Health Regions Board Briefing

26 January 2024

Agenda

Agenda Item
1. Health Regions Background & Context
2. Health Regions Progress to Date
3. HSE Structures – HSE Centre, Region EMT, Region IHA
4. Health Regions IHA Mapping
5. Health Regions Headquarters
6. Health Regions Programme Plan
7. Implementation Plan Actions Status
8. Health Regions Change Management Supports
9. Patient and Service User Partnerships
10. HR Plan/ People Update
11. Implementation Approach and Transition Plan
12. Health Regions Programme Governance Model
13. Key Programme Risks
14. AOB

Health Regions Background & Context

Health Regions Vision

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

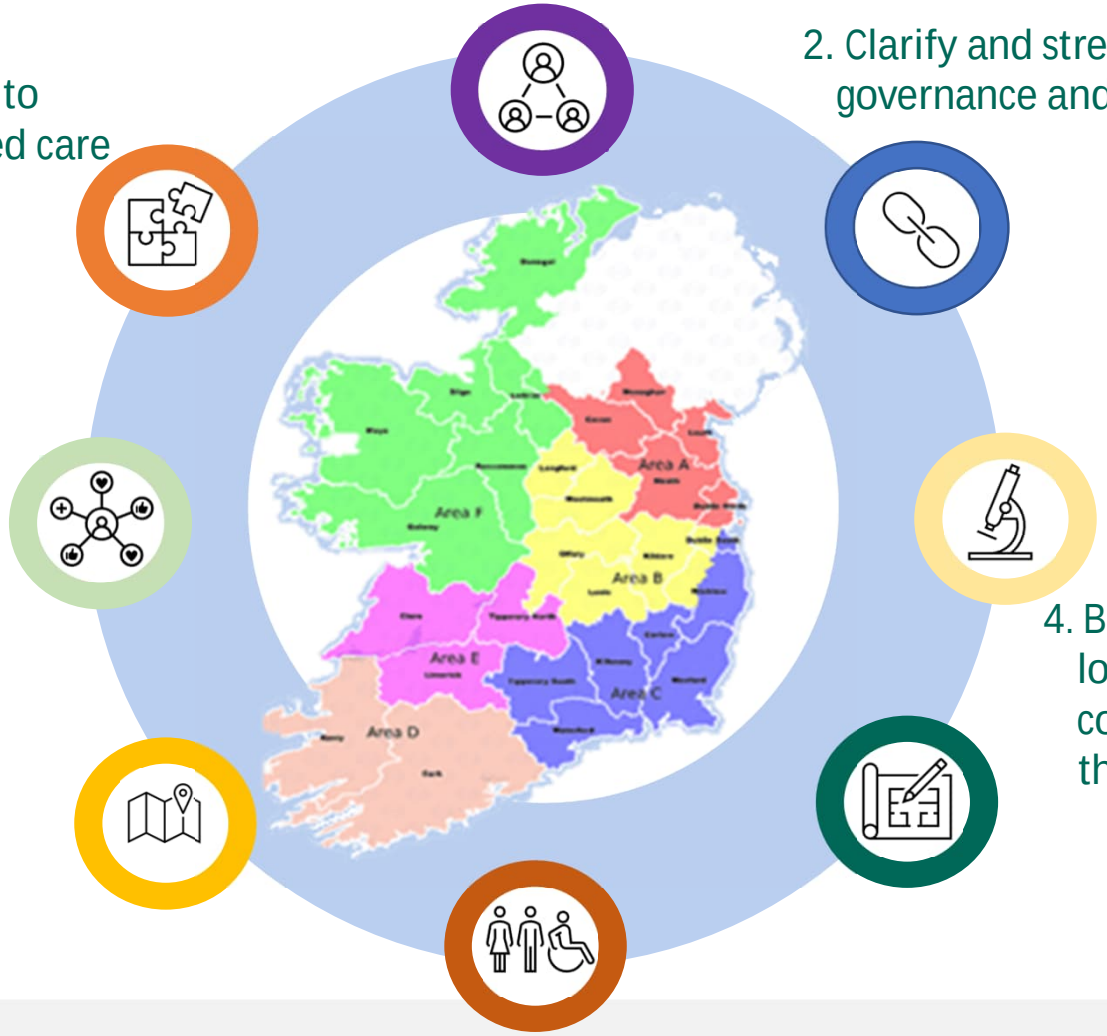
To balance national standards of care and direction with local decision-making to ensure people can access the same quality of care no matter where they live

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

Health Regions Strategic Objectives

1. Align hospital-based and community-based services to deliver joined-up, integrated care closer to home

2. Clarify and strengthen corporate and clinical governance and accountability at all levels



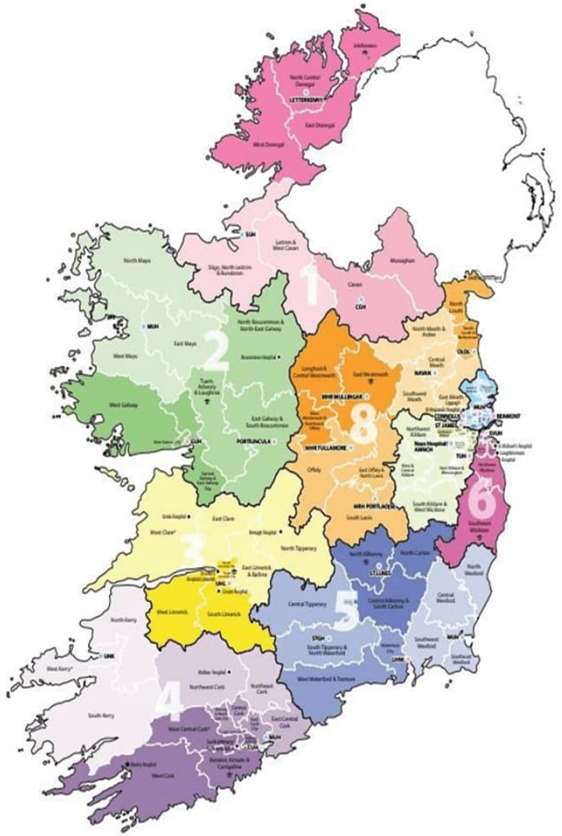
3. Support a population-based approach to service planning and delivery

4. Balance national consistency with local autonomy to maintain consistent quality of care across the country

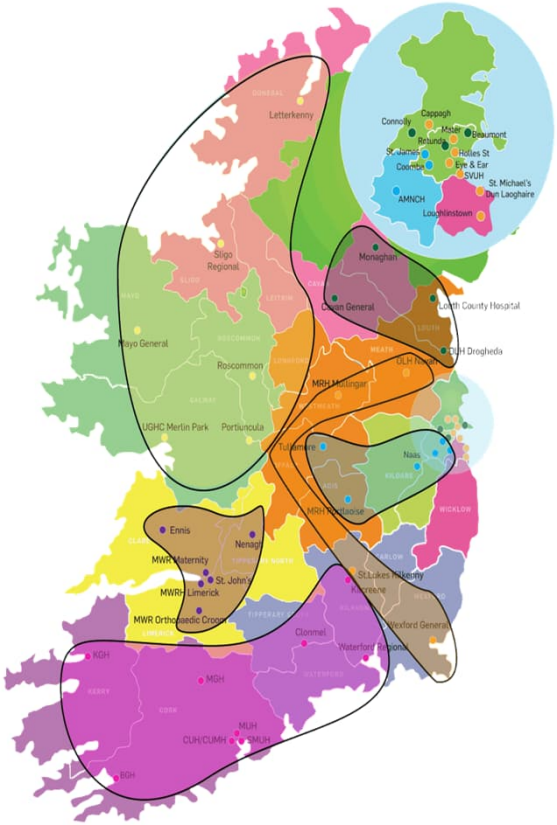
Source: RHA Strategic Objectives

CHOs and HGs to Health Regions

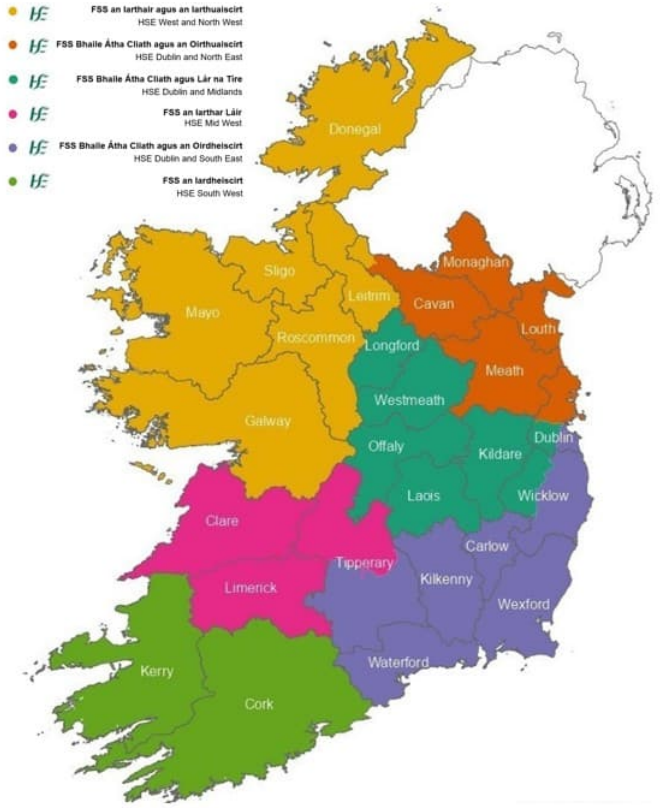
Community Health Organisations



Hospital Groups



Health regions



Health Regions Design Principles

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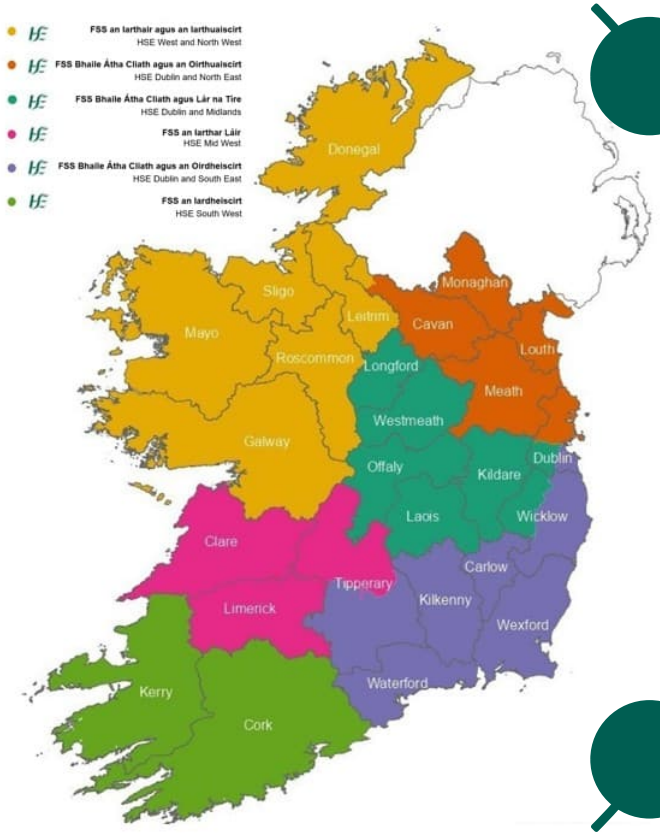
Theme	Design Principle
Patient Focused Integrated Care	Ensure the design of Health Regions and associated system reforms are person focused to enable the delivery of high-quality, population-based integrated health and social care services, with equity of provision based on need (through Population Based Resource Allocation), to maximise health and wellbeing and care closer to people's homes.
Governance and Accountability	Ensure clear definition and understanding of governance, scope of mandate, clear lines of accountability and reporting lines for the HSE Centre, Department of Health and Health Regions, to provide foundation to enable integrated care.
Devolved Decision-making and Activities	Support empowered, devolved decision-making at a local level to enhance autonomy in the Health Regions and other service delivery entities, and to ensure decisions made and the services delivered meet the need of the community in which the patient/citizen/service user is based.
National Consistency	Create a design to enable standardisation, and to avoid duplication. Enhance national consistency in appropriate areas (e.g., models of care and patient safety standards) to improve effectiveness and deliver economies of scale where appropriate.
Our People	Ensure that the Irish health and social care system is an attractive place to work, making health and social care professionals feel valued, allowing staff to maximise their potential, as well as providing opportunities for career progression and skills development.
Maximise Data and Information	Set-up health and social care services and Health Regions to collect, leverage and enable the use of health and social care data and information in respect of national, regional, and local populations, 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.
Collective Leadership and Collaboration in Design	Consider and incorporate insights from all impacted stakeholders through engagement. Enable a collaborative approach to design, seeking input on national and local parameters from regional and local leadership.
Clear Interfaces and Partnerships	Ensure clear interfaces for key Irish health and social care system stakeholders and partners, both internal and external including citizens/service users, enabling transparent communication, continue to build on positive trusted relationships and partnerships and enhanced collaboration.
Evidence-Based Design	Consider evidence from multiple sources, including international lessons and national experience, and ensure design is informed by relevant regulatory standards, policy standards, and frameworks.

** Design will also consider Sláintecare Fundamental Principles*

What's Decided?

We will still be a single HSE organisation with 6 health regions. Services will integrated across hospitals and community in these health regions.



- Six geographical boundaries agreed within the HSE - Health Regions not separate statutory bodies
- They'll use the HSE logo and be under the governance of the HSE Board
- Following a transition period, the Health Region management structure will replace existing CHO and HG management structures
- Regional Health Forum structure to remain but will reflect Health Regions structure
- Operational focus to move from HSE Centre to the Health Regions
- HSE Centre will develop and oversee standards and guidelines for implementation at regional level

Health Regions Progress to Date

Health Regions Programme – Progress to Date

Clinical and Corporate Governance

Finance

People and Development

Capital and ICT

Change, Comms and Culture

Jan 2024

2022

5 Workstreams established to progress design

High-Level Design

2023

HSE Health Regions Implementation Plan Approved (31/7/23)

Geographic Impact Assessment Complete

REO Recruitment complete

Patient / Service User Partnership Approach co-designed

Memo to Government approved

Regional Events with key stakeholders

High-Level Integrated Service Delivery Model

HSE Health Regions Programme Team Established

Health Region Executive Officer (REO) Posts Approved

HSE Centre Structure

HSE Health Regions EMT & IHA Structure advanced design

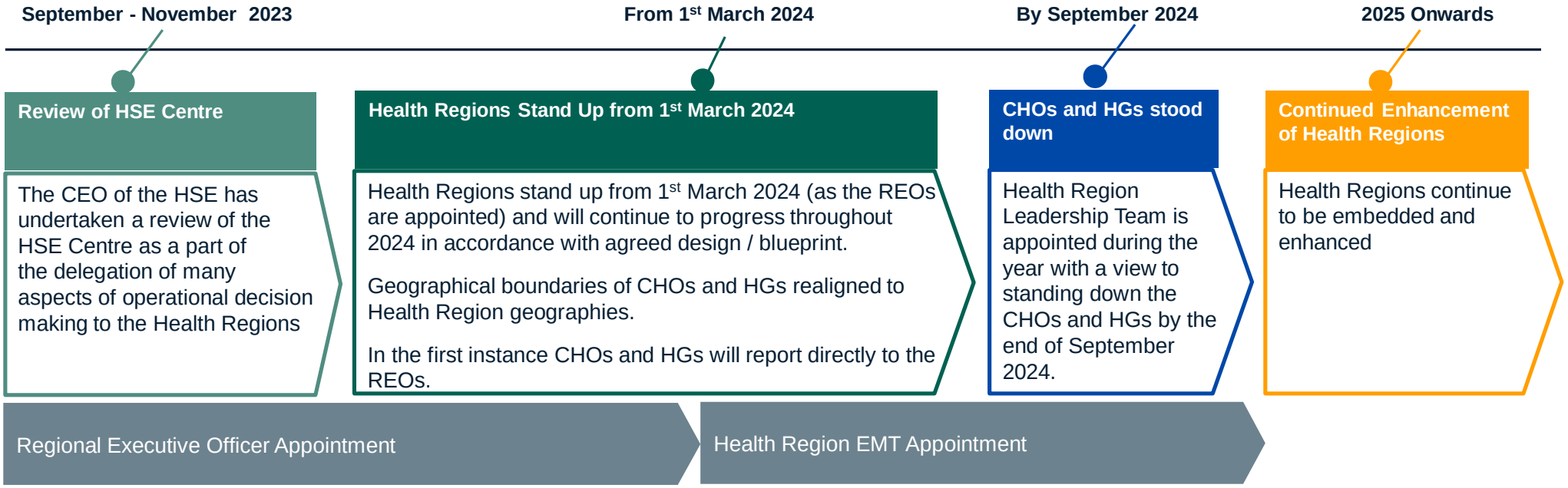
2022
Over **1,200** stakeholders engaged

2023
over **5,100** stakeholders engaged

Ongoing Engagement with CHOs, Hospital Groups, Patient / Service User Representatives, HSE Centre Staff, Voluntary Organisations and more

High-Level Implementation Timelines and Expected Phases

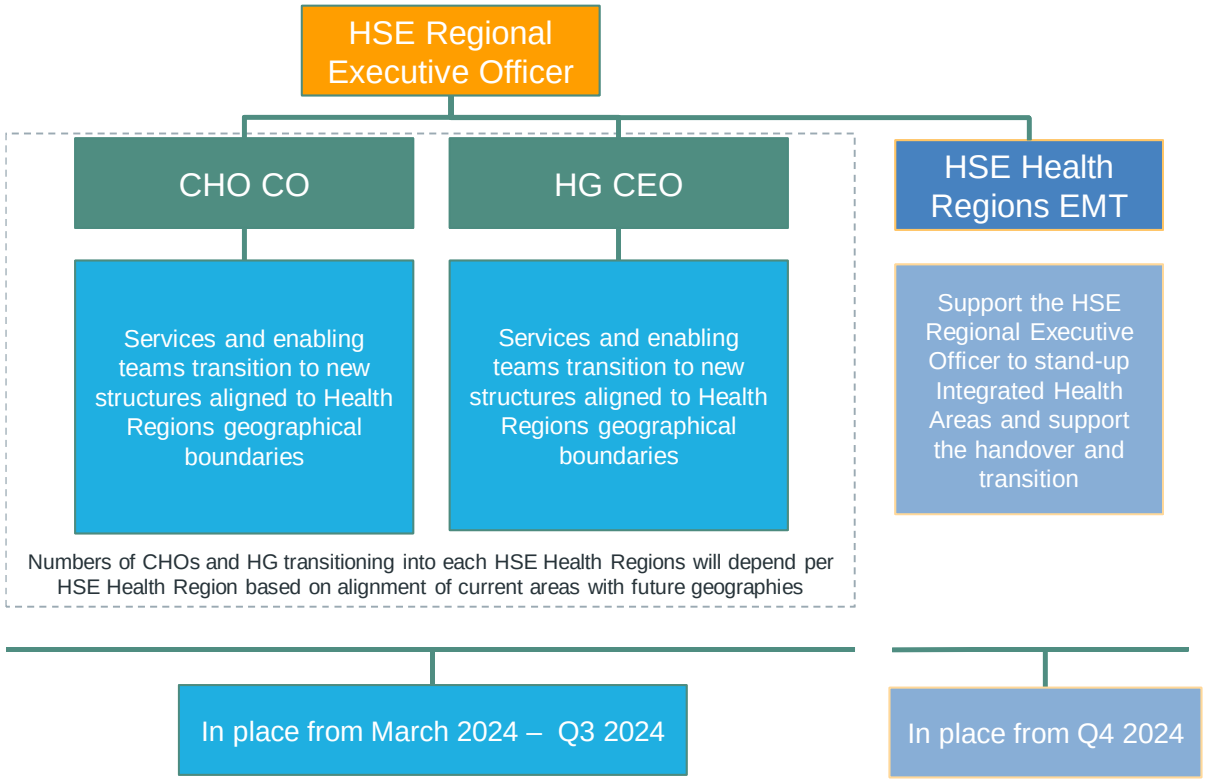
- The Health Regions Programme is a multi-year journey
- It is expected that there will be multiple phases on this journey to full Health Region Implementation
- There is a transition process to be managed and supported
- The current high-level view of phases and expected timelines are included below



**Please note that the above is a high-level timeline of implementation phases and does not reflect the full scope of programme activities e.g. engagement, design, which will continue in detail over coming months.*

