Joint Committee

on

Health

OPENING STATEMENT

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Chief Executive Officer

7th December 2022

Introduction

Good morning Chairman and members. Thank you for the invitation to meet with the Joint Committee on Health for an update on matters regarding Sláintecare. I am joined by my colleague(s):

- Damien McCallion, Chief Operations Officer
- Dr Colm Henry, Chief Clinical Officer
- Ms. Anne Marie Hoey, National Director HR
- Ms Yvonne Goff, National Director, Change and Innovation
- Mr Liam Woods, National Director, RHA Implementation

REGIONAL HEALTH AREAS (RHA'S):

The HSE is continuing to actively progress the implementation of RHAs in line with Sláintecare and the HSE Corporate Plan 2021-2024. The RHAs will enable the alignment and integration of hospital and community healthcare services at a regional level, based on defined populations and their local needs.

The implementation of RHAs is a fundamental reform of our health and social care system and will have far-reaching implications across the health service. Phase one of RHA design and implementation planning is ongoing with each of the working groups focused on the system-level design i.e., the key **functions and activities** that will be delivered at RHA, HSE Centre and DoH levels. This work is feeding into the detailed draft implementation plan which will be prepared by the end of the year. Work has also started on the development of a **population-based approach** to service planning and resource allocation, the outputs of which will inform the allocation of funding to the RHAs that are being established from 1st January 2024.

The committee that produced the Sláintecare Report defined integrated care as:

"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 in 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."

The committee also recommended that:

"The HSE strategic national centre will be supported by regional care delivery through regional bodies, recognising the value of geographical alignment for population-based resource allocation and governance to enable integrated care. The role of the Integrated Care Regional Organisations (now referred to as RHAs) will be to ensure timely access to integrated healthcare services in line with the reform programme. The role will include the following functions:

- *Resource allocation for integrated care, as appropriate*
- *Staff recruitment for integrated care, as appropriate*
- *Governance and co-ordination of established integrated care goals*
- *Accountability through regular reporting to the 'Health Service National Centre"*

In recent weeks, I have asked the HSE's Executive Management Team (EMT), and specifically the National Directors leading on Slaintecare, and RHA Implementation, to ensure that as we continue with the work outlined above, our efforts have an over-riding focus:

1. Firstly, on identifying the barriers to high quality integrated care and the evidence informed known ways to overcome such barriers.

2. Secondly, on how best to move to, and embed, a culture of appropriately self-managed local front-line teams.
3. Finally, on ensuring that all structures, roles and processes being designed at any level above the local front-line, including RHA and HSE Centre levels, are validated against how well they are aligned with the achievement of 1 and 2 above.

In summary, in keeping with the original intent of Slaintecare, and in line with the requirements of the HSE Board, which was established as part of the implementation of Slaintecare, the Executive is very clear that the primary purpose for implementation of RHAs is to create the conditions for improved integrated care.

By intent, and by design, it is the Executives expectation that, for example:

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

2. RHAs will 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.

3. RHAs will also provide input to, and have influence over the agreed framework of 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 the HSE centre, and strict compliance with data governance and data standardisation requirements, will be central to ensuring the framework of standards, guidelines and policies can provide the maximum desired appropriate degree of independence and autonomy to the RHAs, and to their front-line teams, as possible, in keeping with the important principle of **subsidiarity**.

4. RHAs will have **budget autonomy**, within the framework of standards etc. to manage, and allocate, within their region, the funding assigned to them, in pursuit of the objectives, outcomes and outputs they have committed to.

5. 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.

6. RHA Chiefs will have direct access to meetings of the HSE Executive Management Team (EMT) and they will also have direct access to the HSE Chief Executive Officer.

The EMT and I have agreed that there is significant merit in beginning immediately to make a start towards modelling the type of behaviours and arrangements that are expected to be in place when we have RHAs. Each National Director has been tasked with reverting before the end of 2022 with an initial list of the current types of approval requests and similar that CHOs and Hospital Groups are required to seek from the HSE Centre. This is with a view to determining which of these can be dispensed with or reduced, subject to any appropriate guidance, starting from Q1 2023.

Conclusion

I have deliberately confined my opening statement to providing clarity in relating to the HSE's expectation around the very important Slaintecare programme element that is the Implementation of RHAs. During the course of the meeting my colleagues and I are also happy to answer questions on other Slaintecare related topics that may be of interest to committee members including progress on:

- Enhancing Community Care Programme and General Practice
- Eligibility
- The Slaintecare Consultants Contract including the removal of private practice from public hospitals
- The Waiting List Action Plan
- Elective Centres
- E-Health / Digital / IT Systems

This concludes my Opening Statement.

Thank you