An Roinn Sláinte
DEPARTMENT OF HEALTH

Tús Áite do Shábháilteacht Othar
Patient Safety First

Better Health,
Improving Health Care

Overview

1. The purpose of this document is to provide some strategic considerations to inform the task of developing a clear and coherent agenda for action to improve the health service. A more responsive and improved health service is achievable, but only on the basis of a more effective and integrated model of care.

Short-term action must support the long-term vision

2. The strategy outlined here encompasses both short-term and long-term perspectives. Purposeful action is required to address the needs of our health service, which must be consistent with a long-term vision, but which must also deliver tangible benefits to patients and service users in the short term. Significant change is needed, but implementation must be progressive and take account of the priority to avoid adverse short term consequences for ongoing service delivery.

Health services should be planned, organised and delivered to meet population health needs

3. Any strategy for health service reform must be clearly based on population health needs. A population-based framework should support the formulation and implementation of evidence-based policy and the planning, organisation and evaluation of health services. We need to ensure that the model of healthcare is capable of responding at a pace which matches ongoing changes in demographic structure and patterns of demand. This requires greater focus by planners, providers and the health workforce on population health needs as well as responsiveness to changes in such needs.

The starting point for a more effective and integrated model of care is the development of comprehensive primary care

4. The key requirement is to build a model of care focused on the provision of integrated care, provided as far as possible within primary care, consistent with the highest standards of patient safety. While acute hospital care will always be an essential part of the health service, it needs to be provided within an integrated model which seeks to avoid unnecessary hospital stays. Where patients need acute services the transition between primary, acute and community care must be well-managed so that it is effective, efficient and safe.

Not least because the existing system is unsustainable

5. This approach will provide a better patient experience and better health outcomes, but it is also vital if the health services are to deal effectively with the demographic pressures and rising burden of chronic disease, which are no longer simply a future concern, but are real and present in the demands currently being faced by the health service. This approach is also essential to driving efficiency and better value-for-money across the system. Although during

the economic crisis the health service managed an overall increase in its activities with a smaller budget, to meet future health needs on a more sustainable basis a much more effective and modern operating model will be required.

Investing resources where they can make the greatest impact

6. As the Irish economy recovers, Government may have some resources to commit to enhancing the provision of health services. It is vital that any such investment deliver clear health benefits, but also that such resources are directed in a strategic manner to facilitate deep impact reform in line with modern models of care, and ensure long-term sustainability given growing demographic pressures.

Irish People are living longer

7. Between 2003 and 2013, life expectancy in Ireland for males increased from 75.7 years to 79 years and for females from 80.7 to 83.1 years. The proportionate gains in life expectancy in Ireland over the period were the fourth highest of the 34 OECD member countries. This is the welcome result of many factors including advances in health technology and health services. Age standardised death rates from circulatory diseases have been reduced by 50% between 2000 and 2014. For diseases of the circulatory system rates of mortality are some 9% below the EU average (2012 data from Eurostat). Cancer death rates (excluding cancer of the trachea, bronchus and lung) fell by 15% from 2000 to 2014, while death rates for respiratory disease (including cancer of the trachea, bronchus and lung) fell by 45% over the same time period.

Which brings with it new healthcare needs

8. Longer life expectancy is a welcome development, since it signifies that Irish people are living longer, healthier lives, with health services making an important contribution to this achievement. It also, however, brings challenges. Population ageing is no longer a future eventuality – it is a present day reality that is being felt on the front-line of our health services. The number of people over 85 years in Ireland is currently increasing by approximately 3.3% each year, according to CSO estimates. The effect of ageing on health services is complex, particularly since, for many people, it implies living longer and continuing to enjoy good health. Inevitably, however, an ageing population brings with it additional care requirements, particularly in respect of managing chronic disease, the health needs of those who survive major illness such as cancer and the health and social care needs of the frail elderly.

9. Approximately 38% of Irish people over 50 years have one chronic disease, i.e. conditions which are not acquired from someone else, and which are of long duration and 11% have more than one. Chronic disease accounts for 80% of all GP visits, 40% of hospital admissions, and 75% of hospital bed days. As the number of older people increases, this burden of chronic disease will also increase. The very elderly (over 85 years) often have multiple and particularly complex health and social care needs.

10. The problems being experienced in Emergency Departments and in respect of hospital waiting lists are the result of many factors, but in several respects they can be traced back to

an out-dated model of care, struggling to cope with new types and levels of demand. Attempting to address these rising needs based on out-dated models and assumptions will not achieve an acceptable health service for the Irish people. Our present system has largely been built up to provide episodic treatment, often for discrete once-off needs. Today, however, some three-quarters of health service activity relates to dealing with chronic disease, sometimes multiple chronic diseases – illnesses which of their nature are ongoing and therefore require ongoing care and substantial coordination.

Changing the Model of Healthcare

11. To maintain health and well-being and build a better health service we need to change some of the operating assumptions on which health policy and health services were traditionally based. This is already happening in some respects, but the change needs to be accelerated and implemented both systematically and system-wide. Change should be based upon a set of agreed principles, such as:

    - Our aim is to enhance health and well-being, not just to provide services. Prevention is therefore a vital part of any strategy
    - When people become ill, their illness should be managed at the lowest possible level of complexity, starting with self-management
    - The vast majority of health-care needs should be addressed by a comprehensive range of primary care services
    - More integration of care is needed and this should be supported by the assignment to primary care of an explicit coordination and case management role for all but the most complex of cases
    - Patient safety and greater choice and voice for service users in their dealings with the health service should underpin planning and delivery of all services.

12. The diseases which are currently dictating health service usage are preventable through addressing risk factors and health behaviours. The reverse is also the case – if we are not more successful in preventing disease, even the most efficient health services will be overwhelmed. The emphasis in developing preventative approaches must be based on population health needs. This starts at the national level, through continued support for the Healthy Ireland programme, but must make its way into communities, particularly those with the most serious health challenges. Significant progress has been made in recent years in promoting population health, with very important measures taken and progress made in the area of tobacco control. New measures are also being introduced to limit harm from alcohol, a new National Drugs Strategy is being developed, and a major strategy on obesity is close to completion. This work must be continued and developed, while emerging threats such as antimicrobial resistance must also be addressed. The sharp social gradient in life expectancy and health status requires a strong focus on the social determinants of health and targeting of specific risk factors and barriers to healthy living which are more prevalent amongst poorer sections of the population and communities.

13. We have to do more to maintain health and well-being, but we also have to be better at managing disease. Chronic disease is ongoing and continuous, so care models also need to be continuous, reliable and capable of addressing and responding to the many and sometimes complex needs of patients. Disease management should be located at the lowest possible level of complexity, starting with the patient themselves. The vast majority of health care needs should be addressed in primary care with a strong focus on keeping patients well,

active management of patients' needs and the minimum possible level of admission to acute hospitals. Patients' needs have to be met by a range of professionals, whose work requires co-ordination and integration. This range of professionals extends well beyond the traditional demarcation of primary care to include those in acute hospital and social care services. Thus a core requirement is to equip primary care with an enhanced capacity to partner with patients and clients in seeking to ensure that all care, wherever it is delivered, is integrated and tailored to their needs.

Developing Comprehensive Primary Care

14. Primary care is where the vast majority of healthcare needs can be addressed at the most appropriate level of complexity and at least cost. There are important existing strengths in our current primary care services including overall standards of professional training and competency, the gate keeper role which provides the opportunity to coordinate care and reduce unnecessary specialisation and same-day or ready access to key professionals such as GPs. Primary care in Ireland, however, is fragmented and insufficiently developed to meet growing needs in an equitable manner. It is provided on a number of platforms and through a variety of contractual means. Some progress has been made in recent years, but the experience of implementing the previous primary care strategy points to significant challenges in this area. Nonetheless, augmenting primary care services is central to any successful strategy to address healthcare needs and promote population health.

15. The development of primary care in recent years has seen investment in the employment of additional primary care professionals, enhanced facilities including primary care centres and the development of new services such as community intervention teams to assist in the management of patients at home. The introduction in 2015 of universal GP services for those under 6 years and those over 70 years also allows for a whole-of-population approach to the health needs of these priority groups. The arrangements for under 6s includes preventative health checks at age two and age five which are focused on health and wellbeing and disease prevention. It also includes improved management of asthma including maintaining a register of patients aged under 6 years with asthma and providing services in accordance with an agreed cycle of asthma care. In 2015 a new cycle of care was also introduced for the management of diabetes amongst all adults with GMS eligibility.

16. Developing primary care requires enhanced deployment of staff, ICT and other resources, including GPs and community pharmacists, who are independent contractors, and HSE staff working for Community Health Organisations. Detailed planning is required to deploy these resources across different platforms in an effective and cost efficient manner. The re-negotiation of the GP contract and the development of Community Health Organisations present important opportunities to make progress in this area. Issues to be addressed in the development of a new GP contract will include strengthening of the management of chronic illness and the incorporation of supports for GPs working in areas of high need (e.g. rural areas and areas of high socio-economic deprivation), including the incorporation of the revised proposals for the Rural Practice Allowance recently developed with the Irish Medical Organisation. Overall significant work is required to achieve much greater agreement and support within primary care and beyond for a new approach to the delivery of more comprehensive primary care services.

Role of Acute Hospitals

17. Historically in Ireland, the acute hospital system has evolved in a manner that is insufficiently based on population health needs and too provider-driven. Ireland has a large number of small (by international standards) hospitals, which, until recently, have operated almost entirely independently. Traditionally, the main driver of service development has been hospitals responding in a piecemeal fashion to perceived local and regional needs. The inevitable result has been a historical pattern of service gaps, geographic inequities, inefficiencies, duplication, quality issues and a system pre-occupied with institutional or workforce concerns, rather than planning and prioritisation of services around population health needs. Some improvements have been achieved in recent years, including through nationally led programmes such as the cancer strategy.