Phased Transition to Health Regions from 1st March 2024

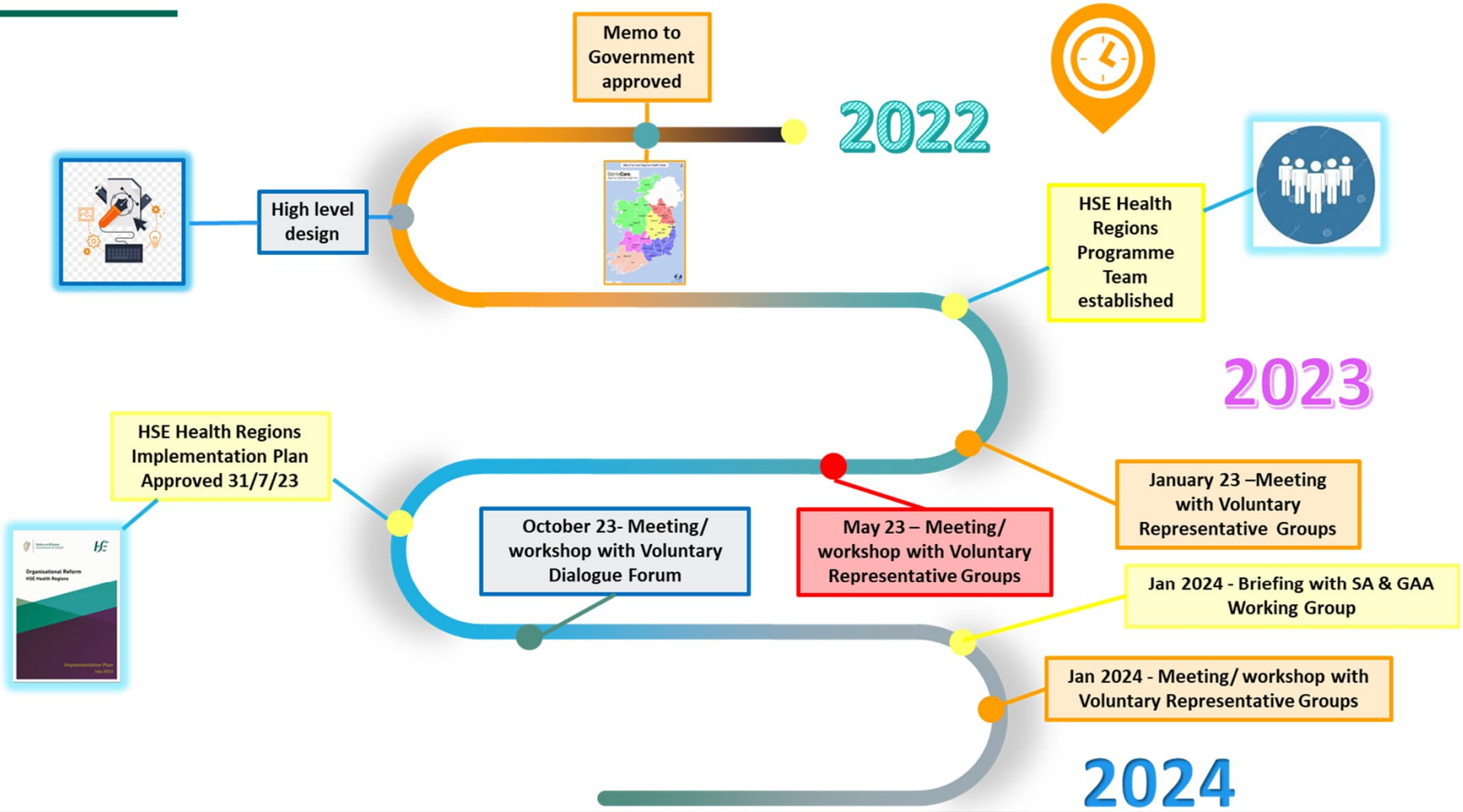
Interim Health Region Team Structures



Description of Transition

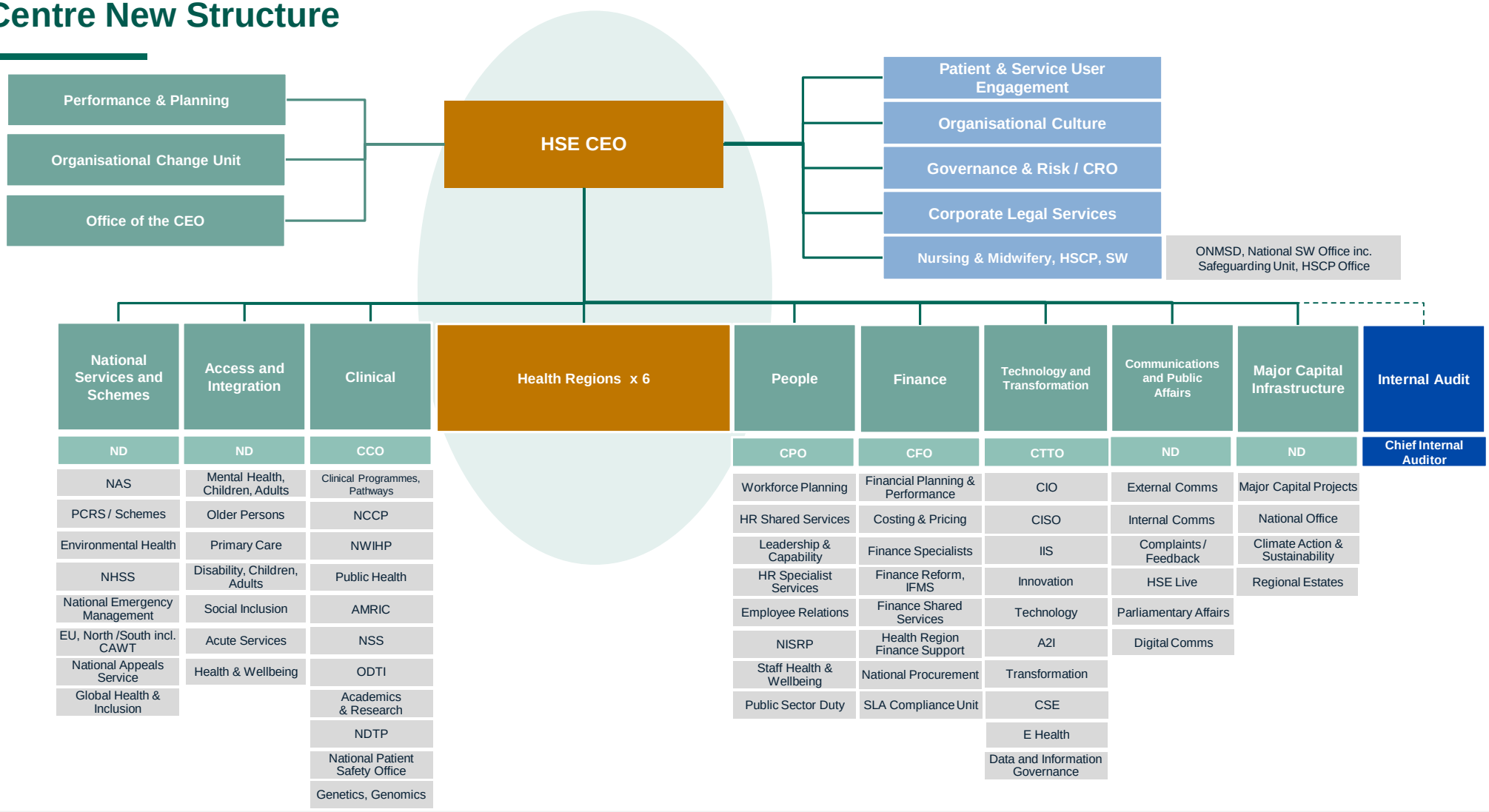
- HSE Regional Executive Officer (REO) appointed with formal accountability for their area, reporting to the HSE CEO
- 15 CHO and HG COs / CEOs remain in place reporting to HSE Regional Executive Officers
- CHO and HG boundaries changed to align to future boundaries.
- HSE Health Region Executive Management Team appointed to support the HSE REO to stand-up the Integrated Health Areas and support the handover and transition to Health Regions from current structures

Voluntaries Engagement Timeline

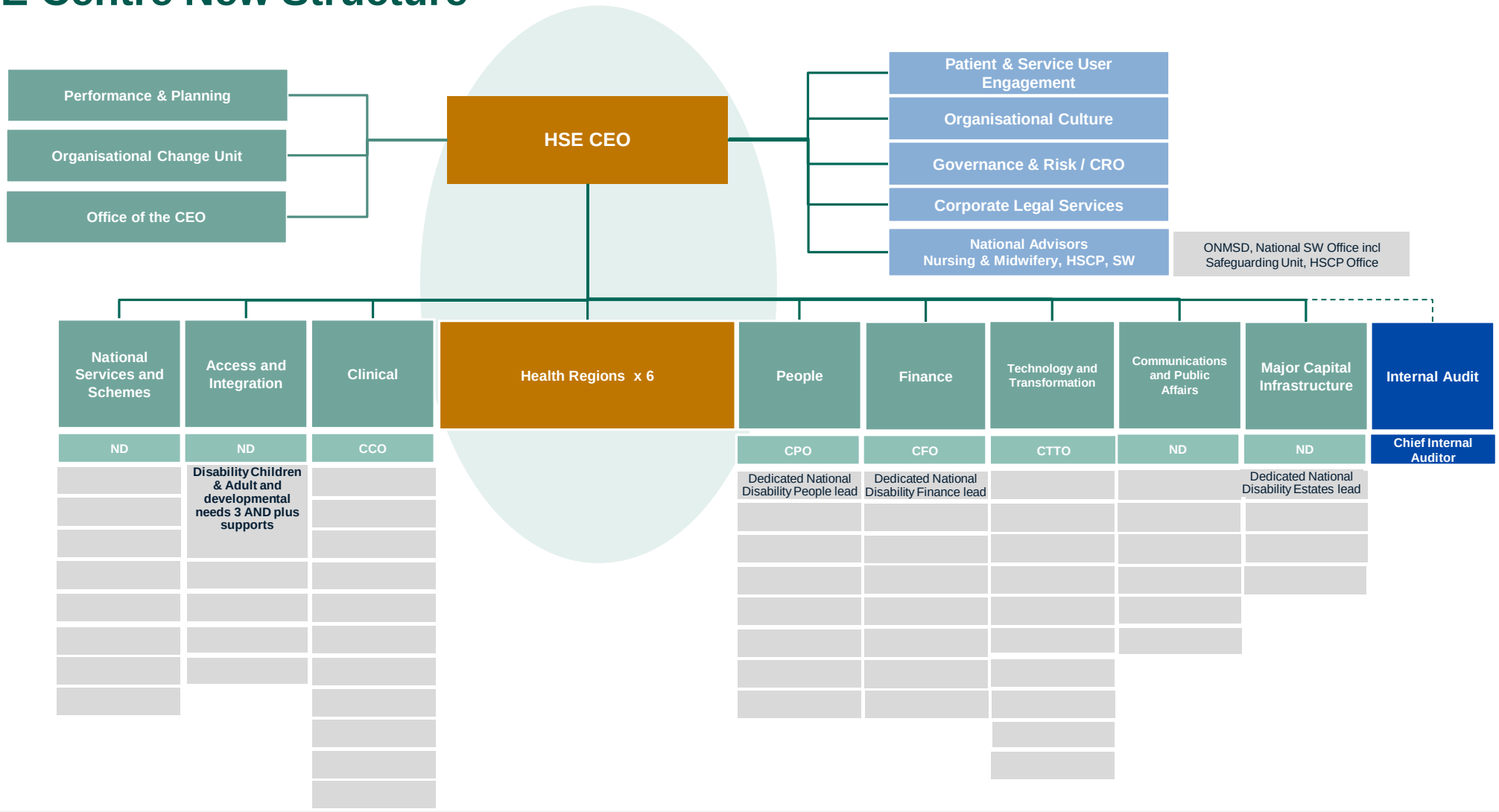


HSE Centre Structure

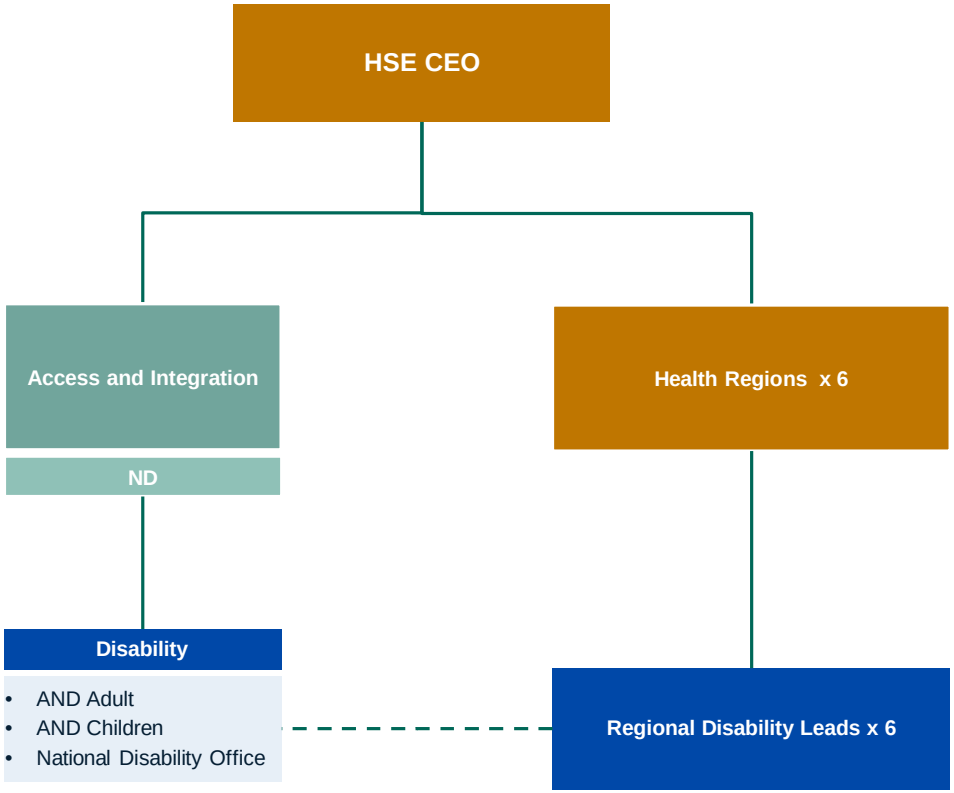
HSE Centre New Structure



HSE Centre New Structure



Disability Services

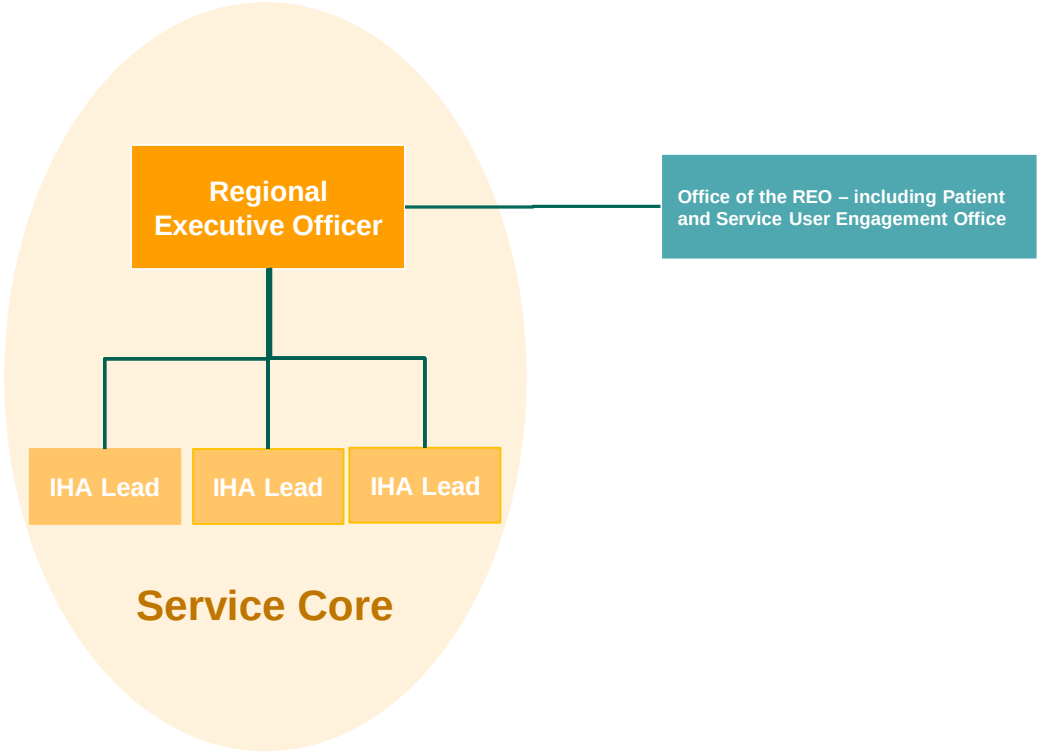


The organisation of the Health Regions is still under consideration. The intention is to have visibility of disability services in each region while also allowing for the appropriate integration with other services in the best interests of service users.

Health Region Executive Management Team (EMT) Structure

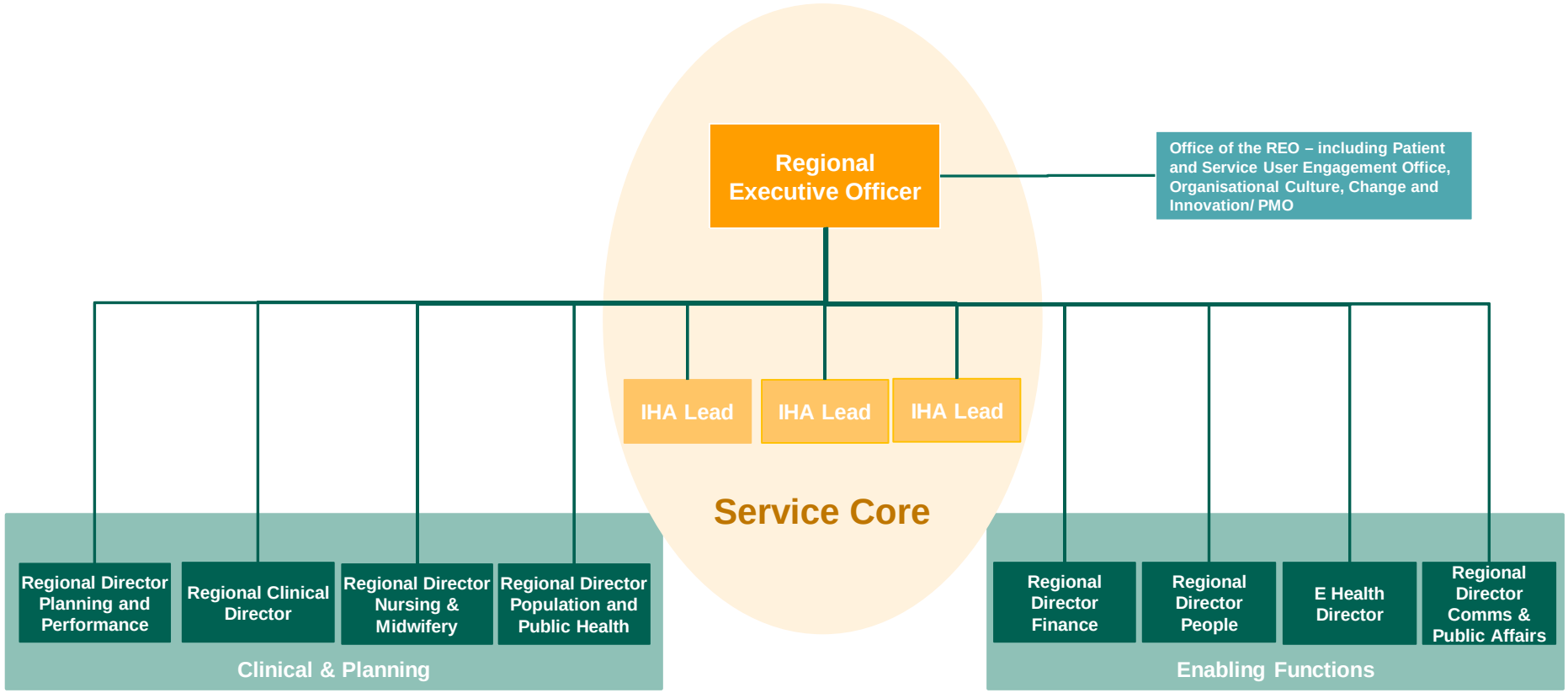
HSE EMT Model – Advanced Design, Service Core

REO Direct Reports	12 *(3 IHA Leads assumed for design purposes)*



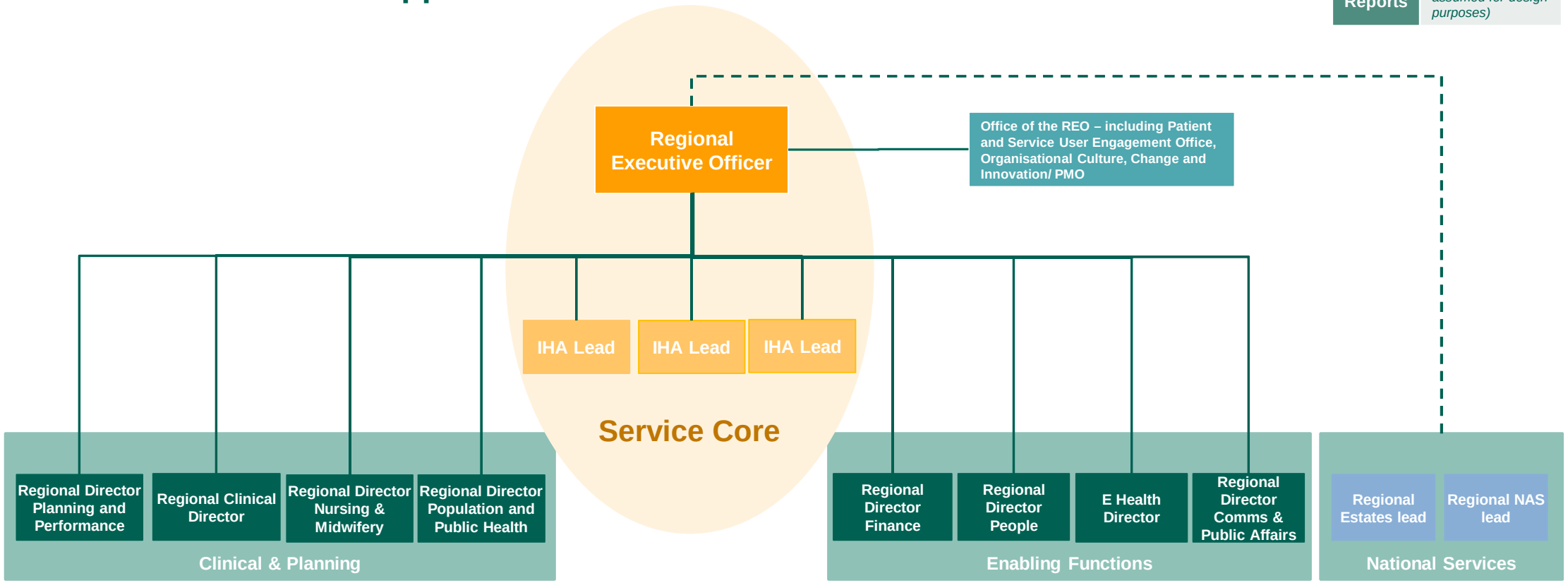
HSE EMT Model – Advanced Design, Executive Management Team

