still a significant risk that RHAs are being viewed primarily as an organisational, 'back-office' exercise. If this perception remains, it will undermine this reform programme.

### **Governance and Accountability**

A key issue at the heart of the RHA implementation is the belief that the current centralised and hierarchical governance approach to the health service needs to fundamentally and radically change.

It is not possible to define a clear role for an RHA without also doing the same for HSE Centre, and for the Department of Health, including how all these entities relate to each other.

The guiding principle that should underpin this work is that of subsidiarity – there should be a guarantee of independence and authority for the RHAs commensurate with the responsibility they are being given; with absolute clarity as to how an accountability framework will work; and the same should apply to HSE Centre in relation to the Department of Health. As a natural consequence, the plan to implement RHAs must also include an aligned change plan for HSE National and Department of Health.

In determining levels of authority, the bias should be towards providing maximum devolved authority, sufficient to allow the RHA to exercise effective decision-making to deliver on its responsibilities, while working within relevant national frameworks. The only authorities that should be retained at national level are those that are necessary to be retained at national level; and where they are retained, there should be an explicitly stated rationale as to why this is the case.

## **Leadership & Organisation**

Each RHA will be a very large and complex entity within the national health service, serving a significant population with a budget of multiple billions, tens of thousands of staff, and responsible for planning and oversight of integrated service provision incorporating prevention, primary care, community, specialist and acute care; and for all aspects of care including mental health, children and older persons care; and will have to plan and deliver these services across multiple national and local service providers; including voluntary and private providers, and develop integrated service provision with other sectors such as Local Authorities.

In this context, it is essential that the core leadership team for each RHA be appointed as soon as possible, to take ownership of the implementation from the perspective of the RHA. A reasonable aim could be to have the RHA CEOs recruitment commence early in 2023, with a view to the appointment of the core leadership team by mid to end-2023.

Given their scale there is a risk that RHAs could themselves become centralised, top-down organisations, and simply introduce another bureaucratic layer to the health service. Therefore, maximum devolved authority also needs to be translated into the organisational arrangements within RHAs. This must ensure appropriate levels of authority for decision-making at the level of the patient pathway and enabling local and regional structures to enable relationships and trust building across boundaries. We wish to emphasise this point, as the core rationale for RHAs is to enable integrated pathways of care to patients and clients. Thus, any RHA that does not organise itself in a way that devolves relevant and necessary responsibility, authority, and accountability as close to the patient pathway as possible, will not be fit for purpose.

In order to provide clarity and avoid varying or conflicting understandings on this matter, it is important to establish at an early stage the level of authority devolved to RHAs for Finance, HR (Human Resources), ICT (Information and Communications Technology) and Estates etc, and then some basic models as to how this will be operationalised, bearing in mind the principle of subsidiarity mentioned earlier. This will, of course have implications for service planning, budget allocations, care group funding, and will have to provide for transition periods and nuances such as care provided across RHA boundaries, or where services are provided nationally and drawn down regionally. It will have implications for the role of HSE Centre and the Department of Health in relation to Finance and HR, which will have to change from current practices. The importance of ICT and Data as a critical enabler of integrated care must also be emphasised.

The national clinical programmes have been a success for the health service over the past number of years. In the context of the RHAs and the reformed role for HSE Centre, these frameworks/models will assume a much more fundamental responsibility for HSE Centre, and the development, enhancement, and expansion of these should continue. There are many excellent examples of such frameworks e.g., the National Cancer Programme; Integrated Care Programme for Older Persons; Chronic Management etc., which demonstrate many of the characteristics of an effective national framework.

## **Workforce Planning and Human Resources**

At the heart of the motivation to implement RHAs is the concept that this will enable services to be designed and delivered in an integrated way to meet the needs of people at local level. Right across the health service, people will buy into this as a concept worth committing to. However, without staff, this vision will never be realised, and people understand this also. It is important to acknowledge that this exercise is taking place at a time when we are experiencing a workforce crisis at many levels.

Therefore, it is necessary to establish a credible, sustained, cross-system approach to a multi-layered workforce strategy. Failure to make parallel progress on this will fatally undermine efforts to implement RHAs as it will indicate to people that the implementation of RHAs is not serious about the delivery of better care.

There must also be an acknowledgement that for many and varied reasons there is a deficit of trust and a strong sense that people working in the health system do not feel valued. We need to improve the culture in our health service so that we rebuild trust among staff at all levels. Doing so will help to create the sense that people are valued.

Inherent to this culture change is ensuring that staff are included in all changes that will impact upon them so that they have confidence in the direction of travel. This is key to successful change and not addressing this poses a risk to successful RHA implementation.

## **Engagement & Implementation**

The implementation of RHAs is not simply an organisation or administrative change within the HSE, it requires systemic change; and involves multiple parties. These various entities must be fully engaged in the design and implementation of RHAs. Simply presenting them with a fait accompli will not work. So, thought needs to be given as to how these organisations and entities will be meaningfully involved, and not just communicated with, from the beginning and throughout the lifetime of this implementation so that they are part of leading the change.

Implementing RHAs is an extremely challenging and large-scale change. It is not credible that change of this magnitude can be managed without a significant investment in an implementation support infrastructure. While the leadership and drive for the implementation needs to come from within the system, they must be supported by thought leadership, research, specialist expertise, change and programme management from outside as required. Significant project support and specialist expertise is required at Department of Health, HSE National and RHA level and must be co-ordinated across all three.

It is difficult to see much real progress being made on implementation unless senior leaders in HSE and Department of Health are freed up from some of their 'business as usual' responsibilities to devote significant thought and time to this.

While work is ongoing to draft the implementation plan, there is a need to draft a critical path plan based on the key milestones so that it is easier to visualise and understand critical steps in the pathway to implementation. The critical path plan should be shared and communicated widely – transparency will be vital in building confidence and support. Progress towards implementation should then be evaluated against this critical path plan.

## **Conclusion**

The implementation of the RHAs is absolutely essential if we are to set ourselves up to deliver joined up care to our patients and clients. This is not a simple task and will require significant sustained investment and outstanding leadership at all levels, but particularly at national level to make it happen. We must stop depending on short-term, reactive solutions to crisis situations, and commit to making the fundamental reforms that are necessary to allow us to develop sustainable solutions to the very real problems we have in our health system.

Finally, I would like to extend my thanks to the RHA Advisory Group members for their enthusiastic engagement and I would like to thank the committee again for their invitation today.