18. However, between hospitals and primary care there needs to be much stronger linkage and genuine integration. The recently published Maternity Strategy, for example, proposes the development of a community midwifery service which will be provided by hospital midwives operating in the community as part of an integrated maternity service. This is one example of an approach to integration which could be replicated across the system. Developments such as these can support more locally accessible and responsive care but with the quality assurance required to sustain ongoing service delivery and skills of the requisite standard.

19. Further planning and realignment of services between acute hospitals is also required. The services provided across acute hospitals need to re-configure so that the majority of patients, who require only a routine, straightforward level of urgent or planned care, are safely managed locally and the minority of patients, who require major emergency or more complex planned care, are treated safely in acute regional or national centres where all the relevant specialist clinical expertise is available. For reasons of volume, safety and quality, some specialist services need to be planned and organised based upon a large population base and in line with strategic guidance provided at national level. The new system of Hospital Groups provides a basis for re-configuration of services to deliver an integrated hospital network of acute care in each geographic area. It is envisaged that this reform process will progress in a phased manner, providing for devolved decision making, fostering flexibility, innovation and local responsiveness, while also ensuring adherence to prescribed national service objectives and standards.

20. Within each Hospital Group there is significant further scope to improve the appropriateness of bed occupancy, reduce average length of stay, shift care from in-patient to ambulatory and day case treatment and promote more efficient patient flow, including better integration with community services. The further introduction of Activity Based Funding, whereby hospitals budgets are tied to productivity, is intended to add a strong on-going incentive to achieve further improvements. The 10 per cent reduction in average length of stay which was achieved between 2008 and 2014 equates to approximately 1,000 acute beds in terms of bed days freed up. Looking at appropriate bed usage we know, for example, that there is scope to reduce admissions for chronic illnesses such as chronic obstructive pulmonary disease (COPD). Rates of admission and length of hospital stay for patients with COPD in Ireland are considerably higher than other countries, such as the UK, where significant reductions have been achieved in recent years. Current admissions to Irish public hospitals for COPD entail an acute hospital bed requirement of approximately 300 beds annually. Therefore, as illustrated by this example, more appropriate care pathways which reduce hospital admission could potentially free up significant bed numbers.

21. Some hospitals consistently experience difficulties in balancing emergency and elective workloads. This is leading to Emergency Department delays on the one hand and cancellations and inefficient deployment of personnel and facilities on the other. Improved operational management and clinical practices can contribute significantly, as evidenced by significant performance improvements achieved in a number of hospitals. However, it seems likely that in some cases a more thorough redesign of staffing and capacity may need to be considered in order to achieve a greater separation between urgent and non-urgent (scheduled) care. At present, competition for resources between urgent and non-urgent care is undermining the output and rate of throughput of the system as a whole. Scheduled care cancellations result in inefficient service provision and access delays add to costs as, by the time they get admitted, patients may have more complex requirements. The formation of Hospital Groups provides a platform upon which optimum service configuration can be achieved, in a manner which best meets the needs of local communities and patient safety requirements. This is likely to see greater role clarity between hospitals in respect of all aspects of unscheduled and scheduled care with larger hospitals in a group transferring appropriate services to smaller hospitals so that they can focus on meeting the access requirements for more complex care.

Developing social care and mental health services

22. Substantial progress has been made in Ireland in recent times in moving the provision of social care and mental health services out of institutions, and building up community-based services. In addition to the need to further enhance the availability of these services in response to demographic and other demands, and in particular to promote early intervention and anticipatory care, there is also an opportunity and a requirement to achieve greater connectedness between primary care and other community-based services.

23. Social care and mental health services have to be integrated into the overall model of care. The provision of primary care, social care (disabilities and older persons) and mental health services in a manner that is insufficiently connected can complicate referral and access for individuals, as they and their families have to “navigate” their way through divided administrative and professional arrangements. Many social care and mental health services have traditionally been provided in institutions. Even where services have migrated from institutions to the community they have, in many cases, maintained firm boundaries separating them from other community services. Access is by means of referral with priority determined by the specialist service (often through the operation of waiting lists) and insufficient shared care through an ongoing relationship with primary care providers.

24. The move away from institutions to more inclusive participation in communities also provides the basis upon which to provide people with more choice and voice in respect of the supports they wish to receive. New funding models and more comprehensive regulatory systems have a role in supporting people with a greater range of service options and information. For example, the eligibility and financing arrangements under the Nursing Home Subvention Scheme and the public reporting by HIQA on residential care inspections provide older people and their families with more choice and information in respect of nursing home care. Building upon this experience there is a need to develop greater clarity as to the public funding supports and regulatory oversight of service provision for those with long term care needs who wish to remain in their own homes.

25. It is also essential that the planning and delivery of these services is integrated within a wider range of supports provided by other sectors. This includes housing, education, employment and training, transport and planning of the built environment since these are essential supports for more independent and inclusive models for older people or those with disabilities or mental health needs. For example, some innovative models of housing for older people show the potential to promote independent living and reduce social isolation for older people. However, currently such models are insufficiently developed in Ireland and there is an opportunity to promote the wider availability of such models.

System- wide thinking and reform is also required

26. While reform is required across and between primary, social and acute care, it is also important to think on a whole-system basis, particularly about strategic enablers of reform. These include organisational structures, workforce planning, better ICT systems, improved financial models and stronger leadership and management capability. These whole-system functions are critical, and in some circumstances can be core drivers of better, more integrated and more efficient services.

Structural reform is necessary but not sufficient

27. The health service is currently embarked on a major programme of change. This includes the creation of seven Hospital Groups with approximately six to eleven hospitals in each group. At the same time nine Community Health Organisations have been introduced, in order to manage primary, community and social care services. Development of these entities is under way with chief executives in place. These will be important developments in addressing the overly centralised, command-and-control tendency which has been a feature of the HSE (understandably, perhaps, in establishing a national organisation over a period which spanned a very difficult financial environment).

28. While structural reform is needed, and it is important to progress this agenda expeditiously, it would be a mistake to believe that structural change on its own will deliver reform on the scale and of the nature required. Nor is it the case that the greater the structural change the deeper the reform since some changes in structure have proven to be primarily administrative. The cost and time associated with structural change – including through the diversion of attention from the improvement of care processes – also demand that changes in structure be carefully considered and properly implemented in line with overall reform objectives.

29. One notable feature of the current direction of travel is the fact that Hospital Groups and Community Health Organisations are not geographically aligned. This non-alignment is not ideal for the purposes of assessing population health needs and achieving integration between services and merits further consideration in advance of the next phase of implementation. There is likely to be potential to improve the geographic alignment of Hospital Groups with Community Health Organisations without undue delay to the overall reform process.

30. The existing governance structure of the HSE was devised as a temporary construct. The original HSE Board was disbanded in 2011 and in due course was replaced with a Directorate made up of senior HSE executives. This is a relatively unusual model taken from public

bodies with narrower mandates and not common in health care internationally. There is a need to consider this issue in the short term as part of an overall approach to transitioning to a system with more devolved accountability amongst a number of delivery organisations with their own distinct governance but overseen by a body which adds value and manages national responsibilities.

31. This paper goes on to deal with the above issues in more depth setting out a more detailed case for a new model of healthcare and its likely shape. A series of suggested areas for action are identified throughout the document and these are first summarised below:

Summary of Suggested Action Areas:

(i) Purposeful implementation of the *Healthy Ireland* agenda combined with further work on reducing health inequalities and addressing antimicrobial resistance.

(ii) Implement the Public Health (Alcohol) Bill, publish and implement a National Obesity Policy and consider the introduction of evidence based fiscal measures including a sugar levy. Use a portion of the revenue from increased tobacco and alcohol taxes and any new sugar levy to fund population health programmes. Publish and implement a new National Drugs Strategy.

(iii) Prioritise the development of comprehensive primary care services as the most fundamental building block of a new, more integrated model of health and social care. Seek to build consensus amongst key primary care stakeholders on the vision, operating model and approach to delivery of comprehensive primary care

(iv) Clearly define the workforce, ICT and financial requirements to deliver better primary care, and develop a clear plan for how these resources will be deployed. A key focus of this work should be how to deliver better management of chronic disease and frail elderly patients within primary care. Negotiate a revised GP contract that supports more comprehensive primary care services, chronic disease management and multi-disciplinary working.

(v) Fully implement the five integrated care programmes established by the HSE covering Chronic Disease, Older Persons, Children, Patient Flow and Maternity in a manner that moves beyond hospital-focused care pathways to build integrated models of care across all services – acute, primary care, social care and mental health services.

(vi) Accelerate the hospital reform programme through delivery of a limited number of key national strategies and reconfiguration of services at Hospital Group level. Develop strategies and implementation plans for improved patient flow, shorter lengths of stay and greater separation of scheduled and unscheduled care. Establish the new National Children's Hospital.

(vii) Implement the recommendations of the Emergency Department Task Force to realise consistent improvement in delays in Emergency Departments through hospital-wide improvement and strengthened community supports to facilitate admission avoidance or earlier discharge.

(viii) Support Hospital Groups in the strategic planning and improvement of service provision in response to population health needs and in line with national strategy, including the need to support primary care in facilitating greater integration and coordination of care.

(ix) Develop the ambulance service as a key facilitator of improved health service responsiveness, service quality and appropriate utilisation in line with expert

recommendations.

(x) Accelerate the implementation of Activity Based Funding to promote productivity and appropriate care and support Hospital Groups to implement continuous operational improvement through the sharing of learning and proven expertise.