REO Direct Reports	12 *(3 IHA Leads assumed for design purposes)*



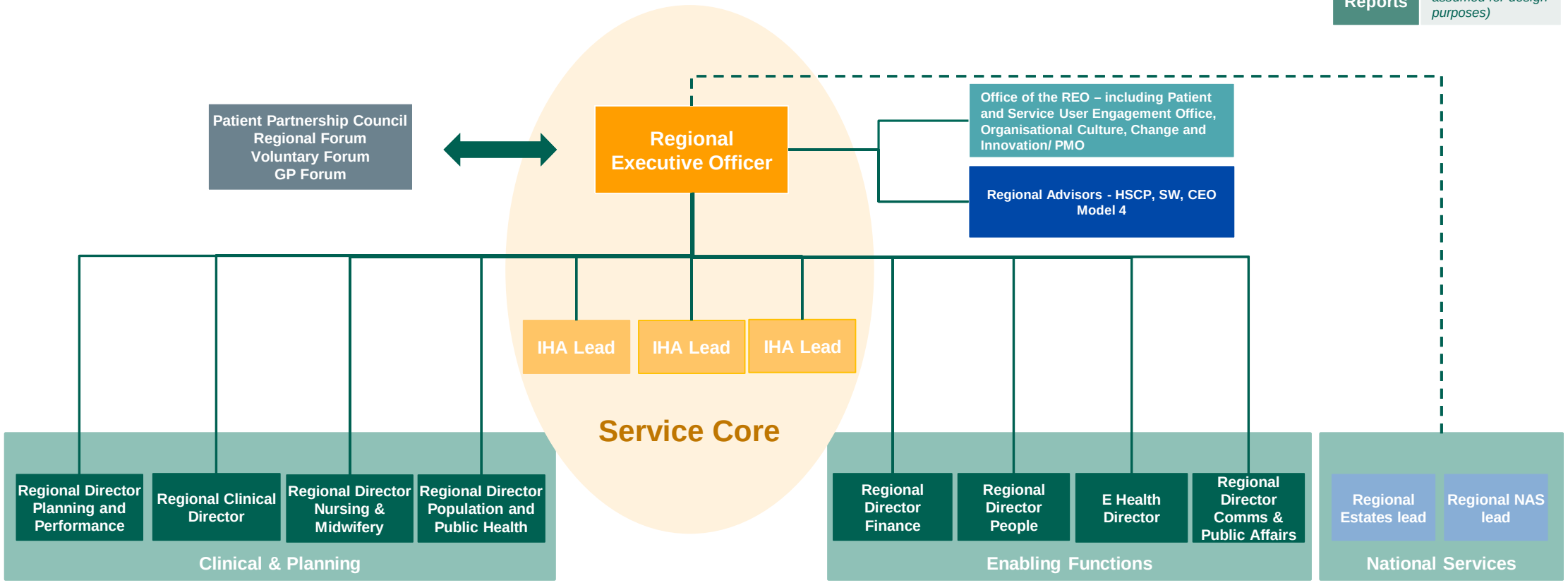
HSE EMT Model – Advanced Design, Executive Management Team inc. National Service Support

REO Direct Reports 12 *(3 IHA Leads assumed for design purposes)*

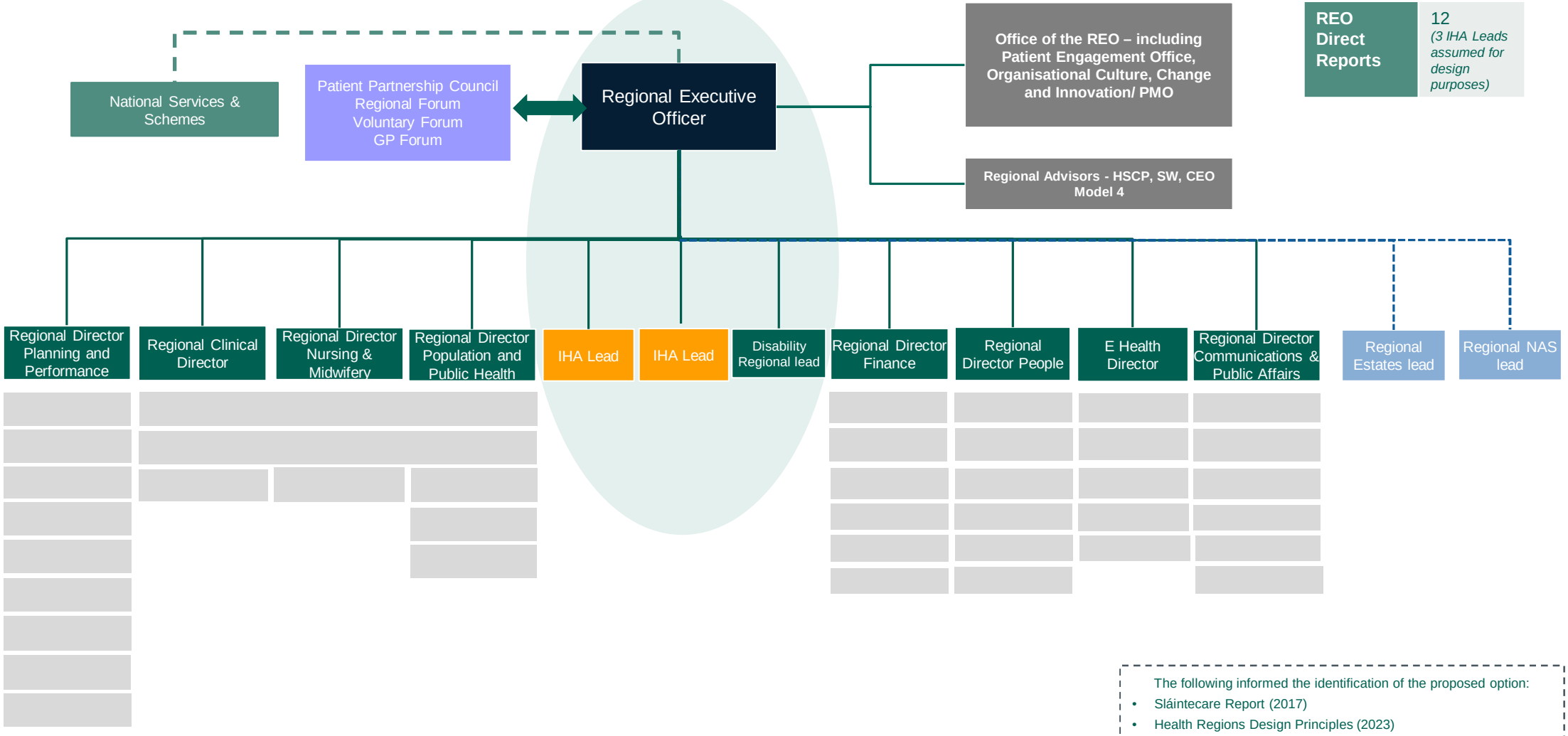


HSE EMT Model – Advanced Design

REO Direct Reports 12 *(3 IHA Leads assumed for design purposes)*



Health Region EMT Model Advanced Design



The following informed the identification of the proposed option:

- Sláintecare Report (2017)
- Health Regions Design Principles (2023)
- Stakeholder engagement and consultation
- Review of international health systems and structures
- Multi criteria analysis options appraisal process

EMT Structures - Areas for further consideration (1/2)

1. Clinical Governance and Leadership (related to EMT and IHAs)

There has been strong feedback from stakeholders for the need to ensure high standards of clinical governance and clinical leadership for all health care services across the Health Region, underpinned by national clinical programmes, care pathways and regional care networks. Opportunities exist to learn from and build upon existing clinical leadership and oversight structures as part of the move to the new Regional and population-based focus to service provision, e.g., maternity networks, cancer care, trauma networks, etc. The roles, responsibilities and relationships of clinical leads must be clearly defined at each level so that there is clarity on the relationship between for example, clinical leads at hospital, IHA, and Regional levels.

2. Independent and Voluntary agencies

There is a necessity to embed independent and voluntary entities delivering health and social care services (Acute and Community) as core participants within the region structure. Work is progressing in partnership with the Dialogue Forum to agree the approach for this. This is particularly important as these are entities that often span multiple Regions and may potentially have multiple reporting lines.

There is a risk that the new system perpetuates a view of HSE versus non-HSE care. In a patient-centred integrated healthcare system, they must be seen as part of the system and not separate. Exceptional arrangements with voluntary organisations present complexity which needs to be managed within the overall governance.

3. Model 4 Hospitals

It is important that governance and oversight structures at Regional level take account of the more complex and specialised services that model 3 and 4 hospitals provide at a regional and supra-regional level, to ensure that these services are fully integrated. Further discussion on this is required and will be factored into the evolving design of the region blueprint.

EMT Structures - Areas for further consideration (2/2)

4. Hospital Networks

There was clear and consistent feedback from stakeholders about the importance of hospital networks, particularly with regard to the support they provide to smaller hospitals that cannot standalone in the provision of acute hospital care. The core safety and functionality of hospital networks needs to be safeguarded and strengthened across the Region and beyond, as breaking down networks carries the potential for increased patient safety risk. Detail on how this can be supported at regional level will be further considered in the next phase of design.

5. Multi-disciplinary Training and Development and Academic Linkages between Hospital Groups, Hospitals and Universities

Further clarification is required with respect to how academic training and interprofessional collaboration will be facilitated across the region and how Education, Training, Research and Innovation will be represented as part of regional development, high quality healthcare, and workforce planning. Feedback has been provided from stakeholders on the need for regional structures, partnerships, processes and ways of working to support a collaborative and integrated approach to learning and development, supported by research and innovation.

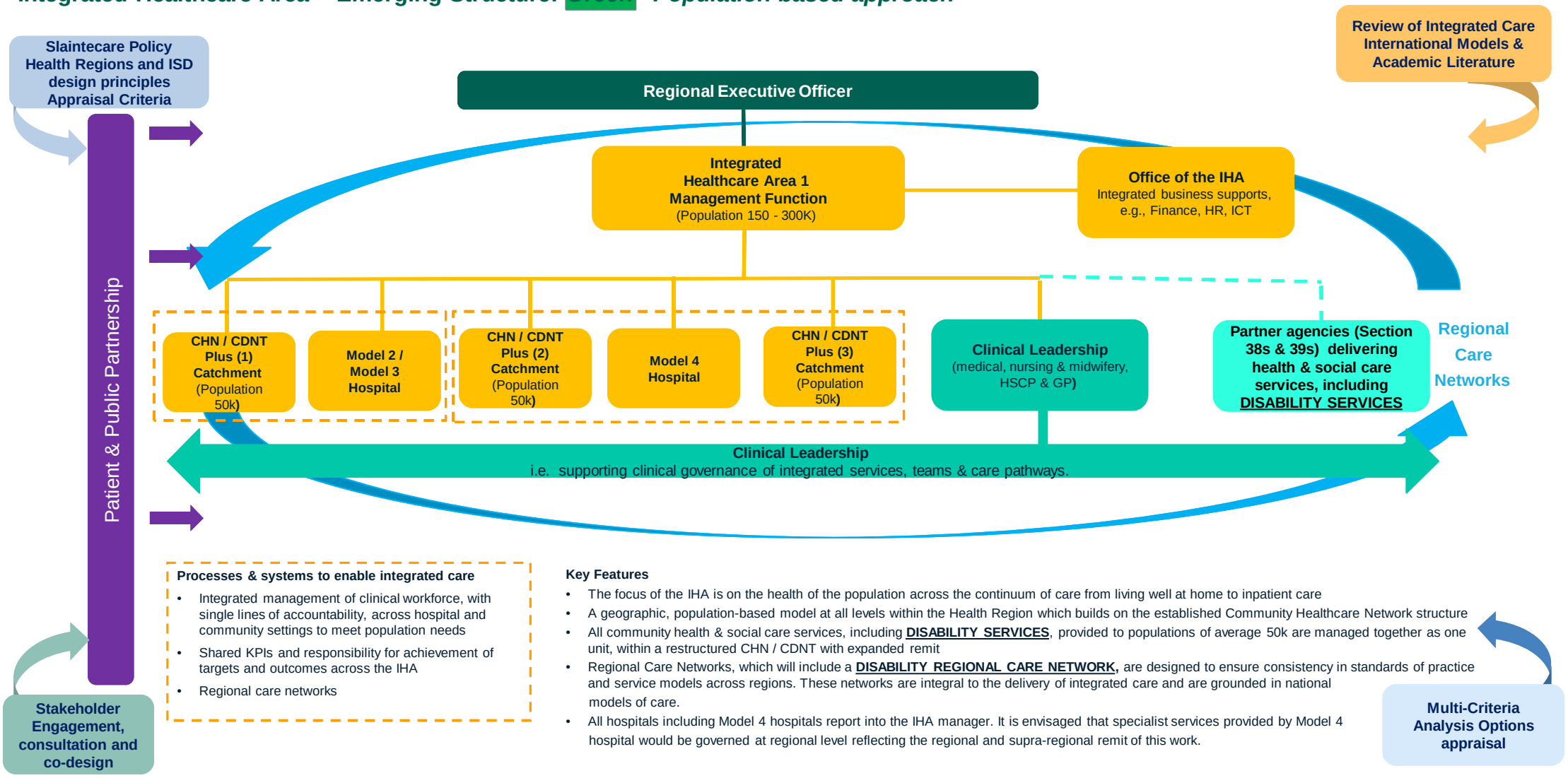
Further discussion is needed on Health Service/Health Academia association and where accountability for the co-ordination and engagement with primary academic partners sits in the Health Regions, factoring in already established linkages between hospitals and academic institutions. The CAO group have made some recommendations with regard to linkage with the universities.

6. Governance of Consumer Affairs

Further definition of the governance structure for QSSI, Consumer Affairs including FOI, data protection, GDPR, Your Service Your Say and maintenance at Region level has been requested by services representatives to ensure the model is robust and fit for purpose.

Health Region Integrated Healthcare Area (IHA) Structure

Integrated Healthcare Area – Emerging Structure: Green - *Population based approach*



Processes & systems to enable integrated care

- Integrated management of clinical workforce, with single lines of accountability, across hospital and community settings to meet population needs
- Shared KPIs and responsibility for achievement of targets and outcomes across the IHA
- Regional care networks

Key Features

- The focus of the IHA is on the health of the population across the continuum of care from living well at home to inpatient care
- A geographic, population-based model at all levels within the Health Region which builds on the established Community Healthcare Network structure
- All community health & social care services, including **DISABILITY SERVICES**, provided to populations of average 50k are managed together as one unit, within a restructured CHN / CDNT with expanded remit
- Regional Care Networks, which will include a **DISABILITY REGIONAL CARE NETWORK,** are designed to ensure consistency in standards of practice and service models across regions. These networks are integral to the delivery of integrated care and are grounded in national models of care.
- All hospitals including Model 4 hospitals report into the IHA manager. It is envisaged that specialist services provided by Model 4 hospital would be governed at regional level reflecting the regional and supra-regional remit of this work.

Stakeholder Engagement, consultation and co-design

Multi-Criteria Analysis Options appraisal

IHA Structures - Key issues to be addressed in next phase of detailed design (1)

1. Delivering Integrated Care for patients

A new IHA structure will not alone deliver true integrated care for patients, across community and acute, and health and social care. It will be necessary to drive integrated service delivery through ways of working, processes and whole system integrated governance arrangements

2. Independent and Voluntary agencies

There is a necessity to embed independent and voluntary entities delivering health & social care services (Acute and Community) as core participants within the IHA structure. As part of the Health Regions programme there is work progressing in partnership with the Dialogue Forum in agreeing the approach for this.

3. Community Healthcare Networks

The role of CHNs will need to expand and change to accommodate the changes proposed within the recommended IHA structure. This will require enhancement of the CHN organisational structure to include and align all community health & social care services. Specific challenges in the case of Mental Health Sectors that are not currently co-terminous with CHNs and Approved Centre beds that are not evenly distributed across IHAs will be addressed

4. Hospital Networks

The importance of preserving Hospital Networks to ensure pathways to and from specialist services, quality and patient safety, joint appointments, education and training and clinical networks has been emphasised by stakeholders. Regional hospital networks will be supported and maintained and will work with community services within an integrated operational framework to deliver the full range of primary and secondary level services to IHA populations.

IHA Structures - Key issues to be addressed in next phase of detailed design (2)

5. Specialist and Regulated health & social care services

There is a requirement to ensure within the model that there is appropriate clinical and corporate governance arrangements at regional and IHA level for;

a) Specialist services (Acute and community) that have a remit which extends beyond that of individual IHAs and Health Regions in both service and responsibility terms and

b) Regulated services and designated centres such as nursing homes, and residential settings within Disability and Mental health services

6. Change Management

Stakeholders have consistently emphasised that a Change Management function should be put in place to support staff and resources should be deployed for the transition so that the process is managed smoothly and delivers intended results.

Change management expertise is required to enhance the underlying culture to that of a learning organisation and empower front-line staff in embracing continuous improvement as core, all the while communicating the vision of Health Regions and Integrated Services Delivery clearly to staff.

Health Region IHA Mapping

Introduction

- Mapping of Integrated Healthcare Area (IHA) geographical boundaries has been progressed by a working group made of colleagues from the Health Regions Programme team, HSE Health Intelligence, Primary Care Strategy and the Department of Health.

- Options were developed for each Health Region based on a set of guiding principles – set out on next slide.

- In November and December 2023, feedback was sought from HSE Senior Leadership Team (SLT), the Health Regions governance groups and the Department of Health.

- The options presented here have been revised following feedback. A summary slide showing the options for each region has been included in this deck. There is more detailed information available on each option including a breakdown of the feedback received and a summary of each option's 'pros and cons'.

- It is important to note that the options presented need to be considered in the context of the proposed Health Region EMT and Integrated Healthcare Area management team structures.

Guiding Principles

IHA maps have been developed based on the following principles:

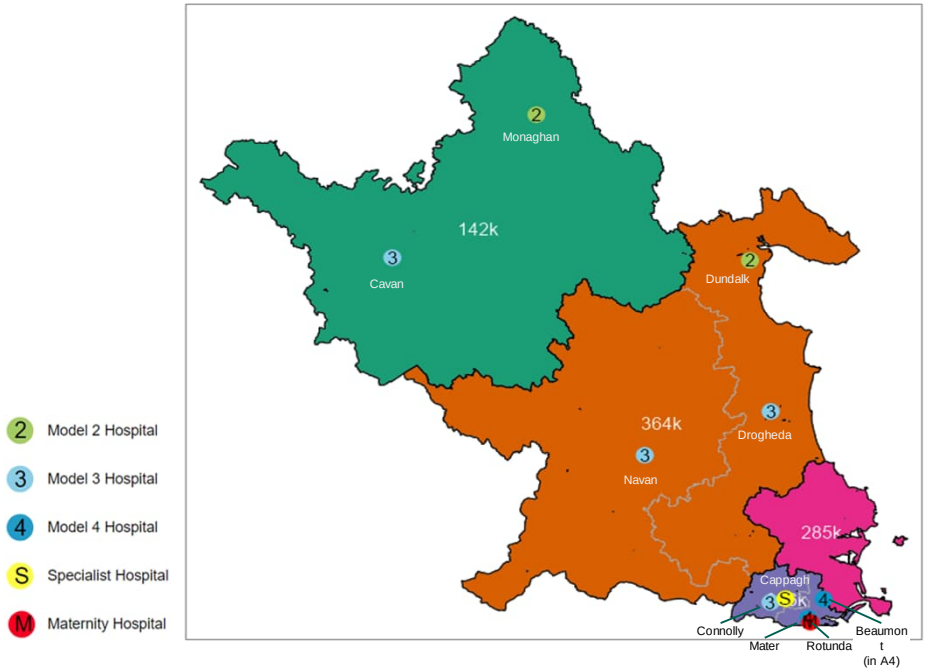
1. Uses the 96 Community Healthcare Networks (CHNs) as its “building blocks”.
2. Cannot break HSE Health Region boundaries and should respect the boundaries of the 30 Community Specialist Teams (CSTs) as much as possible, ensuring continuity of current reform and expansion of community specialist services under the Enhanced Community Care (ECC) Programme.
3. Should be a geographic unit serving a population up to 300,000 (this remains in discussion, see footnote below).
4. Must include a Primary to Secondary Care Interface. This means that primary care should be able to refer to the following services within the same IHA: acute care, disability, mental health and older person services.
5. Must be geographically contiguous and “make sense” in terms of relatability and accessibility.
6. Must align with strategic priorities and, as much as possible, the known future direction of travel.

