

Future Health

A Strategic Framework for Reform of the Health Service 2012 – 2015

Department of Health

November 2012

NOVEMBER 2012
DEPARTMENT OF HEALTH

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Executive Summary

1. INTRODUCTION

The Programme for Government promises the most fundamental reform of our health services in the history of the State. ***Future Health – A Strategic Framework for Reform of the Health Service 2012 – 2015*** details the actions that we will take to deliver on this promise.

The need for change in the health service is unquestionable. The current system is unfair to patients; it often fails to meet their needs fast enough; and it does not deliver value for money. The system is facing major challenges including significantly reducing budgets; long waiting lists; capacity deficits; an ageing population; and a significant growth in the incidence of chronic illness. It is simply not possible to address these challenges within the confines of the existing health system. *We must implement large-scale change that delivers fundamental reform.*

The core of the Government's health reform programme is a single-tier health service, supported by Universal Health Insurance (UHI), that is designed in accordance with the principles of social solidarity. This will mean that:

- the population will have equal access to healthcare based on need, not income;
- everyone will be insured for a standard package of curative health services;
- there will be no distinction between "public" and "private" patients;
- we will introduce universal primary care, with GP care free at the point of use for all;
- universal hospital care will include independent, not-for-profit trusts and private hospitals;
- social care services will be outside of the UHI system but integrated around the user;
- the health system will be based on a multi-payer insurer model, with competing insurers; and
- the service will remain, fundamentally, publicly provided.

Future Health sets out the building blocks that are required prior to the introduction of UHI. It maps out the key actions, with timelines, that are required to achieve the Government's objectives. A full list of the actions is set out at Appendix 1.

2. HOW WE WILL DELIVER THE REFORM PROGRAMME

While the reforms envisaged are comprehensive and transformative, we must maintain access and quality during the reform process. For this reason, ***Future Health*** proposes that change will be implemented in a step by step manner, on the basis of good evidence. Further detailed actions will be built on the foundations of this strategic framework as the reform process proceeds. A White Paper on Universal Health Insurance, to be published in 2013, will provide the basis for many of these actions.

Robust governance and management arrangements will be crucial to drive, manage and monitor implementation of the reform programme due to its complexity. To this end, we will establish a Programme Management Office (PMO), in the Department to act as a central, overarching, co-ordination function for health reform. The PMO will be responsible for: ensuring that all of the various work strands pull together to achieve the overall reform objectives; taking a strategic view on

the timetabling and sequencing of the work strands; and communication, monitoring and control activities for the programme. We will work closely with all of the main stakeholders in the health system to ensure successful, collaborative implementation.

3. WHAT THE REFORMS WILL MEAN FOR THE POPULATION

Bringing about the change planned for the system will not be easy. However, the reform programme will result in real change that will be experienced on the ground by everyone. Examples of the tangible changes that patients and clients will experience include:

- (i) Improved health and wellbeing:** The reforms will help people to protect and improve their health; manage their illness; and help to identify illness at an earlier stage.
- (ii) Faster, fairer access to hospital care:** Waiting times for patients accessing both scheduled (inpatient, outpatient, diagnostics) and unscheduled (Emergency Department) care, including the number of people on trolleys will be significantly reduced.
- (iii) Free access to GP care:** The population will have access to free GP Care, on a phased basis. This will be a key part of the overall reform of the way healthcare services are delivered in the community.
- (iv) Better management of chronic illness:** Patients with chronic diseases will have access to chronic disease management programmes. Roll-out of the programmes will begin with diabetes care ahead of the roll-out of programmes for cardiac, respiratory and neurological conditions between 2013 and 2015.
- (v) More people cared for in their homes:** The reforms in social care will help older people and people with disabilities to live in their homes for as long as possible rather than go into residential care.
- (vi) Improved quality and safety:** The reforms will increase the quality of care for patients, where quality is understood not only with respect to patient outcomes but also to the cost of achieving those outcomes.
- (vii) Affordability:** Under UHI, people will be insured for a comprehensive package of curative services. The cost of insurance payments will be related to ability to pay, with the State subsidising or paying insurance premia for those who qualify for a subsidy.

4. FOUR PILLARS OF REFORM

Future Health is built on four key inter-dependent pillars of reform.

(i) Health and Wellbeing: There will be a new focus on the need to move away from simply treating ill people, to a new concentration on keeping people healthy. The health and wellbeing pillar recognises the need for a whole-of-government approach to addressing health issues and commits to the development of a comprehensive health and wellbeing policy framework and the establishment of a Health and Wellbeing Agency.

(ii) Service Reform: The service reform pillar will move us away from the current hospital-centric model of care towards a new model of integrated care which treats patients at the lowest level of complexity that is safe, timely, efficient, and as close to home as possible. This will help to reduce costs, improve access and move from the existing emphasis on episodic reactive care towards preventative, planned and well co-ordinated care. This is particularly important for the growing numbers of people with chronic conditions and those with two or more diseases and disorders. **Future Health** commits to publishing proposals for reform of the payment and service delivery systems that will support real integrated care for patients.

(iii) Structural Reform: We recognise that structural reform of the health service will be key to addressing the problems with our current health system, and will also be critical in the journey to UHI. We acknowledge that getting the structures right will be a complex task and, as such, we intend to evaluate each phase of the transition carefully as we progress towards UHI. For this reason, we do not attempt to give a detailed description now of how the later phases will operate. Instead the focus is on the key elements that need to change. Among our key concerns are to promote good governance, avoid duplication and ensure a strong regional focus in managing performance and delivering value for money.

The first phase of the process will deliver a greater degree of accountability for the HSE to the Minister. It includes abolition of the Board of the HSE, establishment of a Directorate and a new management structure in the HSE. Hospital groups will be established on an administrative basis, with Group Chief Executives having budgetary and staff responsibility for both the HSE and voluntary hospitals in their group. Smaller hospitals will be developed in tandem with the establishment of hospital groups. There will be a review of Integrated Service Areas which will (i) ensure maximum alignment between all service providers at the local level; (ii) review executive management and governance arrangements; and (iii) inform new structures for the delivery of primary care. This phase will also see the establishment of the new Child and Family Support Agency. The legal status of the HSE will not change during phase 1 and HSE employees will remain employees of the Executive.

The second phase will involve the development of a formal purchaser/provider split and, effectively, the dissolution of the HSE. The third phase, to be implemented as we move to UHI, will move us from a tax-funded system to a combination of UHI and tax funding. **Future Health** sketches out the main elements of the second and third phases and notes that there will be a high level of collaboration with stakeholders on the detailed design of the new structures.

(iv) Financial Reform: The financial challenges facing the health system are immense. Demand is increasing on an annual basis while the amount of funding available to provide services has decreased significantly and will continue to reduce in the years ahead. The financial reforms envisaged under *Future Health* are designed to ensure that the financing system is based on incentives that are aligned to fairness and efficiency, while reducing costs, improving control and also improving quality.

Measures aimed at addressing financial control issues to be implemented under the reform programme include the return of the Vote to the Department of Health from the HSE; the introduction of programme based budgeting; implementation of the recommendations set out in the Reviews of Financial Management Systems in the Irish Health Service; and the development and roll-out of a comprehensive financial management system as a matter of priority.

A new Money Follows the Patient (MFTP) funding model will be introduced in order to create incentives that encourage treatment at the lowest level of complexity that is safe, timely, efficient, and is delivered as close to home as possible. This shift will be used as an opportunity to use money as a lever to achieve quality and safety objectives rather than simply being a means of paying for activity. Ultimately, the MFTP system will be designed so that money can follow the patient out of the hospital setting to primary care and related services. This, along with other initiatives such as the introduction of integrated payment systems, will help to support integration between primary, community and hospital care.

Important reforms of the private health insurance market are also planned, including a new permanent scheme of risk equalisation from 1 January next, an emphasis on cost control and an examination of the options in relation to the future status of the VHI.

In the context of UHI, the Programme for Government envisages a statutory system of health insurance, guaranteed by the State, in which the system would not be subject to European or national competition law. *Future Health* recognises that the legal and practical requirements to achieve this are likely to be very complex, and are being explored at present. Any decision on the exact way forward will take full account of the Government's previous commitment to address an important European Court of Justice judgement in relation to the regulatory status of the VHI by the end of 2013.

5. REFORM OF THE DELIVERY SYSTEM

Future Health identifies reform initiatives across the delivery system aimed at improving the quality of, and access to services.

(i) Primary Care: Our vision for primary care is one where: no one must pay fees for GP care; GPs work in teams with other primary care professionals; the focus is on the prevention of illness and structured care for people with chronic conditions; primary care teams work from dedicated facilities; and staffing and resourcing of primary care is allocated rationally to meet regularly assessed needs.

Primary care teams will provide the foundation medical and non-medical care that people need, whether it is for health or social needs. Patients will be referred from primary care only when their needs for care are sufficiently complex; otherwise they will be managed through primary care. Registration with a primary care team will be compulsory once the Universal Primary Care system is fully implemented. We will retain the community ethos of primary care, in which the patient's needs are the first concern.

(ii) Hospitals: *Future Health* identifies three main areas of reform for the hospital system. We will deliver more responsive and equitable access to scheduled and unscheduled care for all patients through continued implementation of the Special Delivery Unit's initiatives in this area. Public hospitals will be reorganised into more efficient and accountable hospital groups that will harness the benefits of increased independence and a greater control at local level. The introduction of hospital groups and the development of smaller hospitals are interrelated. A Framework for the Development of Smaller Hospitals will be published shortly which will ensure that smaller hospitals will play a vital role in service delivery.

(iii) Social and Continuing Care: *Future Health* commits to the development of a social and continuing care system that maximises independence and achieves value for the resources invested. The measures include a reform of the Fair Deal scheme to allow many more people to continue living at home as they would wish. Consideration will also be given to the extension of the Fair Deal model to the disability and mental health sectors. Disability services will be reformed in line with the findings of the recent Value for Money and Policy Review of Disability Services. *Future Health* also reaffirms our support for the move from the traditional institutional based model of mental health care, towards a patient-centred, flexible community based service. Other important measures identified include the introduction of: a standardised framework to commission services from both public and non-public providers; individualised budgeting to bring about a closer alignment between funding and the outcomes of individuals; and a robust regulatory regime to ensure quality and safety.

6. CONCLUSIONS

The actions in *Future Health* are time-bound and specific. They comprise the major building blocks for the transition to a reformed health system based on UHI. They represent an ambitious and challenging agenda of change, and will require the support of all to achieve real reform.

SECTION A: THE CASE FOR REFORM

Chapter 1: Introduction to *Future Health*

1.1 INTRODUCTION

The Government is committed to putting in place a single tier health service, supported by universal health insurance, which will ensure equal access to care based on need, not income. *Future Health*, details a set of time-bound actions that will be taken in support of this objective. It sets out the major healthcare reforms that will be introduced by 2015, prior to the launch of Universal Health Insurance (UHI) in 2016. The reforms will help to deliver on the overall objective of the health service, which is to improve the health and wellbeing of the people of Ireland by:

- keeping people healthy;
- providing the healthcare people need;
- delivering high quality services; and
- getting best value from health system resources.

The design of the future single-tier system will be guided by the following core principles:

- **Keeping People Healthy** – The system should promote health and wellbeing by working across sectors to create the conditions which support good health, on equal terms, for the entire population.
- **Equity** – The system should provide financial protection against catastrophic out of pocket expenditure through universal coverage of the entire population. A system of compulsory universal health insurance should ensure universal access to healthcare for all citizens based on need rather than ability to pay.
- **Quality** – The system should support the best health outcomes for citizens within available resources.
- **Empowerment** – The system should empower and support citizens, patients and healthcare workers to make evidence-informed decisions through appropriate sharing of knowledge and information.
- **Patient-centredness** – The system should be responsive to patient needs, providing timely, proactive, continuous care which takes account, where possible, of the individual's needs and preferences.
- **Efficiency and Effectiveness** – Incentives should be aligned throughout the health system to support the efficient use of resources and the elimination of waste and drive continuous performance improvement and co-ordination across different providers.
- **Regulation and Patient Safety** – Regulatory, governance and payment structures should support the provision of safe, high quality, integrated care based on national standards and protocols, and delivered in the most appropriate setting.

1.2 THE NEED FOR REFORM

Our health system is facing huge challenges. We need to implement reform now, so as to ensure sustainability and deliver a service that meets the people's needs. The main challenges are set out below.

1.2.1 NEAR TERM CHALLENGES

- **Significantly reducing budgets:** The health system has had to find savings of €2.5 billion over the last three years. Savings totalling €750m are required in 2012 and further savings will be required in the years ahead.
- **Long waiting lists and inequitable access to care:** Waiting times for some services, though improving, remain unacceptable.
- **Lack of integration:** We need much better integrated delivery systems based on multi-disciplinary care. This will reduce costs and improve quality.
- **Capacity deficits:** There are significant capability deficits across the health system, particularly in clinical systems management, IT and financial control.
- **Quality based reporting:** We must significantly improve our national systems for measuring, reporting and demanding accountability for quality, patient safety and patient experience.
- **Prioritisation and planning:** We will always have to make difficult choices in health care. However, we lack sufficient systems to prioritise and plan. We need to develop these systems, based on needs assessment, evidence, technology assessment and performance monitoring.
- **People:** We must foster and develop sufficient clinical and managerial leadership and capability commensurate with the requirements of a modern health care system.