(xi) Develop the community based model of social care, with earlier intervention and strengthened supports for those with disabilities and older people and their families and better integration with other services.

(xii) Continue to strengthen specialist community-based mental health services, while supporting primary care as central to addressing mental health needs. Implement the *Connecting for Life* national suicide reduction strategy and work closely with the Department of Education and Skills and the Department of Children and Youth Affairs to promote youth mental health.

(xiii) Consider the potential to improve the geographic alignment of Hospital Groups with Community Health Organisations in advance of the next stage of implementation. Develop an overall health service design to include national functions, such as commissioning and shared services, which will not be devolved to Hospital Groups and Community Health Organisations.

(xiv) Review the HSE Directorate governance arrangements as provided for in legislation and, based upon the potential role for national functions in the overall health service design, put in place appropriate governance arrangements

(xv) Implement the Taskforce on Staffing and Skill Mix in Nursing and the Strategic Review of Medical Training and Career Structures and complete an overall Health Workforce Planning Framework.

(xvi) Ensure a programmatic approach to the planning and management of large-scale and complex change with ambitious but realistic timelines, dedicated resourcing and clear accountability.

Population Health

Demographic change

32. The population in Ireland has grown rapidly in recent years with an 8.2% increase between 2006 and 2011, and CSO projections estimate a further 4.9% increase in the population by 2021. During the period 2010-2015, Ireland experienced net outward migration but this trend has slowed since 2013. At the same time immigration continues, mostly amongst those of working age (15-44 year age-group). It is expected that the number of refugees arriving will increase, including under EU resettlement programmes. Migrants, including refugees, have a range of health needs determined by factors such as their age, gender, ethnicity, and socio-economic circumstances. Those fleeing conflict zones may have particular health and social care needs.

33. While the population in Ireland is younger than the majority of other European countries, we are also seeing a very large increase in our older population. Projections suggest that between 2011 and 2021, the population aged 65 and over will increase by 38%. By 2046 population projections suggest that over 20% of the population will be aged 65 or over compared with less than 12% in 2011 and up to 9% of the population will be aged 80 or over compared with 2.7% in 2011.

34. Analysis published by the Department of Health has demonstrated that the projected demographic changes to the population will add approximately €200 million per annum to health service costs.

35. Overall life expectancy for both males and females continues to improve in Ireland and is now higher than the EU average for both genders. Ireland's increase in life expectancy between 2000 and 2013 was the fourth highest achieved amongst the 34 OECD member countries. Life expectancy for males is 79 years, while life expectancy for females is 83.1 years. Furthermore, life expectancy at 65 years of age has also improved (18.1 years for males, 20.8 years for females). In the 20 years between 1991 and 2011, life expectancy at 65 years of age increased substantially (by 4.4 years for males and 3.7 years for females.)

36. However, life expectancy differs across the population. According to one study, in 2006/2007 life expectancy in the most deprived areas was 4.3 years less for males and 2.7 years less for females when compared with the most affluent areas. Similarly, a 2010 study of the Irish Traveller population demonstrated a shorter life expectancy in both males (15 years less than the male population generally) and females (11½ years less than females generally) when compared with the general Irish population.

37. In 2010, over three-quarters of deaths in Ireland were due to three major conditions – cardiovascular disease (34%), cancer (30%) and respiratory disease (12%). Age standardised death rates from circulatory diseases have been reduced by 50% between 2000 and 2014. For diseases of the circulatory system rates of mortality are some 9% below the EU average (2012 data from Eurostat). Cancer death rates (excluding cancer of the trachea, bronchus and lung) fell by 15% from 2000 to 2014, while death rates for respiratory disease (including cancer of the trachea, bronchus and lung) over the same time period fell by 45%. However, inequalities are again apparent. Studies suggest that mortality rates for cardiovascular disease, cancer and respiratory disease are between 100 and 200% higher in the lowest social classes when compared with the highest.

Chronic Disease

38. While mortality from major chronic diseases has improved in recent years, the burden of chronic disease in the population is large. Studies have estimated that up to 250,000 people in Ireland are living with diagnosed cardiovascular disease and up to 440,000 suffer from chronic obstructive pulmonary disease, many of whom are undiagnosed. Approximately 30,000 new cancer cases are diagnosed every year in Ireland with a further 90,000 people living with cancer. In addition, studies estimate that 9% of the population over 45 have diabetes.

39. It is estimated that the prevalence of major chronic diseases will increase by 20% by 2020 (HSE 2014), largely driven by an ageing population and also improved survivorship. The number of people with cancer, cardiovascular disease, diabetes and respiratory disease is projected to increase by 4-5% per annum. Cancer estimates project a 70% increase in cancer cases in females and an 83% increase in cancer cases in males between 2015 and 2040.

40. The burden of chronic diseases and the lifestyle factors that contribute to them rests more heavily in the lower socioeconomic groups. Chronic diseases occur more frequently among the poor and vulnerable. Inequalities in chronic disease prevalence result in two to three-fold increases in prevalence of cardiovascular disease, diabetes and chronic respiratory disease in lower socio-economic groups when compared with higher socio-economic groups. Similarly, lung, cervical and head and neck cancers all occur at higher incidence in more deprived populations than in more affluent ones.

41. Care of chronic diseases consumes a considerable amount of health resources. In 2011, 40% of all hospitalisations in patients over 35 years (80% of total hospitalisations) related to four chronic diseases; cardiovascular disease, cancer, respiratory disease and diabetes (either as a direct reason for hospitalisation 19%, or a contributory factor 22%). Seventy-six per cent of all bed days were used, either directly (46%) or as a contributory factor (30%), by patients with the aforementioned four chronic diseases. Within the acute hospital sector, 55% (€1.68 billion) of the acute hospital budget is attributable to care of patients with these chronic conditions, admitted as a direct consequence of their illness or where the illness was a contributory factor.

42. Chronic diseases cluster in individuals. Approximately one third of men over 60 years of age have two or more chronic conditions and this trend increases with age. Chronic diseases have a lifelong course and place a significant burden on the patient, their families and carers. Eighty six per cent of deaths and 77% of disease burden are now caused by chronic disease.

Health determinants

43. Lifestyle factors including tobacco and alcohol usage, together with physical inactivity, poor diet and obesity are key risk factors, along with high blood pressure and cholesterol, for chronic disease. These risk factors are also linked with ill-health in the general population where health improvement activities are not only directed against chronic diseases but aim to promote health generally. Effective interventions are known and it is estimated that 80% of cardiovascular disease and type 2 diabetes as well as 40% of cancer could be prevented if major risk factors were eliminated. A number of critical lifestyle risk factors greatly influence the prevalence of the chronic diseases responsible for the majority of morbidity and mortality in Ireland.

44. ***Tobacco:*** In Ireland, 5,200 people die from tobacco-related illness each year mainly from cancers, respiratory and cardiovascular diseases. Thirty per cent of all cancer cases and deaths due to cancer are attributable to tobacco consumption. Ireland has made

considerable progress in reducing smoking prevalence from 29% in 2007 to 23% in 2015, with the overall aim to be a 'Tobacco free Ireland' by 2025. Of concern is the association between smoking prevalence and social deprivation. Those from lower social classes are almost twice as likely to smoke as those from the highest social classes (28% vs 15% prevalence).

45. ***Alcohol:*** The average alcohol consumption in the adult population in Ireland is 11 litres (pure alcohol per person per year). Alcohol related harm results in a considerable burden to society through illness, violence, accidents, work absences, crime and premature mortality. Alcohol consumption increases the risk of over 60 illnesses including liver disease, hypertension, certain cancers and mental health disorders. In addition, it is a contributing factor in many cases of domestic violence, public order offences, road traffic accidents and suicides. Over 75% of the Irish population drink alcohol, with almost 40% binge-drinking on a typical drinking occasion. While alcohol consumption prevalence is lower in lower social classes, patterns of harmful binge-drinking are higher in deprived areas (31% at least weekly) when compared with least deprived areas (23% at least weekly).

46. ***Obesity:*** Reducing the extent of overweight and obesity is a key public health priority. There is a real danger that the health gains in life expectancy made from addressing factors such as smoking, high blood pressure and high lipid levels will be reversed due to the rising prevalence of obesity. Recent Irish studies have demonstrated that:
    - 1 in 4 children is overweight or obese.
    - 60% of adults surveyed were either overweight or obese.
    - 52% of Irish adults aged 50 years and over are at a substantially increased risk of metabolic and cardiovascular disease based on their waist circumference.
    - Obesity levels are greater in lower social classes than in higher.

47. Obesity causes considerable health complications from premature onset diabetes in children, fertility and pregnancy-related complications in young women to chronic disease development and premature mortality in the adult population. Obesity is one of the major risk factors for, and worsens outcomes from, cardiovascular disease, diabetes and cancer. Severely obese people have a premature mortality similar to smokers and on average die eight to ten years sooner than people of normal weight. In Ireland, the cost of obesity to the state in 2009 was estimated at €1.13 billion. A 5% reduction in overweight and obesity levels will result in a €495 million reduction in direct healthcare costs attributable to obesity and overweight related morbidity over the next 20 years.

48. ***Physical activity:*** The benefits of physical activity are extensive. Not only does physical activity prevent disease, it also promotes wellbeing. Being physically active on a regular basis reduces one's risk of cardiovascular disease, diabetes and some cancers. It has also been shown to improve mental health, reducing symptoms of depression and anxiety.