Notes:

- *The Report of the Expert Group on Resource Allocation and Financing in the Health Sector (Department of Health and Children, 2010) lists the following as a requirement against the report's second guiding principle for resource allocation ("a resource allocation model should support local implementation of national priorities based on nationally-set clinical, accountability and governance standards"): Having resources allocated as close to the users as possible, consistent with the scale of the local delivery system being safe and sustainable in light of demand uncertainty, quality standards and scale efficiencies. International evidence suggests that this should be to a geographic unit with a minimum population of 250,000-300,000 (although there may be exceptions in areas where there is extreme geographical dispersion and very poor public transport links).*

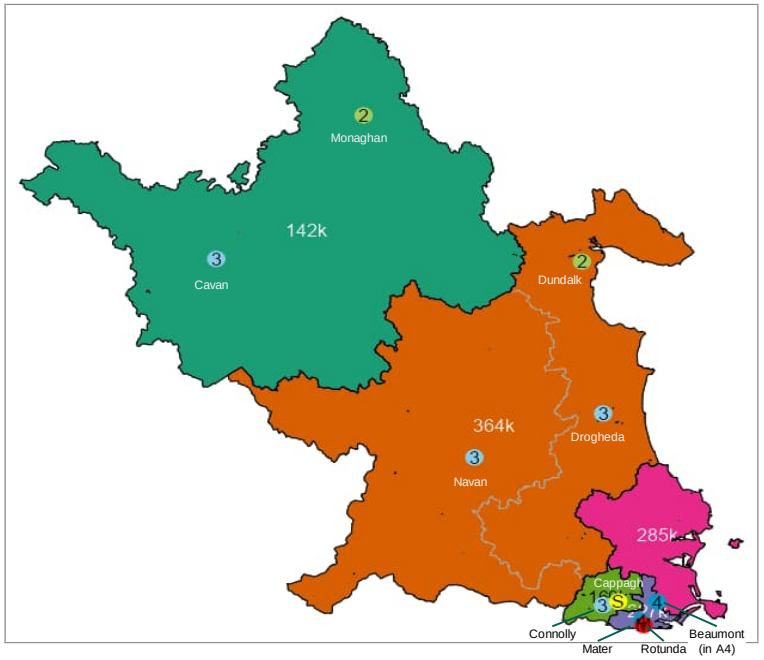
HSE Dublin & North East

Option 1 for HSE Dublin & North East



IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs	% Pop Chg ('16 to '22)
A1	Cavan & Monaghan	142,452	M3 + M2	2	1	+ 7%
A2	Louth & Meath	363,864	M3 x2 + M2	6	2	+ 11%
A3	Dublin North City & North West	396,039	M4 + M3 + Spec. x2	7	2	+ 9%
A4	Dublin North	284,727	M4	5	2	+ 10%

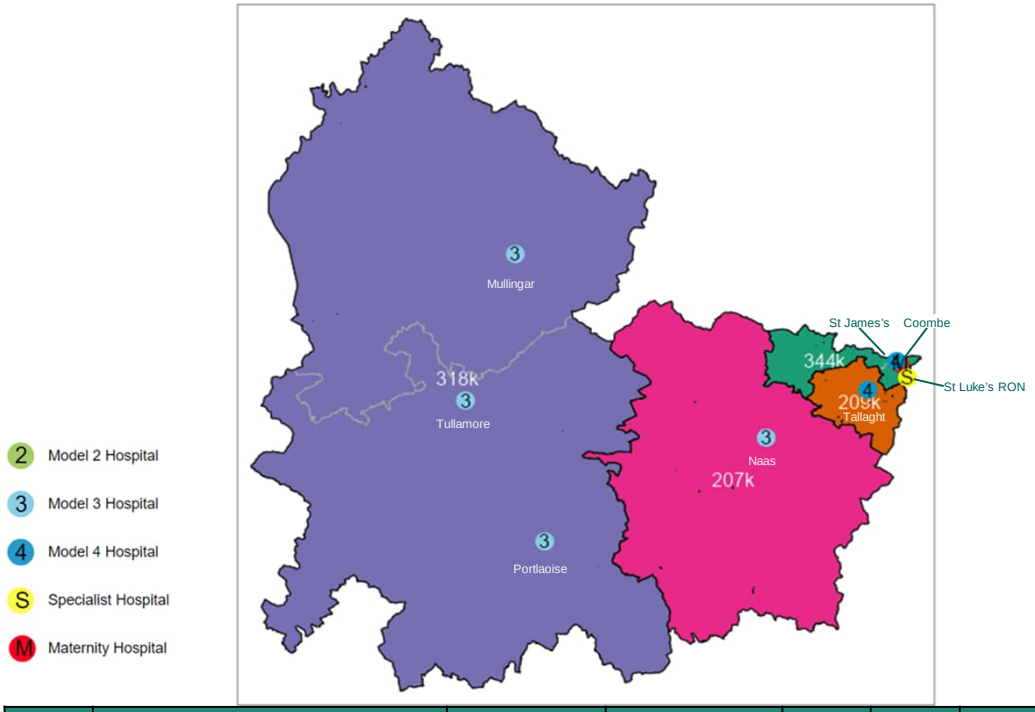
Option 2 for HSE Dublin & North East



IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs	% Pop Chg ('16 to '22)
A1	Cavan & Monaghan	142,452	M3 + M2	2	1	+ 7%
A2	Louth & Meath	363,864	M3 x2 + M2	6	2	+ 11%
A3	Dublin North City	226,946	M4 + Spec.	4	1	+ 9%
A4	Dublin North West	169,093	M3 + Spec.	3	1	+ 9%
A5	Dublin North	284,727	M4	5	2	+ 10%

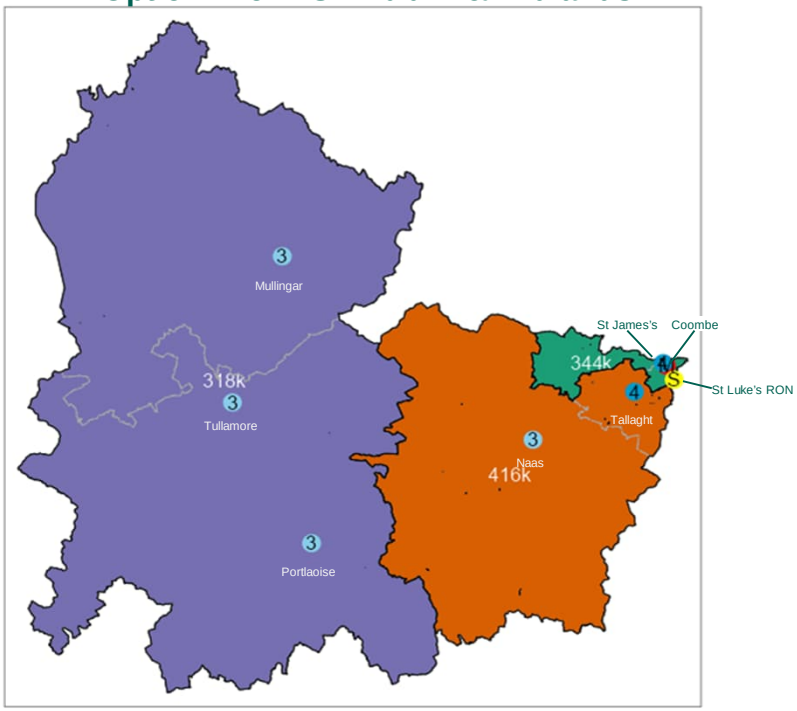
HSE Dublin & Midlands

Option 1 for HSE Dublin & Midlands



IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs	% Pop Chg ('16 to '22)
B1	Dublin South City & West	343,616	M4 + Spec. x2	6	2	+ 8%
B2	Dublin South West	208,621	M4	4	1	+ 7%
B3	Kildare & West Wicklow	207,403	M3	4	1	+ 11%
B4	Midlands	317,999	M3 x3	6	2	+ 9%

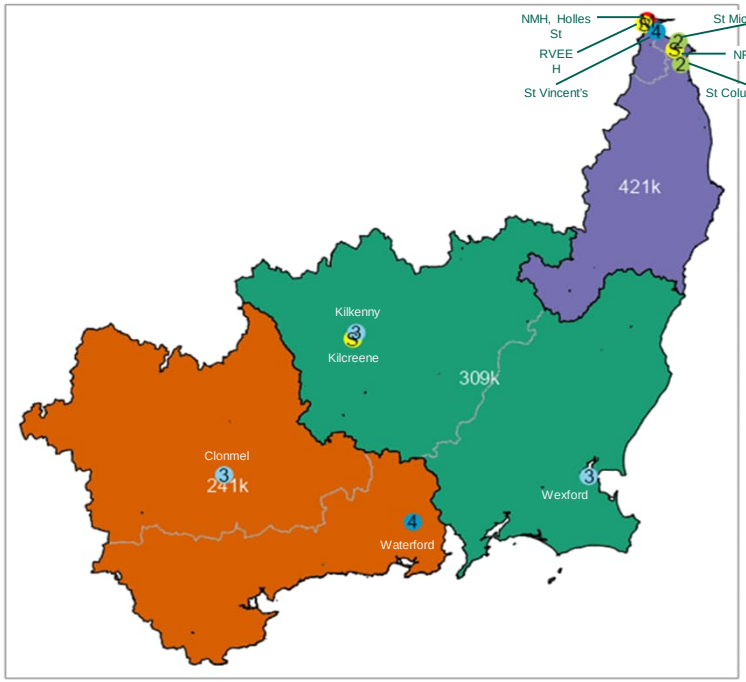
Option 2 for HSE Dublin & Midlands



IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs	% Pop Chg ('16 to '22)
B1	Dublin South City & West	343,616	M4 + Spec. x2	6	2	+ 8%
B2	Dublin SW, Kildare & W Wicklow	416,024	M4 + M3	8	2	+ 9%
B3	Midlands	317,999	M3 x3	6	2	+ 9%

HSE Dublin & South East

HSE Dublin & South East

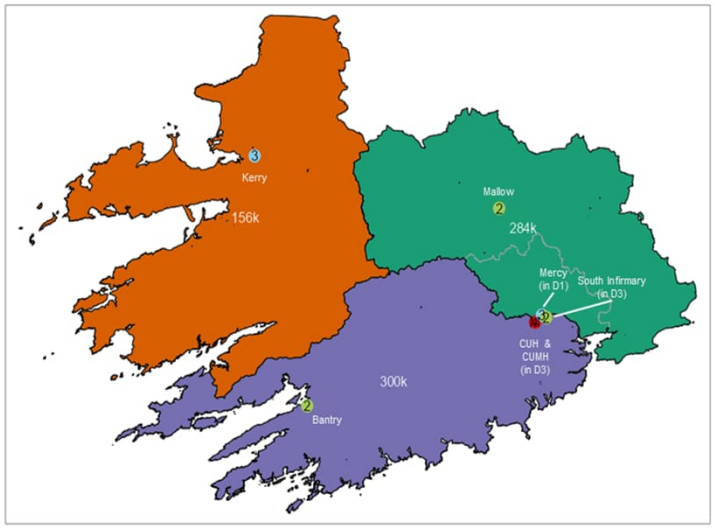


- Model 2 Hospital
- Model 3 Hospital
- Model 4 Hospital
- Specialist Hospital
- Maternity Hospital

IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs	% Pop Chg ('16 to '22)
C1	Carlow, Kilkenny & Wexford	308,590	M3 x2 + Spec.	7	2	+ 8%
C2	Waterford & South Tipperary	241,130	M4 + M3	4	2	+ 7%
C3	Dublin South East & Wicklow	421,373	M4 + M2 x2 + Spec. x3	8	2	+ 7%

HSE South West

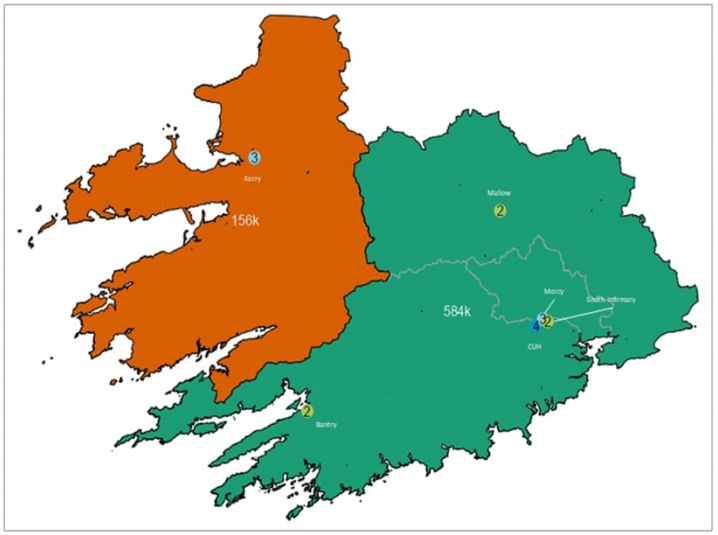
Option 1 for HSE South West



2 Model 2 Hospital
3 Model 3 Hospital
4 Model 4 Hospital
S Specialist Hospital
M Maternity Hospital

IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs	% Pop Chg ('16 to '22)
D1	North & East Cork	284,323	M3 + M2	6	2	+ 7%
D2	Kerry	156,458	M3	3	1	+ 6%
D3	South & West Cork	299,833	M4 + M2 + Spec. x2	5	1	+ 8%

Option 2 for HSE South West



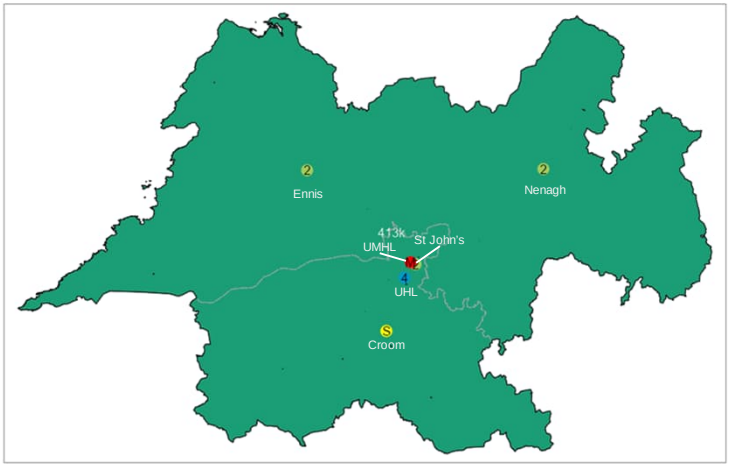
IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs	% Pop Chg ('16 to '22)
D1	Cork	584,156	M4 + M3 + M2 x2 + Spec. x2	11	3	+8%
D2	Kerry	156,458	M3	3	1	+6%

Note: The South Infirmary Victoria University Hospital is an elective hospital with no Emergency Department.

Mapping Options: HSE Midwest

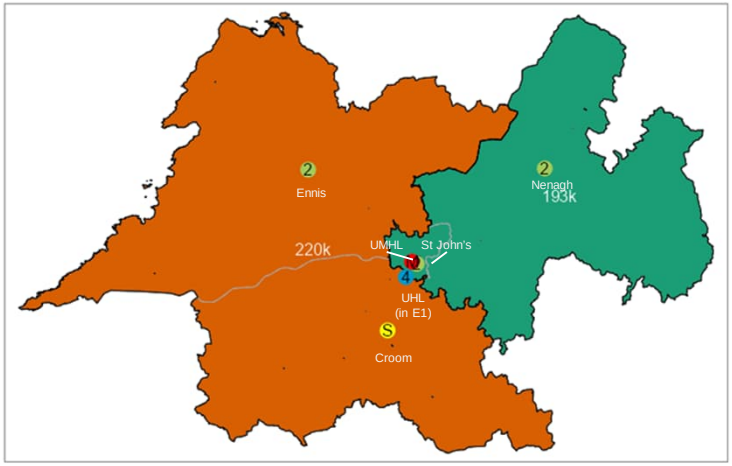
- 2 Model 2 Hospital
- 3 Model 3 Hospital
- 4 Model 4 Hospital
- S Specialist Hospital
- M Maternity Hospital

Option 1 for HSE Midwest



IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs
E1	Clare, Limerick & North Tipperary	413,059	M4 + M2 x3 + Spec. x2	8	2

Option 2 for HSE Midwest

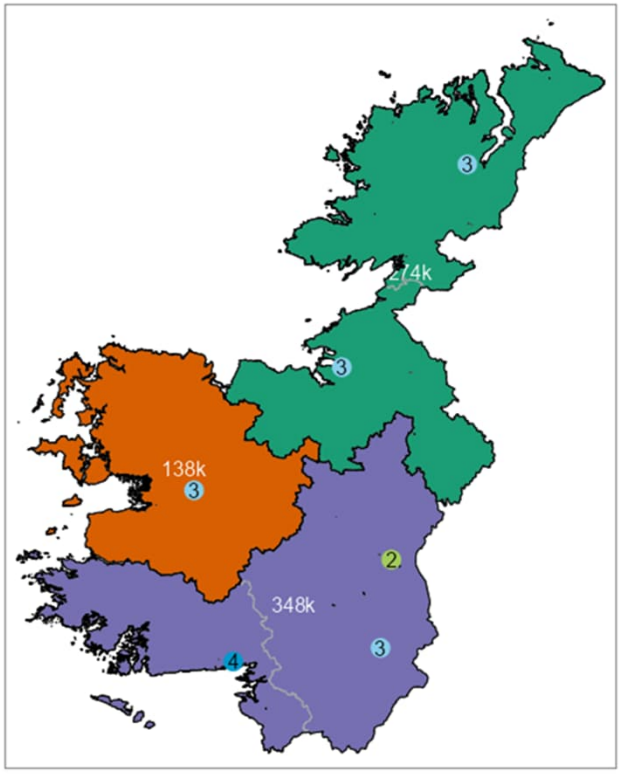


IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs
E1	Limerick City, East & N Tipperary	193,287	M4 + M2 x2 + Spec.	4	2**
E2	Clare, Limerick South & West	219,772	M2 + Spec	4	2**

Mapping Options: HSE West & North West

- 2 Model 2 Hospital
- 3 Model 3 Hospital
- 4 Model 4 Hospital
- S Specialist Hospital
- M Maternity Hospital

HSE West & North West



IHA	Geographic Area	Pop. (2022)	Hospital(s)	No. of CHNs	No. of CSTs
F1	Donegal, Sligo, Leitrim, South Donegal & West Cavan	273,686	M3 x2	6	2
F2	Mayo	137,970	M3	3	1
F3	Galway & Roscommon	347,996	M4+M3+M2	6	2

Health Regions Headquarters

Health Regions Headquarters

- The purpose of these slides is to outline the proposed headquarter locations within the 6 new Health Regions to the HSE Board for review and feedback, taking account of key criteria that may need to be considered in making that decision.
- The tables below outline the current headquarter locations for each of the 6 hospital groups and CHOs. Although the HGs and CHOs remain in operation today, these will be stood down before the end of 2024 following the implementation of the 6 new Health Regions.
- Consideration has been given as to whether any of the below listed HG or CHO headquarter locations are feasible and viable Health Regions headquarter locations.
- Note that although each HG and CHO has specific headquarter locations, some also have sub office locations which operate in other areas reflective of geography. It is proposed that although new Heath Regions headquarters will be identified, sub office arrangements may continue as required for the purposes of managing the delivery of services in a particular region.

Current Hospital Group Headquarters	
SSWHG	Erinville, Cork
ULHG	City Gate, Limerick
Saolta HG	GUH, Galway
RCSI	St. Stephens Green, Dublin
DMHG	Islandbridge, Dublin
IEHG	Kilmainham, Dublin

Current CHO Headquarters	
CHO 1	Ballyshannon, Co Donegal
CHO 2	Galway
CHO 3	Limerick
CHO 4	Model Farm Road, Cork
CHO 5	St Lukes, Kilkenny
CHO 6	Main Street, Bray, Co Wicklow
CHO 7	Millennium Park, Naas, Co Kildare
CHO 8	Tullamore & Ardee
CHO 9	Swords Business Park, Co Dublin

Proposed Health Regions Headquarters

- The table below outlines proposed Health Regions Headquarter locations for consideration by the HSE Board.
- While it is acknowledged that the identification of Health Region headquarters may result in the movement of staff, it is proposed that the REO as part of implementation, will engage with his/her staff locally to ensure teams and redeployed appropriately before any move would occur.

Health Region	Proposed Health Region Headquarter location – Options for consideration
HSE Dublin and North East	Dublin (Swords) with 2nd location in Ardee
HSE Dublin and Midlands	Kildare (Naas) with locations in Kilmainham and Tullamore
HSE Dublin and South East	Wicklow (Bray) with sub-office in Kilkenny
HSE South West	Model Farm Road, Cork with a sub-office in Tralee
HSE Midwest	Catherine St. Limerick
HSE West and North West	Galway with a sub-office in Ballyshannon

Key Considerations

- To determine the most appropriate headquarter location for each of the 6 Health Regions, there are a number of criteria that need to be considered;

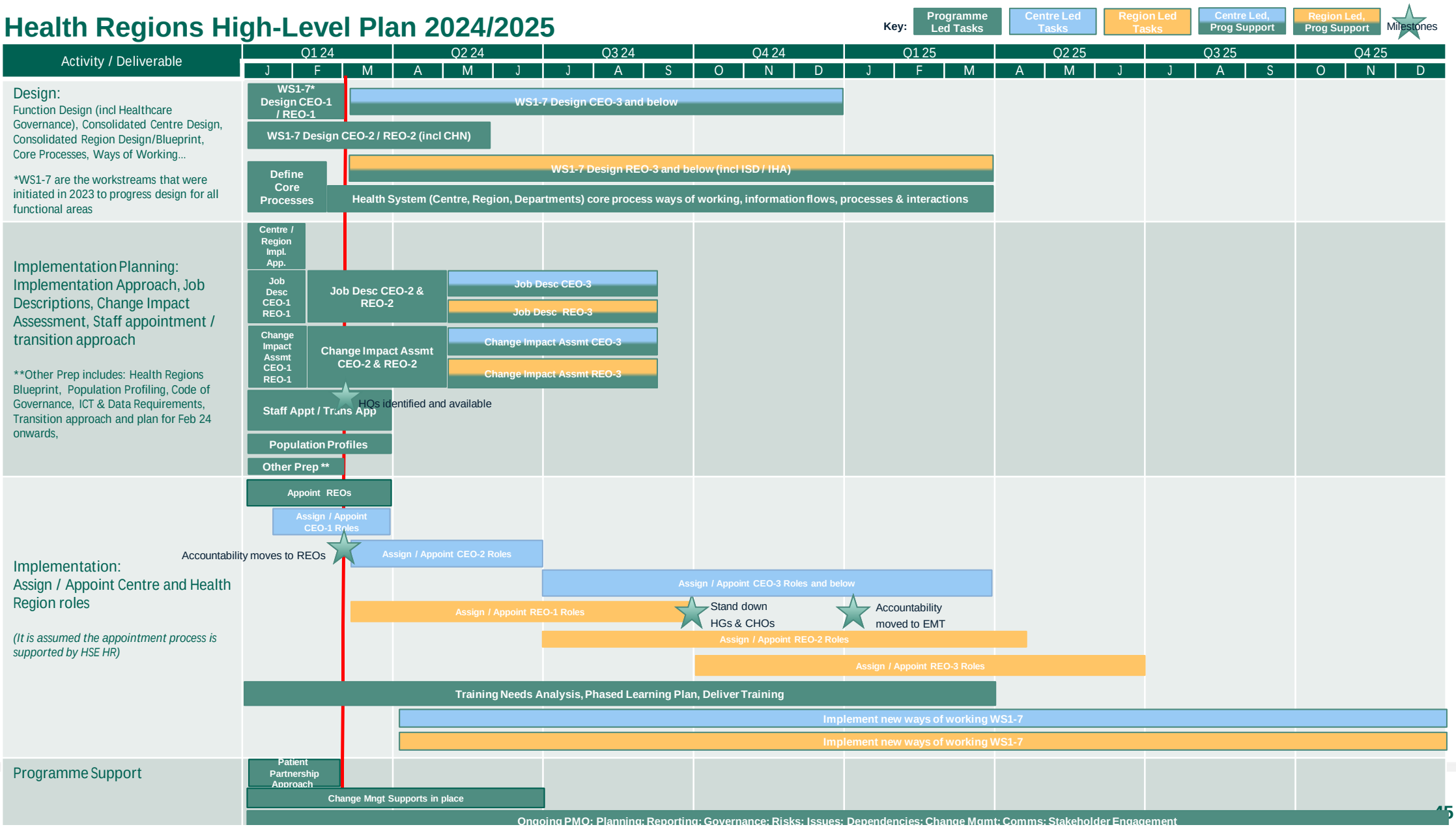
Criteria	Action
Ownership of building / Lease of Building	Determine what buildings are owned by the HSE versus those that are leased. For leased buildings, the nature and length of the lease will need to be assessed to determine whether there is adequate time left in the lease/appetite to renew leases that are expiring in the short term to enable a particular location to become the headquarters for the region.
Capacity	Assess the anticipated capacity and amount of space required in each region to cater for headquarter staff in light of staff likely being redistributed from other locations or office buildings.
Technology and networks	Determine the technology requirements for each of the proposed headquarter locations and assess the feasibility and timelines associated with securing system/network access for employees located in the headquarters. The availability of physical IT equipment in each headquarter will also need to be considered.
Geographic spread	Consider the geographic spread of the population of the Health Region. It will be important to aim for even distribution of headquarter locations around the country and avoid clustering Health Region headquarters within close proximity to one another e.g. 3 Health Region headquarters in Dublin which would lead to the absence of headquarters in the Midlands.
Centre of gravity	Consider locations within each Health Region that service users gravitate to and have the most activity.
Cost	Assess the cost involved in the relocation of staff, e.g. ensuring that there is enough IT equipment, furniture etc on site in order to cater for revised numbers. Existing stock should be utilised where possible.
Political Considerations	Consider the political and optical implications of locating headquarters in one city or town over another, including the political barriers or challenges that may be encountered.
Integrated Health Areas (IHAs)	Consideration will be given to the future IHAs in the context of Health Region headquarters.
Hybrid Working	Consider the impact of current hybrid working arrangements on longer term space requirements.
Sustainability	Consider the impact on sustainability and energy efficiency when determining HQ locations.