1.2.2 LONG TERM CHALLENGES

Over the longer term the health service will also have to respond to very significant increases in demand driven by:

- **An ageing and changing population:** Each year the total number of people over the age of 65 grows by around 20,000. The number of over-65s will increase by about 54% between 2011 and 2025, while the number of over-85s will double during the same time period. In addition, mortality is falling, birth rates have risen and inward migration has increased, all leading to growth in the total population.
- **Changing dependence:** We face an increase in the proportion of the population who are dependent. This is due to ageing, the impact of chronic illness, the increase in the prevalence of disability and the fall in the numbers of people in work.
- **Significant growth in the incidence of chronic illnesses:** Chronic diseases in Ireland are associated with 86% of mortality and 77% of the overall disease burden. Patients with chronic diseases presently utilise around 70% of health resources. Due to our ageing population and lifestyle factors, chronic conditions will generally increase by around 40% between 2007 and 2020. This trend presents huge challenges for both costs and capacity.
- **New technologies are allowing clinicians to do more:** New technology has enabled us to treat more types of illness. Many of these treatments are life-saving, life-enhancing and cost-effective but we will only be able to adopt them as soon as they are demonstrably safe if we refuse to accept inefficient, sub-optimal care in any part of the health system.
- **Patient empowerment and consumerism:** As patients become more informed and empowered, their expectations rise. This is a welcome development as it helps people to take more control over, and responsibility for, their health. However, our ability to provide the

access and choice people want, to the quality of service they expect, at a price that they are prepared to pay is a growing challenge.

1.2.3 IMPLICATIONS FOR THE SYSTEM

Individually any one of these challenges would constitute a serious problem for the health system. Collectively they raise profound questions about its long-term sustainability in the absence of real change.

The scale of the challenges now facing the health service, as evident from the above, means that taking a “business as usual” approach is simply not possible. Reform, as a result, is no longer optional – it is essential.

1.3 OUR APPROACH TO REFORM

The Strategic Framework envisages transformative change for the health system. It will involve a comprehensive reshaping of our health landscape affecting all levels and all elements of the health system. It includes restructuring of service delivery and organisational, financial, governance and accountability processes and systems across the primary, community and hospital sectors. This programme of health reform will be led by innovation; comprehensive rather than fragmented; and most importantly – patient focused instead of system focused.

While the reform of individual elements of the service will be informed by the experience of other countries and best practice, the system as a whole will be uniquely Irish. Our goal is not simply to copy other health systems but instead to learn from what works best elsewhere. This will help us to design a truly Irish model of healthcare which meets the needs and requirements of the Irish people.

The Strategic Framework has been designed to do three things:

- Set out the strategic policy direction for health reform up to 2015;
- Deliver real tangible improvement in the quality of patient care well ahead of the introduction of UHI;
- Prepare the ground for the introduction of UHI by radically reforming the way in which the current health system is organised, financed and delivered.

1.4 THE FOUR PILLARS OF REFORM

The Strategic Framework is built on the four key inter-dependent pillars of reform (described in greater detail in Chapters 4-7) as follows:

1.4.1 HEALTH & WELLBEING

Health is more than merely the absence of disease; it is physical, mental, and social well-being. Most common chronic diseases, disabilities and injuries can be prevented. Investments in prevention complement and support treatment and care. Prevention policies and programmes can be cost-effective, can reduce health care costs, and can improve the health of the population. Health is also a key factor in productivity, economic development and growth. The role of the

health service must be seen as keeping people healthy as opposed to just treating sick people. This underlying principle informs many of the reforms throughout this document.

1.4.2 SERVICE REFORM

The current hospital-centric model of care cannot deliver the quality of care required at a price which the country can afford. It is time to ground the system in a robust model of primary and preventative care. Primary care is an essential pre-requisite to developing a new integrated model of care that treats patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible (see Chapters 5 and 8-10).

1.4.3 STRUCTURAL REFORM

We will replace the current over-centralised model of healthcare with a new system of earned autonomy. Under the new model, healthcare professionals will be given much greater leadership roles and providers will secure ever more operational freedom – provided that they in turn deliver on the budgetary, patient quality and access outcomes required. This more devolved system will necessitate a significant structural re-organisation of both the HSE and the Department of Health. Important changes will also be made to the structure of the insurance market ahead of UHI (see Chapters 6 and 7).

The success of all of these reforms will depend on significant improvements in information and in the IT infrastructure to support the integrated and effective utilisation of that information. Improved leadership and increased flexibility from staff across the health system will also be key to successfully reforming the system. A rigorous performance management system will be rolled out across the health system (see Chapter 11).

1.4.4 FINANCIAL REFORM

One of the most challenging aspects of the reform process will be to reduce costs while also increasing quality and delivering a fairer system. In order to do this we need a new financial model to incentivise better outcomes for less money. The current system of fixed annual budgets does not encourage clinical and managerial leaders to value prevention and early intervention, to adopt more efficient working practices or to consider outcomes as the key issue for patients. Under Money Follows the Patient, providers will be paid for the needs they address, the quantity and quality of the services they provide and the outcomes they deliver. They will be liberated, subject to overall budgetary ceilings, to pursue the most cost-effective means of achieving this standard of performance (see Chapter 7).

1.5 KEY FEATURES OF THE FUTURE HEALTH SYSTEM

The Programme for Government provides that the UHI system will be designed according to the principles of social solidarity. This means delivering equal access to healthcare based on need, not income. It will be achieved through the introduction of a single-tier health service supported by UHI.

Under UHI, everyone will be insured for a standard package of primary and acute hospital services, including acute mental health services. While insurance will be mandatory, people will have their

choice of health insurer including a 'public' option and the cost of insurance payments will be related to ability to pay. In line with the Programme for Government, other social solidarity measures enshrined within the universal health insurance system will include risk equalisation, open enrolment, lifetime cover and the right to switch insurers periodically.

An integrated system of primary and hospital care will be key features under the new system. The first point of contact for a person needing healthcare will be primary care which should meet 90-95% of people's health needs. Primary care will be available on a universal basis with GP care free at the point of use for the whole population. Where a person needs hospital care, it will be provided by independent hospitals/ 'not for profit' hospital trusts. An integrated payment system will allow incentives to be effectively aligned across different providers and will encourage collaboration in the provision of quality, continuous care across settings.

While primary and hospital care will be funded mainly via the UHI system, specialised and social care services, including long term care, will be funded by general taxation. While funded separately, these services will still be delivered in an integrated manner around the needs of the person.

In implementing UHI, we recognise that there are many important building blocks to be put in place. We need to implement change step by step, on the basis of good evidence, so that an equitable, effective system can be achieved. The Programme for Government acknowledges that the full implementation of UHI covering both acute hospitals and primary care, will take some years to achieve, with a target date of 2016.

Finally, the future UHI landscape will include a number of important regulators and national statutory bodies including the Health Information and Quality Authority. These bodies will regulate the quality of all health and social care services and will ensure that providers exercise good governance, thereby ensuring their long-term viability and availability for the communities they serve. The health insurance market will also be subject to regulation. An Insurance Fund, within a new agency, will have an important role, directly financing and centrally controlling some healthcare costs and also managing the payment of insurance premia and risk equalisation payments.

An Implementation Group on Universal Health Insurance has been established to support the Government in developing detailed plans for the introduction of UHI. As part of this, the Group will assist the Department in drafting a White Paper on UHI for publication in 2013.

It is important to emphasise that the reforms in the organisation of the health service will not change the fundamental nature of the Irish health service as a publicly-provided service, supported by appropriate private sector provision.

<p>Action 1: The Department of Health will publish a White Paper on Universal Health Insurance in 2013. A preliminary document will be produced by end 2012.</p>

1.6 WHAT REFORM WILL MEAN FOR THE POPULATION

Future Health represents the most comprehensive reform of Irish healthcare since the establishment of the State. It seeks genuine change which puts the needs of the patient first. It has been specifically designed to develop a patient-centred system which will deliver improved patient outcomes and improved population health, not just on managing inputs. Examples of the tangible changes that patients will experience include:

(i) Improved health and wellbeing. The reforms will: (i) help people to protect and improve their health; (ii) manage their illness; and (iii) enable identification of illness at an earlier stage.

(ii) Faster more equitable access to hospital care: Waiting times for patients accessing both scheduled (inpatient, outpatient, diagnostics) and unscheduled (Emergency Departments) care, including the number of people on trolleys will be significantly reduced.

(iii) Free access to GP care: The population will have access to free GP Care, on a phased basis. This will be a key part of the Government's overall reform of the way healthcare services are delivered in the community.

(iv) Better management of chronic illness: Patients with chronic diseases will have access to chronic disease management programmes. Roll-out of the programmes will begin with diabetes care ahead of the roll-out of programmes for cardiac, respiratory and neurological conditions between 2013 and 2015. While these will be separate care pathways in specialist settings, it is recognised that a disease management approach would fragment primary care. Therefore, developments in primary care will ensure that the critical chronic disease requirements (in terms of promotion, prevention, early detection, patient education and empowerment, registration and recall and quality assurance) are all progressed in a holistic and patient centred manner that recognises the difference between managing patients and people and managing diseases.

(v) More people cared for in their homes: The reforms in social care will help older people and people with disabilities to live in their homes for as long as possible rather than go into long term residential care.

(vi) Improved quality and safety: The reforms will increase the quality of care for patients, where quality is understood not only with respect to patient outcomes but also to the cost of achieving those outcomes.

(vii) Affordability: Under UHI, people will be insured for a comprehensive package of curative services. The cost of insurance payments will be related to ability to pay, with the State subsidising or paying insurance premia for those who qualify for a subsidy.

1.7 STRUCTURE OF THIS DOCUMENT

Future Health is structured in three main parts:

- The *case for reform*, how it will be delivered and proposals for improving patient safety and quality are set out in Section A.

- The *four pillars* on which reform will be built are described in Section B.
- Detail of how the *delivery system* will be reformed is provided in Section C.
- A full set of actions is set out at Appendix 1.

Chapter 2: Delivering the Reform Programme: Governance, Management and Collaboration

2.1 A STRUCTURED, STAGED APPROACH TO IMPLEMENTATION

We recognise that wholesale change cannot be undertaken all at once and that it is vital to ensure continuity of a safe service while we reform. The reforms need to be implemented as quickly as possible, but in a considered, staged manner. This will allow for the system to learn from the reform process as the various elements are implemented.

This “reform – learn – reform” approach will allow us to make changes to the proposed approach while simultaneously making progress towards the final structures and delivering tangible improvements as we go. While this approach protects patients and helps us learn from experience, it also by definition means that there is greater clarity on the structures envisaged in the early stages of the reform process as opposed to the latter stages. We will review progress at key stages to allow any necessary adjustments to be made as required.

2.2 GOVERNANCE AND MANAGEMENT ARRANGEMENTS

Robust governance and management arrangements will be established to drive, manage and monitor implementation of the reform programme.

The reform planned for the health service is not a single piece of work. Instead it is a series or “programme” of related projects which when delivered, will result in the achievement of the overarching objectives. The utilisation of a programme management approach will be a key driver in the successful implementation of the reform programme while simultaneously assisting in the protection of existing services during the transformation process.

Appropriate governance will be assured through the development of an effective programme governance structure. This structure will clearly define roles; set out the accountabilities and responsibilities for each of the roles; and develop effective management and reporting arrangements. The structure will be designed to help lead and drive the programme without stifling innovation at the individual project level. The governance arrangements will involve a Sponsoring Group/Programme Board (including a Senior Responsible Owner); a Programme Management Office in the Department of Health; a Programme Manager; Business Change Managers; and Project Managers.

Action 2: The Department of Health will establish a robust governance structure to oversee the health reform programme by Q1 2013.

We need a central, overarching, co-ordination function to drive the health reform process. With this in mind, an appropriately resourced Programme Management Office (PMO) will be established

within the Department of Health. The PMO will ensure that a structured, service-wide approach is taken to implementation, with all of the various work strands pulling together to achieve the overall reform objectives. The PMO will also be responsible for taking a strategic view on the timetabling and sequencing of the various work strands since they are highly inter-connected. In addition, it will be responsible for communication, monitoring and control activities for the programme, with individual policy units and project teams retaining responsibility for implementation of projects under their remit.

Action 3: The Department of Health will establish an appropriately resourced Programme Management Office in Q1 2013 to drive, co-ordinate and monitor the reform process.

2.3 RISK MANAGEMENT

Any reform process of the scale envisaged for the health system brings with it risks of many types. For this reason, an effective risk management process will be established which will anticipate, quantify, mitigate and manage risks as effectively as possible.

2.4 ENGAGING THE STAKEHOLDERS

We fully recognise that the successful implementation of the reform programme will require the active support and cooperation of all of the main stakeholders in the health system. These include patients and clients; advocacy groups; health and social care professionals; health system managers; others working in the system; professional bodies and staff associations; the Oireachtas; the wider political system; Government Departments; relevant statutory bodies; colleges and institutes; and EU and international bodies. We are committed to working in a collaborative way and will engage in active consultation with stakeholders in relation to implementation of the reform programme. This process will help to build relationships, establish confidence and trust in the programme, foster innovation and remove barriers to delivering best outcomes for patients.

Action 4: The Department of Health will develop a proactive Consultation, Collaboration and Communication Plan for the reform programme by Q4 2012.

Chapter 3: Patient Safety and Quality

3.1 INTRODUCTION

There have been considerable improvements in the safety and quality of services in recent years and the Government is committed to building on this progress through further improvements that form part of its reform programme. A key priority will be to ensure that the systems and structures required to promote and guarantee patient safety remain in place throughout the implementation of the reform process.

3.2 PATIENT SAFETY AGENCY

The establishment of a new Patient Safety Agency (PSA) to build on the existing functions of the Quality and Safety Directorate in the HSE will represent a major step in improving safety and quality. The PSA will be modelled on international examples such as the Canadian Patient Safety Institute which aims to improve the safety of patient care through learning, sharing, and supporting implementation of interventions that are known to reduce avoidable harm on the basis of partnership, working with service providers and education bodies. The PSA will be established on an administrative basis. Its initial focus will be on leadership and capacity building for patient safety, clinical effectiveness, adverse event learning and clinical audit. We will ensure that the health services are funded and governed in a manner which gives a mandate to the work of the PSA, including in the legal mandates which will underpin new provider and funding authorities.