49. Ireland has experienced an increase in those participating in sport in recent years (33% in 2007, 47% 2013). The Healthy Ireland Survey reported that 32% of the population are highly active. Men (40%) are more active than women (24%). Activity levels decline with age in both males and females, with those aged over 75 years taking very little exercise. Fifty-one per cent of children report exercising four or more times a week (60% boys, 40% girls). In the 15-17 years age group the rates for boys are almost twice that for girls (55% vs 28%).

50. The National Physical Activity Plan (published in 2016) aims to increase physical activity levels across the entire population by creating increased opportunities for people to be active, removing barriers to being active, enhancing cross-sectoral co-operation at national, local

and community level to encourage physical activity, encouraging supportive environments, promoting good practice and finding new models of participation which get more people active.

51. ***Sexual health:*** During the 1995-2013 period, sexually transmitted infection (STI) notifications more than tripled from 3,361 per annum to 12,753, a rise of 279%. The greatest burden of STIs is seen in those aged less than 25 years and in men who have sex with men (MSM). Chlamydia is the most common infection, especially in young people and if untreated, can result in future fertility difficulties. In 2014, 377 new cases of human immune deficiency virus (HIV) were diagnosed in Ireland, an increase of 11% on 2013 figures. MSM account for the highest number of new HIV diagnoses (49%), as has been the case since 2009.

52. Risky sexual behaviour is common in Ireland as shown in the recent Healthy Ireland Survey. 17% of those having sex outside a steady relationship did not use any contraception and 54% of MSMs did not use a condom. The three goals of Ireland's first National Sexual Health Strategy (published in 2015) are access for all to appropriate sexual health education and information; affordable and accessible, high-quality sexual health services; and the availability of good data to guide the service. Achievement of these goals should enable all members of Irish society to make positive, responsible decisions related to their sexual health and provide them with access to a comprehensive, quality sexual health service.

53. ***Antimicrobial resistance:*** Antibiotics have transformed modern health care and save lives. However using them when they are not indicated contributes to increasing resistance, reducing their effectiveness and is a waste of money. Antimicrobial resistance is one of the critical emerging public health risks for our health care system and for the global community. Rates of MRSA bloodstream infections have decreased substantially over the past decade and improvements have also been achieved with *C. difficile*. However, increased rates of resistance have been seen in other pathogens. Ireland has by far the highest proportion of vancomycin resistant enterococci (VRE) in Europe and the rate of VRE resistant infections continues to increase. Antimicrobial usage has been identified as a key component in the WHO Global Strategy of Containment of Antimicrobial Resistance and the Strategy for the Control of Antimicrobial Resistance in Ireland. The Department of Health and the Department of Agriculture, Food and the Marine are working jointly to reduce unnecessary usage of antimicrobials in the management of both human and animal health.

Inequalities

54. While improvements have been made in many health indicators in recent years, inequalities are apparent across levels of deprivation and social classes. Lifestyle risk-factors for chronic diseases are not distributed evenly throughout society. Overall, poorer people are more likely to smoke, be obese and drink alcohol in a hazardous pattern. Notably, smoking is the greatest contributor to health inequalities between the richest and poorest sections of society. Those in the lowest social classes are almost twice as likely to smoke compared with those in the highest social classes. In addition, those in lower social classes are much more likely to be obese than those in higher social classes. Populations in more deprived areas are less likely to cook/eat using fresh ingredients most of the time, less likely to consume daily fruit and vegetables, less likely to eat breakfast and more likely to consume daily sugar-sweetened drinks than those in the most affluent areas.

55. As reported earlier, studies have shown that life expectancy in deprived areas is significantly less when compared with the most affluent areas with similar, but even greater gaps, being

found between Travellers and the general Irish population. Chronic disease mortality is also considerably higher in lower social classes, with studies suggesting that mortality rates for cardiovascular disease, cancer and respiratory disease are between 100 and 200% higher in the lowest social classes when compared with the highest. Certain groups experience particularly acute health inequalities. These include marginalised groups such as Travellers and Roma, refugees and asylum-seekers, people who are homeless and those affected by addiction issues. Social inclusion measures will continue to be a priority to ensure equity of access to health services for these groups.

56. Gender–based inequalities also exist. Young females are more likely to smoke cigarettes and to exercise less than their male counterparts. However, young males are more likely to drink sugar sweetened drinks than their female counterparts and males of all ages were more likely to binge drink than females.

57. In recent years, considerable improvement has been made to the health of the population of Ireland. Life expectancy has increased and mortality rates from cancer, respiratory disease and cardiovascular disease have decreased substantially. Very considerable progress is being made on improving the health and wellbeing of our population through a range of major, recent, evidence-based Government policy initiatives in line with the Government's overall framework to improve health and wellbeing, *Healthy Ireland*. Against this background some clear priorities relating to population need exist for the coming five years which should inform the priorities for Government, the Minister for Health and the work programme for the health sector.

Suggested Action Areas – Population Health

(i) Purposeful implementation of the *Healthy Ireland* agenda combined with further work on reducing health inequalities, reducing tobacco consumption and substance misuse, promoting physical activity and sexual health, and preventing suicide.

(ii) Develop a new national programme to comprehensively deal with anti-microbial resistance as a major threat to current and future health and well-being.

(iii) Implement the Public Health (Alcohol) Bill 2015 including minimum unit pricing to tackle cheap, high alcohol content products and strengthen advertising and sponsorship restrictions.

(iv) Publish and implement a National Obesity Policy and consider the introduction of evidence based fiscal measures including a sugar levy.

(v) Publish and implement a new National Drugs Strategy.

(vi) Use a portion of the revenue from increased tobacco and alcohol taxes and the new sugar levy to fund population health programmes.

(vii) Tackle the growing burden of chronic disease through a new model of care that focuses on prevention, health promotion and structured care for those with chronic conditions.

Comprehensive and Integrated Care

Overview

58. The landscape of healthcare in Ireland is changing. Changes in our population profile, advances in health technology and improvements in healthcare services, mean that we are living longer, but with a rising burden of disease and the requirement to provide care to more elderly citizens. We need to do more to prevent disease, but since treating chronic disease accounts for such a large share of current and future health service activity, improving outcomes for all patients requires new strategies to address this need. In this section, we outline ways in which a new model of care can be developed which is both integrated, on the one hand, and which reduces the demands on acute hospitals on the other.

59. Chronic disease, of its nature, is continuous and long-lasting. It can also be complex, in the sense that patients suffering from chronic disease may have multiple conditions or needs. Patients may have more than one illness (comorbidity), and those with physical conditions, for example, may also have mental health vulnerabilities. While healthcare staff can treat illness, the consequences of an illness may need to be addressed by a range of other professionals and services, including social care. Just as chronic disease is continuous and complex, so must be our response to it. We need to develop systems which are able to manage patients with multiple needs on an ongoing basis. The same is true of frail elderly patients who also have complex and ongoing needs.

60. Across the world, this is a major challenge for healthcare systems, which have traditionally been developed to provide care that is essentially episodic in nature. Episodic care lends itself to specialisation, but greater specialisation makes it harder to integrate and manage the totality of the patient's needs. Specialist care may also be expensive. As a result, many healthcare systems are looking for ways to complement high-tech, episodic, specialist care, with a greater focus on managing patients' needs at the lowest possible level of complexity on a continuous and integrated basis, starting with the patient themselves. A core focus of these approaches is to do more to keep patients well, thereby reducing the need for acute services in the first instance. One recent evidence review (McKinsey), found that, on average, integrated and managed care can reduce the need for hospital admissions by 19%.

61. In health service terms, this means moving from a traditional approach which focused on providing the best possible episodic care, to one which integrates care across providers. It means shifting activity from acute hospitals to primary care, thereby reducing the need for hospital admissions, but also ensuring far greater integration within primary care and between primary care, hospitals and social care. Services need to be joined up across acute, primary and social care, so that the individual needs of patients are managed in a more integrated manner.

The Role for Comprehensive Primary Care

62. In Ireland, as in many developed heath care systems, integration of services is hampered by the fragmented organisation and supply of health and social services. A strong system of primary care is needed to overcome these challenges. Primary care can and should be the setting in which people are managed and treated in an integrated way, with multidisciplinary teams and networks capable of providing comprehensive care. Of course not all or even the majority of people will require such an approach, but the more complex a person's needs, the more they stand to benefit from a joined-up approach to the provision of care. The focus of chronic disease management is on health promotion, prevention, early identification, simple and early interventions, patient empowerment, care in the community and on preventing

acute episodes from occurring. Therefore, a central plank of policy should be the frontloading of efforts to deliver more and better management of chronic disease within primary care, integrated with acute hospital services and social care.

63. Countries with a strong primary care sector have demonstrably better health outcomes, greater equity, lower mortality rates and lower overall costs of healthcare. Primary care includes a range of services designed to keep people well, from promotion of health and screening for diseases to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is accessible by self-referral and with a strong emphasis on working with communities and individuals to improve their health and wellbeing. Primary care encompasses services which in the HSE may be arranged or delivered by non-primary care parts of the service, e.g. home care supports. Primary care should be the first point of contact that people have with the health system. Most care needs are basic and non-complex and can and should be met from primary care. They do not need hospitals or specialised community-based services. Ninety to 95% of all health and personal social service needs can be met in this way.

64. Primary care is much broader than general practice alone, although an integrated partnership approach involving GPs is a key element. Primary care teams should be the principal organisational unit of the service and provide the basic non-specialist care that patients need, whether this is for GP services, psychological services, social work, public health/community nursing services, physiotherapy, occupational therapy and other diagnostic, treatment and rehabilitation services. Part of the motivation for setting up primary care teams is to find ways to encourage people to work together who have different employment relationships e.g. directly employed HSE staff and GPs who are independent contractors. Ideally, all the professionals in a primary care team should provide care to the same population (although this is not always possible). This facilitates the targeted care of patients, promotion of health and wellbeing and measurement of outcomes on a population basis. Formal enrolment with a team facilitates this and is more likely to promote continuity of involvement with the same team over an extended period.