Next Steps

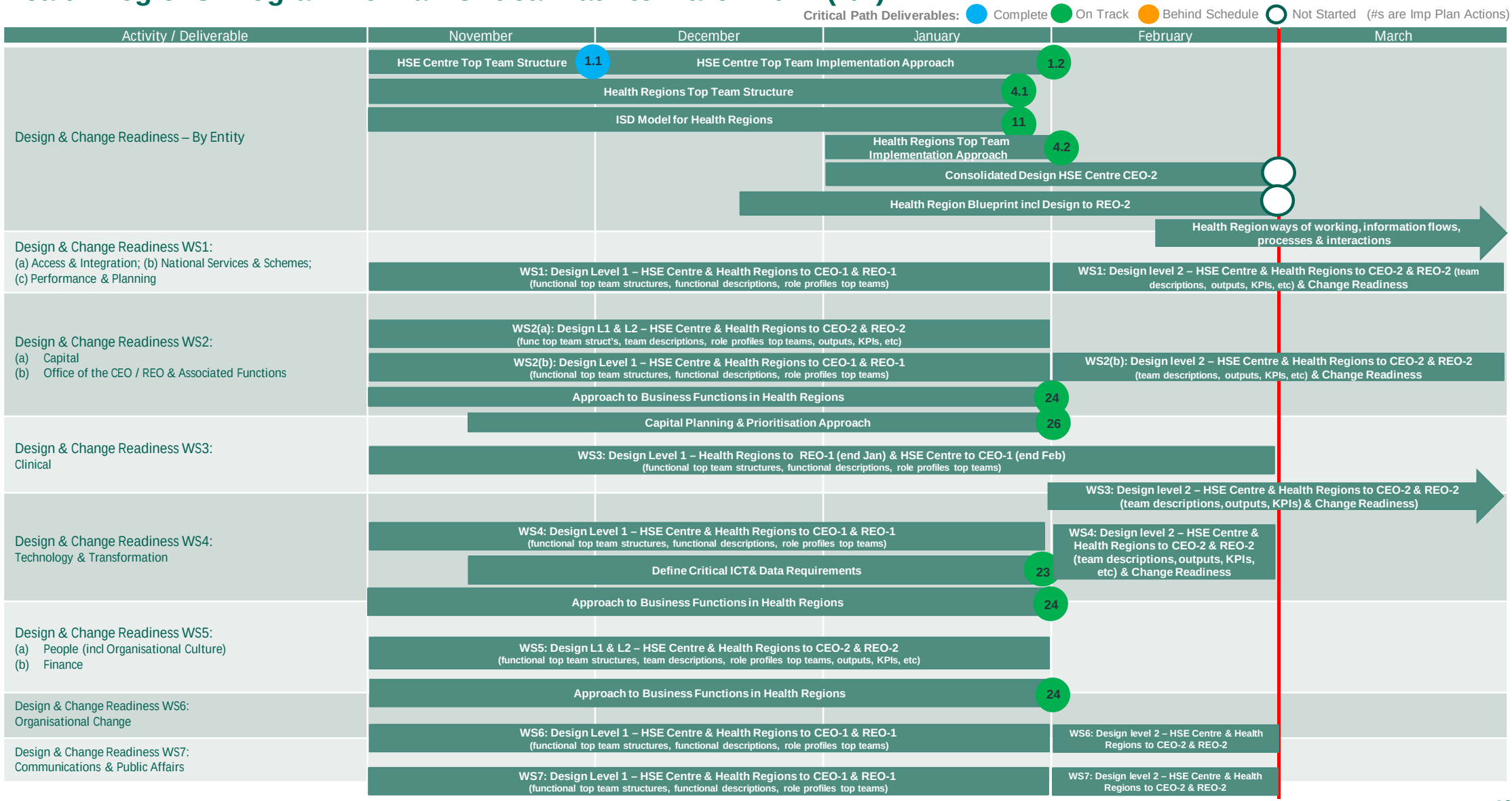
1. Proposed HQ locations to be considered by the HSE Board for review and feedback
2. Incorporate feedback from the HSE Board
3. Consider the proposed Health Region headquarter locations outlined above, or any alternate suggestions by the HSE Board, in light of the key considerations identified to determine feasibility.
4. Circulate proposed HQ locations to the Dept. of Health for review and feedback.
5. Obtain approval to proceed with proposed locations via the Health Regions Programme governance process.

Health Regions Programme Plan

Health Regions High-Level Plan 2024/2025

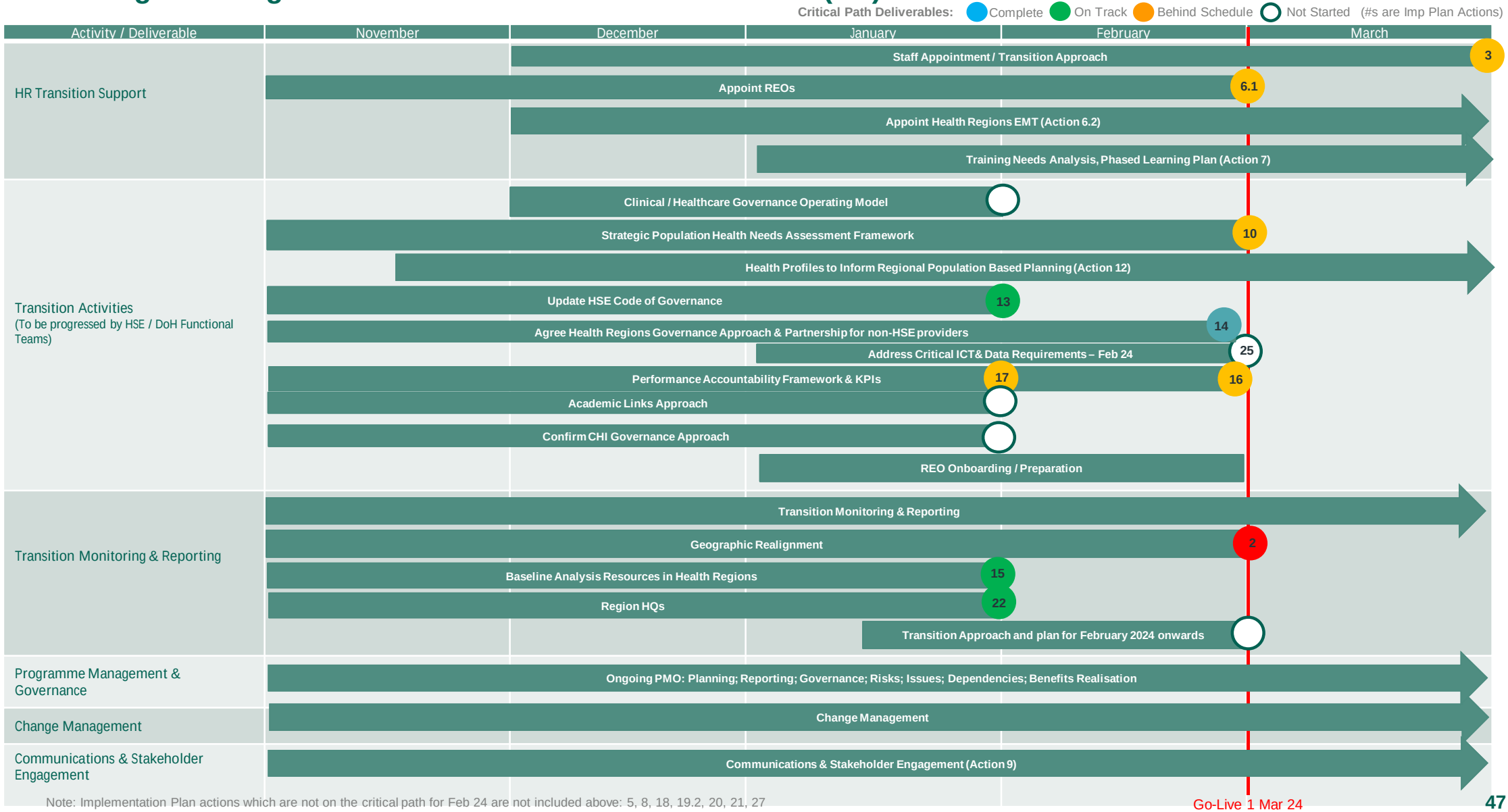


Health Regions Programme Plan Critical Path to March 2024 (1/2)



Note: Implementation Plan actions which are not on the critical path for Feb 24 are not included above: 5, 8, 18, 19.2, 20, 21, 27

Health Regions Programme Plan Critical Path to March 2024 (2/2)



Note: Implementation Plan actions which are not on the critical path for Feb 24 are not included above: 5, 8, 18, 19.2, 20, 21, 27

Implementation Plan Actions Status

Implementation Plan Actions – Red / Amber

Action #	Action	Implementation Plan Timeline	Revised Timeline	Lead	Status	RAG	RAG Reason
2	Align geographies to Health Regions: (a) Conduct geographical impact analysis. (b) Align the geographies of the existing Hospital Group and Community Healthcare Organisations.	(a) Jul-23 (b) From Sept-23	Feb-24	Mary Day, David Walsh	In Progress	Red	(a) This is complete. (b) HG realignment continuing (IEHG & RCSI from 02 Jan, others from 22 Jan). CHO plan awaited. Current IR climate a key factor.
3	Agree staff appointments/transition approach for Health Regions	Sep-23	Mar-24	Ann Marie Hoey, Michael O'Leary (DoH)	In Progress	Amber	Some work completed and consultation with staff representative groups, further work required following HSE Centre Structure Design. Meeting held with DoH 22 December.
6.1	Appoint HSE Health Region leadership: Regional Executive Officers	From Oct-23		CEO, Sec Gen	In Progress	Amber	Appointment process ongoing. Amber due to risk of not having all 6 in place by end of February. Mid West REO in place from 18 December. Recommendations from PAS received.
10	Strategic Population Health Needs Assessment Framework	Jul-23	Feb-24	Public Health	In Progress	Amber	Population Based Planning (PBP) workstream led by Public Health initiated with steering group and expert advisory group to oversee project. V1 of Framework has been drafted and will be updated following feedback from stakeholders.
12	Health Profiles to inform Regional Population Based Planning: (a) Produce National Comparative Population Profile (b) Produce Regional Population Profiles (c) Develop Population Profile Dashboard - National, Regional and Local (d) Produce Local Population profiles (e) Co-produce with regional population standardised Regional Strategic Population Needs Assessments	From Sept-23	(a) Feb-2024 (b) Feb-2024 (c) Dec 2024 (d)TBC (e) TBC	Public Health	In progress	Amber	Work started on National Comparative Profile, Regional population profiles and Population Profile Dashboard on E Health overseen and managed by PBP workstream.
14	Agree Health Region governance approach and partnership arrangements with non-HSE providers including S38 and S39s.	Dec-23	Feb-24	Stephen Mulvany, Mike Corbett, Kevin Cleary	In Progress	Amber	SLA review is ongoing via working group chaired by HSE CFO. Approach for governance of non-HSE providers for further consideration and engagement. Date updated to Feb 24.
16	Agree performance accountability framework: Update to reflect new structures, informed by DoH HSPA framework as appropriate. Several updates to PAF required: 1) Update pre Feb 2024, post geographical realignment 2) Update post Feb 2024 when REO and Regional EMT in place	Dec-23	Feb-24	Joe Ryan, Orla Tracey	In Progress	Amber	Work is ongoing within the HSE and is being led by Operational Performance & Integration. Meeting scheduled for week commencing 15 January to review status and completion date. Date updated to Feb 24.
17	Agree baseline KPIs for Feb 24 for Health Regions, the HSE Centre and DoH, aligned to HSPA & NSP	Dec-23	Jan-24	Joe Ryan, DoH	In Progress	Amber	Work has commenced within the HSE to realign reporting to Health Regions. Date updated to Jan 24.
20	Establish PBRA expert group	Jul-23	Jan-24	DoH	In Progress	Amber	The Department shortly intends to establish this group. Date revised to Jan.

Implementation Plan Actions – Green

Action #	Action	Implementation Plan Timeline	Revised Timeline	Lead	Status	RAG	RAG Reason
1.2	Define the structure of the HSE Centre: Implementation Approach to be agreed.		Jan-24	CEO	In Progress	Green	Implementation Approach to be complete by end Jan.
4.1	Define the structure of the Health Regions: Structure to be agreed	Sep-23	Jan-24	HSE & DoH Health Regions Programme Team	In Progress	Green	Recommended option for consideration between CEO and Sec Gen. Further dialogue required with REOs in finalising proposed regional structure.
4.2	Define the structure of the Health Regions: Implementation Approach to be agreed.		Jan-24	HSE & DoH Health Regions Programme Team	In Progress	Green	Implementation Approach to be complete by end Jan.
5	Integrated pods to further progress Integrated Care Pathways and improved ways of working between hospitals and communities.	From Sept-23		Integrated Pods (HG CEOs, CHO COs)	In Progress	Green	Ongoing
8	Clarify the Dept of Healths role in enabling Health Regions	Mar-24		Sec Gen	In Progress	Green	DoH progressing.
9	Engage with stakeholders: Implement a schedule of engagement and consultation with internal and external stakeholders including HSE staff, patients and service users, voluntary organisations, GPs, and others.	Ongoing		HSE & DoH Health Regions Programme Team	In Progress	Green	Engagement is ongoing.
11	Agree integrated service delivery model for Health Regions	Aug-23	Jan-24	HSE & DoH Health Regions Programme Team	In Progress	Green	Emerging IHA structure brought to Oversight Group and to be ratified by CEO/REOs.
13	Update HSE Code of Governance: Update to include Health Regions (corporate and clinical), taking into account wider health system including GPs, patients and service users, Section 38 and 39 organisations, and others.	Nov-23	Jan-24	Darragh Purcell, Sarah Murphy	In Progress	Green	Work is ongoing with DoH and HSE. Date revised to January 2024. Code of governance to include clinical governance. Clinical governance operating model is being progressed by CCO office, to be completed by end Jan.
15	Undertake baseline analysis of resources by Health Region: Broken down by current function, e.g. capital, financial, ICT and human resources.	Dec-23	Jan-24	HSE & DoH Health Regions Programme Team, working with HSE functional areas	In Progress	Green	Initial outputs completed, work ongoing.
22	Identify Health Region 'headquarters'	From Sept-23		CEO	In Progress	Green	Proposal completed and for consideration by HSE Board.
23	Define critical Digital, ICT and Data requirements: For Feb 2024; For post Feb 2024 - medium to long term	Oct-23	TBC	Fran Thompson (CIO), Derek McCormack (BIU)	In Progress	Green	Initial discussions held. Further engagement with REOs to take place to define requirements. Approach, RAG and due date to be confirmed.
24	Agree future approach to business functions for Health Regions	Dec-23	Jan-24	HSE & DoH Health Regions Programme Team, working with HSE functional areas	In Progress	Green	This will be completed as part of design work which is ongoing.
26	Agree Capital Planning and Prioritisation approach	Jan-24		HSE & DoH Health Regions Programme Team, working with HSE functional areas	Not Started	Green	This will be completed as part of design work which is ongoing.
27	Complete branding exercise for Health Regions	Feb-24		HSE Communications	In Progress	Green	Current health region naming to remain. Further work ongoing by HSE National Comms to support visual identity.

Implementation Plan Actions – Complete / Not Started

Action #	Action	Implementation Plan Timeline	Revised Timeline	Lead	Status	RAG	RAG Reason
1.1	Define the structure of the HSE Centre: HSE CEO to define the future structure of the HSE Centre to support the implementation of Health Regions	Sep-23	Nov-23	CEO	Complete	Complete	Document circulated by CEO on 23 Nov with final intended HSE Centre Structure.
19.1	Approve revised process for service plans 2024	Jul-23		Complete	Complete	Complete	Complete for 2024.
6.2	Appoint HSE Health Region leadership: Agree HSE Health Region Executive Management Team with a view to recruitment in early 2024, once REOs are in place.	From Oct-23	From Mar-24	CEO, Sec Gen	Not Started	Not Started	This action is due to start later once Health Region structure has been finalised and REOs are in place.
7	Support and upskill staff transitioning to Health Regions: (a) Conduct training needs analysis (HSE) (b) Develop phased learning plan for Health Regions and HSE Centre (HSE) (c) Deliver required training programmes to leadership & staff (HSE + tender) (d) Competency of REOs and leadership team - coaching, mentoring, training	(a) From Dec-23 (b) From Dec-23 (c) From Feb-24 (d) Date TBC with AMH		National HR	Not Started	Not Started	Dates and approach to be confirmed with National HR.
18	Implement integrated service delivery model for Health Regions	From Jun-24		REOs	Not Started	Not Started	This action is due to start later.
19.2	Approve revised process for service plans 2025	N/A	TBC	TBC	Not Started	Not Started	This action is due to start later. Due date to be confirmed.
21	Approve revised process for multiannual HSE corporate plans (Capital Plan, IT Plan, Corporate Plan)	Jun-24		National Planning Lead	Not Started	Not Started	This action is due to start later. Due date to be confirmed.
25	Address critical Digital, ICT and Data requirement for Feb 2024	Jan-24	Feb-24	Fran Thompson (CIO)	Not Started	Not Started	RAG and due date to be updated once approach is agreed

Health Regions Change Management Supports

Driving Regional Reform in line with National Direction

Compelling need to have **dedicated change management supports** in place to support Health Region implementation.
Establish an **'implementation vehicle'** that has the scale and expertise to make the change happen (Health Region Advisory Group and HSE Board.)

Ensuring **'line of sight'** from front line service delivery to national will be achieved through the agreed **spine of control** driving major change locally supporting the:

- **REOs**
- **EMTs**
- **Integrated Healthcare Area Managers**
- **Community Healthcare / Hospital Network Managers**

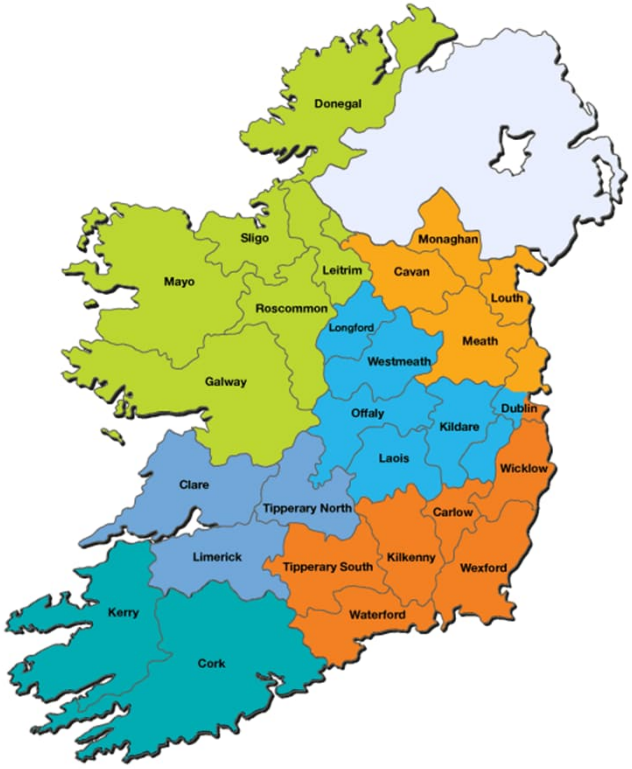
Improve **access and integration** from the first point of contact and at all levels in the care journey for individuals, families and local communities.

Bring about the radical **organisational culture change** required - ways of working, enabling processes and working relationships within the IHAs and CHNs in particular.