The optimum statutory framework for the PSA will be identified and developed in light of evidence and experience over time. At this point, it is anticipated that the functions of the PSA will include:

- Patient advocacy services including the Health Service Charter “You and Your Health Service” and the web-based information service – www.healthcomplaints.ie.
- Development and implementation of national quality and patient safety initiatives.
- Compilation, interpretation and dissemination of learning from adverse events reported via the Clinical Indemnity Scheme.
- Developing leadership capacity in healthcare.
- Patient safety training and education programmes.
- Responsibility for the National Clinical Effectiveness Committee.
- Oversight of the National Office of Clinical Audit.
- Working with independent healthcare providers in relation to patient safety and quality issues.
- Maintaining a knowledge base and building capacity for patient safety and quality across the health system.

The health and social service regulatory and monitoring function will be maintained separately from the PSA and enhanced within the Health Information and Quality Authority (HIQA). HIQA will continue to set and monitor standards. In time, consideration will be given to merging the appropriate regulatory functions of the Mental Health Commission (MHC) with HIQA to form a single regulating body. Consideration will also be given to transferring other functions of the MHC to the PSA.

Action 5: The Department of Health will establish a new Patient Safety Agency on an administrative basis in 2013.

3.3 LICENSING AND ACCREDITATION OF HEALTH CARE

‘Standards for Safer Better Health Care’, which provide a national framework for good governance, patient safety and quality of care, were formally launched in June 2012. These national standards apply to all healthcare services (excluding mental health) provided or funded by the HSE. These will lead on to the development of a licensing system to be operated by HIQA which will commence on 1 January 2015 and will focus on all hospitals and providers of specialised ambulatory services such as cosmetic surgery.

Action 6: The Department of Health will develop a licensing system initially focussed on hospitals and specialist service providers to commence in Q1 2015.

Consideration will be given to the introduction of a system of primary care accreditation. Such a system of accreditation will drive improvements in quality as well as facilitating integration between services within primary care and between primary care and secondary care.

3.4 ENHANCING PROFESSIONAL REGULATION

We will continue to strengthen the systems of professional regulation that are in place as well as rolling professional regulation out to an increasing number of health professionals on a phased basis. The form of professional regulation being legislated for puts protection of the public at the heart of process by promoting high standards of professional conduct and professional education, training and competence among registrants. We will also continue to support the regulators’ forum and will protect the sharing of information between regulators on patient safety through the Health Information Bill. The development of better analysis by regulators of throughput of complaints and the outcome of cases heard under Fitness to Practice will also be supported. This analysis will enable learning that can inform the practice of professionals, which in turn will strengthen protection of the public.

3.5 ENABLING QUALITY AND SAFETY THROUGH INDEMNITY

The State underwrites indemnity for all public services and the professionals who provide them. In effect, this means that the State carries the risk of services which may not be safe or which do not align with national policy goals. This system of enterprise liability is managed through the Clinical Indemnity Scheme. The Department will work with the HSE and the State Claims Agency (which operates the Clinical Indemnity Scheme) to ensure that the indemnity provided to services aligns with health systems policy. For example, if it is deemed appropriate that all specialised surgery for a given cancer be provided in identified centres, then indemnity will not be provided for that service to be provided in other locations. Seen in this way, indemnity can help to drive change rapidly in clinical behaviour.

Action 7: The Department of Health will work with the HSE and the State Claims Agency to develop a risk based approach to provision of indemnity to services and professionals by end 2013.

3.6 CLINICAL EFFECTIVENESS

There has been considerable debate recently about the ability of the health service to meet the cost of new and expensive medicines, technologies and services as they become available. At the same time, questions have rightly been raised about the quality, safety and value for money of existing prescribing practices.

There is substantial international evidence demonstrating the scope for improving the quality and safety of prescribing and dispensing practice and behaviours. Improvements in this area would also help control costs and promote value for money for the very substantial existing expenditure on medications.

This is an international issue. Most other healthcare systems have clear and explicit systems to make decisions in a transparent, equitable way regarding the availability of technologies and services, including new medicines. We must also deal with the need to provide for drugs to manage rare diseases which will never meet thresholds of cost effectiveness. In order to address this, a National Task Force will take an intelligence led approach (using Primary Care Reimbursement Service/Drug Payment Scheme data) to improve the quality and safety of prescribing. It will work with professional groups to ensure sustainability and, in time, will broaden its remit to include other services.

Action 8: The Department of Health will establish a National Task Force on Prescribing and Dispensing Practice by end Q4 2012.

SECTION B: THE FOUR PILLARS OF REFORM

Chapter 4: Health and Wellbeing

4.1 INTRODUCTION

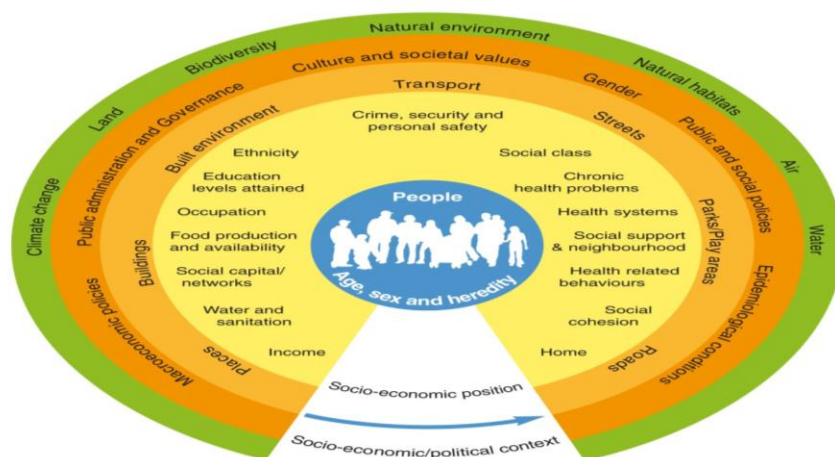
The core purpose of the health system is to help improve the overall health and wellbeing of the Irish people. To achieve this we need to combine an effective public health system that is focused on the determinants of health and wellbeing across the life course at the national level, with strong and consistent implementation and delivery at the local level. The Government's reform programme provides us with a unique opportunity to ensure that promotion, prevention and protection become integral parts of a whole-of-Government approach to improve population health, the delivery of health services and the treatment and management of all patients. It also allows an opportunity to overcome any perception that health and wellbeing is solely the preserve of the health service.

4.2 NEED FOR A GREATER FOCUS ON HEALTH AND WELLBEING

The challenges to creating a truly healthy population are both many and complex. Figure 1 illustrates the multi-dimensional nature of the factors that influence individual and population health. National and international research confirms that while capacity and efficiency of the health system are important determinants of health, many of the strongest predictors of health and wellbeing fall outside the healthcare setting, e.g., housing, transportation, education and the built environment. It is also clear that an individual's socio-economic status has a direct impact on health status. The only way to tackle this complexity is through a whole-of-Government and whole-of-society approach to wellbeing and health.

Figure 1: Factors which determine Health and Wellbeing

(Adapted from Dalghron and Whitehead (1991) and Grant and Barton (2000))



4.3 HEALTH AND WELLBEING FRAMEWORK: A WHOLE OF GOVERNMENT APPROACH

Overall, health reform must lead to a healthy Ireland where health and wellbeing is valued by all individuals at every level of society, is embraced by every sector and is everyone's responsibility. It is only in this manner that we can expect to reduce the upward pressure on money, resources, staffing, medications and services that is arising as a result of the ageing of our population. To implement these reforms we will specify structural, process, people and strategic changes required to enable successful delivery of measurable targets and agree mechanisms to monitor productivity resulting from change.

Our reforms will set ambitious but important goals for improved health and wellbeing. These are to:

- Increase the proportion of Irish people who are healthy at all stages of life;
- Enable every sector of society to play its part in improving health;
- Empower people and communities to work together to improve, and take responsibility for increasing health and wellbeing;
- Reduce health inequalities; and
- Protect the public from threats to public health.

We will develop a Health and Wellbeing Framework to assist in the achievement of our goals for improved health and wellbeing. The Framework will provide a structured mechanism to mandate other sectors to support the health system in dealing collectively with the challenges in a holistic and fundamental way to improve the health and quality of life for individuals, families and communities. It will assist policy makers to integrate considerations of health, wellbeing and equity in the development, implementation and evaluation of policies and services. In this way, the Framework envisages actions and outcomes beyond the boundaries of the health sector. The Framework will also propose a shift towards more horizontal and inclusive approaches to governance for health and wellbeing which is mandated and has strong leadership at highest government level and in the health system and, involving all society and its sectors, including the people themselves.

Action 9: The Department of Health will produce a comprehensive Health and Wellbeing Policy Framework by end 2012.

The Department has established a Health and Wellbeing Programme in the Department of Health which will coordinate implementation of the Health and Wellbeing Framework and drive the cross-sectoral approach. The Programme will ensure that appropriate governance structures are in place to support a reform process which aims to improve efficiency in the use of resources; eliminate duplication and waste; and set indicators, monitoring and reporting schedules to drive performance and coordination of actions in the new HSE Health and Wellbeing Directorate.

A separate stand-alone Health and Wellbeing Agency will be established from January 2015. It will continue and build on the work with other relevant sectors to produce inter-sectoral plans to address risk factors and social determinants of health. The Agency will move forward integrated initiatives to promote for example, healthier diet and physical activity. It will build on the

Substance Misuse Strategy to reduce the level of alcohol use and misuse across the population. It will also implement tobacco policy with a view to making Ireland a tobacco free society.

Action 10: The Department of Health will establish a Health and Wellbeing Agency in Q1 2015.

4.4 SCREENING PROGRAMMES

We are committed to delivering on the Programme for Government commitment to extend the BreastCheck service to include 65-69 year old women. It is also intended to introduce a national colorectal screening programme for 60-69 year old men and women, with the first round to be completed by 2015.

Action 11: The Department of Health will work with the HSE to ensure that the age range extension of BreastCheck to 65-69 year old women will commence in 2014.

Action 12: The Department of Health will work with the HSE to ensure that the national colorectal screening programme will have completed the first round of screening for 60-69 year old men and women by end 2015.

4.5 ACCESS TO DIAGNOSTICS

Improved access to diagnostics is another priority for the Government. The initial focus is on improving access to GI (Gastrointestinal) endoscopy services and challenging targets have been set for both routine and urgent endoscopy procedures. A multi-disciplinary and multi-agency approach will be crucial to delivery of these targets. In that context the Special Delivery Unit (SDU) has commenced an Endoscopy Performance Improvement Programme that will support the development and implementation of standardised referral pathways, develop sustainable capacity, ensure a quality assured endoscopy service in Ireland, optimise access and achieve waiting time targets.

Action 13: The Department of Health will work with the HSE to ensure the delivery of the targets for routine and urgent endoscopy procedures by end Q4 2012.

Chapter 5: Service Reform: A New Integrated Model of Care

5.1 INTRODUCTION

The current hospital-centric model of care cannot deliver the quality of care required by our people at a price which the country can afford. For this reason the Government is determined to create a new integrated model of care that treats patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible. The aim of increasing integration is consistent with initiatives in other countries that seek to shift the emphasis from episodic reactive care to care based on needs which is evaluated as to its impact on outcomes.

5.2 WHAT IS INTEGRATED CARE?

It is clear from international literature as well as from policy discussion in Ireland that integrated care means different things to different people. Integrated care can be defined as care that improves the quality and outcome of care for patients and their immediate families and carers by ensuring that needs are measured and understood and that services are well co-ordinated around these assessed needs. It is preventative, enabling, anticipatory, planned, well-coordinated and evaluated. It is a system of care that critically looks at the impact on health and wellbeing of the patients concerned.

Understanding integrated care means looking at processes and outcomes of care rather than at structural and organisation issues. Achieving integrated care means that services must be planned and delivered with the patient's needs and wishes as the organising principle. It is preferable that the term integrated care rather than "integration" be used so that it is clear that the focus is where it should be i.e. on patients and families and the services they need rather than on funding systems, organisation or professionals. Each of these will be important levers in enabling and facilitating integrated care – but they in themselves are not the objectives.

International research on integrated care shows three things very clearly:

- (i) It can make a real difference to the quality of care received by patients: The danger of a fragmented delivery system is that individuals' needs will not be fully met, substantially reducing patient outcomes.
- (ii) It is very difficult to turn the concept of integrated care into a cost effective operational reality. One of the main challenges is to target the right individuals and conditions. For instance, it is clear that case management must be a crucial part of integrated care. However, because case management is a labour intensive activity it is unlikely to be cost effective unless it is targeted effectively.
- (iii) There are many ways to implement integrated care: Crucially organisational integration is not necessarily required. The key requirement is clinical and service level integration, supported by an appropriate incentives system.

5.3 ENABLING INTEGRATED CARE

The Kings Fund and the Nuffield Trust¹ identified ten key elements to enabling integrated care as follows:

- (i) Provide a compelling and supporting narrative for integrated care;
- (ii) Allow innovations in integrated care to embed;
- (iii) Align financial incentives by allowing commissioners flexibility in the use of tariffs and other contract currencies;
- (iv) Support commissioners in the development of new types of contracts with providers;
- (v) Allow providers to take on financial risks and innovate;
- (vi) Develop system governance and accountability arrangements that support integrated care, based on a single outcomes framework;
- (vii) Ensure clarity on the interpretation of competition and integration rules;
- (viii) Set out a more nuanced interpretation of patient choice;
- (ix) Support programmes for leadership and organisational development;
- (x) Evaluate the impact of integrated care.

We can translate its final conclusions to an Irish context as follows:

- (i) Government policy should be founded on a clear, ambitious and measurable goal to improve the experience of patients and service users and to be delivered by a defined date.
- (ii) Setting an ambitious goal to improve patient experience should be reinforced by enhanced guarantees to patients with complex needs. These guarantees would include an entitlement to an agreed care plan, a named case manager responsible for co-ordinating care, and access to telehealth and telecare and a personal health budget where appropriate.
- (iii) Change must be implemented at scale and pace. This will require work across large populations at a city and county-wide level. There should be flexibility to take forward different approaches in different areas and to evaluate the impact, with the emphasis being on people with complex needs.