65. A wider primary care network can provide services which are also generalist in nature but the requirement for which does not demand that they be present in each individual primary care team. These professionals include speech and language therapists, community pharmacists, dieticians and psychologists. Patients should be referred to specialised services with a care groups focus (e.g. mental health, disability, etc.) only when their needs for care are either sufficiently complex or chronic that they need such specialised care.

66. A system of true multidisciplinary primary care will require professionals to work in teams, to report across professional boundaries and to practise with an appropriate degree of autonomy. Hierarchical "silo" reporting within individual professional groups acts as a barrier to the establishment of strong linkages across professional boundaries and to care being centred on patients' needs. Primary care services also need to be subject to appropriate leadership, governance, quality and safety standards and performance measurement.

67. Primary care is provided through a combination of GPs (and other professionals) acting as independent contractors, and clinical and other staff who are employed directly by the HSE. Part of the challenge in delivering integrated care is to develop a financial model which ensures that the payment system for GPs and other professionals both incentivises and resources continuous and managed care.

68. The original primary care strategy (*Primary Care: A New Direction*) was published in 2001. Much of its thinking remains valid and is in line with reform initiatives successfully undertaken in the intervening period in a number of other countries. The experience of implementing the Primary Care Strategy points to significant challenges. There has been investment in the employment of additional primary care professionals, the formation of primary care teams and provision of enhanced facilities including primary care centres. Nevertheless it has not proven possible generally to introduce the full level of primary care-based staff and achieving a high level of team-working across diverse professionals with different employment/contractual relationships, priorities and approaches has proven to be challenging in practice. Nonetheless, augmenting primary care services is central to any successful strategy to address healthcare needs and promote population health. Doing so in an effective manner will require broad support amongst primary care stakeholders for an updated vision, day-to-day operating model and approach to implementation over a multi annual period.

69. A number of more recent developments have also taken place. In 2015 GP care without fees was successfully introduced for children under the age of six years and all people aged 70 years and over. Some 220,000 children under six and 50,000 seniors aged 70 or more registered for GP care without fees. The under six programme includes health checks and also a new cycle of asthma care for which 20,000 children have been signed up. Over 60,000 adults with type 2 diabetes have been recruited for a new programme to improve the management of diabetes in primary care. These priority developments took place in advance of the planned renegotiation of the overall GP contract. In addition, there has been investment in improving access to diagnostics and the delivery of minor surgery in primary care.

70. Substantial improvements in patient care have been achieved in some areas in recent years through the National Clinical Programmes. There have been notable successes in some areas including the treatment of heart attack and stroke. These programmes, however, tend to be focused on discrete illnesses or areas of specialisation and have generally focused primarily on improvement in the delivery of hospital services. In order to introduce more comprehensive change the HSE has now established five integrated care programmes covering Chronic Disease, Older Persons, Children, Patient Flow and Maternity. These programmes are, however, still in their infancy. A critical priority should be to move beyond hospital-focused care pathways to build integrated models of care across all services – acute, primary care, social care and mental health services. This should contribute to the strengthening of primary care as a mechanism for delivering integrated care, and the building of much stronger links between primary care and acute services, including through an integrated health workforce.

71. The right capital facilities are an enabler of team-working in primary care. Those teams which have been able to locate all professionals on one site, or at least a limited number of sites, have enjoyed a substantial advantage in the establishment of effective interdisciplinary working between professionals that have hitherto not worked closely together, with clear benefits to patient care. This is an important enabler of success, but not a sufficient one.

72. The greater the extent to which basic primary care services can be accessed out-of-hours, the less the reliance on hospital-based emergency services and the greater the proportion of people's care needs that can be met in the community.

73. There is a significant value in expanding access to diagnostics for primary care. It can help to avoid hospital referrals and, of course, deliver faster diagnosis for patients and doctors alike.

It is important that use of such services conform to clinical guidelines with decision support systems and review required to limit unnecessary testing, which drives up costs without improving outcomes. Diagnostics for primary care and inpatient services should not be in competition for resources or priority, as is usually the case currently. This requires dedicated resourcing and provision of diagnostic support for primary care. Direct access to a range of diagnostics is required from primary care including imaging, laboratory tests and spirometry (for COPD and asthma).

74. The benefits that can flow from ICT have particular relevance to the achievement of the goals of primary care reform, whether it is in terms of empowering patients, facilitating integration within the primary care team or linking electronically with hospitals and other specialised care providers. There is very good penetration of ICT in GP practices but insufficient access to ICT by a range of other primary care professionals. In addition, GP ICT is practice-based with insufficient integration across practices to facilitate collaboration, peer learning and comparison, decision support and epidemiological analysis. Implementation of the Individual Health Identifier will be an important means by which such datasets can be integrated and linkage between primary care and hospitals achieved.

75. The electronic generation of such information in a streamlined and efficient fashion has the potential to address existing information gaps in relation to the primary care workforce (whether employed or contracted), the health needs dealt with in primary care and the types of services delivered. Technology can also minimise reporting burdens while facilitating the tracking of outcomes. The focus on outcomes and support for this approach amongst stakeholders will be an important component of any multi annual investment strategy for primary care.

Suggested Action Areas – Primary Care

- (i) Prioritise the development of comprehensive primary care services as the most fundamental building block of a new, more integrated model of health and social care
- (ii) Seek to build consensus amongst key primary care stakeholders on the vision, operating model and approach to delivery of comprehensive primary care
- (iii) Undertake workforce planning to identify the requirements, nationally and for each primary care network, to resource this more comprehensive primary care service, and provide for an integrated health workforce. These should build on the existing evidence-based methodologies being used in, for example, the Taskforce on Staffing and Skill Mix for Nursing and the Strategic Review of Medical Training and Career structure.
- (iv) Increase funding, training places and recruitment to progressively increase staffing on a multi annual basis in line with these workforce plans
- (v) Negotiate a revised GP contract that supports more comprehensive primary care services, chronic disease management and multi-disciplinary working
- (vi) Develop community and specialist nursing and midwifery, dieticians, counsellors, care assistants, physiotherapists, occupational therapists and other health professionals serving local communities
- (vii) Ensure that all health professionals, and in particular specialists, support those in population based primary care in early intervention and care coordination
- (viii) Invest in providing faster and more direct access to dedicated community diagnostics based upon GP referral in line with clinical guidelines
- (ix) Promote patient engagement and the delivery of integrated primary care services through enhanced technology and facilities
- (x) Introduce an outcomes-based measurement framework to ensure the full potential of more comprehensive primary care services is realised in line with increased investment.

The Role for Acute Hospitals

76. Historically in Ireland, the acute hospital system has evolved in an unplanned, provider-driven manner. Ireland has a large number of small (by international standards) hospitals, which, until recently, have operated almost entirely independently. Traditionally, the main driver of service development has been individual hospitals responding to perceived local and regional needs. The inevitable result of this piecemeal approach has been a historical pattern of inefficiency, duplication, and a system that tends to be designed around institutional concerns, rather than planning of services around population health needs.

77. These issues have been identified in a number of studies, and important reform initiatives have been undertaken, with notable results in some areas. The overriding concern in reorganising our hospital service is ensuring that the quality and safety of care provided is of the highest standard. Best practice in hospital care has changed, with more specialisation and a focus on achieving critical mass in the treatment of less common conditions. The broad trust of existing policy involves organising hospitals into Hospital Groups, so that acute hospital services can be configured in such a way as to provide a full range of services appropriate to a region and to designate suitable roles for each type of hospital including major, general and local hospitals.

78. Some recent developments in the reform of the acute hospital sector include:
    - The period 2008 – 2014 saw significant reductions in hospital budgets and staffing, but with continued increase in hospital output. Expenditure in 2014 on acute hospital services was below 2008 levels but a significant increase was achieved in the volume and complexity of activity. Efficiency has improved significantly as is evident from major reductions in unit costs. A 10 per cent reduction in average length of stay was achieved between 2008 and 2014 contributing, in terms of bed days freed up, the equivalent of approximately 1,000 acute beds.
    - The development of enhanced pre-hospital care including through fleet investment, training and upskilling, the centralisation of all regional control and dispatch functions outside Dublin within the single National Ambulance Service control system and the establishment of a permanent Emergency Aeromedical Service.
    - Introduction of over thirty National Clinical Programmes which are clinically-led and aim to improve patient care through the development of standardised models of care and clinical guidelines. For example, in stroke care this has resulted in the saving of additional lives and prevention of disability every day. Our thrombolysis rates are now amongst the best in Europe. Acute Medical Assessment Units have been introduced providing for more effective management of medical admissions.
    - Initiation of a programme of development of paediatric services based upon a new National Model of Care for Paediatrics and Neonatology and planning for a New Children's Hospital at the St.James's campus with satelite centres in Tallght and Blanchardstown.
    - Publication of Ireland's first National Maternity Strategy providing for decision in principle to relocate all stand-alone maternity hospitals to acute hospital campuses and introduce a new model of care based upon networked services across hospitals and community which are woman centred and provide integrated, team based care, with women seeing the most appropriate professional based on their needs.
    - Following review by the National Clinical Programme for Acute Coronary Syndrome it was decided to consolidate the specialist service 24/7 PPCI services in Dublin into 2 centres in 2015, -at the Mater and St James's. The rationale for two 24/7 centres for the delivery of PPCI in the greater Dublin area is in line with the

international experience that centres with a larger critical mass of trained operators, working within a 24/7 team, are less dependent on individual personnel and more robust.
- The development of north/south linkages including in respect of an all-island paediatric congenital cardiac service and access by patients from Donegal to radiotherapy and cardiac intervention services at Altnagelvin Hospital, Derry.