Change and Innovation Hubs – Health Region

6 Change & Innovation Hubs integrated into each Health Region

Aligned and supported by an Organisational Change Unit at the Centre



- HSE Dublin and North East
- HSE Dublin and Midlands
- HSE Dublin and South East
- HSE Mid West
- HSE South West
- HSE West and North West

Partnership working and relationships will be key to integrating efforts and resources across services

Focus of C&I Hubs

- Portfolio and Programme Management
- Organisation Development & Design
- Strategic Alliances – Organisational Adaptability

Optimise existing partnerships

Collectively deliver on population-based outcomes through evidence, local knowledge & experience.
Support spread and mainstreaming across the system.

- Programme Management Offices in CHOs and HGs
- Quality, Patient Safety & Service Improvement
- HR – leadership, learning & talent development
- Chief Academic Officers
- Research & Evaluation
- Public Health – service improvement
- Nursing & Midwifery Planning & Development Units
- HSCP National Office
- Professional bodies
- Frontline Clinical Innovation & Simulation - Spark Innovation
- Staff Engagement Fora

Patient, service user & community engagement
core to service delivery and development

- Modernised Care Pathways & Clinical Hubs
- Enhanced Community Care
- Community Healthcare Networks
- Service Reform (mental health, disability etc.)
- Sláintecare Innovation Fund Projects
- National Care Groups
- Digital Transformation & eHealth
- Integrated Financial Mgt System
- NiSPR
- Professional bodies
- Other national change programmes
- Digital Academy
- Lean Academy
- Academic alignments & others

Resourcing model

Regularisation of resources

- Existing PMOs in CHOs and HGs - 32 posts across six Health Regions
- Teams repurposed to support Health Region implementation and focus on integration of services

Realigned resources

- Existing change programmes connected, mainstreamed and/or realigned to Health Region programme of change – Public Health, ECC, Digital Health etc.

Additional resources

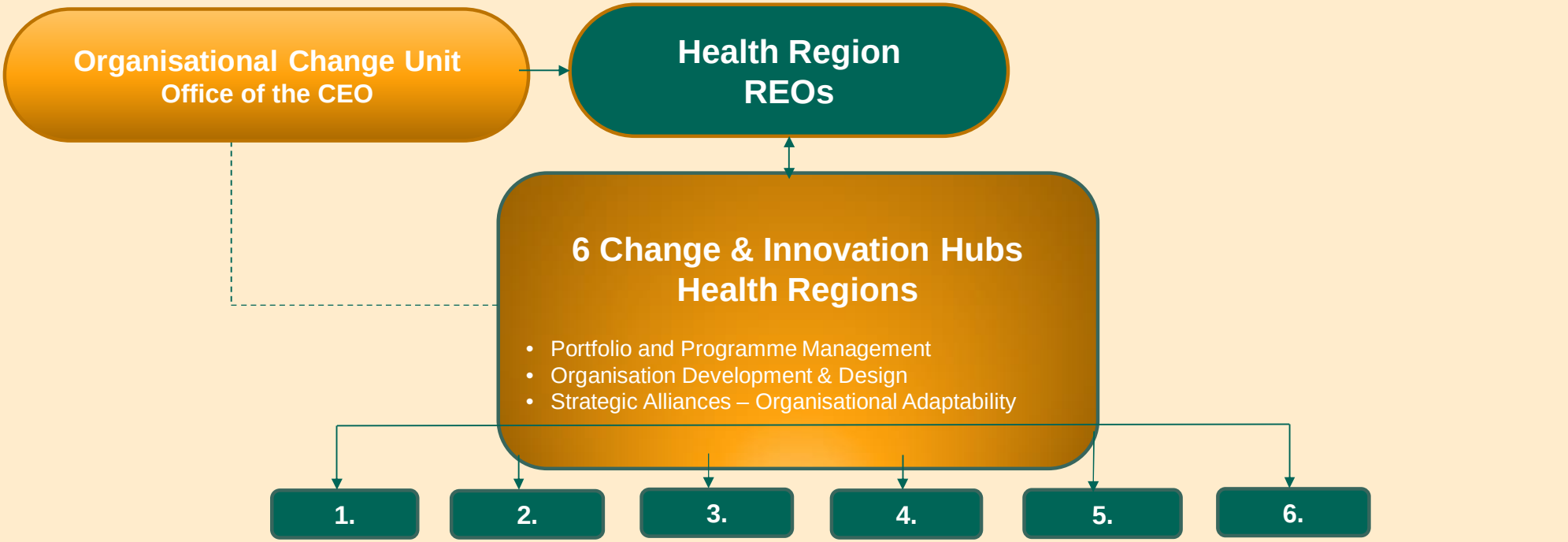
- 14 posts 2024 – 2 additional posts for each Health Region (12) and 2 to support alignment between national and regional agendas

Operating model

- Reflect focus on Integrated Healthcare Areas – i.e. dedicated change teams to support REOs and in particular IHA managers (population-based focus on integration of services)

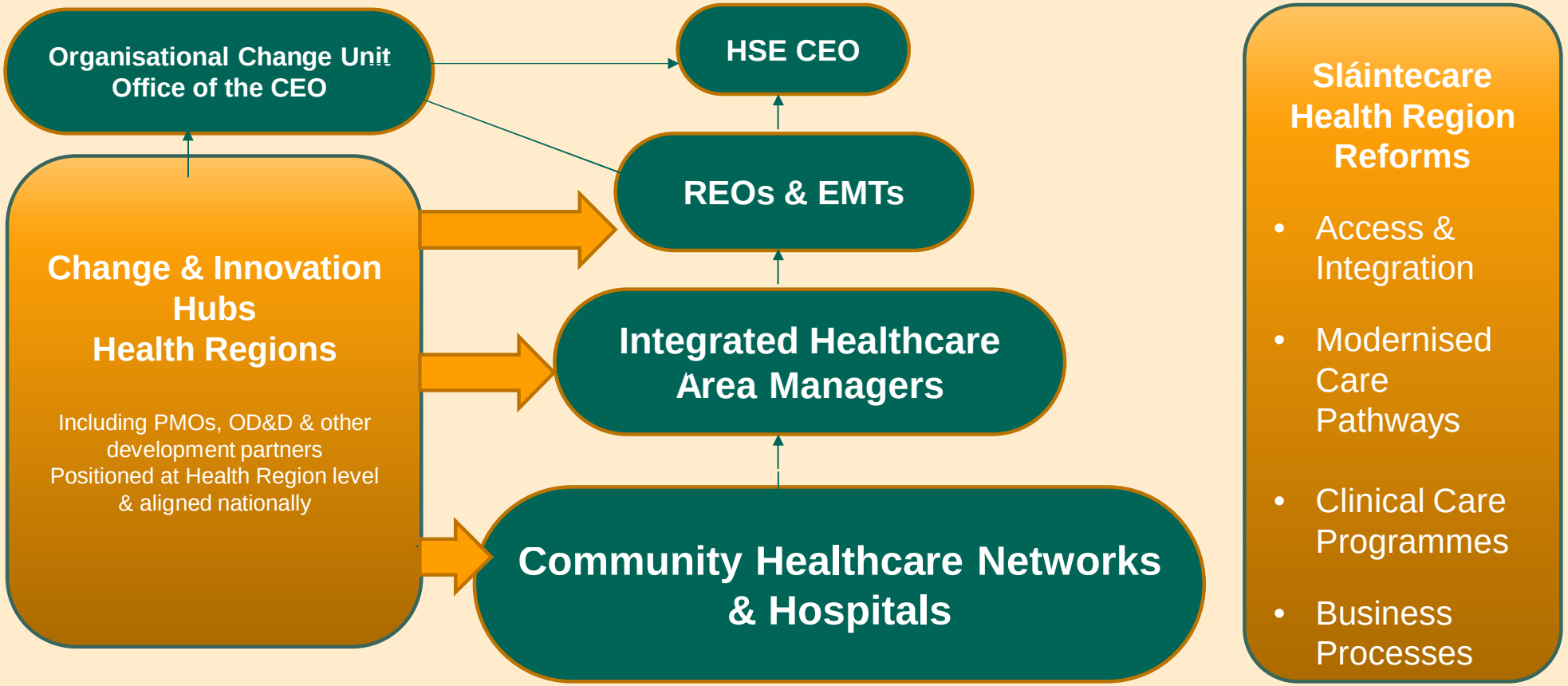
Organisational Change Unit &
Change & Innovation Hubs – proposed design

DRAFT Jan 2024
For further discussion

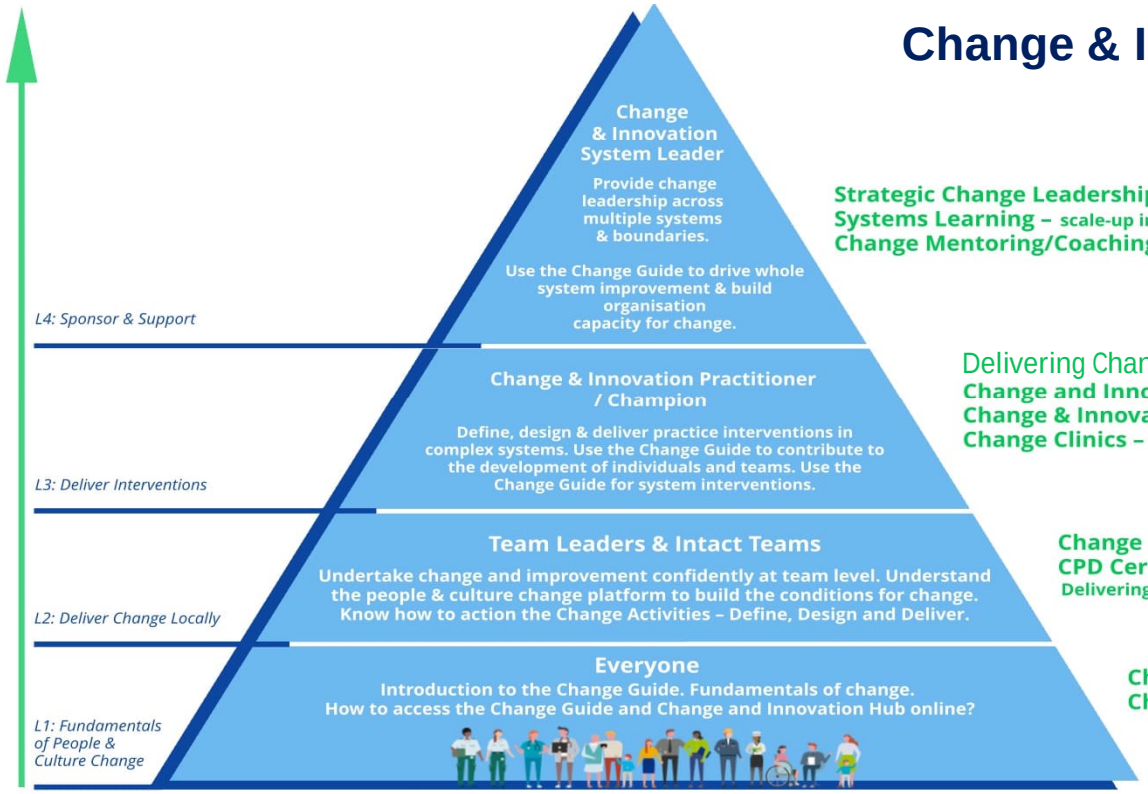


Purpose: Provide dedicated support to REOs, EMTs, Integrated Care Area and CHNs
Service Design: Design of C&I Hubs to be developed further - needs to be 'fit for purpose' to adapt the national blueprint for local implementation.

Organisational Change Unit &
Change & Innovation Hubs – Operating Model



Change & Innovation Developmental Pathway



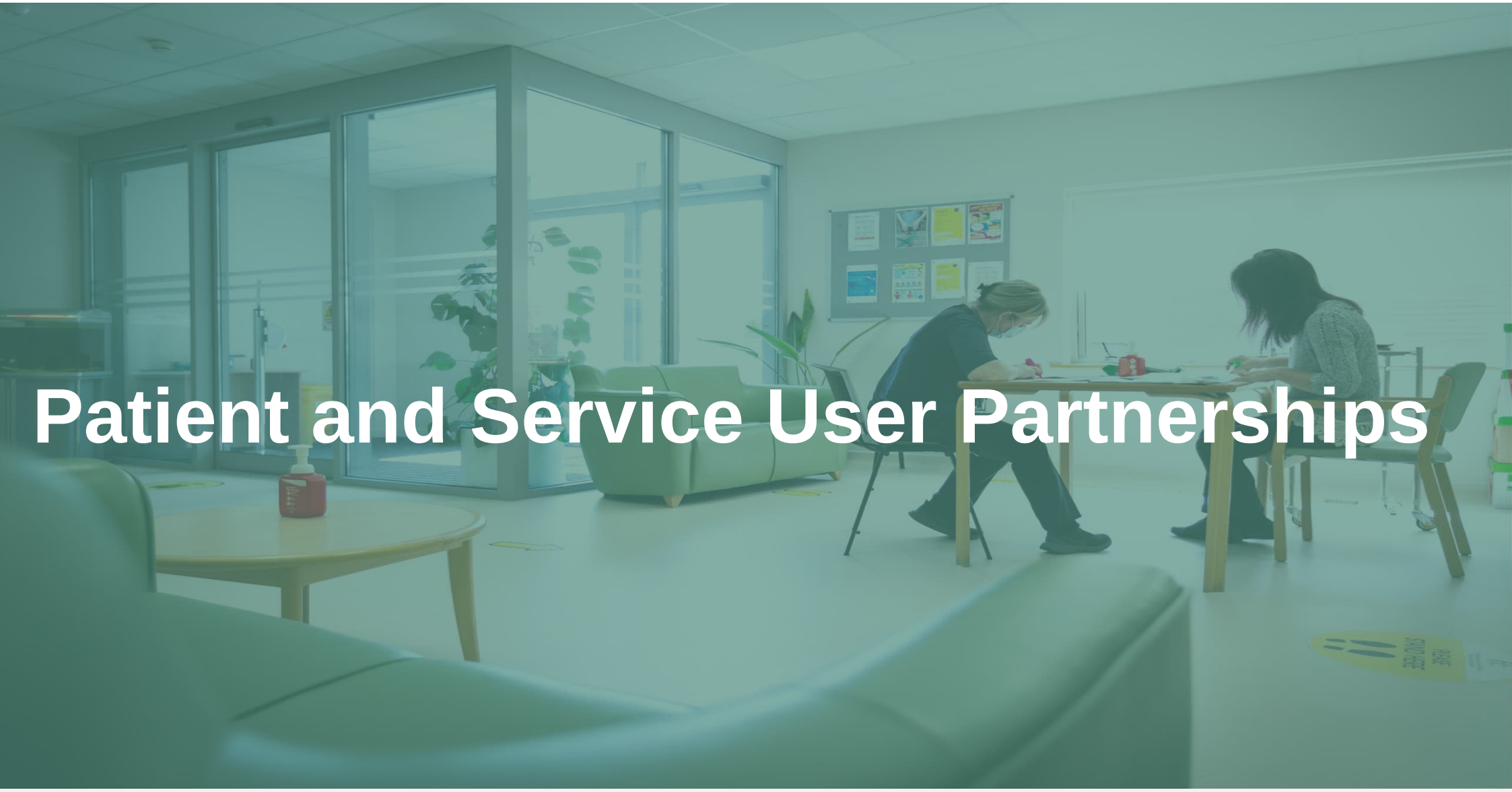
Change & Innovation Development Pathway

Strategic Change Leadership Interventions
Systems Learning – scale-up innovations
Change Mentoring/Coaching

Delivering Change Together – Experiential Change Programme (CPD Points)
Change and Innovation Practice Programme/s
Change & Innovation Hubs – Proposal at Health Region level
Change Clinics – practice based

Change Guide in Action Sessions
CPD Certificate Programme -
Delivering Change in Health Services (HSE/RCSI)

Change Guide eLearning Programme
Change & Innovation Hub – online resources HSeLanD



Patient and Service User Partnerships

Patient Partnership Proposal in Health Regions Design

A key focus for the Health Regions programme is ensuring that the patient and service user voice is integral to:

- Design work within the programme (Co-design workshops, ISD representation, Implementation Planning Group and Oversight Governance Group)
- Health Regions governance and decision making as structures are stood up (Implementation Planning Group and Oversight Group)
- Functioning of Health Region patient and service user partnership structures (Patient Councils, Patient Partnership Office & Partnership Lead)

Objective

The objective of the Health Regions Programme was to set out through co-design a future approach to patient and service user partnership within Health Regions.

The Proposal

This document captures:

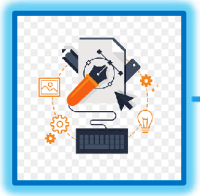
- The pathway taken to both understand and develop the requirements for patient and service user structures
- The main themes and recommendations for formalised involvement of patient and service user partners in the Health Regions structures

Health Regions Programme Team - Methodology

2022

Memo to Government approved

High level design



HSE Health Regions Programme Team established

January: Presentation to NDOPI (National Director Operational Performance and Integration) & Patient & Service User Partners

2023

HSE Health Regions Implementation Plan Approved 31/7/23

7/7/23 – 3rd Co-Design Workshop

7/6/23 – 2nd Co-Design Workshop

10/5/23 – 1st Co-Design Workshop

April: 4 Submissions from Patient & Service User Partners

Consideration & incorporation of feedback

Circulation of 1st draft of proposal to Patient & Service User Partners – Oct 2023

Jan 2024: Bringing Patient & Service User Partners Proposal to governance groupings

Targeted consultation with Chair & Vice Chair of Patient Partnership Forum

2024

Patient Partnership proposal in Health Regions Design – Concept Propositions

- The proposal is guided by a co-design approach using the Design Thinking Methodology.
- The co-design process consisted of 3 workshops (Patient Partners/HSE staff/DoH Staff).
- The group prioritised areas of development under three themes:
    1. Formal patient and service user representation in Health Region structures through appropriate forums. Concept proposition: '*Communications = A voice that is listened to and equal'.*
    2. Patient and service user partners being able to effectively navigate health and social services. Concept proposition*: 'The Compass - Navigation of the Health Regions- A Symphony of Efficiency'.*
    3. Key Principles and patient and service user partnership. The importance of respect, behaviours, culture and the strengthening of accountability (at HSE level) was emphasised. Concept proposition: *'Key Principles, Why partnership?'*

Patient Partnership Proposal for Health Regions Design – Proposal Overview

Patient and service user representation. This priority makes recommendations in the areas of:

- Patient Councils;
- Patient Partnering Office;
- Patient Partner Lead;
- Strategy & Planning.

Improving the patient and service user experience. This priority makes recommendations in the areas of:

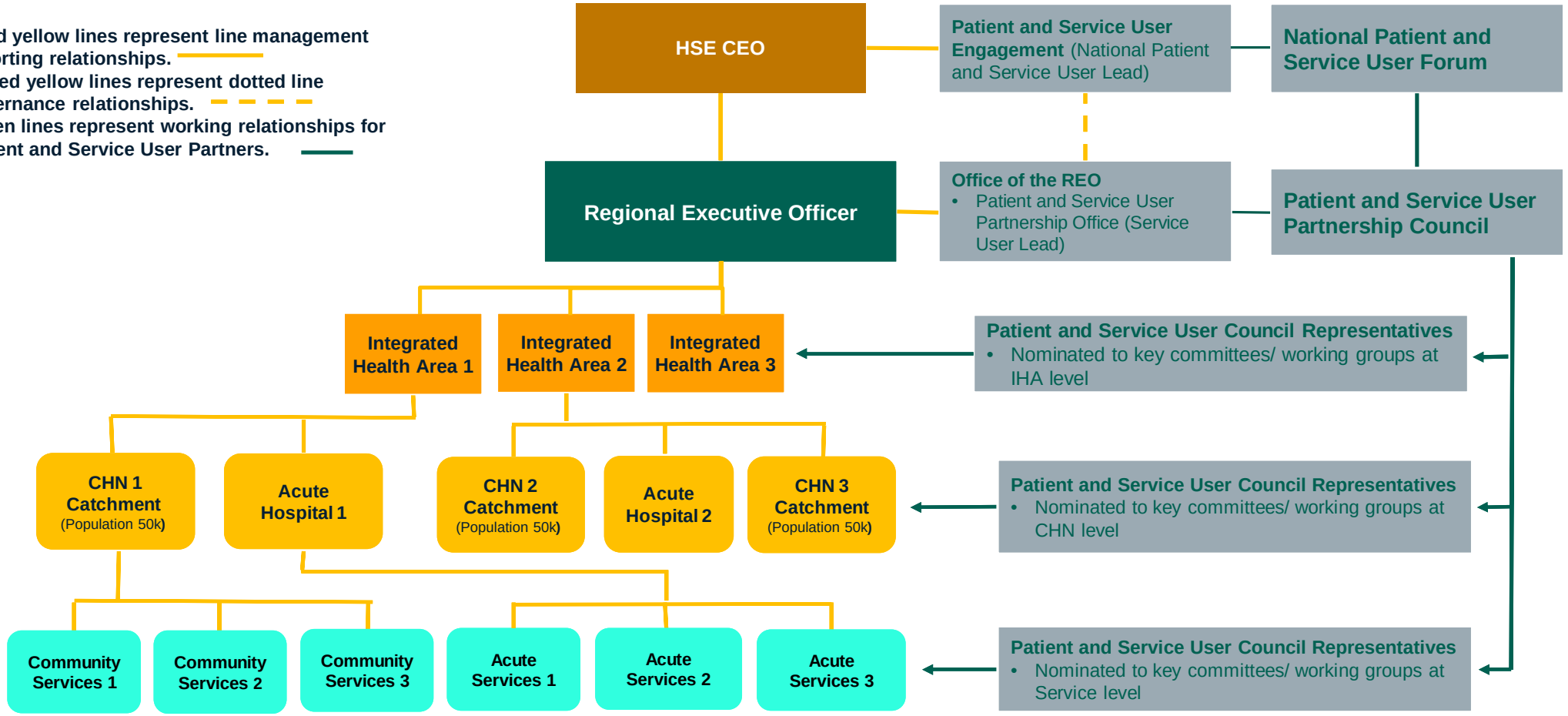
- Communication;
- Culture;
- Access & integration;
- Data & information;
- Training, education & research.