5.4 A NEW MODEL OF INTEGRATED CARE FOR IRELAND

Integrated service delivery is required in order to respond to the challenges of growing numbers of people with chronic conditions and the increasing prevalence of co-morbidity in the population (i.e. patients with two or more diseases or disorders).

We want to build service delivery around the full cycle of care for the major condition/diseases which a patient may have, i.e., from prevention to self-care to primary care to acute care. The current fragmented system means, for instance, that the care of individuals with diabetes or at

¹ Report to the UK Department of Health and the NHS Future Forum entitled “*Integrated care for patients and populations: Improving outcomes by working together*”

major risk of diabetes is sub-optimal. Resources tend to be concentrated on providing acute care when diabetes becomes a major problem. Not enough is done to prevent the condition in the first place, or to manage it effectively in its early stages through greater self-care and enhanced primary care. This resource misalignment has two major consequences: much poorer health outcomes for individuals and significantly higher costs for the system as a whole.

As set out in later chapters, we will publish proposals for reforming the payment and service delivery systems so that they support real integrated care for the patient. As part of this work we will look at:

- How the payment system can be built around: (i) disease prevention; and (ii) greater use of integrated payments to allow standard episodes of care to be purchased, delivered and billed as a single service across a variety of different providers; and
- How health providers can move towards the creation of integrated multi-disciplinary teams, composed of clinicians and other healthcare professionals from both the hospital and primary care sectors, who would be charged with delivering these episodes of care most effectively and efficiently.

5.5 TARGETING OF RESOURCES

In order to maximise our health system's ability to deliver a truly integrated care system, it is vital to measure the distribution of healthcare needs throughout the population. Resources will need to be targeted on the basis of formal needs assessment at the population level to ensure the greatest possible impact in terms of health outcomes for a given level of resources. Integrated care will require the development of capacity in primary care, specialised community services and in social care. It implies, especially in a resource constrained system, a clear transfer of capacity to non-institutional care and the necessary and consequent downsizing of activity undertaken in acute hospitals and other institutions.

5.6 DETAIL ON SERVICE REFORMS

Detailed actions relating to primary care, acute hospitals and social and continuing care are outlined in chapters 8-10.

Chapter 6: Structural Reform

6.1 INTRODUCTION

In order to achieve the overarching objectives of the reform programme, we need real changes in the structures of the health system. A phased transition is required for this structural change. This chapter sets out the main structural reforms that are envisaged over the coming years. Structural reform in this context refers to the governance, organisational and service delivery arrangements of the health service. National governance and organisational reforms are identified in this chapter and the detail of service delivery reform is set out in Chapters 8-11.

6.2 PRINCIPLES OF THE PROPOSED STRUCTURAL REFORM

The structural reforms to be implemented in the coming years are informed by a number of key principles:

- (i) Structural reform is not an end in itself. Instead it is a key enabler that will facilitate the achievement of the Government's vision for the health service.
- (ii) Appropriate governance arrangements will be in place at all times during the reform process.
- (iii) Structural reforms will not lead to duplication or the creation of unnecessary management tiers or numbers. However, development of management capacity will be crucial.
- (iv) The clear focus of the reforms will be on the development and improvement of frontline services.
- (v) The regions will remain important throughout the reform process and beyond. While the role of the regional offices will transform through the process, the Government sees strong regions playing a major role in performance management/improvement.
- (vi) There will be a high level of collaboration and consultation with stakeholders including other Government Departments, the delivery system and staff associations on the design and implementation of the health structures.

6.3 TRANSITION PHASE ONE

The first phase of the transition process for health structures will introduce a greater degree of accountability for the HSE to the Minister and Department, as committed to in the Programme for Government. It will also drive clarity in relation to the funding and staffing associated with the various care group areas as well as bringing a focus on service management during the transition process.

Delivery of the first phase of the transition process for health structures has already commenced through publication of the Health Service Executive (Governance) Bill 2012 in July 2012. The Bill provides for the abolition of the Board of the HSE under the Health Act 2004 and the putting in place of a new governance structure. The Board will be replaced by a Directorate, headed by a Director General, with strengthened accountability arrangements for the HSE. It is important to note that the legal status of the HSE under the Health Act 2004 does not change under the Bill, and that HSE employees will remain employees of the Executive.

Under the Bill, the Directorate will consist of a Director General and other appointed directors. The appointed directors will be drawn from amongst HSE senior managers at National Director level. To offer flexibility and allow the size of the governing structure to adapt to changing circumstances, the Bill does not specify a fixed number of members for the Directorate but instead provides for a maximum of seven and a minimum of three members, including the Director General who is automatically a member – and Chairperson – of the Directorate. The Directorate will be accountable to the Minister for the performance of the HSE’s functions as well as its own. As Chairperson, the Director General will account to the Minister on behalf of the Directorate in regard to how the HSE’s functions are performed. He will do this through the Secretary General of the Department of Health.

In anticipation of the legislative changes, the Minister intends that the HSE will recruit and appoint National Directors for Health & Wellbeing, Hospitals, Primary Care, Mental Health and Social Care to manage the services.

The roles of the new National Directors will be different to that held by National Directors in the old management system. The newly appointed heads in these portfolios will be responsible at national level for the delivery of services in the relevant service domain. They will also lead the development of national service strategies associated with their areas. They will monitor performance of their sectors on behalf of the Director General, escalating any issues of persistent poor performance as they arise. They will also be required to work to develop the strategic commissioning frameworks for their areas in accordance with overall policy on financial reform. Under the new management structure, the Regional Directors’ role will, over time, change from a direct operations management function to a control and performance management function for finance, access and quality.

The new governance and management structures will allow for re-organisation of services to prepare the way for the wider introduction of Money Follows the Patient and the ultimate introduction of Universal Health Insurance. In each case, the directorate management team will have a clear budget or ‘Fund’ and a mandate to deliver sustained performance improvement. This will involve supporting the development of strengthened frontline provider structures, while simultaneously establishing enhanced accountability arrangements via new performance contracts. This will be underpinned by a transparent Money Follows the Patient payment system, where appropriate.

As evident from Figure 2, the new structure will see hospital groups reporting to the National Director for Hospitals and the Integrated Service Areas reporting to the National Directors for Primary Care, Mental Health and Social Care as appropriate. It is intended that the new hospital groups will be established on an administrative basis from Q1 2013 (more detail on this can be found in Chapter 9). Progress will also be made in relation to reforming the way services are provided in the areas of primary, social and mental health care (as outlined in chapters 8 and 10).

We acknowledge the need for a joint approach to service delivery, and the alignment of boundaries, between Health Services and Local Government and other sectors. In order to deliver this, we will conduct a review of the number of Integrated Service Areas which will (i) ensure

maximum alignment between all service providers at local level, (ii) review executive management and governance arrangements and (iii) inform new structures for the delivery of primary care.

We will ensure that the creation of new administrative structures does not result in duplication of administrative functions across care groups or increases in administrative costs overall. In this regard, and in the context of future changes to meet Government objectives on health reform, adherence to the Government's Public Service Reform objectives regarding the use of shared services, particularly in relation to procurement, payroll, ICT and financial management will also be a requirement for the newly created structures. In order to progress this, we will conduct a review in 2013 of corporate functions and resources (staff and budget) of the various corporate/support/shared services as they presently exist within the HSE to decide how these functions and resources might best be distributed in the future between the Department, a shared service function, the delivery units (e.g. hospital groups) or otherwise.

This phase will also see the establishment of the new Child and Family Support Agency under the Department of Children and Youth Affairs. Once robust provider structures and accountability arrangements have been established, the system will be ready for the next phase of structural reform.

Action 14: The Department of Health will make recommendations by Q4 2012 on (i) the composition of hospital groups; (ii) the criteria for the formation of hospital groups and (iii) the first wave of new hospital groups to be established immediately thereafter.

Action 15: The Department of Health in conjunction with the HSE will conduct a review of Integrated Service Areas in Q2 2013.

Action 16: The Department of Health will work with the HSE to develop Sectoral Plans for Shared Services and External Service Delivery by Q4 2012.

Action 17: The Department of Health in conjunction with the HSE will conduct a review in 2013 of corporate functions and resources (staff and budget) of the various corporate/support/shared services as they currently exist within the HSE and make recommendations for the future.

6.4 TRANSITION PHASE TWO

The next phase will involve the creation of a formal purchaser/provider split within the health sector though the system will remain entirely tax funded during this phase. The directorate management teams involved in performance contracting and financing of services will be subsumed into a new commissioning body the *Healthcare Commissioning Agency* in 2014, where they will be charged with continuing to drive performance improvement through value-based purchasing. At this point, the HSE will effectively be dissolved. There will be consultation with staff interests on all relevant issues which may arise in this context.

The Healthcare Commissioning Agency will encompass the funds previously managed by the HSE directorates. It will be subject to the instructions of the Department of Health and will transform

national policy priorities and service targets set out by the Minister for Health into detailed performance contracts with healthcare providers. It will then manage all payments to providers. Performance contracts will explicitly link payment with the achievement of targets across the spectrum of quality, access and activity.

In the case of health and wellbeing, a national agency will be established to promote health and wellbeing, drive preventative care and also drive a wider cross-governmental, cross-sectoral focus on health in all policies.

At the provider level, hospitals will evolve from groups to trusts, as a new legal entity. The new structures for primary care referred to above will be responsible for the provision of primary, community mental health and community care services as well as the management of the non-acute contracts for the provision of services.

6.5 TRANSITION PHASE THREE

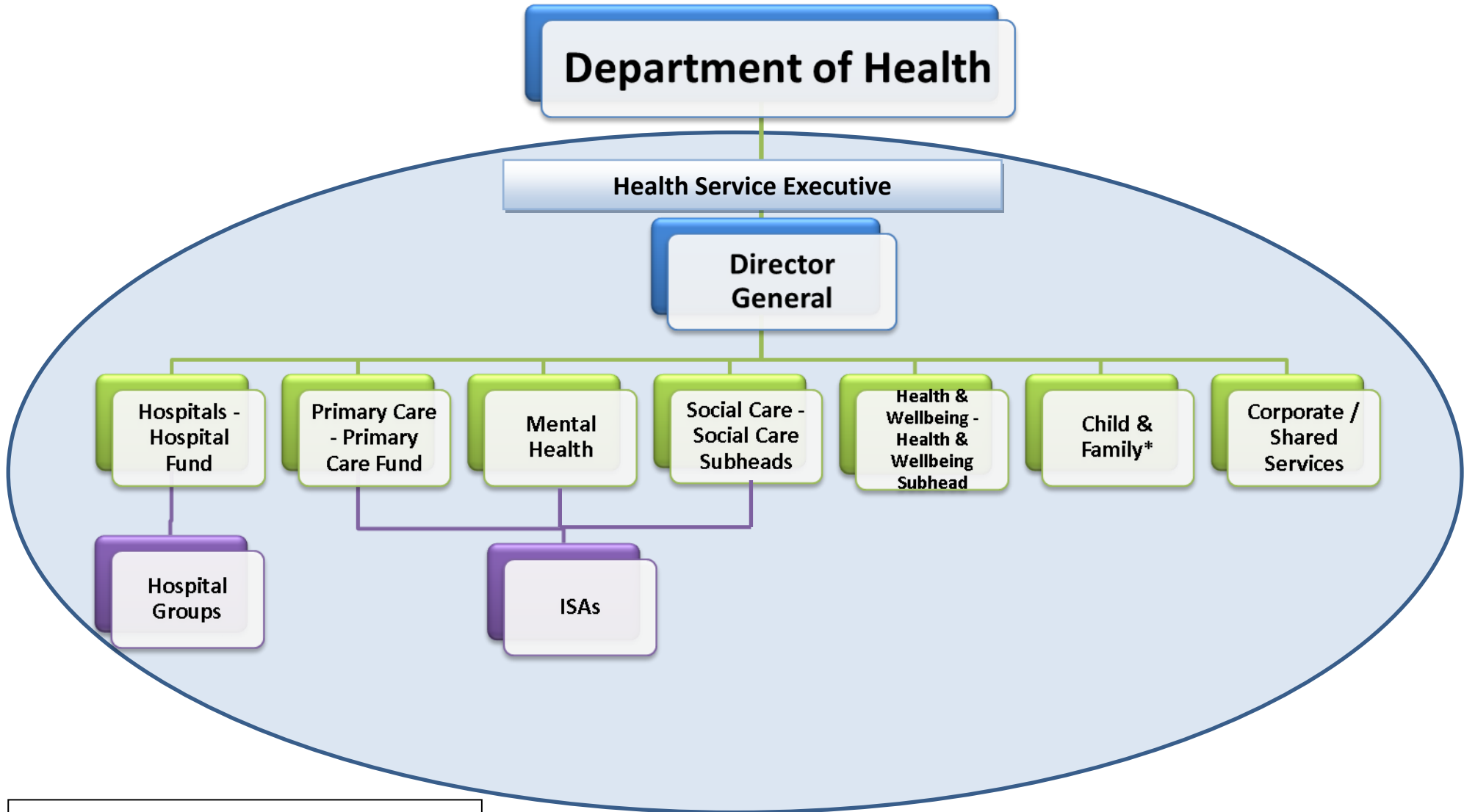
The final phase of structural reform will see the move to a combination of universal health insurance funding for acute hospital and certain primary care services, with general taxation funding for other services including the social care services such as disability and long-term care. The Healthcare Commissioning Agency established in phase two will divest some of its purchasing functions to health insurers under UHI, but will still play a central role within the health system. Within the Agency, the transitional primary and hospital care funds will transform into a health insurance fund. The Healthcare Commissioning Agency will also continue to finance certain health and social care costs directly via the other funds. As such, it will retain a central strategic role in terms of managing the flow of funds between different arms of the health system and in working with health insurers to support the delivery of high quality, integrated care.