79. Further planned development includes:
    - Implementing the recommendations of the Emergency Department Task Force to resolve critical patient delays in Emergency Departments. A high level group, jointly chaired by the Director General of the HSE and the General Secretary of the INMO, is in place to drive this process.
    - National strategic direction on the future organisation of national specialist and supra regional services. A national policy on trauma services is currently under development reflecting the international evidence of the benefits of major trauma networks.
    - Further development of Hospital Groups, including required governance and management arrangements, to provide robust corporate and clinical governance to ensure clear accountability with regard to strategy, quality, access and financial performance.
    - Development of strategic plans by each Hospital Group based upon needs assessment for the population served and the aplication of the findings of the national clinical care programmes in relation to the organisation of emergency services, critical care, acute medicine and surgery.
    - Larger hospitals in the Group transferring relevant services to the smaller hospitals to promote local accessibility and so that larger hospitals can focus on meeting the access requirements for more complex care.
    - Deployment and rotation of staff resources across each Group so as to support smaller hospitals within each Group to recruit high quality clinical staff and provide appropriate education and training.
    - Implementation of Phase I of the Taskforce on Staffing and Skill Mix for Nursing to determine the optimum nurse staffing resource across general and specialist in-patient acute hospital care settings.
    - Enhancing the scope to meet patient needs on an ambulatory basis in association with primary care, reducing the necessity for inpatient admission.
    - Publication of a new National Cancer Strategy which will build on progress made under the 1996 Strategy, address the projected doubling of cancer incidence to 2040 and focus on key areas incuding prevention, survivorship, new technology and treatment, workforce and quality
    - Utilise the five Integrated Care Programmes to achieve large scale transformation in patient pathways and greater emphasis on strenthening integration between primary and acute care.

80. Notwithstanding the above current and planned developments, access delays for both emergency care and elective treatment have persisted at a level which poses formidable difficulties for how patients experience the health service and the reputation which our health service enjoys amongst the general public.

81. In addressing these difficulties a major challenge is to build upon recent productivity improvements and bring consistent operational excellence to the delivery of acute hospital services across 48 hospitals. This will be an issue whatever the overall funding and staffing

constraints since growing demand will continually put the responsiveness of services to the test. While the immediate focus tends quite rightly to be on short-term indicators such as trolley waits other underlying performance issues that drive productivity must also be the subject of concerted attention. These include the appropriateness of bed occupancy in the acute sector, the average length of stay in hospital, rates of ambulatory and day case treatment and the overall responsibility to improve patient flow. This entails a commitment to operational excellence within each hospital and Hospital Group.

82. We know, for example, that there is scope to reduce admissions for chronic illnesses such as chronic obstructive pulmonary disease (COPD). There has been a modest increase in COPD admissions over the last decade in contrast to reductions achieved in other countries. At the same time length of stays for COPD are considerably higher in Irish hospitals than in some other countries such as the UK. Hospital stays for COPD in Irish hospitals entail an acute hospital bed requirement of approximately 300 beds annually. More appropriate care pathways which avoid hospital admission could potentially free up a portion of these bed numbers. There are other such examples.

83. The lack of alignment between the 24/7 needs of major actue hospitals and the traditional 5 day work patterns of staff other than nurses, midwives and doctors (eg radiographers, theatre support staff, laboratory staff) results in limited use out of hours of high tech facilities. This contributes to patient flow delays and is an inefficient use of major capital infrastructures. The alignment of incentives for consultants and the dual nature of many consultants' contracts are widely regarded as problematic. Investment in additional acute capacity may be merited in specific areas, backed up by robust needs assessment – for example, critical care bed capacity and medical and surgical assessment units. However, achieving optimum levels of hospital efficiency on a consistent basis and rebalancing the model of care towards more effective management of disease within primary care are essential. This is not just a financial issue but reflects other constraints on the expansion of acute services including the availability of specialist medical, nurse/midwife and other staffing in an environment of global constraints.

84. Many of the changes required to improve hospital access and operational efficiency have been mapped in detail by the National Clinical Programmes and the Emergency Department Task Force. Significant improvements have also been realised by a number of hospitals but not with the consistency across all hospitals that is required. A number of hospitals have undertaken significant improvement processes utilising operational management techniques. The Irish Hospital Redesign Programme has been launched in pilot sites and this programme of work is being taken forward nationally by the HSE's Integrated Care Programme on Patient Flow. In addition to the experience now available within the Irish health care system, further significant operational improvement expertise can be accessed through academic partners. Ireland is also home to companies with a world class reputation in this area – for example, three out of six worldwide winners of the Shingo prize for operational excellence over the last two years were the Irish plants of global medical device companies.

85. The further introduction of Activity Based Funding, whereby hospitals budgets are tied to productivity, is expected to add a strong ongoing incentive to achieve further operational improvement. A relatively small portion of each hospital's budget was this year determined based upon measurement of efficiency but it is intended that this will grow significantly as Activity Based Funding is phased in. A period of adjustment is necessary to refine information and allow hospitals to respond through tackling inefficiencies but it is important

for service responsiveness and productivity that momentum is maintained and performance incentives strengthened.

86. Achieving better performance in the acute sector will also depend on achieving a greater separation between urgent and non-urgent (scheduled) care. At present, competition for resources between urgent and non-urgent care is undermining the output and rate of throughput of the system as a whole. Scheduled care cancellations result in inefficient use of scarce resources and access delays add to costs as patients may have more complex requirements by the time they get access. It should be possible to secure better separation of scheduled and unscheduled care within either the wider provider network or within a particular hospital.

87. In major urban areas with multiple general hospitals one potential approach would be to divide hospitals into those whose primary focus should be emergency care and those with a focus on scheduled care, including ambulatory and day services. In hospitals which provide emergency care a far greater share of beds would be devoted to the needs of emergency patients. With greater separation of emergency and elective workloads there would be much less disruption of elective activities in the face of emergency demand pressures. At present, each competes for resources in a way which undermines the system as a whole. In areas with lower population bases served by one hospital, both emergency and elective workloads would need to be undertaken but with much greater physical and resource separation. The precise formula to guide decision making, including investment and capacity planning, and restore balance over time should be determined through the process of agreeing strategic plans for each Hospital Group.

Suggested Action Areas – Acute Hospitals

(i) Implementation of the recommendations of the Emergency Department Task Force to realise consistent improvement in delays in Emergency Departments through hospital-wide improvement and strengthened community supports to facilitate admission avoidance or earlier discharge.

(ii) Implementation of national strategies, including cancer, maternity services, a national model of care for paediatrics and neonatology and trauma services.

(iii) Establish the New Children's Hospital through the merger of the three Dublin paediatric hospitals and the construction, subject to planning, of a new hospital on the St. James's campus with satellite centres at Tallaght and Blanchardstown.

(iv) Support Hospital Groups in the strategic planning and improvement of service provision in response to population health needs and in line with national strategy, including the need to support primary care in facilitating greater integration and coordination of care.

(v) Develop the ambulance service as a key facilitator of improved health service responsiveness, service quality and appropriate utilisation in line with expert recommendations.

(vi) Accelerate the implementation of Activity Based Funding to promote productivity and appropriate care and support Hospital Groups to implement continuous operational improvement through the sharing of learning and proven expertise.

Social Care – Supporting Individuals to live independent lives

88. Social care services are provided to older people and people with disabilities. Similar type services are provided to many people with mental health issues. Demographic demands (in relation both young and old) and other factors mean there is a need to enhance the availability of these services. In addition, policy changes already commenced for the modernisation of these services require significant further implementation.

89. Policy in the social care area is increasingly informed by the desired shift in emphasis towards the development of a community-based response, independent living and access to mainstream services supported by recourse to specialist services where required. This policy shift is also increasingly being framed within the broader health and wellness approach in society, and the focus on prevention and community-level care within the health service generally. The preventive and health and wellbeing approaches are informed by the shift internationally from a medical model of health and social care, towards an emphasis on autonomy and equal citizenship.

90. The objective of a more integrated model of care across health and social care is to build services around the needs of individuals so that a single pathway of care which takes account of individual preferences is provided. Services should be provided at the lowest level of complexity and on a personalised basis so that individuals can continue to live independently in their own community for as long as possible. This requires an early intervention approach so that loss of independence is avoided and problems anticipated. This model seeks to:
    - Support older people to live in dignity and independence in their homes and communities for as long as possible;
    - Support people with disabilities so that they can participate in society and lead fulfilled lives based upon inclusion and self-determination;
    - Provide services to people with mental health issues at the lowest level of complexity, with the emphasis on rehabilitation and recovery at community level.

91. In respect of services for older people's services, improving the provision and integration of care also has implications for the effectiveness of other services, particularly the acute sector. The availability of home care, respite care, rehabilitation, and the services provided by day hospitals, helps to reduce the number of avoidable hospital admissions, and also contributes to reduction in the average length of stay, which is desirable from both a health and cost-effectiveness perspective.

92. This approach is consistent with the concept of mainstreaming for people with disabilities and those with mental health difficulties, which has been accepted as national policy since the Commission on the Status of People with Disabilities in 1997. While specifically used in relation to people with disabilities, the concept is generally accepted as a guiding principle in the development of policy across social care. Mainstreaming means that, as far as possible, people should be supported to access the same public services as other citizens e.g. health, transport, education, etc. Within the health sector, it means that people with disabilities and mental health issues should have access to the same health services as others with additional supports as required. Services for older people are also organised around the same principle, although reflecting their more specific, longer-term care needs.