Improving governance and accountability. This priority makes recommendations in the areas of:

- Governance;
- Standards & measurement.

Proposed Regional Patient and Service User Partnership Structures

Note:
- **Solid yellow lines represent line management reporting relationships.**
- **Dotted yellow lines represent dotted line governance relationships.**
- **Green lines represent working relationships for Patient and Service User Partners.**



This is one of a number of management structure options being considered. This is being used for illustration purposes to identify the Patient and Service User Partnership Council and its interactions in the National and Regional structure. It does not represent all interactions with partnership/ governance forums etc.

HR Plan / People Update

Staff Transition Principles

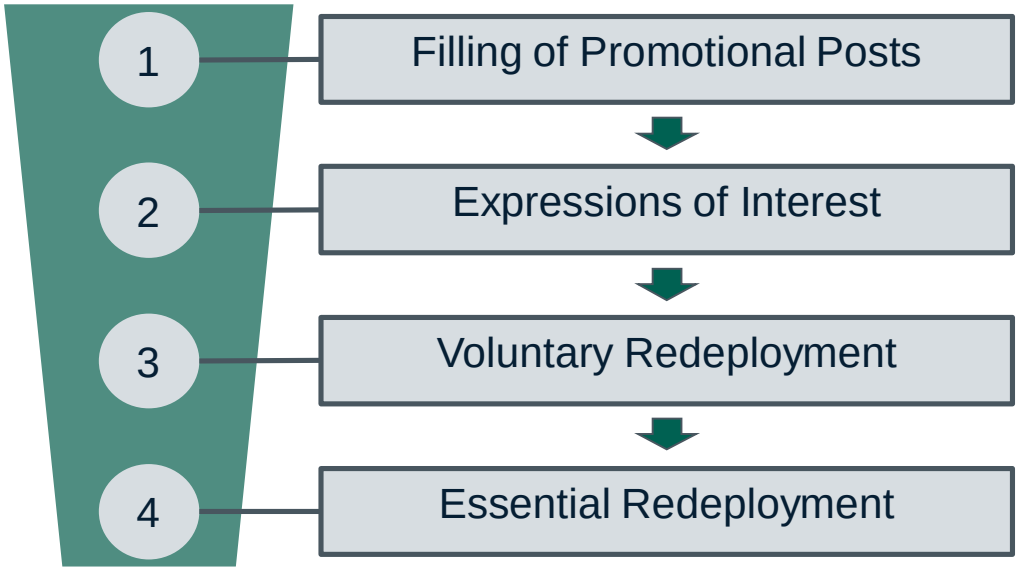
- Work is ongoing on the review of the HSE Centre and the design of Health Regions.

- The Programme Team is working closely with National HR to progress transition planning and processes for staff transition.

- The following two slides outline:
  1. Draft overall Health Region Programme Staff Transition Principles - for discussion and consultation
  2. General/ sample scenarios pertaining to staff – for discussion and consultation

1. Overall Health Region Programme Staff Transition Principles

The below outlines the proposed order of processes that will be followed.
This process may iterate a number of times, as the implementation of Health Regions progresses.



1. Overall Health Region Programme Staff Transition Principles

1	**Alignment with Existing Agreements**		We will work with and through existing agreements and structures including: • The Information and Consultation Agreement for the Health Service • The Health Service Redeployment Protocol, agreed under the terms of the Public Service Agreement (PSA) • A Framework for Dispute Resolution in the health Services
2	**Recruitment and Selection Policies**		HSE recruitment and selection policies / processes will apply, unless otherwise provided for.
3	**Promotional Posts**		In accordance with Public Appointments Commission regulations, promotional posts may only be obtained through competition: ➢ 'New' promotional roles within Health Regions will be filled by open competition ➢ Some posts may be filled by way of confined competition to a defined group
4	**Expressions of Interest**		Job opportunities and grade for grade EOI's will be advertised on the HSE website. Account will be taken of: Grade; qualifications; skills and experience to carry out the work; working arrangements.
5	**Redeployment/ Reassignment**	Reassignment	If following the establishment of the Health Regions, an employee's role no longer exists fully in its current format, in line with the Redeployment Protocol, they will be reassigned to another role. Every effort will be made to ensure that each employee is assigned to an equivalent role, however redeployment may not always be to a role/grade of similar/equal status. The employee will be engaged with throughout. Regardless, an employee's existing pay and terms and conditions of employment, including their grade, will be protected.
		Role Matching	When determining an appropriate role match, account will be taken of: ➢nature of work; ➢qualifications; ➢Skills, competencies and experience required to carry out the work; ➢capability of the individual to undertake the work; ➢working arrangements e.g. hours of work, shift arrangements; ➢level of responsibility.
		Changes to Location	In accordance with public service norms, where a staff member is required to move location, the Protocol allows that they may be moved to positions within 45km of their current work address or home address, whichever is the shorter, with account also being taken of a reasonable daily commute. Remote Working will be considered in the context of HSE HR Circular 33/2023 Blended Working Policy for Public Sector employments.
6	**Other Roles**		Roles in the HSE will still arise and staff will continue to have access to those opportunities which will be advertised on the HSE website.

2. General/ sample scenarios pertaining to staff

While the outcomes of design for HSE Centre and Health Regions are not yet fully complete, there are general/ sample scenarios pertaining to staff that we can begin to consult on, along with the Transition Principles for same.

It is expected that initially there will no substantial change for the majority of staff in the services.

For discussion:

Sample scenario 1: Some staff / services may be required to be repointed from HSE Centre to a Health Region aligned to the future role of the Centre and the Health Regions.

- Please note that this scenario is intended for discussion as 'HSE Centre' in its broadest sense e.g. not Dr Steevens' Hospital, but the already geographically dispersed staff base working across central functions.

Sample scenario 2: Some staff currently in Hospital Groups or CHOs may be required to change role/ location as a result of boundary/delivery changes with the introduction of Health Regions (Redeployment / Reassignment principles apply).

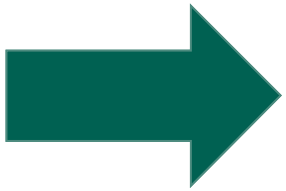
Implementation Approach and Transition Plan

Implementation Approach and Transition Plan Introduction

The Implementation Approach provides a holistic view of the key activities required to transition to the Health Regions and HSE Centre structures from early 2024.

Key considerations to be addressed by the Implementation Approach and Transition Plan:

- What are the principles for transitioning staff to roles in the new structures – in the Centre and Health Region? Who will define these?
- How and when will changes in reporting line be communicated to staff?
- What support will be provided to REO's in standing up their leadership teams?
- What is the fallback position if all REOs are not in place by 1 March?
- What is the role of the Hospital Group lead and Integrated Health Area lead in the interim period (2024)?
- What support will be provided to HSE Centre National Directors in managing changes in reporting line of direct reports and teams?
- Accountability at the HSE Centre – how does this change on 1 March when REOs are in place?
- When CEO-1 roles are filled in the Centre, what happens to those who no longer have roles in the new structure?
- How will gaps in the HSE Centre structure be filled?



Key inputs to the Implementation Approach and Transition Plan

- Implementation Plan 2023 (Government published paper)
- 1 March 2024 Vision (describing what will be in place on 1 March 2024 in the Regions and Centre)
- Centre design to CEO-1 level (Centre Senior Leadership Team)
- Health Regions design to REO-1 level (Region Executive Management Team)
- 2024 / 2025 Programme Plan
- 2024 Critical Path

Components of the Implementation Approach and Transition Plan

To support a smooth transition and mitigate risks to service delivery, there are a number of critical interdependent activities that need to be completed **across six key areas**, as follows:

1. Transition Support	2. Organisation Design	3. People Transition Approach and Principles	4. Role Fulfilment and Resourcing	5. Change Management and Communications	6. Business Readiness
					
Design and manage the transition process from current to future state, including the transition plan and tracking approach for the Health Regions and HSE Centre. Manage the transition programme and the associated change	Organisation charts, functional descriptions and role descriptions for senior management roles in the Health Region and HSE Centre	Define the People Transition Approach and Principles that will enable a smooth transition to the future state in the Health Regions and HSE Centre and ensure the success of the new organisation design	Resourcing plan for existing and new roles in the Health Region and HSE Centre, including reallocation of resources in line with HR policy, and recruitment to fulfil the future state design	Assess and mitigate the impact to the organisation and engage and support key stakeholders through the transition. Define and deliver change management and communications activities to ensure stakeholders are ready, willing and able to transition to and operate effectively in the new structure	Confirm that all key business readiness activities have been completed and the function is ready to work fully in accordance with the new design and all agreed responsibilities

Health Regions Programme Governance Model

Health Regions Programme Governance Model and Decision Route

Escalations

The HSE Board will give overall strategic guidance, based on recommendations from the Health Region Oversight Group and make go / no go decisions

HSE Board

Monthly

The Health Region Oversight Group will review and approve key decisions made by the Health Region Implementation Planning Group. It will make recommendations to the Board, provide oversight, and monitor progress and resolve key barriers to the programme

Health Region Oversight Group

Monthly

Chair: HSE CEO
Membership: Some SLT members, Voluntary Org Rep, Patient Reps, DoH in attendance as required

The Health Region Implementation Planning Group will make decisions / recommendations that have national and regional level implications and / or sensitive issues. It will manage risks and issues and escalate to the Oversight Group as necessary, and agree key positions ahead of key external meetings.

Health Region Implementation Planning Group

Monthly :- more frequently when required

Chair: Liam Woods, Health Region Implementation Lead
Membership: SLT members/nominees Voluntary reps, Patients, DoH in attendance as required

The Programme Team will make decisions that are primarily internal to the programme. National and regional levels or sensitive decisions will be escalated to the Health Region Implementation Planning Group.

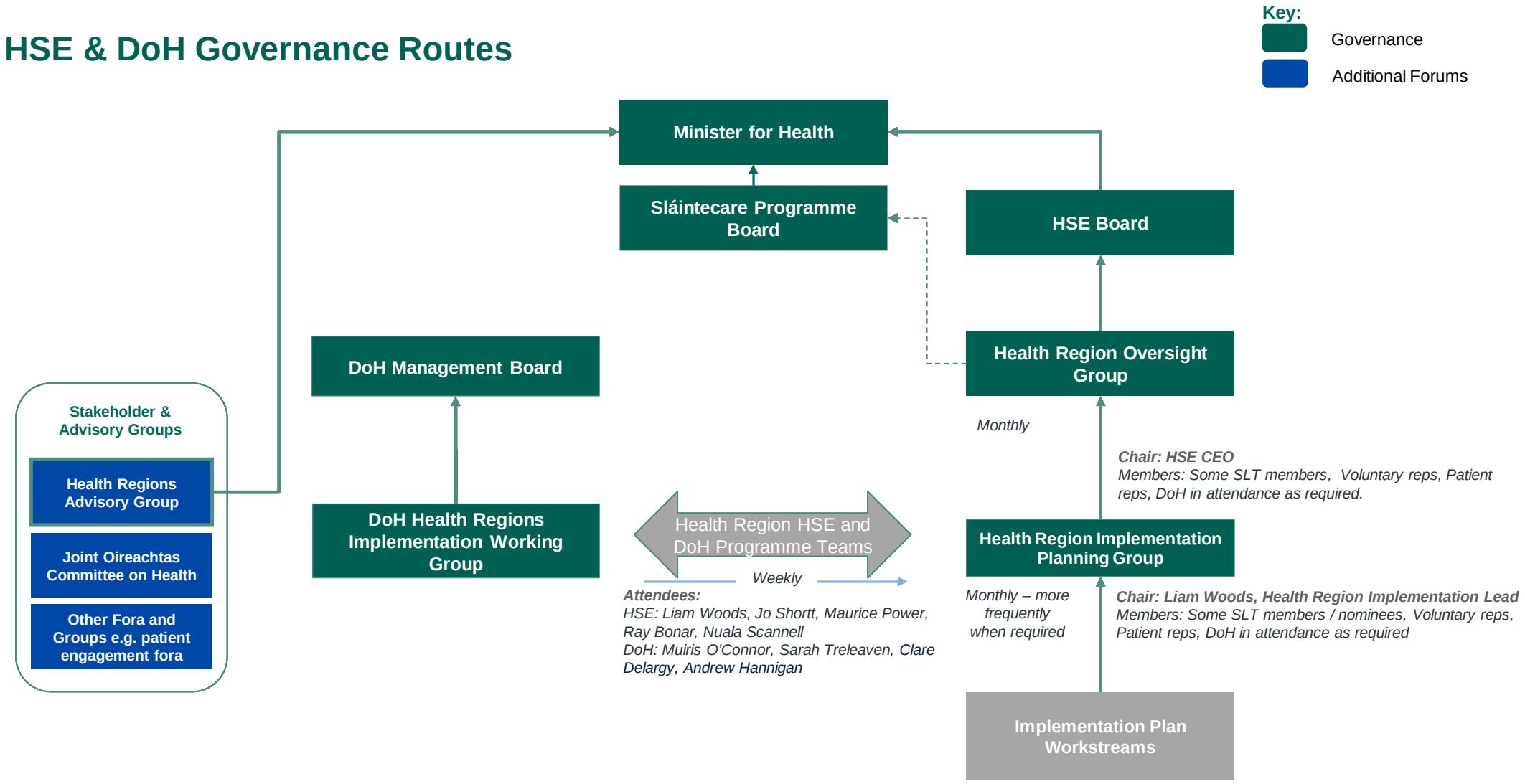
Health Region Programme Team

Weekly

Decisions

Further dialogue required as to decision making / governance group to include REOs

HSE & DoH Governance Routes



Further dialogue required as to decision making / governance group to include REOs

Key Programme Risks

Health Region Programme – Top Risks (For Noting)

- There are currently 19 risks on the Health Regions Programme Risk Register: 1 Red; 17 Amber; 1 Green.
- The 4 highest rated risks are summarised in the table below.

Risk #	Description	Rating (Score)	Existing Control	Summary Risk Action
HRP17	There is a risk that the **current Fórsa industrial action may impact on the ability to engage with a wide range of stakeholders** resulting in delayed delivery of programme implementation as per email on 5/10/23 from the National Secretary (Fórsa).	Red (20)	Work is ongoing within the Health Regions Programme Team (HRPT) to establish the limitations within the programme of work to allow it to function within the boundaries of the current industrial action.	Continue to work within the boundaries of what is appropriate during the Fórsa Industrial Action.
HRP5	There is a risk that **the benefits of the integrated service delivery model cannot be fully realised if the supporting ICT systems, resources, infrastructure and available data is not in place,** which may result in an inability to support integrated patient centred service delivery. Note: Score reflects the benefit of some integrated systems being realised in the absence of full integration.	Amber (12)	Requires building on the work done during the cyber-attack to inventorise ICT provision and develop architectural approaches to maximise integration for patient ID and EHR. Engagement with staff involved in service delivery to prioritise highest impact interventions to deliver ICT support for integrated care.	Ongoing review in the context of detailed design. Consideration of interim solutions at a Health Region level for integrated systems.
HRP10	There is a risk of **instability within the leadership teams during transition if any of the future leadership appointments within the Health Regions or the HSE Centre come from existing leadership structures**, which may impact on service delivery or line management at local levels.	Amber (12)	Risk to be managed by Health Regions REO using existing HR frameworks. HR transition planning underway.	As part of design and implementation, Health Region specific transition plans will be put in place. This will be supported by dedicated roles in each region including PMOs and change managers.
HRP13	There is a risk that **Quality and Patient Safety (QPS) Issues may not be progressed in a timely manner when CHOs (including QPS) are split across Regions and when hospital groups (HGs) are split across regions**, if proper due diligence is not completed and detailed handover plan is not put in place in advance of realignment. This may result in key patient safety issues not progressing on time or being missed off an entities register.	Amber (12)	Continue to address QPS issues as per current practice.	Due diligence to be completed on active QPS issues by each CHO and HG to ensure a full understanding of active issues are captured, addressed and handed over to the appropriate resource.

Note: A full risk log is available from the Health Regions Programme Team

AoB

Appendices

IHA Mapping Options update

- The IHA Mapping Working Group includes colleagues from the Health Regions Programme team, HSE Health Intelligence, Primary Care Strategy and the Department of Health. This group developed mapping options for IHAs that have been shared with the Health Regions Programme governance groups.

- In November 2023, the National Director of the Health Regions Programme sought feedback from the members of the HSE Senior Leadership Team (SLT), Health Regions Programme governance groups and the Department of Health on the proposed options for the IHAs.

- The maps are currently being refined in light of the feedback received.

- It is important to note that the options presented need to be considered in the context of the output emerging from the work stream on Health Region Executive Management Team Structure.

Overview of Feedback Received

- In total, there were 23 respondents. Some members of the Senior Leadership Teams sought feedback from their teams which widened the field of respondents, resulting in a total of 130 pieces of feedback.
- The majority of the responses were submitted by 6 out of the 9 CHO Chief Officers *(49.2%)*. This was followed by HSE Centre *(30.0%)* and beyond this, the feedback analysed originated from 4 out of the 7 Hospital Group CEOs *(8.5%)*, DOH *(6.9%)*, Health Regions Programme *(3.8%)*, Hospice Providers *(0.8%)* and Section 38/39 *(0.8%)*.

Chart 1: Who gave feedback?

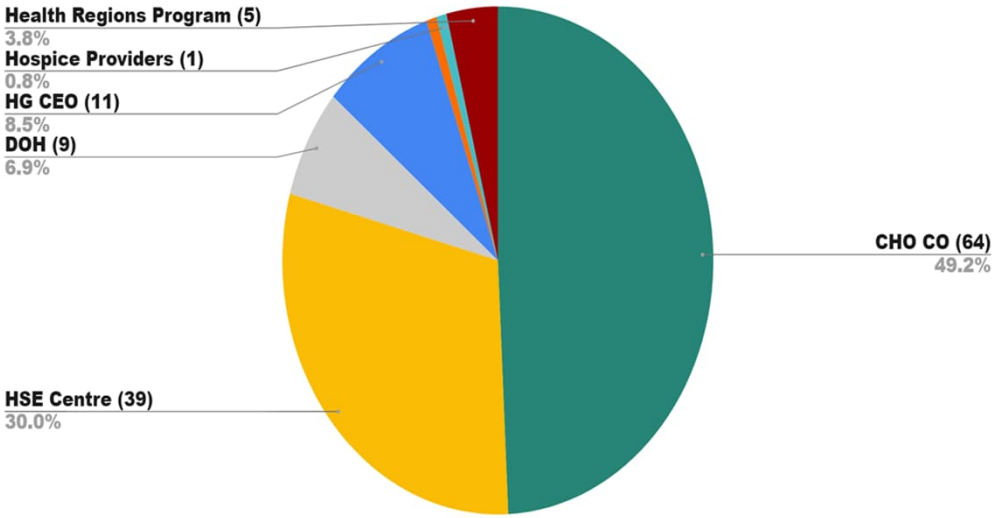
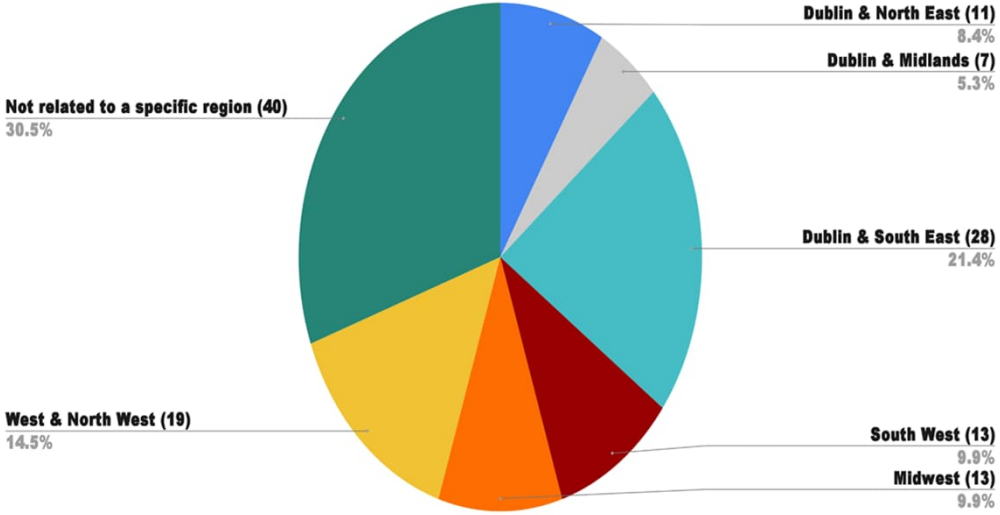
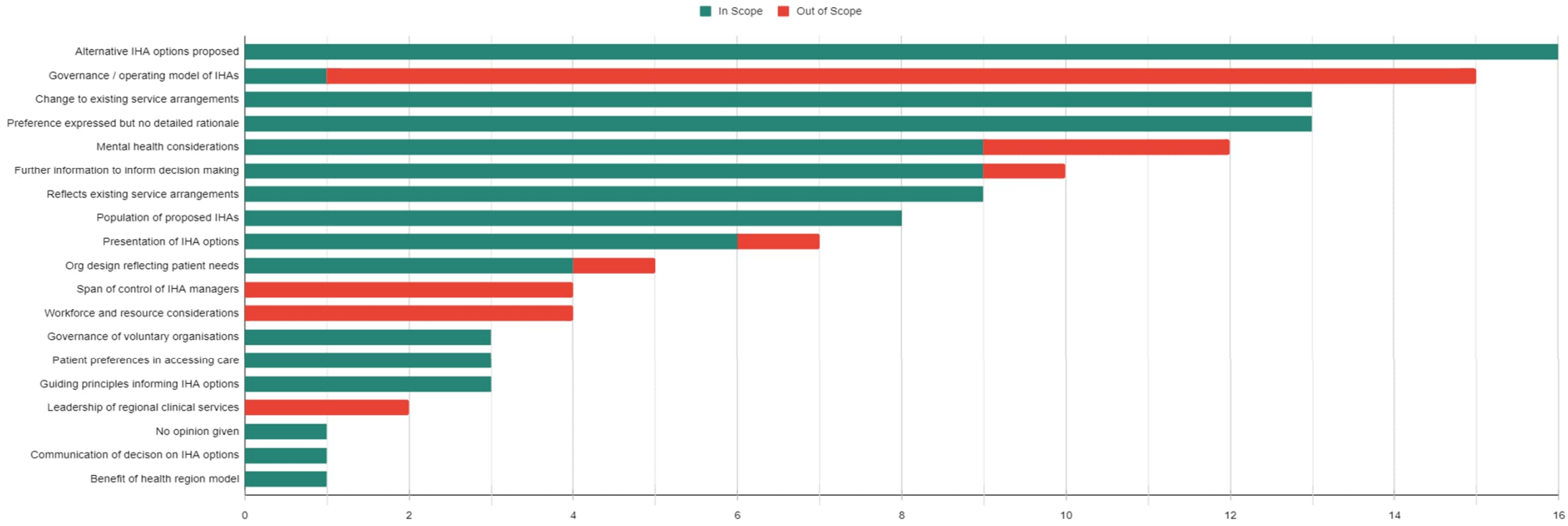


Chart 2: Which HSE Health Regions were the focus of respondents' feedback?