6.6 GETTING OUR STRUCTURES RIGHT

As noted earlier, it is vital to develop the right organisational structures for our health services so that we can deliver a high quality, responsive and cost effective service to our people. Getting these structures right is a complex exercise, and we will evaluate each phase of the transition carefully as we move towards UHI. For this reason, we do not attempt to give a detailed description at this stage of how the later phases will operate. Instead we focus on the key elements that need to change, with a particular emphasis on:

- Clear accountability;
- The move to a purchaser/provider split;
- The use of performance contracts to link payments with the achievement of targets; and
- The transformation (in phase 3) from a general taxation to a combination of universal health insurance and general tax funding of health care. This will apply from 2016 and beyond.

Figure 2: Phase 1



*Note: It is intended that the Child and Family Support Agency will be established in January, 2013.

Chapter 7: Financial Reform

7.1 INTRODUCTION

The financial challenge facing the health system can be described very simply – demand is increasing even as resources are declining. Between 2009 and 2011 €2.5bn was taken out of the system, mainly by reducing costs and achieving greater efficiencies. Savings totalling €750m are required in 2012 and further savings will be required in 2013 and beyond. These reductions are required to meet the targets for health set out in the Comprehensive Review of Expenditure 2012 – 2014 as well as meeting unavoidable pressures, increases in demand due to demographic pressures and commitments in the Programme for Government.

The traditional solution to this problem has been to cut services, leading to increased waiting lists, reduced quality and significantly increased financial risk. The new approach is different. We want to reshape and redesign services and their delivery, rather than just enact a series of “cuts”. Collectively, the reforms set out in **Future Health** will ensure that the financing system is based on incentives that are aligned with the dual objectives of fairness and efficiency while also reducing costs and improving quality. Each of these reforms are also important stepping stones towards the introduction of UHI.

7.2 KEY FINANCIAL CHALLENGES

The financial challenges facing the system go beyond the limited amount of funding available. Other challenges to be addressed are outlined below.

7.2.1 DESIGN OF THE RESOURCE ALLOCATION SYSTEM

The current resource allocation system does not incorporate appropriate incentives to achieve desired actions/behaviour. For instance, annual global budgets are primarily determined on the basis of historic block grant allocations and provide little incentive for good financial management and performance or obvious penalty for poor financial performance (see 7.3.3 below).

7.2.2 ABSENCE OF AN INTEGRATED FINANCIAL MANAGEMENT SYSTEM

The financial and service information systems of the health service are not fit for purpose. The Department of Health and the HSE spend public funds on the formulation of health policy and the provision of health and personal social services. All expenditure incurred by these entities must meet stringent criteria in terms of accountability and transparency to fulfil their duties as public bodies. Maintaining an effective system of internal control involves significant challenges, particularly in the HSE where financial and service information systems are multiple and fragmented. Financial processing is not fully automated and significant manual intervention is still required to facilitate the preparation of monthly management accounts, the Financial Statements and the Appropriation Account.

7.2.3 FINANCIAL CONTROL

The absence of a standard financial system makes comprehensive reporting sub-optimal. This makes financial control and financial monitoring difficult at all levels. The financial monitoring system is more focused towards expenditure control in the hospital sector and less so in the other sectors. There can be delays and gaps in the information available concerning budgets and profiles, which does not optimise financial monitoring and control.

7.2.4 MEDICAL INFLATION

The cost of providing health services has increased considerably in recent years, with increases in medical inflation running above the general inflation rates in all but one of the last ten years. Consumer Price Index (CPI) data indicates that the overall increase in health inflation during the last decade was 63.7% compared with an increase of 24.7% in the “all items” index.

7.3 ADDRESSING CONTROL ISSUES AND ESTABLISHMENT OF AN INTEGRATED FINANCIAL MANAGEMENT SYSTEM

The Department will take immediate action to strengthen financial control including the measures as outlined below.

7.3.1 THE VOTE WILL RETURN TO THE DEPARTMENT OF HEALTH FROM THE HSE

As part of the reconfiguration of the health services, the Vote of the HSE will be disestablished and funding for the services will be provided through the Vote of the Office of the Minister for Health with effect from January 2014. From the beginning of 2013, preparatory work for the return of the Vote will be carried out, including significantly strengthening the financial control and planning capabilities of the Department for this purpose. The Department of Health will road-test and apply risk management techniques to ensure statutory obligations under the Vote are met by 1 January, 2014. The necessary legislative and administrative measures required to implement this reform will be implemented in 2013. Transferring the Vote will allow for greater accountability to the Minister for Health through the Department of Health and allow the Department to exercise much greater control of expenditure and resource allocation in the health system.

Action 18: Funding for the health service will be provided through the Vote of the Office of the Minister for Health from Q1 2014. The Department of Health will work closely with the HSE and the Department of Public Expenditure and Reform on the detailed arrangements that are required to bring about this change.

7.3.2 PROGRAMME BASED BUDGETING

The Department of Public Expenditure and Reform has embarked on a transformation of the presentation of the Estimates as part of reforms to strengthen performance budgeting. In line with the requirements, it is endeavouring to restructure Votes along Programme lines. The objective is to align the Estimates with inputs and outputs. A working group was established in 2012 to examine the issues regarding the allocation of funding according to care group. As a first step,

programme based reporting will be introduced in the Health Vote within the limitations of the existing financial systems.

Action 19: The Department of Health will work with the HSE and the Department of Public Expenditure and Reform to develop Programme Based Budgeting in 2013 within the confines of the existing financial systems.

7.3.3 REVIEW OF FINANCIAL MANAGEMENT SYSTEMS

In June/July 2012, a Review of Financial Management Systems (FMS) in the health service was undertaken by a project team led by an international expert. The overall intention of the project was to review the present state of the financial management system in place in the health sector in the context of the serious overruns projected to occur in 2012, the continuation of a challenging financial environment for the foreseeable future, and the radical reforms envisaged in the Programme for Government.

The FMS Review was completed in July 2012 and numerous recommendations were made across a number of areas including financial management capacity, the process of managing surpluses and deficits, accountability arrangements, the role of the regions and risk management.

A wide ranging review of financial management and cost containment systems in the health service has commenced since the FMS review was completed. This second review, which is due to be finalised during Q4 2012, will include the preparation of an action plan for the implementation of the FMS review. It will also include an analysis of existing cost containment plans, an assessment of various options for achieving cash savings and recommendations for strengthening the financial management infrastructure within the Irish health service.

Action 20: The Department of Health and the HSE will oversee implementation of the recommendations contained in the 2012 Reviews of Financial Management Systems in the Irish Health Service from Q4 2012.

Closer monitoring of expenditure on health services will be crucial to the success of the reform programme and the better allocation of resources. Therefore, it is essential that a single enterprise-wide financial management system is developed and implemented as a matter of urgency. This will form part of the broader changes to IT and information systems as outlined in Chapter 11.

Action 21: The Department of Health will work with the HSE to ensure the development and roll-out of a comprehensive financial management system as a matter of priority.

7.4 TRANSFORMING OUR FUNDING SYSTEM TO CREATE APPROPRIATE INCENTIVES AND SUPPORT BEST PRACTICE

Successful transformation of our services requires a corresponding transformation of our funding model. Payment mechanisms must be designed so that they create the correct incentives and encourage treatment at the lowest level of complexity that is safe, timely and efficient and as close to home as possible.

The first stage in transforming our funding model is to clarify funding streams through the creation of directorates and corresponding programme based budgets. This, in turn, will support the further development of MFTP funding initiatives.

It should be noted that, in the case of primary and social care, the principles of MFTP are already embedded in the General Medical Services schemes and the Fair Deal scheme and this approach will be further developed with the roll out of free GP care and individualised budgets.

In the case of hospitals, each Hospital Group will have a clearly defined budget which must be earned through a new MFTP system. It is imperative that the shift in funding fully seizes the opportunity to use money as a lever to achieve quality and safety objectives rather than simply being a means of paying for activity. MFTP will, therefore, be a quality based rather than simply an activity based system of funding. Hospitals will be paid for episodes of care, with caps set on spending to ensure that budgetary discipline is maintained and with requirements to deliver on national safety and quality targets.

Hospitals will be paid on a fair and transparent basis for the care they deliver and will be encouraged to provide quality services more efficiently. An initial pilot project on orthopaedic services has already demonstrated some of these benefits. Early results suggested that the pilot encouraged many hospitals to focus on both a reduction in length of stay rates and an increased day of surgery admission rate in an effort to increase efficiency in the hospital.

In addition to the pilot project, a number of other key building blocks for MFTP are currently being put in place. These include electronic claims management systems and a patient level costing study which traces resources actually used by patients from point of admission to point of discharge. The Minister intends to publish plans for the implementation of MFTP later this year which will form the basis of intensive engagement with stakeholders. The aim is to commence implementation of the scheme in shadow form in 2013.

Action 22: The Department of Health will develop time-bound plans for the implementation of Money Follows the Patient by end 2012.

Of course, a real benefit of MFTP is the fact that the payment system will be designed to ensure that money can follow the patient *out* of hospital settings altogether and towards the provision of safe, timely care in primary care and related services. As such, the funding system should support

the critical work of the clinical programmes and the wider objective of an integrated model of care which treats patients at the lowest level of complexity.

We will also undertake work aimed at developing incentives to support models of care that increase substantially the level of integration between primary, community and hospital care. In this context we will develop policy in relation to the introduction of integrated payment systems that will allow episodes of care to be purchased, delivered and billed as a single service across a variety of different providers.

7.5 TACKLING COSTS

The Comprehensive Review of Expenditure, published by the Department of Health in 2011 identified various initiatives aimed at driving efficiencies and cost-reductions while protecting services to the greatest extent possible. The savings measures cut across all programme areas including pharmaceutical expenditure; pay costs; demand led schemes; child welfare and protection; and increased income generation and collection (particularly for private activity in public hospitals). The document also focuses on change management measures such as changes in the way services (both back-office and front line) are organised and delivered.

The Minister is also determined to address high costs in the private health insurance market. We need action on costs to protect consumers now, and to help us prepare for the move to UHI. The Minister established a Consultative Forum on Health Insurance to help identify means of addressing costs throughout the industry, while always respecting the requirements of competition law. The Forum comprises representatives of the commercial health insurers, the Health Insurance Authority and the Department. The Forum is used to exchange information, generate ideas and to help the industry to prepare for the introduction of UHI.

As the largest provider of health insurance in Ireland, the Minister has instructed the VHI to address cost issues urgently. The VHI has commissioned a detailed external review of its claims costs which is aimed at harnessing all possible opportunities for savings. It will also explore the scope for a system of utilisation management. The main elements of the project will be completed shortly, and implementation of the results will commence immediately.

Action 23: The Department of Health will pursue cost control in the private health insurance market in particular through the Consultative Forum on Health Insurance and through the external review in 2012 of the VHI's claims costs. Implementation of these initiatives will continue through 2013 and beyond.

7.6 REFORM OF THE HEALTH INSURANCE MARKET

We recognise that the short term problems of the current private health insurance market must be addressed in tandem with planning for the introduction of UHI in the future. The current health insurance market has resulted in insurers having a considerable financial incentive to cover younger, better risks rather than older, poorer risks as well as seeing the cost of private health insurance continue to increase. The Government's clear objective is for the health insurance

market to remain as competitive and affordable as possible, as we move towards a new system of UHI. In this regard, the key deliverables are to (i) fulfil the Programme for Government commitment to introduce a system of risk equalisation for the current insurance market; (ii) examine options in relation to the future status of the VHI; and (iii) ensure that the private health insurance market is regulated appropriately in the context of a future move towards UHI. The key reform initiatives currently underway are set out in the sections below.

7.6.1 PERMANENT SCHEME OF RISK EQUALISATION

The Programme for Government contains a commitment to put a permanent scheme of risk equalisation in place, which will support the principle of community rating. This is a key requirement for the existing PHI market and also in the context of plans to introduce UHI. Legislation will be enacted in Autumn 2012 to implement a new Risk Equalisation Scheme (RES) with effect from 1 January 2013. It will replace the present Interim Scheme and will allow for an increased number of risk factors, including a measure of health status. The RES will be operated by the Health Insurance Authority (HIA).

Action 24: The Department of Health will introduce a permanent scheme of risk equalisation to support the principle of community rating from Q1 2013.

7.6.2 REGULATORY STATUS OF THE VHI

In September 2011, the European Court of Justice (ECJ) ruled that the VHI can no longer enjoy a derogation from the requirement to be authorised by the Central Bank. The Government is committed to addressing the findings of the European Court of Justice. The Minister is proceeding with all necessary steps to bring the VHI to the point of authorisation, with a final decision regarding authorisation to be taken by Government when these steps have been completed. The Department has been working intensively with the VHI and the Central Bank of Ireland to progress these issues. Possible alternatives to authorisation are also being examined.

Action 25: The Department of Health will address the regulatory status of the VHI, in line with the European Court of Justice ruling, by no later than the end of 2013.

7.6.3 STATUTORY SYSTEM OF HEALTH INSURANCE

The Programme for Government envisages a statutory system of health insurance, guaranteed by the State, in which the UHI system will not be subject to European or national competition law. The legal and practical requirements of this approach are likely to be very complex. These areas are being explored and the Government will make a decision on the best way forward as soon as possible. Any decision must take full account of the need to address the European Court of Justice judgement comprehensively by the end of 2013.

SECTION C: REFORMING THE DELIVERY SYSTEM

Chapter 8: Reforming Primary Care

8.1 VISION FOR PRIMARY CARE

The Government is committed to reforming our model of delivering healthcare, so that more care is delivered in the community. The first point of contact for a person needing healthcare will be primary care, which should meet 90-95% of people's health and personal social care needs.