93. The distinction between health care and social care is in fact abstract since people generally require both health and social care, often at the same time. Over half of acute hospital bed days are utilised by people over 65 years and this proportion is growing. In-patient mental health services are provided in acute hospitals and many mental health problems can be

appropriately managed in primary care. The manner in which our services are currently organised does not always assist in managing the complex needs of individuals. Provision of social care and mental health services in a manner that is insufficiently connected can complicate referral and access for individuals, as they and their families have to "navigate" their way through divided administrative and professional arrangements. Access is commonly by means of referral with priority determined by the specialist service (often through the operation of waiting lists).

94. Social Care services have also traditionally been provided in institutions. Substantial progress has been made in recent times in moving the provision of social care and mental health services out of institutions, and building up community-based services. While progress has been made in dismantling institutional approaches, in line with best practice and international trends, the process is certainly not sufficiently complete. Even with a strong community model there is a continuing necessity to achieve greater connectedness with other services. While social care services are increasingly being delivered at community level properly realising the policy of independent living requires stronger mainstreamed responses across different areas of Government policy and not just health.

95. Early intervention in health and social care refers to the provision of treatment or supports at the earliest possible stage once a health problem has been identified. It is aimed at ameliorating and supporting the individual so that their condition does not deteriorate or their needs become greater due to lack of support. Effective early intervention is particularly important in regard to addressing the needs of children with disabilities. The HSE's *Progressing Disability Services for Children and Young People Aged 0-18* involves a community based model of therapeutic support for young people with disabilities and their families. Existing services are being reconfigured on a geographic basis, new staff recruited and waiting lists addressed based upon an agreed service model with a consistent approach to planning and organising based upon population need. This is a multi-annual programme which, as changes are taking place and resources allocated, seeks to achieve earlier and more effective assessment and response to the needs of children and their families. In parallel cross-Government collaboration between Children and Youth Affairs, Health and Education has seen agreement on additional supports for children with special needs to participate fully in the free pre-school year. This offers the potential to identify and begin to address developmental and behavioural issues before the commencement of primary school.

96. Disability policy is also influenced by the objective of achieving greater value and choice for service users and tax payers which was identified in the Value for Money & Policy Review (2012). The recommendations of this review are being implemented under the *Transforming Lives* programme. The *Congregated Settings Report* identified the need to decisively move disability services out of institutional settings, as has been achieved elsewhere. The development of community based services is being supported by the Health Capital Programme and housing authorities. The Department of Health and the Department of Environment, Community and Local Government jointly published the *National Housing Strategy for people with Disabilities and Mental Health Issues*, and work together on the implementation of the strategy.

97. Our current policy on mental health *A Vision for Change* (2006) is due to be reassessed by way of an international evidence and expert review of existing services. This will be followed by the development of a new policy which will add to the direction set out in *A Vision for Change*. The WHO report *Mental Health: New Understanding, New Hope* recommended that treatment for people with mental disorders should be provided in primary care as this

enables the largest number of people to get easier and faster access to services. *A Vision for Change* identified that 90 per cent of mental health problems are dealt with in primary care without referral to a specialist mental health service. This does not take from the requirement for strong specialist mental health expertise but it does require very good integration between primary care and specialist mental health services.

98. Supporting a positive attitude to mental health forms part of an overall health and wellbeing approach, as set out in *Healthy Ireland.* The new suicide reduction strategy, *Connecting for Life,* emphasises health and wellbeing and cross-sectoral working in order to address stigma and provide support to people experiencing mental health problems. *Connecting for Life* has led to youth mental health being selected as a whole-of-government priority and the subject of a joint initiative by the Departments of Health, Education and Children and Youth Affairs under the Civil Service Renewal process. The implementation of this Strategy, through a cross-governmental structure, may provide useful pointers for the development of wider mental health and social care policy generally.

99. Good progress was made in 2015 in reducing waiting times for access to specialist mental health services, in particular child and adolescent mental health (CAMHs). The initiative included a joint approach with primary care to assess the extent to which those awaiting specialist services could in fact be diverted in the first instance to counselling services in primary care. Projects such as Jigsaw, which have been successfully implemented or are planned in a number of locations around the country, also provide direct access to mental health supports for young people.

100. Specialist mental health services have been subject to development, in particular in the staffing of community based mental health teams in CAMHs, adult and psychiatry of later life services. Other areas of focus include dual diagnosis supports for those with mental health and substance misuse issues, perinatal mental health and forensic psychiatry. The later will undergo major development through the replacement of the Central Mental Hospital with a new National Forensic Mental Health Hospital at Portrane. Planning permission is in place for this development and enabling works commenced.

101. It is also important that policy and service delivery reflect human rights principles. For example, the planned re-consideration of mental health policy will be informed by the recommendations in the Review of the Mental Health Act 2001, which was completed last year and places a strong focus on individual autonomy and the best interests of the individual, with care being made available in the most appropriate environment.

102. Many people availing of social care services are quite vulnerable whether due to advanced age, an intellectual disability, mental health or physical disability. Awareness of the need for high quality, safe services has increased in regard to residential services and there is statutory regulation of residential centres for older people, people with disabilities and those with mental health difficulties. Regulation of nursing home care has been in place for some years now, whereas regulation of disability centres was introduced in late 2014. There has been a settling in period for providers and for residents and their families. Considerable investment has been approved to refurbish and replace public nursing homes over the period 2016 to 2021 to achieve compliance with national standards.

103. The challenge of regulating long term care provided in a person's home has been the subject of preliminary policy examination and, building upon comprehensive review of international

approaches which is underway, it is intended to bring forward detailed legislative proposals to address this area.

104. Generally the funding of social care providers is on a block grant basis. The exception is the Nursing Home Support Scheme where applicants are subject to clinical and financial assessment and following approval they chose their preferred nursing home. Providers, including private nursing homes, are paid an agreed rate per person under the Scheme. A Review of the Nursing Home Support Scheme was completed last year. It identified increased funding requirements based upon demographic change over the period ahead and came up with a number of administrative recommendations which are being implemented.

105. There is an opportunity to explore funding models for community services where older people or those with disabilities have on-going long term care requirements. The degree of certainty and choice provided by the Nursing Homes Support Scheme for residential care is absent in other parts of social care and, while not directly replicable, could be the subject of further examination.

106. It is also essential that the planning and delivery of social care services is integrated within a wider range of supports provided by a range of other sectors (spanning public bodies and the voluntary sector) from public funds. This includes housing, education, employment and training, transport and planning of the built environment since these are essential supports for more independent and inclusive models for older people and those with disabilities or mental health needs. The national *Positive Ageing Strategy* seeks to formulate a cross-sectoral approach to health and wellbeing and the active inclusion of older people as full citizens in communities. The objective is similar in relation to people with disabilities and those with mental health issues. Recent cross-sectoral initiatives on housing and employment for vulnerable groups in the social care area have great potential to support better integration in the community. There is further potential, for example, to promote innovative models of housing for older people which can contribute to independent living and reduce social isolation amongst older people. There is an opportunity to work with the Department of the Environment, Community and Local Government and local authorities to encourage and support such models. Overall, not just care but a range of public services should be provided at the appropriate level of complexity, consistent with mainstreaming and principles of equal citizenship.

Suggested Action Areas – Social Care

(i) Develop services in line with national policy to promote mainstream community-based models of care, with greater integration with primary care, and taking account of demographic change.

(ii) Improve access to therapeutic supports for children with disabilities based upon a consistent national approach to planning and organising services on a population basis, and appropriate investment.

(iii) Work with the Departments of Children and Youth Affairs and Education and Skills to implement support children with special needs in participating in the free pre-school year.

(iv) Implement the *Transforming Lives* Programme, incorporating the reports *New Directions: Review of HSE Adult Day Services* and *Time to Move on from Congregated Setting: A Strategy for Community Inclusion* to ensure those with disabilities are provided with individualised supports tailored to their needs.

(v) Conduct an international expert review of the implementation of the *Vision for Change* mental health policy and develop a new successor policy.
(vi) Implement the *Connecting for Life* national suicide reduction strategy and work closely with the Department of Education and Skills and the Department of Children and Youth Affairs to promote youth mental health.
(vii) Continue the development of mental health service based upon multi-disciplinary community-based mental health teams working closely with primary care services.
(viii) Complete the new National Forensic Mental Health Hospital at Portrane allowing for the relocation of services from the Central Mental Hospital.
(ix) Implement the recommendations of the Review of the Mental Health Act 2001, starting with the publication of a General Scheme and Heads of Bill by end 2016.
(x) Complete the registration of public nursing homes and disability centres based upon revised standards and timetables.
(xi) Review international approaches to the financing and regulation of short-term and long-term home care with a view to considering policy proposals.
(xii) Work with other sectors to promote community-based supports for independent living including innovative housing options.

Organisational and Other Supporting Reforms

Organisational Reforms

107. The HSE is currently embarked on a major structural reform programme, including the creation of Hospital Groups and Community Health Organisations. This process, which has already significantly progressed, presents a number of important strategic issues.

108. Hospital Groups have their origins in the expert group chaired by Professor John Higgins which completed the report "*The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts"* (known as The Report on Hospital Groups). This report was published in 2013 alongside *The Framework for Development – Securing the Future of Smaller Hospitals*. Both reports were approved by Government.