Overview of Feedback Received

The feedback varies in scale from commentary on specific IHA options to general comments pertaining to all or some regions and can be broken down into 19 categories show in the below table.



Note: Categories were considered in scope if they related to the design and options of the proposed IHAs within the HSE Health Regions. Categories were considered out of scope if they related to the governance arrangements and operating model of the IHAs or the HSE Health Regions, the span of control of IHA management, considerations related to workforce and resources, or the leadership of regional clinical services.

General Feedback

General feedback on IHA mapping process – not related to options for specific regions

- Further information to inform decision making
  - Feedback from a number of respondents suggested that further detail on deprivation and other factors would inform decision making
  - Additional information was also sought on the structure and role of the IHAs within the HSE Health Regions and the impact on areas such as national services, regional services and clinical education, innovation and research.

- Population of proposed IHAs
  - Feedback was received on why census data alone, without growth projections or the use of population demographics, was used to determine IHA's and whether the health needs of a population was considered alongside the geography to better understand IHA alignment

- Presentation of IHA Options
  - Respondents highlighted that a number of services are not included on the maps including: Maternity Services, Mental Health Services, Section 38/39, CHI and Nursing Homes
  - A clear explanation of the logic/reasoning behind the final decision needs to presented

- Guiding Principles informing IHA Options
  - Social Inclusion and Primary Care should be included as part of the Secondary care interface

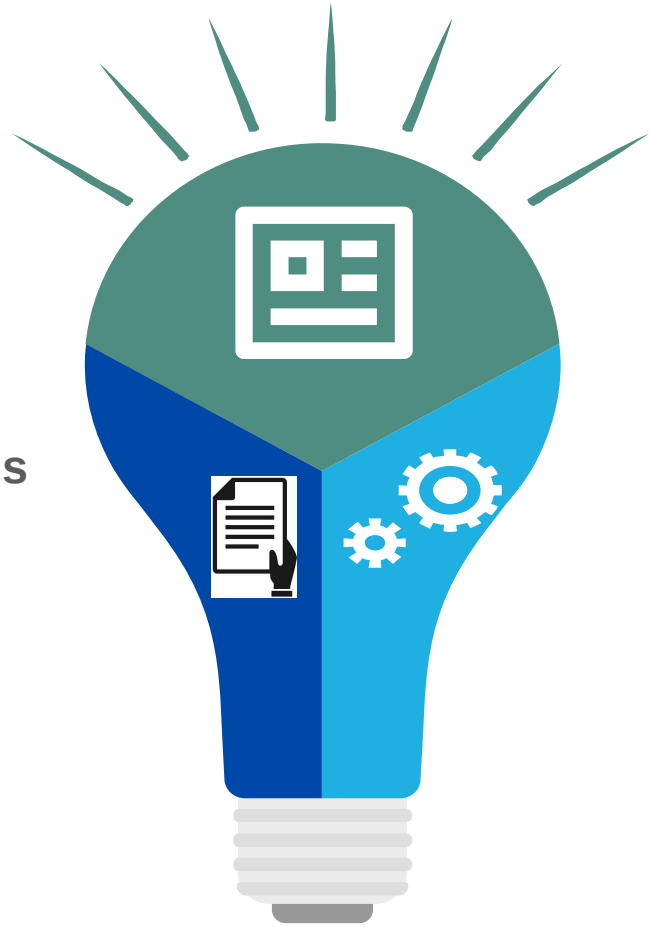
Patient and Service User Partnership Approach within Health Regions

Proposal Development - 3 main themes

based on the 3 Concept Propositions and 4 Submissions

Completed Co-Design Workshops - 3 x Concept Propositions

Received Patient Partner Submissions



Patient and Service User Representation

Patient and Service User Representation

Patient and Service User Council in each of the 6 Health Regions:

- Will have a mandate to assist the Regional Executive Officer (REO) and Executive Management Team (EMT) to deliver an improved service to patients and service users and to ensure their needs are met.
- These councils will be the primary mechanism for patients and service users and organisations to come together and discuss cross-organisational, strategic issues.
- Will have membership/roles on various different committees and working groups across all layers of the Health Region.
- Will have a clear mandate which is standardised nationally.
- Broad representation across geographic, ethnic, health, age, gender and sexuality
- Will actively recruit patient and service user partners with appropriate skills match with each of the respective committees to ensure a diverse and inclusive cohort of interested representatives.
- Will have a clear set of achievable outcomes which are measurable, collated and analysed nationally to ensure consistency.

Patient and Service User Representation

1. Supported by Health Region Patient and Service User Partnering Office
2. Each office will have a designated Patient and Service User Partnership Lead
3. Office should report directly to the Office of the REO with dotted line of governance to National PSUE Office (or delegated authority)
4. Regional Partnership Council Chairs will be linked with the National Patient and Service User Forum
5. Design at Regional level will need to be aligned to the National Patient Service User Partnership Strategy through a Regional Implementation Plan
6. Co-designed Regional Implementation Plan to be co-ordinated, implemented and monitored by the Patient and Service User Partnership Office within each Region

*National Patient and Service User Partnership Strategy

Regional Implementation Plan / Design

- **Timelines & measurable indicators**
- **Clear objectives & targets**
- **Adequately resourced for delivery of objectives**

**To note: National Patient Service User Partnership Strategy currently in development*

Improving the Patient Experience

Improving the Patient Experience

1. Communication
2. Culture
3. Access & Integration
4. Data & Information
5. Training, Education and Research

Communication

Establish focus groups
.

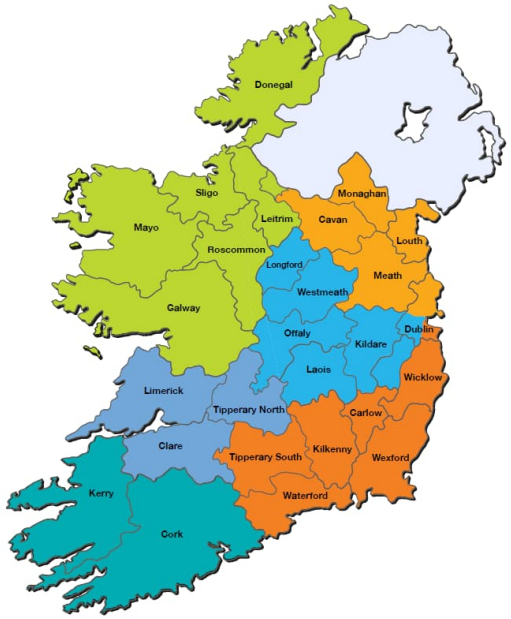
Assist with the implementation and follow up of surveys/schemes – The National Inpatient Experience Survey

Work with policy makers on the use of clear, plain language and accessible formats on any literature or communications

Work with Organisational Communications - improve communication so that it is more open, through user friendly systems

Create a 'deliberate dialogue' with members of the Health Region Executive Management Team (EMT) - build & maintain working relationships

National Patient and Service User Partnership Strategy – communicate & implement.



Culture

Patient and Service User Councils and Partnering Offices will be mandated to:

Support

Support the Health Regions to develop a patient and service user-friendly culture

Partner

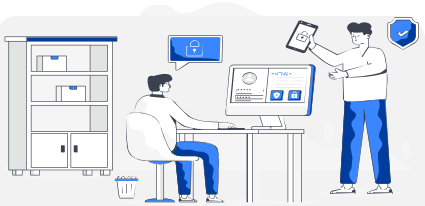
Work with the Health Regions Executive Teams on furthering **partnership** arrangements through training and education on patient and service user partnership

Be holistic

Work with the Health Region Executive Teams to develop a culture where the patient and service user is seen **holistically** and not just in the context of their condition/illness

Access & Integration

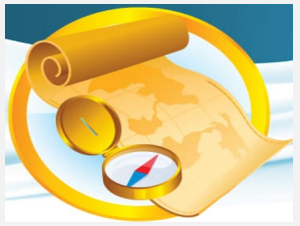
Patient and Service User Councils and Partnering Offices will be mandated to:



Support the Health Regions in the development of technical solutions to improve access and integration by providing the end users perspective on how the solutions would work best

Assist on integration projects as patient and service user partners providing guidance on the end users perspective

Support the Health Region to future proof the integrated structures and ways of working with longer term systems development. e.g. Electronic Health Record [EHR]).



Work with the Health Regions on the ongoing development of ‘maps and a compass’ for services

Data & Information

Patient and Service User Councils and Partnering Offices will be mandated to:

Be involved in the co-creation / development of data / information systems to improve access to information (where appropriate)

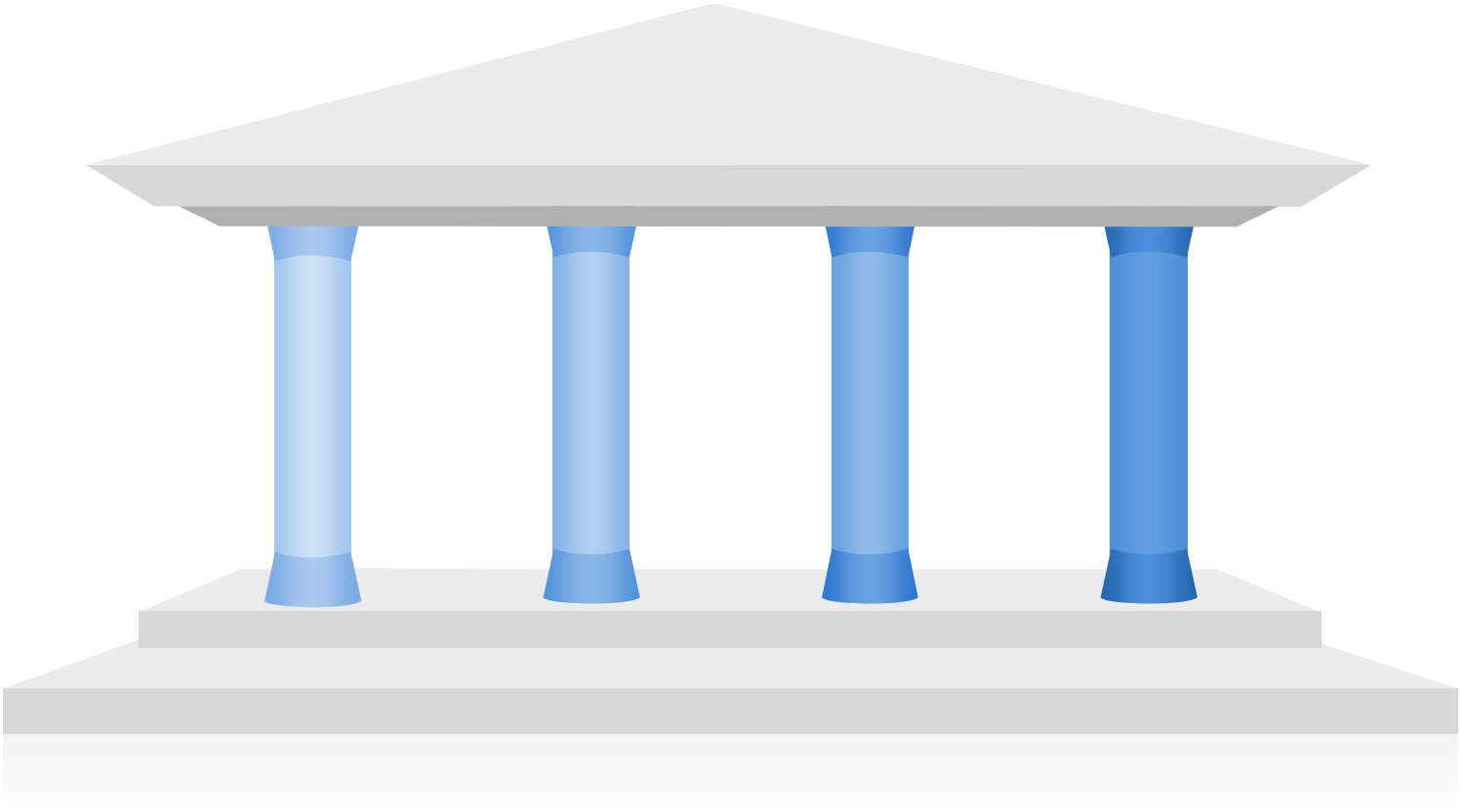
Training, Education and Research

Patient and Service User Councils and Partnering Offices will be mandated to:

Develop a training and education plan for patients and service users to educate them so that they have the skills, and also the knowledge of the organisation to facilitate optimal engagement at all levels.

Develop strong links with Academic Partners to build on patient and service user partner representation in areas such as research and evaluation.

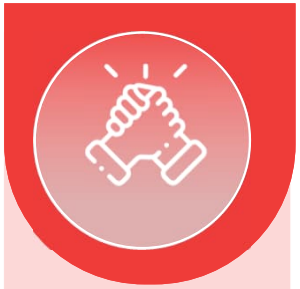
Improving Governance and Accountability



Governance

Standards & Measurement

Patient and Service User Councils and Partnering Offices will be mandated to:



Support the improvement of patient and service user experience within the Health Regions structure through the development of relevant metrics in the Accountability Framework

Hold twice yearly joint planning meetings between the Health Region EMT and the regional patient and service user council to consider progress on the Implementation Plan

Strengthen accountability within Health Regions through partnership and patient and service user feedback

Co-design of the development of Key Performance Indicators (KPIs) and national standards for patient partnership.

Support local audit to ensure that there is effective implementation & governance of relevant policy & guidelines to ensure consistency nationally & support learning & continuous improvement

Support the development of policy and performance.

Establish a Model of Improvement to implement outcomes from service initiatives e.g. focus groups

High-Level Implementation Timelines and Next Steps

- The Health Regions Programme is a multi-year journey
- It is expected that there will be multiple phases on this journey to full Health Region Implementation
- There is a transition process to be managed and supported
- The current high-level view of phases and expected timelines are included below

**Please note that the above is a high level timeline of implementation phases and does not reflect the full scope of programme activities e.g. engagement, design, which will continue in detail over coming months.*

Health Regions Programme – Risk Approach

- The Health Regions Risk Register is based on the Enterprise Risk Management (ERM) Policy as set out by the HSE (HSE 2023).
- Risk is measured in terms of two dimensions, likelihood and impact i.e., the likelihood (probability / frequency) of the risk occurring and the impact (consequence) of the risk should it occur.
- The scoring applied to the likelihood and the impact are based on a scale of 1-5.
- These scores are then multiplied by each other which gives the overall risk rating of between 1 and 25.

HSE Risk Scoring Matrix

LIKELIHOOD	1 Negligible	2 Minor	3 Moderate	4 Major	5 Extreme
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

IMPACT

HSE Risk Rating Matrix

LIKELIHOOD	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Low	Medium	High	High	High
Likely	Low	Medium	Medium	High	High
Possible	Low	Medium	Medium	Medium	High
Unlikely	Low	Low	Medium	Medium	Medium
Rare	Low	Low	Low	Low	Low

IMPACT

* High risks are scored between 15 and 25 and coloured Red; Medium risks are scored between 6 and 12 and coloured Amber; Low risks are scored between 1 and 5 and coloured Green.

Action / Deliverable RAG ratings

RAG	Criteria
Green	• Strong assurance that the targets will be fully achieved • All KPIs and Outputs/Deliverables are progressing according to planned trajectory • There are no issues or dependencies that are expected to impede delivery of targets
Amber	• Some concerns that the targets will not be substantially achieved • Some KPIs and Outputs/Deliverables are not progressing according to planned trajectory • There are particular issues or dependencies that may impact on the delivery of targets
Red	• Significant concerns that the targets will not be substantially achieved • A number of KPIs and Outputs/Deliverables are not progressing according to planned trajectory • There are issues or dependencies that will impact materially on the delivery of targets

Transition Tracking and Reporting Approach

The transition tracking and reporting approach will serve to monitor progress of transition to the new design across the Regions and Centre.

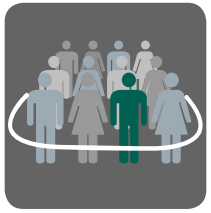
1. Key Groups Involved in Transition

Centre Function Representatives

Region Function Representatives OR Region representative for overall Region

Centre Function Representatives (e.g. HR, Finance, Technology, Estates etc)

Region Change / PMO Representatives



Programme Team

Manage transition

Provide support pre and during transition

Monitor and track transition

2. Reporting and Tracking

It is proposed that transition is tracked on a function-by-function basis, monthly, with a summary report being shared by Centre Function Reps and Region Function Reps with the Programme Team. The Programme Team will provide a template to Centre and Region reps to complete ahead of Transition launch.

Transition Plan Activity (1/3)

Area	Activity Type	Activity Description	Owner	Status
1. Transition Support	**Implementation Approach**	Develop the implementation approach to address: • Principles of implementation • Assumptions underpinning the implementation approach • The transition activities and responsible owners • Timelines for the first wave of transition in the Health Regions and Centre (Q1 2024) • Transition tracking and measurement approach	• Programme Team	• In Progress
	Transition Plan	Develop a transition plan containing: • Key steps to be taken under the 5 core activities • Timings for transition activities and steps • Transition activity owners	• Programme Team	• In Progress
	Transition tracking and monitoring	Ongoing tracking and monitoring of transition activity in the Health Regions and Centre	• Programme Team	• Not Started
2. Organisation Design	**Functional / Team Descriptions**	Functional descriptions for each function, including the key role of the function, what it is responsible for and what it is not responsible for, key interdependencies / hand-offs with other functions and key interfaces	• Programme Team	• In Progress
	Organisation Structures	• Define the CEO-1 and REO-1 layer for Centre and Health Regions, including the functions, head of function role titles, proposed grading of the layer • Develop the recommended organisation design for each function in the Centre and Health Region including the corresponding organisation charts	• Programme Team	• In Progress
	Role Descriptions	• Develop role descriptions for roles in the Health Region and HSE Centre to ensure clarity on roles, responsibilities and ways of working. In the first wave of transition, role descriptions will be provided for CEO-1 and REO-1 roles	• Programme Team	• In Progress

Transition Plan Activity (2/3)

Area	Activity Type	Activity Description	Owner	Status
3. People Transition Approach and Principles	**Transition Approach and Principles**	Define the People Transition Approach and Principles that will enable a smooth transition to the future state in the Health Regions and HSE Centre and ensure the success of the new organisation design. Manage ongoing consultation with the unions to agree the transition principles and approach	• National HR	• TBC
	Guidance for REOs and Centre National Directors	Develop and share guidance material for senior leaders to understand the principles and approach for people transition in their respective areas. Provide points of contact for the Regions and Centre, should queries arise in the transition of staff to new roles/team/functions	• National HR	• TBC

4. Role Fulfilment and Resourcing	**Resource assessment and fulfilment plan**	• Conduct an assessment (starting at the EMT level/ most senior levels in the organisation) to:
		  • New roles that need to be filled in the future design (Region and Centre)
		  • Roles that no longer exist in the future design and where there are instances of displaced staff (Region and Centre)
		• Develop a resourcing plan for new or open roles in the Health Region and HSE Centre
		• Manage the reallocation of resources in line with HR policy, including any recruitment required to fulfil the future state design (during the first wave in Q1 2024, it is expected that this will be for senior level and priority roles only in the Health Regions and Centre)
			• National HR	• TBC

	REO Onboarding	• Manage the onboarding of new REO's, linking in with the Office of the CEO and the Programme Team to gather relevant information and inputs to support the new role-holders.	• National HR	• TBC

Transition Plan Activity (3/3)

Area	Activity Type	Activity Description	Owner	Status
5. Change Management and Comms	**Change Impact Analysis**	Conduct an impact analysis to understand: • The high-level impact of the new design on structure/functions, services, people, process, technology and governance, including where work is moving from one function to another and requires handover • The most impacted areas of the organisation that need to be assessed for business readiness • The key stakeholders to engage with based on the nature/ extent of change impact	• Programme Team and Centre and Region reps	• Not Started
	Comms and Engagement	• Develop a communication and engagement plan for the transition period (starting with first wave, Q1 2024) – informed by the outputs of the change impact analysis • Develop the Case for Change including benefits, positive outputs and key changes for staff and stakeholders. Key messages to be incorporated into stakeholder communications.	• Programme Team	• In Progress (tbc)
6. Business Readiness	**Business Readiness Checklist**	Develop the business readiness checklist for the first wave of transition in the Centre and Regions (Q1 2024). Agree checklist with the relevant functions i.e. Finance, HR, Estates, Technology etc.	• Programme Team	• In Progress
	Business Readiness Review	Using the outputs of the change impact analysis, conduct a business readiness assessment for the most impacted functions and teams. In Q1 2024 this will be focused on senior level roles (CEO-1 and REO-1): • Review existing work to identify in-progress work / inflight projects and initiatives • Understand who is responsible for each work activity in the new function • Review progress completion and status for each work item • Determine whether each work item should be handed over or completed in advance of the agreed transition date • If being handed over, identify owner and prepare relevant handover materials	• Programme Team and Centre and Region reps	• Not Started
	Transition and Handover	• Hold handover meetings with the new owner to ensure knowledge transfer • Compete transfer plan and confirm completion with the Centre/Region rep	• Programme Team	