The vision for primary care which the Government is committing to implementing is one where: no one must pay fees for GP care; GPs work in teams with other primary care professionals; the focus is on the prevention of illness and structured care for people with chronic conditions; primary care teams work from dedicated facilities; and staffing and resourcing of primary care is allocated rationally to meet regularly assessed needs. We will retain the existing community ethos of primary care, in which services are delivered with patient needs at the forefront of our concerns. Primary care teams will provide the foundation medical and non-medical care that people need, whether it is for health or social needs. Patients will be referred from primary care only when their needs for care are sufficiently complex. Otherwise they will be managed through primary care. Primary care teams will comprise of general practitioners, nurses, speech and language therapists, occupational therapists, physiotherapists, social workers, health care assistants, home helps, managers and administrative staff. Primary care networks will provide additional resources depending on assessed needs, such as dieticians and psychologists, to a number of primary care teams. Registration with a primary care team will be compulsory once the Universal Primary Care system is fully implemented.

Since the achievement of a universal health insurance system that delivers better health outcomes at an affordable cost requires the movement of care to its most appropriate setting, which for the majority of health needs is in primary care, the Government's reform has been planned in two distinct phases. The first phase is the primary care reform beginning in 2012; the second phase is the introduction of Universal Health Insurance in 2016. The successful introduction of the primary care reform is an essential prerequisite for the introduction of the UHI system.

8.2 IMPLEMENTATION OF PRIMARY CARE REFORMS

A Universal Primary Care Project (UPC) Team is driving the reform of Primary Care. The projects being overseen by the UPC Team include:

- Planning, costing and legislative preparation for the extension of free GP care;
- Development of chronic disease management in primary care;
- Promotion of capital investment in primary care centres;
- Preparation for a new GP Contract to facilitate universal free GP care and intensive chronic disease management;

- Development of a transparent, objective formula for the allocation of resources in primary care;
- Preparation for new governance and funding arrangements for primary care.

A number of specific actions will be implemented to promote the reform of primary care. These will include:

- A review of traditional primary care reporting relationships.
- A better alignment of GP services and services provided by HSE staff according to population need.
- The development of ICT capacity for primary care with role based access for professionals operating on the basis of patient consent.

As indicated, the removal of fees for GP care will be a key initiative under the proposed reform of primary care. This reform is required because of the body of evidence that user fees are a barrier to accessing care at the primary care level and thereby cause late detection of illness, poorer health outcomes and greater pressures on the acute hospital and long-term care systems. The removal of user fees for GPs will enable the phased, planned development of a comprehensive primary care service in which all communities have locally accessible services, delivered by GPs, practice nurses and other allied health professionals.

Action 26: The Department of Health will introduce legislation to extend GP care without fees on a phased basis.

8.3 A NEW MODEL OF CARE - CHRONIC DISEASE MANAGEMENT

There is an increased incidence and prevalence of chronic diseases and conditions worldwide. People with chronic disease are more likely to attend their General Practitioner, to present at Emergency Departments, to be admitted as inpatients and to spend more time in hospital, than people without such conditions.

Chronic Disease Management Programmes will shift the management of chronic diseases such as diabetes, stroke, heart failure, asthma and chronic obstructive pulmonary disease from hospitals to the community.

The focus of such programmes will be on primary prevention, early identification, simple and early interventions, patient empowerment, care in the community and on preventing acute episodes from occurring.

Improved management of chronic diseases will involve a reorientation towards primary care and the provision of integrated health services that are focused on prevention and returning individuals to health and a better quality of life. The main elements of the programmes will include:

- Models of shared care which set out the roles and responsibilities of primary care and specialist services.
- Clinical protocols and guidelines for use in primary care and specialist services.

- Programmes of self-care for patients to encourage better self-monitoring and treatment of chronic disease.
- Clinical information systems, quality assurance and evaluation.

Action 27: The Department of Health will work with the HSE to ensure that chronic disease management programmes will be introduced between 2013 and 2015.

8.4 GP CONTRACT

Under Universal Primary Care, payments to GPs will be structured to encourage them to care more intensively for patients with chronic illnesses. Delivery of free GP care at an affordable cost to the Exchequer will require enhanced team working in primary care with greater delegation of care where appropriate to nurses.

Improved chronic disease management and a renewed focus on prevention in primary care will be reflected in the GP contract. The contract will provide for the enrolment of patients with GPs and primary care teams, structured reviews, individual care plans, call/recall systems for patients with chronic diseases and mechanisms to audit and report on outcomes.

8.5 RESOURCES - SUPPLY OF PRIMARY CARE PROFESSIONALS

To assist in planning for sufficient primary care professionals to meet the demands of universal GP care and with the need for more intensive care for people with chronic diseases, the Department of Health commissioned a model of demand for and supply of general practitioner and practice nurse services. The model is interactive and can be updated to calculate the impact on GP and practice nurse demand of developments such as population growth, ageing or changes in epidemiology. A further phase of the model will examine supply of and demand for allied health care professionals. The model will be extended to other members of the primary care team to ensure the on-going development of our primary care workforce.

The allocation of posts in primary care will be governed by a consistent, transparent methodology, with the aim of improving the supply of primary care staff in areas with the greatest deficit of staff and the most deprived populations.

Action 28: The Department of Health will work with the HSE to increase the numbers of health care professionals working in primary care from 2013.

8.6 RESOURCES - PRIMARY CARE CENTRES

Primary care centres have been identified as a priority for capital investment. The provision of primary care centres will be informed by needs analysis, with priority given to areas of urban and rural deprivation, with due regard to the scope for implementation. There will continue to be a mixture of State-provided centres and privately developed centres.

Action 29: The Department of Health will work with the HSE to implement a programme of investment in primary care centres between 2012 and 2015.

8.7 ORGANISATIONAL AND DELIVERY STRUCTURES

A Primary Care Directorate will be established within the HSE under a National Director of Primary Care. This directorate will oversee the development and strengthening of primary care. The primary care delivery system will be determined following the outcome of the Department/HSE review of Integrated Service Areas as outlined in Chapter 6.

Chapter 9: Reforming Our Hospitals

9.1 STRATEGIC GOALS FOR HOSPITAL REFORM

Our reforms of hospital care are designed to achieve three main goals:

- To deliver more responsive and equitable access to vital services for all patients;
- To organise our public hospitals into more efficient and accountable hospital groups, as part of the move towards establishing independent hospital trusts, which can deliver better patient care for less cost; and
- To ensure that smaller hospitals continue to play a key role in the delivery of health services.

9.2 FASTER MORE EQUITABLE ACCESS

We are determined to build on the success already achieved by the Special Delivery Unit (SDU) in tackling long waits in Emergency Departments (unscheduled care) and waiting lists for inpatient, outpatient and daycase treatment (scheduled care).

The SDU has established major national programmes aimed at helping hospitals to tackle the problems associated with delays in accessing care. Hospitals have been set ambitious targets in this regard. Achievement of these targets will require professionals across the service to adopt new ways of working, the introduction of new technologies and the continued roll out of improvements to performance management systems. These targets will be monitored by the Department on an on-going basis.

Action 30: The Department of Health will work with the HSE on an on-going basis to drive implementation of the programmes aimed at reducing waiting times for scheduled and unscheduled care in hospitals.

9.3 MOVING TO HOSPITAL TRUSTS

The current system of governance in the Irish hospital sector is unsatisfactory. The distinction between the voluntary and statutory sectors has created an uneven terrain for optimising patient care and has restricted the development of the management systems and leadership we require to run a world-class national hospital network. We want to take the best of the governance and autonomy currently found in the voluntary sector and create a new governance system that can give the benefits of increased independence and greater control of local clinical and managerial leaders to every hospital in Ireland.

We cannot create the governance and leadership capability to achieve this in one move, so in 2013 administrative hospital groups will be created that will have increased autonomy and will incorporate every statutory and voluntary hospital. Each group will be led by a Group Chief Executive with a defined budget and staff complement to help in the efficient delivery of high quality services. These arrangements will be transitional and will be formally reviewed in 2014 in the light of the emerging UHI model to create an effective framework within which independent, competing hospital trusts will be formed in 2015.

Action 31: The Department of Health will work with the HSE to oversee the establishment of administrative hospital groups during Q1 2013 as a first in a series of steps leading to the introduction of independent hospital trusts for all hospitals by December 2015.

9.4 ROLE OF SMALLER HOSPITALS IS CRUCIAL

The Minister's primary concern is the safety of patients. The original focus of the HSE in relation to smaller hospitals was the immediate and medium term mitigation of any risks associated with services provided by these hospitals arising from the HIQA Ennis and HIQA Mallow reports. Many positive changes have been achieved to date including the cessation of any cancer, paediatric and maternity services at these sites. Each region continues to implement changes in the relevant hospitals in line with sound clinical practice and the HIQA recommendations.

In developing the framework to address the development of smaller hospitals, the Government is clear that:

- There is an important future role for smaller hospitals, in which they will provide services for more patients, not fewer;
- No acute hospital will close; and
- Safety issues in all acute hospitals, large or small, must be fully addressed, first by ensuring that national performance measurement systems for quality and safety are in place and secondly by providing the right type of service, for the right patient in the right setting.

The Smaller Hospitals Framework will demonstrate clearly that the future of smaller hospitals is secure. It will set out what services can be delivered safely by these hospitals in the interest of best outcomes for patients. Consultation with all the stakeholders, including patients and public representatives, will be an integral part of the process.

The organisation of hospital services nationally, regionally and locally will be informed by the work of the inter-related clinical programmes which aim to improve service quality, effectiveness and patient access. The reorganisation will also ensure that patient care is provided in the service setting most appropriate to individuals' needs. This objective is also underpinned by the work on the Smaller Hospitals Framework. The introduction of hospital groups and the development of smaller hospitals is interrelated. With this in mind, the development of the role of smaller hospitals will be led by the new executive teams of the hospital groups and will also provide further opportunities for inter-site co-operation.

Action 32: The Department of Health in conjunction with the HSE will publish in Q4 2012 a framework to address the development of smaller hospitals, setting out what services can be delivered safely by these hospitals in the interest of better outcomes for patients.

9.5 AMBULANCE SERVICES

The ambulance service is currently being reconfigured in line with best clinical practice. This process will result in the number of control centres being reduced to two nationwide (one in the

East and one in Ballyshannon) on a phased basis. The new configuration will be supported by improved technology and will ensure a nationally co-ordinated system. This national service will also encompass the National Aeromedical Co-ordination Centre as recently recommended by HIQA.

It is very important that a clear and transparent system for the use of ambulance services is established as hospital groups are set up and we move towards UHI and the formal inclusion of private hospitals within the overall governance system. As part of the process for the establishment of trusts, a set of national guidelines for ambulance services will cover, among other things, the need for:

- A clear accountability and commissioning system;
- A national booking and information management system for emergency, non-emergency and inter-facility transport; and
- Separate emergency and non-emergency deployment.

Action 33: The Department of Health will work with the HSE to ensure that the Ambulance Service is reconfigured by Q1 2014 to ensure a clinically driven, nationally co-ordinated system, supported by improved technology, which will also encompass the National Aeromedical Co-ordination Centre.

Chapter 10: Reforming Social and Continuing Care

10.1 DEFINING SOCIAL AND CONTINUING CARE

The groups for which most social care supports are provided currently are those of disability, older people and mental health. The common thread running through all of these groups is the need to provide a service which holds the individual care recipient at its centre. We need to foster innovation and ensure that a service exists that will maximise independence and achieve value for the resources invested.

Social and continuing care is provided over an extended period of time to meet physical and/or mental health needs that have arisen for any number of reasons such as frailty, disability, an accident or illness. Social care can be provided in a variety of settings including the client's own home, a health centre, community/day hospital, nursing home or hospice.

Social and continuing care will play a key role in our efforts to deliver care at the point of lowest complexity. While there will always be a need for episodic care and treatment (both through hospitals and primary care), social and continuing care is the underlying foundation which draws these strands together. Traditionally, social and continuing care services have covered the life course and encompassed the following care groups:

- People with disabilities;
- People with mental health issues;
- Older people; and
- Palliative Care.

International research suggests strongly that the most effective way to meet the needs of individuals in these care groups is through an integrated system where there is a common funding source as part of a purchaser/provider split, a single care assessment framework, a robust governance and accountability framework, a greater emphasis on individualised budgeting and quality assurance/regulatory underpinning. Such a system will help deliver lower costs, enhance quality of care and give individuals much greater control over their own care.

The sustainability of social and continuing care provision, particularly in light of the current budgetary climate and the changing demographic profile, means that increasingly scarce resources must be efficiently managed, targeted at areas of greatest need, and delivered at the point of lowest complexity.

10.2 KEY PRINCIPLES FOR THE DELIVERY OF SOCIAL AND CONTINUING CARE

Recent policy developments, both nationally and internationally, have identified a number of key principles which will underpin our approach to the delivery of social and continuing care within a reformed health system. These are:

- A focus on the rights and dignity of the person concerned, with care guided by the person's own views and wishes;
- A strengths-based approach to needs assessment, i.e. a focus on supporting and enhancing ability to enable active community living;
- Individual care plans with a focus on personal goals and outcomes;
- A shift towards service provision in the community, which includes natural supports (family, friends, etc.) as far as possible; and
- For people with disabilities, a move towards mainstream services in the community instead of segregated services.

In order to give effect to these principles, an integrated system for social and continuing care with the following four key characteristics will be introduced:

- (i) A Purchaser/Provider Split
- (ii) A Standardised Care Assessment Framework
- (iii) Individualised Budgeting
- (iv) A Quality Standard and Regulatory Structure.

10.3 PURCHASER/PROVIDER SPLIT

A new Social and Continuing Care Fund will allocate funds to public and non-public providers of social and continuing care. This will eventually be done through a strategic commissioning model which will commission or procure packages of services specified by a care needs assessment.