109. The Report on Hospital Groups recommended the establishment of six Hospital Groups as follows: Dublin North East; Dublin Midlands; Dublin East; South/South West; West/North West and Midwest. The Report also recommended the establishment of a Children's Hospital Group covering the acute paediatric services in Dublin. Each Hospital Group comprises between six and eleven hospitals and includes at least one major teaching hospital. Group CEOs are in place with filling of management teams advanced, although not complete in all cases. Chairs of Hospital Group interim Boards were identified but only two Groups (Midwest and West/North West) were provided with Boards and the term of office of these two Boards is coming to an end. There is a need to finalise decisions on these matters and provide interim Boards with a clear mandate consistent with the developmental and legislative process required to achieve distinct operational and legal entities and the need in the interim to fully comply with current statutes.

110. In 2013, at the same time as the launch of The Report on Hospital Groups, the HSE initiated a review of the organisation of community based services. This was necessary to address the questions raised for the HSE's existing geographic management arrangements whereby hospitals and community services were organised into 17 Integrated Service Areas. The review considered the number, scale and geographic boundaries for the organisation of primary and community health services and the associated governance and management arrangements. The process involved wide consultation with health service staff and representative groups, a review of historical arrangements for the delivery of community-based services in Ireland and a review of international experience in developing integrated care.

111. The report, *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group*, was published in October 2014 and outlined how health services, outside of acute hospitals, were to be organised and managed. The report led to the establishment of nine CHOs for the delivery of community healthcare services. Other recommendations included the development of 90 primary care networks (with approx. 10 such networks per CHO and each network covering a population of approximately 50,000 people) with better and more integrated access to specialised services in social care, mental health and health and well-being.

112. A notable feature of these reforms is that the Hospital Groups and CHOs do not geographically align. This non-alignment is not ideal for the purposes of assessing population health needs and achieving integration between services and merits further consideration in advance of the next phase of implementation. There is likely to be potential

to improve the geographic alignment of Hospital Groups with Community Health Organisations without undue delay to the overall reform process.

113. The development of the new structures also raises questions about the long-term future of what remains of the HSE. Or, put another way, what central executive agency will be required once the Hospital Groups and CHOs are fully functional and what will be its role and functions? A number of models are possible, depending on the level of autonomy that is envisaged for the new entities, and the accountability mechanisms that are deemed to be desirable. It seems likely that, at a minimum, there will be a continuing requirement for a central agency with a strong commissioning function and strategic 'back-office' functions, but there are many issues of detail that require to be worked through.

114. The existing governance structure of the HSE was devised as a temporary construct for an interim period. The original HSE Board was disbanded in 2011 and in due course was replaced with a Directorate made up of senior HSE executives. This is a relatively unusual model taken from public bodies with narrower mandates and not proven in a health care context internationally. There is a need to consider this issue in the short term as part of an overall approach to transitioning to a system with more devolved accountability amongst a number of delivery organisations with their own distinct governance but overseen by a body which adds value and manages national responsibilities.

Value for Money and Performance Incentives

115. Public spending on health is over €13 billion and represents 24% of expenditure on public services. It is essential that the best possible value from the resources available is achieved. The largest component of health expenditure is represented by the pay costs of staff. While pay rates are set as part of public service wide pay determination processes, the level of staff and the mix of professionals is subject to decision within the overall available Health budget. In a situation of financial constraints and global shortage of particular health professionals it is important that as a country we achieve an optimum skill mix, a positive work environment to attract and retain staff and very good output from all the staff resources deployed. In recent years there has been a focus on particular professions including, for example, the MacCraith Report on Medical Training and Career Structures. This is also need to have an overall approach encompassing the diverse professions that make up the health service. Therefore, the Department of Health is overseeing the development of a Health Workforce Planning Framework in association with the HSE, the education sector and professional regulators to guide the planning of the health workforce into the future.

116. In the case of nursing, the Taskforce on Staffing and Skill Mix for Nursing has devised a framework to determine optimum nurse staffing and skill mix including amongst healthcare assistants. The framework uses evidence-based methodologies to determine the optimum nursing workforce that will reduce variation in nurse staffing levels and provide for a more stable workforce responsive to patient need. This framework is being piloted in a number of acute hospital sites this year. For the first time there will be an agreed objective and evidenced based tool to determine nursing staff levels on each ward required to deliver high quality, safe care.

117. As well as promoting the optimum skill mix amongst existing professional grades there is also an opportunity to consider the introduction of new grades from those found in other health care systems in areas such as theatre assistants and physician assistants.

118. Another significant area of spending is pharmaceuticals. The Department of Health, in conjunction with the Department of Public Expenditure and Reform and the HSE, is seeking to conclude a new agreement with the Irish Pharmaceutical Healthcare Association (IPHA) which secures competitive pricing arrangements for existing and new drugs. Other initiatives taken in recent years to achieve greater value from pharmaceutical expenditure include the introduction of generic substitution and reference pricing. Expenditure on the overall supply chain for pharmaceuticals was also reduced significantly as a result of fee reductions for community pharmacists introduced using the Financial Emergency in the Public Interest (FEMPI) Act. With public expenditure of €1.8 billion in this area it is essential the pricing is as competitive as possible while facilitating continued access to therapies with proven health benefits.

119. Under the new public spending code the Department is required to work with the HSE on the rolling value for money assessment of spending programmes. This will be a significant undertaking given the range of programmes and scale of spending in health.

120. Development of accurate measurement of costs and activity in particular areas is essential in assessing value and opens up the possibility to move away from historic budgets and reward hospitals and other providers for performance. Significant work is underway to implement Activity Based Funding in the hospital sector which would firmly tie budgets to productivity. Initiatives such as Activity Based Funding offer a means of basing budgets on objective criteria and supplying providers with an incentive to deliver the best value possible within the resources available.

121. Ireland operates a system of voluntary private health insurance, which is regulated by the state insofar as it is a community-rated market, backed up by a system of risk-equalisation. Private health insurance is an important driver of activity in the system, in a way which is often commented on, but imperfectly understood. It is widely believed, for example, that private health insurance is relevant to the incentives and working patterns of some hospital consultants. It may also be a driver of cost in the system if claims costs are not adequately controlled. At a minimum, therefore, the private health insurance system needs to be a facilitator of integrated care and value for money.

122. The use of private hospitals and other private providers is a feature of acute services (mostly related to elective waiting lists), mental health, nursing homes and home care amongst other areas. The evolution away from one hierarchical, directly managed service delivery organisation to a national body with commissioning expertise may open up the opportunity to develop the capability to better align the activities of private providers with overall population health needs and to ensure value is achieved in any such arrangements.

Information Technology

123. Information technology is an essential tool in the modernisation of health service delivery and in facilitating the connection required amongst service users, professionals and organisations to achieve integrated care. The Irish health system is starting from a modest base but has the advantage of learning from the experience of other countries, both positive and negative. A number of important elements have recently been put into place such that there is very good grounds for optimism about the contribution which ICT can make during this next phase of health reform. The Office of the Chief Information Officer and the eHealth Council are in place equipping the health service with considerable ICT leadership and expertise. An overall eHealth Strategy was published in 2014 with work underway to

develop further detail on operational priorities, timelines and costs. The Health Identifier Act has been enacted providing the legal basis for a single health identifier for every member of the public to facilitate electronic usage of their information when accessing health services. The capital budget for ICT has been increased by 38%, though at €55m annually it still lags behind industry standards. A plan for further developing the staff expertise available within the Office of the Chief Information Officer has been finalised and funding provided for its implementation in the current year.

Leadership & Management Capability

124. The health service like other parts of the public service is emerging from a period of significant curtailment of recruitment and training and development programmes. During this period many experienced leaders left through retirement or external recruitment without the opportunity for new talent to be introduced and operational pressures requiring the filling of critical vacancies through redeployment of available personnel. Health care is recognised internationally as amongst the most demanding work environments in which to lead and manage. It is made up of a very diverse and often highly qualified professional workforce but the distinct skills of leadership and management tend not to form part of the early careers of such professionals. Therefore, provision of internal development opportunities – matched to skills, experience and potential – and the introduction of new talent will be essential in expanding the pipeline of current and future health service leaders.

Change management

125. The nature of the challenge in health and the scale of reform required to measure up to public expectations are such as to make this one of the largest change management projects ever undertaken in the Irish public sector. Failure to recognise this sufficiently and to deploy the necessary programme management expertise and resources for an undertaking of this scale will lead to unfulfilled promises, loss of credibility and the risk of negative consequences for ongoing service delivery. Work is underway in the Department and the HSE to design a programme management approach to this major change agenda which is equivalent to the task. Early consideration will need to be given to Government priorities and the change implications in ensuring implementation arrangements are suitable for the task.

<u>Suggested Action Areas – Organisational and Other Reforms</u>

i. Consider the potential to improve the geographic alignment of Hospital Groups with Community Health Organisations in advance of the next stage of implementation.
ii. Develop an overall health service design to include national functions, such as commissioning and shared services, which will not be devolved to Hospital Groups and Community Health Organisations.
iii. Review the HSE Directorate governance arrangements as provided for in legislation and, based upon the potential role for national functions in the overall health service design, put in place appropriate governance arrangements
iv. Implement Phase I of the Taskforce on Staffing and Skill Mix in Nursing and commence preparatory work for Phase II in Emergency Department Settings, the Strategic Review of Medical Training and Career Structures and complete an overall Health Workforce Planning Framework.
v. Secure a competitive supply chain for pharmaceuticals used under community drugs schemes and in hospitals.
vi. Implement funding models based upon objective measurement that provide

performance incentives, in particular through the progressive introduction of Activity Based Funding for hospitals.

vii. Fully exploit the potential of ICT and the eHealth leadership capability now in place to facilitate service modernisation and integration.

viii. Take a strategic approach to the development of the leadership and management capability which the health service requires now and into the future.

ix. Implement a best practice approach to programme management of the major change process required to reform our health services to meet the challenge of improving its response to needs of the population.