The public providers of residential, social and continuing care will be organised as follows:

- As part of the move to hospital groups/trusts, specific arrangements will be put in place to accommodate acute in-patient mental health services. Such services are increasingly being delivered in or on the grounds of general hospitals.
- The provision of public nursing homes and other social and continuing care residential facilities and community supports, including those in the mental health and disability sectors will be managed within the primary care delivery system. In the mental health sector, residential services outside the acute in-patient hospital based services, as well as community based teams and home based treatment services, will continue to be provided by the public sector.

A rigorous performance management process will be put in place with defined national outcomes for all of the care groups. Providers will be measured regularly against the achievement of these outcomes and the results published. Performance against outcomes will be used, in turn, to inform the commissioning process.

While the significant role of voluntary agencies in delivering services is acknowledged, it is clear that their role will have to evolve to meet the new approaches outlined above. Service level agreements will be revised and redrawn to reflect a more rigorous emphasis on budgeting and monitoring in preparation for eventual changes to the procurement or commissioning of individual based services.

10.4 A STANDARDISED CARE ASSESSMENT FRAMEWORK

The Social and Continuing Care Fund will use a standardised framework to commission services from both public and non-public providers. This will allow for an assessment to be made of the needs of all individuals requiring social and continuing care. People with the same needs should not be treated differently depending on whether they are classified as a 'person with a disability' or an 'older person'.

This standardised framework will determine the maximum amount of funding to be allocated to individuals who score highest in the assessment of need, with pro-rata allocations to those with lower scores, taking into account the overall level of funding available and the anticipated level of demand. It will also be used to prioritise allocations within available resources.

Action 34: The Department of Health will develop policy in relation to the introduction of financial assessment, contribution and charges for certain social and continuing care services by 2015.

Action 35: The Department of Health will support the HSE to roll out a single assessment tool for older people services in 2013.

Action 36: The Department of Health will commence work on a national standard assessment tool for people with disabilities as part of a resource allocation framework in 2013.

10.5 INDIVIDUALISED BUDGETING

Fair Deal already provides some of the framework for individualised budgeting in that it is a system of Money Follows the Patient for a defined package of services, following a needs assessment.

In keeping with the broad concept of Money Follows the Patient, it is very important that funding is much more closely aligned to the needs and outcomes of individuals than is presently the case. There are a number of ways in which this may be done, including (but not limited to) the following:

- Funding may be allocated directly to one or more service providers chosen by individuals to provide them with services or supports;
- Funding may be allocated to service brokers nominated by individuals to manage their budgets, or choose supports based on an agreed plan, following assessment of need; or
- Funding may be allocated directly to individual service users where they opt to manage their budgets themselves.

The key change in the short term, as a result of the move to individualised budgeting, will be more transparency in relation to how resources are assigned to each service user and on how they are spent. Over the longer term this information will help empower individual service users and/or their families to negotiate with, or change service providers if they so wish. However, three points need to be emphasised:

- (i) Individualised budgeting must be part of a wider integrated strategy that focuses on universal access to primary care services and supports in mainstream community settings and also addresses issues such as health promotion, prevention and early intervention.
- (ii) Change cannot be confined to the funding mechanism. There must also be a sufficiently wide choice of personalised services over which people have real control, which can only be achieved if the provider market is developed and managed by the purchaser, i.e., the commissioning body.
- (iii) Experience from other countries makes it very clear that moving to individualised budgets must be managed very carefully if it is to deliver cost effective, improved outcomes. Individual budgets tend to work best in the case of people with physical and sensory disability, and least well with older people and individuals with mental health issues or more severe or profound levels of intellectual disability.

Central to the introduction of individualised budgeting however will be the financial systems; transparent and comprehensive governance arrangements; a National Standard Needs Assessment framework; and underpinning legislation already referred to above. Also central is the introduction of a regulatory system for providers to ensure quality and safety for the recipients of social services from whatever sector (see Section 10.6 below).

10.6 A QUALITY STANDARD AND REGULATORY STRUCTURE

The introduction of central commissioning and individualised budgeting has to be accompanied by a regulatory structure which will underpin quality standards and allow flexibility in the commissioning of services from a wider sector. It will also ensure that services procured are up to a baseline of quality and safety.

HIQA already sets standards and monitors and inspects nursing homes for older people. Plans are advanced to extend HIQA's inspection functions to residential services for people with disabilities. The Mental Health Commission promotes, encourages and fosters the establishment and maintenance of high standards in the delivery of mental health services and ensures that the interests of those involuntarily admitted to approved centres are protected. Inspection of approved centres is carried out under the auspices of the Inspector of Mental Health Services.

Primary legislation and resources will be required to introduce a statutory regulation system for the home care sector. The question of possible changes to legislation, including regulation and inspection, for such services is under consideration in the overall context of licensing of health care providers. Legislation is currently being prepared and various options are being considered.

Action 37: The Department of Health will extend the HIQA regulatory regime to residential services for people with disabilities in 2013 and to other social and continuing care settings by 2016.

10.7 KEY SOCIAL AND CONTINUING CARE REFORM INITIATIVES NECESSARY TO UNDERPIN A NEW MODEL OF CARE

10.7.1 REFORMING FAIR DEAL

The Nursing Homes Support Scheme (Fair Deal) is the first national scheme where money follows the patient. The Programme for Government promises a review of the scheme with a view to developing a secure and equitable system of financing for community and long-term care, which supports older people to stay in their own homes.

The scheme will also be examined with a view to extending it to the disability and mental health residential sectors. The extension of a Fair Deal type model to any additional sectors will be carefully examined for feasibility, sustainability and impact. However, many of the principles enshrined in the scheme (money follows the patient, national care assessments, and patient choice) will inform the future policy direction of community services as a whole.

The review of Fair Deal has now commenced and will include the on-going sustainability of the scheme and the viability of extending it to other sectors.

Action 38: The Department of Health will commence a review of the Fair Deal scheme to assess its sustainability by Q4 2012 and will further review the scheme to assess its applicability to other sectors such as the disability and mental health residential sectors by Q4 2013.

10.7.2 REFORM OF DISABILITY SERVICES

The Value for Money & Policy Review of Disability Services was published in July, 2012. It provides an overarching framework for the reform of disability services. The review recommends that a person-centred model should form the basis of the future direction of disability policy, with services delivered in the community based on an individualised range of supports. The achievement of measurable outcomes and quality for service users at the most economically viable cost will underpin the recommendations in the review, together with an emphasis on the governance and administrative processes necessary to ensure full accountability.

Action 39: The Department of Health will develop a high level implementation plan for the Value for Money and Policy Review of Disability Services by Q4 2012.

Action 40: The Department of Health will work with the HSE to move towards a person-centred model of services and supports for disability services, through the initiation of demonstration projects as “proof of concept” in 2013.

10.7.3 REFORM OF MENTAL HEALTH

The Government strongly supports the implementation of the 2006 Report of the Expert Group on Mental Health Policy - *A Vision for Change*. We will continue to close the old psychiatric hospitals and move from the traditional institutional based model of care to a patient-centred, flexible and

community based mental health service, where the need for hospital admission is greatly reduced, while still providing in-patient care when appropriate.

Because of the particular vulnerabilities of people with mental health problems, the use of a standardised care assessment tool and a strict adherence to individualised budgeting will need to be carefully considered. This should not however prevent the commissioning of services from public and non-public providers (even though they are mostly public) in a way that will improve the efficiency of those services. The Department of Health will manage the implementation of the reform programme for mental health services to ensure the best structure for the most effective continued roll-out of *A Vision for Change*.

10.7.4 REFORM OF PALLIATIVE CARE

Palliative care is a form of intermittent and/or social and continuing care that can cross all sectors of the population, from the very young to the old. It is defined by the World Health Organisation as ‘the active, total care of patients whose disease is no longer responsive to curative treatment’. It encompasses three levels of care: Level 1 - the Palliative Care Approach; Level 2 – General Palliative Care; and Level 3 – Specialist Palliative Care.

It is delivered in diverse locations – hospitals, dedicated hospices and in the community. On this basis, it will have to be considered within all of the funding mechanisms now being contemplated and across all service delivery models. The HSE is currently working on a prospective funding model which will assist in integrating and accounting for palliative care across all funding streams and delivery models.

Action 41: The Department of Health will work with the HSE to complete a prospective funding model for palliative care in 2013.

Chapter 11: Tackling the Capacity Deficit

11.1 INTRODUCTION

All of the reforms outlined in this Framework are predicated on our capacity to transform our use of information, enabled by Information and Communications Technology (ICT); to manage our Human Resources (HR) in a manner which best supports the health reform agenda; and to take an evidence based approach to health policy.

This chapter outlines the main issues and challenges facing the health system in relation to Information and ICT capacity (section 11.2) and Human Resources (section 11.3) and sets out the proposed steps to address these capacity deficits. Research capacity and policy development are also addressed (section 11.4).

11.2 INFORMATION AND ICT – GETTING IT RIGHT

The health information environment in Ireland is characterised by a patchwork of information systems, some national and some local. These have varying degrees of quality and comprehensiveness but do not currently support delivery of the efficient, integrated and timely information required for the implementation of the reforms set out in this document. Improvement is urgently needed across non-acute areas such as primary and community care, where ICT remains poorly developed. While significant progress has been made in addressing information deficits and information standards, for instance by HIQA, the patient-level information flows necessary to implement elements of the reform programme will require major strategic initiatives.

Getting the information right is just as important as getting the technology right. Modern technology enables the efficient collection, analysis and use of information, but the technology will not fulfil its promise without sufficient regard to the quality, relevance, timeliness, and standards of information. The proposed joint strategic approach to information and ICT will ensure that information requirements are rigorously specified and that ICT solutions optimise the effectiveness of that information in the delivery of patient care.

ICT and the wider information and informatics agenda, has a critical role to play in improving the overall capacity and performance of the reformed health system and in enabling change. Central elements of the reform programme, including MFTP, UHI and integrated care, will depend on having a fit-for-purpose information and ICT infrastructure in place. The proposed approach to enabling and supporting these reforms is described below. It relies on the development of an “eHealth” based strategic approach together with the requisite structures tasked with delivering on that approach.

11.2.1 INFORMATION AND ICT STRATEGY WITH AN “eHEALTH” APPROACH

While it is important to build on what we have, eHealth solutions will be used to address a more innovative and bottom-up approach, incorporating informatics and process improvement in relation to patient care and in particular shared care delivery. The view of the patient in

information terms can be described as the “eHealth” approach. This approach effectively marries specification of patient data with technology as an enabler and, therefore, offers a wider solution to support models of integrated care.

eHealth is increasingly being seen in the context of new health delivery models outside of traditional hospital computing environments, with a view of patient information extending across the full range of care settings. The Department’s approach will also include building relationships with both the ICT industry and academia, working in tandem with our partners in Europe and progressing the eHealth agenda in line with the EU eHealth Action Plan 2012 – 2020, to maximise the potential for innovation and improvement. In addition to providing a framework, timetable and costings for information and ICT developments, the eHealth Strategy will also deal with the critical issue of governance, both in respect of systems and in terms of the appropriate use and safeguarding of information. It will be guided in this work by the provisions of the forthcoming Health Information Bill.

The Health Information Bill will provide a legal framework for the better governance of health information and the necessary enabling legal framework for a number of initiatives including health identifiers, data matching and health information resources (population registers). The Bill will also facilitate a standards based approach to health information management and to supporting inter-operability between computer systems.

Action 42: The Department of Health will develop an eHealth Strategy in conjunction with the HSE by Q1 2013. This will serve as a blueprint for the design and implementation of eHealth systems to support and enable the delivery of integrated patient care under the reform agenda.

Action 43: The Department of Health will ensure that the necessary preparatory work is undertaken to allow publication of the Health Information Bill by end Q2 2013.

11.2.2 INFORMATION AND ICT STRATEGY UNIT

The health system requires an ICT organisation with defined processes for management and accountability. It requires the right structure and expertise to help provide the right services. It also has to be sufficiently flexible to meet future needs.

An Information and ICT Strategy Unit will be established covering both the Department of Health and HSE, led by a Chief Information Officer (CIO). Its role will be critical in ensuring that the necessary information, technical and governance infrastructure is in place to facilitate and enable the complex use of client-based data required to realise the necessary reforms.

The CIO will be supported by a Chief Medical Information Officer (CMIO) with responsibility for the comprehensive and systematic approach to information required to implement health system reforms, and by a Chief Technology Officer (CTO) with responsibility for ensuring that information requirements are optimally enabled by ICT solutions.

In support of the Strategy Unit, an Information and ICT Advisory Committee will be established with appropriate outside advice and guidance. The Advisory Committee will ensure business buy-in and

commitment, and that best practice and implementation goals for information and ICT continue to be met. Key aspects of its role will be to:

- Ensure that priority projects are identified and implemented in line with agreed information and ICT strategic requirements and wider Government policy;
- Evaluate and recommend corporate level ICT strategies and plans to ensure the cost effective application and management of information and ICT systems and resources, and advise on how best to address capacity issues and champion technology as an enabler of change and reform;
- Advise on ICT strategic capability including an eHealth strategy to complement ICT plans in line with Government policy;
- Support the Information and ICT Strategy Unit in the delivery of solutions;
- Review current and future technologies and standards to identify opportunities to increase the efficiency of information and ICT resources;
- Prioritise, monitor and evaluate information and ICT projects and achievements against the ICT /eHealth strategic plan; and
- Support and promote the embedded role and function of information and ICT within management and the business and service delivery functions.

Action 44: The Department of Health in conjunction with the HSE will establish an Information and ICT Strategy Unit, led by a Chief Information Officer in Q1 2013, to ensure that the necessary information, technical and governance infrastructure is in place.

11.3 HUMAN RESOURCES ISSUES

11.3.1 BACKGROUND

There are significant human resources issues associated with the implementation of the health reform agenda. These are discussed below.

11.3.2 PUBLIC SERVICE AGREEMENT

The Public Service Agreement remains an essential enabler for the health sector, allowing it to respond to the healthcare needs of the population in an appropriate and sustainable manner against a backdrop of very significant reductions in both financial and staff resources. This contraction in resources is taking place at a time of accelerating demand for the provision of health and social care services. Since the Agreement was concluded, staff have risen to the challenge posed by reduced resources and significant changes in work practices and improvements in productivity have been achieved. The provisions of the Public Service Agreement will continue to be used by the HSE to enable the health service to adapt in ways that protect service levels to the maximum extent, in the light of financial and staffing reductions. The Agreement also provides a framework within which any human resources issues that arise in the context of the Government's reform plans for the health sector can be dealt with.

The Health Sector's key priorities for 2012 and beyond include systematic reviews of rosters, skill-mix and staffing levels, increased use of redeployment, further productivity increases and a particular focus on reducing absenteeism. The flexibility and openness to change which the Agreement requires should also facilitate the implementation of the Government's reform plans for the health sector. The 2012 Health Sector Implementation Plan already identifies the need for continued co-operation with the work of the Special Delivery Unit and Clinical Programmes, the establishment of hospital groups and the reassignment of functions between the HSE and the Department of Health.

Action 45: The Department of Health and the HSE will continue to use the Public Service Agreement to the fullest extent possible between 2012 and 2014 to protect health services and to facilitate implementation of the reform programme.

11.3.3 POLICY ON PUBLIC SERVICE NUMBERS

The Government is committed to achieving a reduction in the number of people employed in the public service, from 320,000 in 2008 to 282,500 by 2015. When achieved, this will have reduced the gross pay bill by over €2.5 billion (or 15%) since 2008.

The health sector, as a major component of the public service, has to contribute to the achievement of this goal. Health service staff numbers have already been reduced from a peak of around 111,500 whole-time equivalents (WTE) in 2008 to approximately 102,000 by summer 2012. It is anticipated that substantial further reductions will be required, of the order of 6,500 WTE by 2014/2015.

11.3.4 WORKFORCE PLANNING AND DEVELOPMENT

The necessary reduction in the size of the health workforce must be accompanied by planning for the future needs of the service. The effective management of our human resources requires an approach to workforce planning and development that includes recruiting and retaining the right mix of staff, training and upskilling the workforce, providing for professional and career development and creating supportive and healthy workplaces.

The Department and the HSE have already begun an exercise to assess the composition of the current workforce and how anticipated further reductions in numbers can best be accommodated. We must also ensure on a cross-sectoral basis that the outputs of the education system are aligned with the needs of the health service in terms of disciplines, skills and numbers of staff expected to be required.

11.3.5 STRUCTURAL CHANGE: THE HUMAN IMPLICATIONS

In the current challenging times, it is even more important to create supportive and healthy workplaces for staff. Where there is uncertainty or a lack of clarity about the future, for organisations but more especially for individuals, staff morale may suffer. Therefore the Government wishes to state clearly that:

- The changes in the governance arrangements for the HSE, which will take effect after the necessary legislation has been passed, will not affect the present employment status of health service staff. The HSE's legal status is not being changed at this stage;

- Subsequent changes in the organisation of the health service, involving the establishment on a statutory basis of the Healthcare Commissioning Agency and of hospital trusts, will not change the fundamental nature of the Irish health service as a publicly-provided service;
- The Government is committed to a process of consultation and collaboration on implementation with stakeholders, including health service staff and their representative bodies, as the practical details of implementing reform are worked through.

Action 46: The Department of Health will work with the HSE from 2012 to implement an approach to workforce planning and development that includes recruiting and retaining the right mix of staff, training and upskilling the workforce, providing for professional and career development and creating supportive and healthy workplaces.

11.3.6 LEADERSHIP AND MANAGEMENT CAPACITY

The delivery of high-quality healthcare is highly dependent on the quality of those in frontline roles and the capacity of those charged with leading and managing the services. The HSE has already established a Succession Management Programme, which is intended to address both short-term and long-term succession requirements at senior management level and produce well-developed, capable managers for the health sector.

This approach needs to be developed further to create a strategic leadership, governance and development framework that ensures that services are delivered cost-effectively, are safe and of high quality and are managed in compliance with the highest standards of governance. Upgrading the financial capability of managers has been identified as an immediate priority. In 2012, a quality improvement and training programme for clinical and managerial leaders was established and implemented and this initiative will be expanded from 2013.

Action 47: The Department of Health will work with the HSE and relevant experts to develop a series of leadership and learning sets in relation to governance, quality and safety of health care delivery to meet the requirements set out in the HIQA report on Tallaght hospital.

Action 48: The Department of Health, with the HSE, will further develop an approach to address both short-term and long-term succession requirements at senior management level from 2012.

11.4 RESEARCH CAPACITY AND POLICY DEVELOPMENT

The Government recognises that the development of health policy must be evidence-based and must draw, as appropriate, on the expertise and experience of those who are most closely involved in the delivery of services. As such, we acknowledge that the reform programme must be underpinned by research, data monitoring and evaluation.

The Department will play a leadership role in relation to research and will work in partnership with the Health Research Board and others to drive the capacity for, and development of, excellent research for health. We will ensure that health research is coordinated, prioritised and focussed and that national policies and strategies for health research are framed strategically in the context of the wider science, technology and innovation agenda. Partnerships between the health service and industry will be strengthened to their mutual advantage.

We will also ensure that we have the skills available to us to evaluate impacts based on robust evaluation mechanisms predicated on the availability, reporting and analysis of reliable input, output and impact data. It will also be important to develop research capacity to conduct applied, high quality health services, population health and health behaviour research.

We also intend to create greater opportunities for health professionals to influence the development and implementation of policy, including through their professional bodies and representative organisations. This will include medical, nursing and allied health professional disciplines.

APPENDIX 1: ACTIONS AND TIMELINES

INTRODUCTION	
1.	The Department of Health will publish a White Paper on Universal Health Insurance in 2013. A preliminary document will be produced by end 2012.
DELIVERING THE REFORM PROGRAMME: GOVERNANCE AND MANAGEMENT ARRANGEMENTS	
2.	The Department of Health will establish a robust governance structure to oversee the health reform programme by Q1 2013.
3.	The Department of Health will establish an appropriately resourced Programme Management Office in Q1 2013 to drive, co-ordinate and monitor the reform process.
4.	The Department of Health will develop a proactive Consultation, Collaboration and Communication Plan for the reform programme by Q4 2012.
PATIENT SAFETY AND QUALITY	
5.	The Department of Health will establish a new Patient Safety Agency on an administrative basis in 2013.
6.	The Department of Health will develop a licensing system initially focussed on hospitals and specialist service providers to commence in Q1 2015.
7.	The Department of Health will work with the HSE and the State Claims Agency to develop a risk based approach to provision of indemnity to services and professionals by end 2013.
8.	The Department of Health will establish a National Task Force on Prescribing and Dispensing Practice by end Q4 2012.
HEALTH AND WELLBEING	
9.	The Department of Health will produce a comprehensive Health and Wellbeing Policy Framework by end 2012.
10.	The Department of Health will establish a Health and Wellbeing Agency in Q1 2015.
11.	The Department of Health will work with the HSE to ensure that the age range extension of BreastCheck to 65-69 year old women will commence in 2014.
12.	The Department of Health will work with the HSE to ensure that the national colorectal screening programme will have completed the first round of screening for 60-69 year old men and women by end 2015.
13.	The Department of Health will work with the HSE to ensure the delivery of the targets for routine and urgent endoscopy procedures by end Q4 2012.
STRUCTURAL REFORM	
14.	The Department of Health will make recommendations by Q4 2012 on (i) the composition of hospital groups; (ii) the criteria for the formation of hospitals groups and (iii) the first wave of new hospital groups to be established immediately thereafter.
15.	The Department of Health in conjunction with the HSE will conduct a review of Integrated Service Areas in Q2 2013.
16.	The Department of Health will work with the HSE to develop Sectoral Plans for Shared Services and External Service Delivery by Q4 2012.
17.	The Department of Health in conjunction with the HSE will conduct a review in 2013 of corporate functions and resources (staff and budget) of the various corporate/support/shared services as they currently exist within the HSE and make recommendations for the future.

FINANCIAL REFORM	
18.	Funding for the health service will be provided through the Vote of the Office of the Minister for Health from Q1 2014. The Department of Health will work closely with the HSE and the Department of Public Expenditure & Reform on the detailed arrangements that are required to bring about this change.
19.	The Department of Health will work with the HSE and the Department of Public Expenditure and Reform to develop Programme Based Budgeting in 2013 within the confines of the existing financial systems.
20.	The Department of Health and the HSE will oversee implementation of the recommendations contained in the 2012 Reviews of Financial Management Systems in the Irish Health Service from Q4 2012.
21.	The Department of Health will work with the HSE to ensure the development and roll-out of a comprehensive financial management system as a matter of priority.
22.	The Department of Health will develop time-bound plans for the implementation of Money Follows the Patient by end 2012.
23.	The Department of Health will pursue cost control in the private health insurance market in particular through the Consultative Forum on Health Insurance and through the external review in 2012 of the VHI's claims costs. Implementation of these initiatives will continue through 2013 and beyond.
24.	The Department of Health will introduce a permanent scheme of risk equalisation to support the principle of community rating from Q1 2013.
25.	The Department of Health will address the regulatory status of the VHI, in line with the European Court of Justice ruling, by no later than the end of 2013.
REFORMING PRIMARY CARE	
26.	The Department of Health will introduce legislation to extend GP care without fees on a phased basis.
27.	The Department of Health will work with the HSE to ensure that chronic disease management programmes will be introduced between 2013 and 2015.
28.	The Department of Health will work with the HSE to increase the numbers of health care professionals working in primary care from 2013.
29.	The Department of Health will work with the HSE to implement a programme of investment in primary care centres between 2012 and 2015.
REFORMING OUR HOSPITALS	
30.	The Department of Health will work with the HSE on an on-going basis to drive implementation of the programmes aimed at reducing waiting times for scheduled and unscheduled care in hospitals.
31.	The Department of Health will work with the HSE to oversee the establishment of administrative hospital groups during Q1 2013 as a first in a series of steps leading to the introduction of independent hospital trusts for all hospitals by December 2015.
32.	The Department of Health in conjunction with the HSE will publish in Q4 2012 a framework to address the development of smaller hospitals, setting out what services can be delivered safely by these hospitals in the interest of better outcomes for patients.
33.	The Department of Health will work with the HSE to ensure that the Ambulance Service is reconfigured by Q1 2014 to ensure a clinically driven, nationally co-ordinated system, supported by improved technology, which will also encompass the National Aeromedical Co-

	ordination Centre.
REFORMING SOCIAL AND CONTINUING CARE	
34.	The Department of Health will develop policy in relation to the introduction of financial assessment, contribution and charges for certain social and continuing care services by 2015.
35.	The Department of Health will support the HSE to roll out a Single Assessment Tool for older people services in 2013.
36.	The Department of Health will commence work on a national standard assessment tool for people with disabilities as part of a resource allocation framework in 2013.
37.	The Department of Health will extend the HIQA regulatory regime to residential services for people with disabilities in 2013 and to other social and continuing care settings by 2016.
38.	The Department of Health will commence a review of the Fair Deal scheme to assess its sustainability by Q4 2012 and will further review the scheme to assess its applicability to other sectors such as the disability and mental health residential sectors by Q4 2013.
39.	The Department of Health will develop a high level implementation plan for the Value for Money and Policy Review of Disability Services by Q4 2012.
40.	The Department of Health will work with the HSE to move towards a person-centred model of services and supports for disability services, through the initiation of demonstration projects as “proof of concept” in 2013.
41.	The Department of Health will work with the HSE to complete a prospective funding model for palliative care in 2013.
TACKLING THE CAPACITY DEFICIT	
42.	The Department of Health will develop an eHealth Strategy in conjunction with the HSE by Q1 2013. This will serve as a blueprint for the design and implementation of eHealth systems to support and enable the delivery of integrated patient care under the reform agenda.
43.	The Department of Health will ensure that the necessary preparatory work is undertaken to allow publication of the Health Information Bill by end Q2 2013.
44.	The Department of Health in conjunction with the HSE will establish an Information and ICT Strategy Unit, led by a Chief Information Officer in Q1 2013, to ensure that the necessary information, technical and governance infrastructure is in place.
45.	The Department of Health and the HSE will continue to use the Public Service Agreement to the fullest extent possible between 2012 and 2014 to protect health services and to facilitate implementation of the reform programme.
46.	The Department of Health will work with the HSE from 2012 to implement an approach to workforce planning and development that includes recruiting and retaining the right mix of staff, training and upskilling the workforce, providing for professional and career development and creating supportive and healthy workplaces.
47.	The Department of Health will work with the HSE and relevant experts to develop a series of leadership and learning sets in relation to governance, quality and safety of health care delivery to meet the requirements set out in the HIQA report on Tallaght hospital.
48.	The Department of Health, with the HSE, will further develop an approach to address both short-term and long-term succession requirements at senior management level from 2012.

APPENDIX 2: ACRONYMS

CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
CPI	Consumer Price Index
CTO	Chief Technology Officer
ECJ	European Court of Justice
FMS	Financial Management Systems
GP	General Practitioner
HIA	Health Insurance Authority
HIQA	Health Information and Quality Authority
HR	Human Resources
HSE	Health Service Executive
ICT	Information and Communications Technology
ISA	Integrated Service Area
IT	Information Technology
MFTP	Money Follows the Patient
MHC	Mental Health Commission
PHI	Private Health Insurance
PMO	Programme Management Office
PSA	Patient Safety Agency
RES	Risk Equalisation Scheme
SDU	Special Delivery Unit
UHI	Universal Health Insurance
UPC	Universal Primary Care
VFM	Value For Money
VHI	Voluntary Health Insurance
WTE	Whole Time Equivalent